AGENDA

THE MEETING OF THE

DISABILITY PROCEDURES AND SERVICES COMMITTEE
and
BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 NORTH LAKE AVENUE, SUITE 810
PASADENA, CA 91101

9:00 A.M., WEDNESDAY, OCTOBER 7, 2015 **

COMMITTEE MEMBERS:

Vivian H. Gray, Chair
William de la Garza, Vice Chair
William R. Pryor
Les Robbins
Yves Chery, Alternate

I. APPROVAL OF THE MINUTES

A. Approval of the minutes of the regular meeting of September 2, 2015

II. PUBLIC COMMENT

III. ACTION ITEMS

A. Proposed Updated Policy Statement: Hiring of Panel Physicians: Qualifications, Licensing, Certification and Insurance Requirements for Board Appointed Panel Physicians

B. Consider Application of Kenneth P. Scheffels, M.D., as LACERA Panel Physician

C. Consider Application of Thomas W. Fell, Jr., M.D., as LACERA Panel Physician

IV. FOR INFORMATION

V. GOOD OF THE ORDER

(For information purposes only)

VI. ADJOURNMENT

***The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five (5) or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.**

****Although the meeting is scheduled for 9:00 a.m., it can start anytime thereafter, depending on the length of the Board of Retirement meeting. Please be on call.**

Assistive Listening Devices are available upon request. American Sign Language (ASL) Interpreters are available with at least three (3) business days notice before the meeting date.

Any documents subject to public disclosure that relate to an agenda item for an open session of the Committee, that are distributed to members of the Committee less than 72 hours prior to the meeting, will be available for public inspection at the time they are distributed to a majority of the Committee, at LACERA's offices at 300 North Lake Avenue, suite 820, Pasadena, California during normal business hours from 9:00 a.m. to 5:00 p.m. Monday through Friday.

Persons requiring an alternative format of this agenda pursuant to Section 202 of the Americans with Disabilities Act of 1990 may request one by calling the Disability Retirement Services Division at 626-564-2419 from 7:30 a.m. to 5:00 p.m. Monday through Friday, but no later than 48 hours prior to the time the meeting is to commence.

MINUTES OF THE MEETING OF THE

DISABILITY PROCEDURES AND SERVICES COMMITTEE
and
Board of Retirement**

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

GATEWAY PLAZA - 300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

Wednesday, September 2, 2015, 11:13 A.M. – 11:22 A.M.

COMMITTEE MEMBERS

PRESENT:	Vivian H. Gray, Chair William de la Garza, Vice Chair Yves Chery, Alternate
ABSENT:	William R. Pryor Les Robbins

ALSO ATTENDING:

BOARD MEMBERS AT LARGE

David L. Muir
Ronald A. Okum
Anthony Bravo
Vito M. Campese, M.D.

STAFF, ADVISORS, PARTICIPANTS

Gregg Rademacher
Steven Rice
Vincent Lim
Eugenia Der
Allison E. Barrett
Frank Boyd
Sandra Cortez
Angie Guererro
Maria Muro
Maisha Coulter
Anna Kwan
Ricki Contreras
Tamara Caldwell
Vickie Neely
Kerri Wilson
Debbie Semnanian
Mario Garrido
Russell Lurina
Debra Martin
Marco Legaspi
Justin Stewart
Karla Sarni
Darren Huey
Shamila Freeman
Hernan Barrientos
Ricardo Salinas

ATTORNEYS
Thomas J. Wicke
Michael Treger

GUEST SPEAKER
None

The meeting was called to order by Chair Gray at 11:13 a.m.

I. APPROVAL OF THE MINUTES

A. Approval of minutes of the regular meeting of August 5, 2015

Mr. Chery made a motion, Mr. de la Garza seconded, to approve the minutes of the regular meeting of August 5, 2015. The motion passed unanimously.

II. PUBLIC COMMENT

III. ACTION ITEMS

A. Consider Application of Roger Sohn, M.D.

Mr. Chery made a motion,
Mr. de la Garza seconded, to approve to accept staff's recommendation and submit the application of Roger Sohn, M.D. to the Board of Retirement for approval to the LACERA Panel of Examining Physicians. The motion passed unanimously.

IV. FOR INFORMATION

A. Performance Review – Michael Mahdad, M.D. Board Certified Neurologist

Mr. Muir expressed concerns regarding recent medical reports submitted by Dr. Mahdad. Mr. Muir felt that Dr. Mahdad's reports did not contain much of an analysis and requested the Committee review samples of Dr. Mahdad's reports.

In an effort to protect the applicant's privacy, Mr. Boyd provided the Committee with redacted copies of Dr. Mahdad's reports containing his discussion and analysis. Mr. Boyd advised that he reviews all medical reports submitted to the Board and if he feels a report is conclusory, which he often feels Dr. Mahdad's are, he will request a supplemental report.

The Committee felt that there was not enough information contained in the redacted reports to perform a thorough review; therefore, staff was asked to prepare and submit the full reports of Dr. Mahdad to Dr. Campese for analysis. Dr. Campese was asked to review and report back to the Committee with his concerns.

V. GOOD OF THE ORDER

The committee thanked Mr. Boyd for his brief discussion on Dr. Mahdad's reports.

VI. ADJOURNMENT

With no further business to come before the Disability Procedures and Services Committee, the meeting was adjourned at 11:22 a.m.

**The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five (5) or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.

LACERA

September 29, 2015

TO: Disability Procedures and Services Committee
Vivian H. Gray, Chair
William de la Garza, Vice Chair
William R. Pryor
Les Robbins
Yves Chery, Alternate

FROM: Ricki Contreras, Manager
Disability Retirement Services Division

FOR: October 7, 2015 Disability Procedures and Services Committee Meeting

SUBJECT: Proposed Updated Policy Statement: Hiring of Panel Physicians: Qualifications, Licensing, Certification and Insurance Requirements for Board Appointed Panel Physicians

RECOMMENDATION

Disability Procedures & Services Committee approve the Proposed Updated **"Policy Statement: Hiring of Panel Physicians: Qualifications, Licensing, Certification and Insurance Requirements for Board Appointed Panel Physicians"** and submit for final adoption by the Board of Retirement

BACKGROUND

On July 1, 2015, staff informed the Committee that a LACERA Board appointed panel physician's certification had lapsed as of January 1, 2014. Staff also provided a summary of the immediate actions taken following notification of the certification lapse. The panel physician was informed that he was suspended from the panel, all pending medical appointments were canceled and members were rescheduled with other physicians, and any outstanding medical reports were completed and returned to LACERA.

DISCUSSION

Because of the certification lapse, staff began an audit of its existing policy and procedures to identify gaps in the process that may have caused us to overlook the above referenced certification lapse. Staff found that the Board's current policy did not

address ongoing certification requirements, auditing practices, or LACERA's contractual agreement with its physicians. In an effort to prevent any future oversight, staff has prepared a proposed updated policy, which includes new auditing procedures.

Update Existing Policy

The Board of Retirement's existing policy is limited and simply states that LACERA will hire only board certified[1] physicians to its panel; however, the policy is silent concerning what would happen should a panel physician's certification lapse (Attachment 1). Staff also found there were no written procedures outlining the process for verifying licensing and certification. The Division's current practice is to verify medical licensing and certification when LACERA and the physician first enter into a contract[2.] Medical licensing is checked annually while board certification is not routinely checked following appointment to the Board's of Panel of Examining Physicians.

To address this issue, staff is presenting the attached proposed updated policy statement to establish the Board of Retirement's hiring, licensing, certification, and insurance requirements. Staff has developed written procedures to implement the new policy. The policy ensures frequent monitoring of panel physician licensing, certification, and insurance coverage requirements.

Auditing Procedures

The Division's existing audit procedures for verifying physician licensing, certification, and insurance coverage is almost nonexistent. Each physician had a separate paper file that housed some of the information, but it was not as up to date as required to monitor expiration dates effectively. To address this issue, staff contacted all panel physicians and requested documentation of medical licensing, board certification, and insurance coverage. A database was created to maintain a record of all expiration dates so that staff can monitor the information on an ongoing basis. Staff sent a written follow-up request and placed the 4 (four) physicians who have not responded on suspension until proper documentation has been received. There has been no impact in our ability to service our members.

Contracts Review

Panel physician contracts are in the process of being reviewed by the Legal Office for compliance with the proposed updated policy including consequences for failing to maintain the terms of the agreement.

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1 Board certification refers to a member of the American Board of Medical Specialties, a specialty board with the Accreditation Council for Graduate Medical Education accredited postgraduate training program, or a specialty board approved by the Medical Board of California's Licensing Program or equivalent.

2 Prior to 1990, recertification was not required; physicians were certified for a lifetime, subsequently physicians were required to recertify every 10 years.

IT IS THEREFORE RECOMMENDED THAT THE COMMITTEE approve the Proposed Updated **"Policy Statement: Hiring of Panel Physicians: Qualifications, Licensing, Certification and Insurance Requirements for Board Appointed Panel Physicians"** and submit for final adoption by the Board of Retirement.

Attachment

TLC:RC

Noted and Approved:

JJ Popowich, Assistant Executive Officer

Date: 9/29/15

LACERA POLICY STATEMENT

HIRING OF PANEL PHYSICIANS: QUALIFICATIONS, LICENSING, CERTIFICATION, AND INSURANCE REQUIREMENTS FOR BOARD APPOINTED PANEL PHYSICIANS

(Effective October 7, 2015)

Purpose

The purpose of this policy is to establish the governance concerning the qualifications, hiring, licensing, certification and insurance requirements for all Board Appointed Panel Physicians ("Physician(s)") and to clearly define the auditing mechanism to ensure that all requirements are maintained throughout the life of the contractual relationship with the physicians. This policy will also establish actions in the event a Physician is unable to maintain the Board required licensing, certification, or insurance coverage.

I. Statement of Policy

The Board of Retirement requires all Physicians, wishing to be appointed to the Board of Retirement's Panel of Physicians, to hold and maintain a valid California medical license, board certification when available within a specialty, and medical malpractice insurance coverage.

Medical License

All Physicians shall, at all times during the term of their contractual agreement with LACERA, maintain a valid medical license issued by the State of California Medical Board and shall maintain a medical record free of disciplinary warnings/actions, malpractice judgments/settlements, and criminal charges.

Board Certification

All Physicians shall, at all times during the term of their contractual agreement with LACERA, be a member of the American Board of Medical Specialties, a specialty board with the Accreditation Council for Graduate Medical Education accredited postgraduate training program, or a specialty board approved by the Medical Board of California's Licensing Program or its equivalent when available within a specialty.

Insurance Coverage

All Physicians shall, at all times during the term of their contractual agreement with LACERA, maintain sufficient insurance coverage and limits. Physicians will provide LACERA with proof of such insurance coverage upon entering into a contract and annually thereafter.

Physician Requirements Regarding Reporting of Lapses and Resulting Penalties for Non-Compliance

All Physicians shall immediately notify LACERA if any license, certification, or insurance coverage is lapsed, suspended, or revoked, or if any proceeding or investigation is commenced by an agency relating to the Physician's license or certification.

In the event a Physician no longer meets the Board of Retirement's requirements as outlined above the Physician's contract with LACERA will be immediately suspended.

In the event a Physician does not respond to any LACERA inquiry regarding licensing, certification, or insurance coverage, or any reports of an investigation within 30 days of such a request being made, shall have the Physician's contract with LACERA immediately suspended.

Physicians in non-compliance who correct the non-compliance issue, shall be allowed to request an expedited reinstatement review by the Board of Retirement.

Disability Retirement Services Physician Compliance Audit Procedures

Upon entering a contractual agreement with LACERA, all Physicians shall supply staff with proof of licensing, certification, and insurance coverage as set forth in this policy. Staff shall maintain a record of all expiration dates and conduct quarterly audits to ensure that all licensing, certification, and insurance coverage are current. If a Physician is unable to provide proof upon request, the Physician will be suspended until all policy requirements are met.

DISABILITY RETIREMENT SERVICES

The Board grants staff the authority to suspend services of any Physician that is suspected of violating this policy. Staff shall commence a preliminary inquiry to confirm the validity of the violation. Staff shall notify the Board of any lapses, suspensions, revocations, or any proceedings/investigations commenced by a licensing or certifying agency.

BOARD OF RETIREMENT

The Board may place a Physician on temporary probation or rescind any contractual agreement upon notification of a violation of this policy. The Board reserves the right to reinstate a Physician once a violation has been corrected to its satisfaction. Physicians will undergo an expedited reinstatement process, applications for reinstatement will be submitted directly to the Board of Retirement.

II. Implementation

The policy is established pursuant to the Board of Retirement's fiduciary responsibility to prudently administer the retirement plan in accordance with the County Employees Retirement Law of 1937, and replaces the previous policy titled "Hiring of Panel Physicians". This policy may be modified in the future by Board of Retirement action.

Adopted: _____

LACERA

January 23, 1996

TO: Each Member
Board of Retirement

FROM: Disability Procedures & Services Committee
Jack Thomas, Chairman Jack Thomas by
Alex Soteras
Edgar Twine
Cody Ferguson
Warren Bennett (Alternate)

SUBJECT: Hiring of Panel Physicians

On January 3, 1996, during its regular meeting, the Professional Services Committee reviewed procedures regarding the hiring of LACERA's panel physicians.

After discussion of the issue with our medical advisor, the committee determined that it is in LACERA's best interest to hire only board certified physicians. Dr. Kuzma noted that all medical specialties do not have board certification.

THEREFORE, IT IS RECOMMENDED that when board certification is available within a specialty, only physicians who are board certified may be appointed to LACERA's panel of physicians.

FMB:vc

c: Marsha D. Richter
Jerry Hampton
David L. Muir
Sylvia Miller

E-11

September 23, 2015

TO: Disability Procedures & Services Committee
Vivian H. Gray, Chair
William de la Garza, Vice Chair
William R. Pryor
Les Robbins
Yves Chery, Alternate

FROM: Ricki Contreras, Manager
Disability Retirement Services Division

FOR: October 7, 2015, Disability Procedures and Services Committee Meeting

SUBJECT: **CONSIDER APPLICATION OF KENNETH P. SCHEFFELS, M.D., AS LACERA PANEL PHYSICIAN**

On August 17, 2015, Debbie Semnanian interviewed Kenneth P. Scheffels, M.D., a physician seeking appointment to the LACERA Panel of Examining Physicians.

Attached for your review and consideration are:
- Staff's Interview Summary and Recommendation
- Panel Physician Application
- Curriculum Vitae
- Sample Report(s).

IT IS THEREFORE RECOMMENDED THAT THE COMMITTEE accept the staff recommendation to submit the application of Kenneth P. Scheffels, M.D., to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

JJ:RC/sc

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

Date: 9/24/15

August 17, 2015

TO: **Ricki Contreras, Division Manager**
Disability Retirement Services

FROM: **Debbie Semnanian, WCCP** DS
Supervising Disability Retirement Specialist

SUBJECT: **INTERVIEW OF ORTHOPEDIC SURGEON APPLYING FOR LACERA PHYSICIAN'S PANEL**

On August 17, 2015, I interviewed **Kenneth Scheffels**, M.D. at his office at 4940 Van Nuys Blvd., Suite 302, Sherman Oaks, CA 91403. The office space is located in an older but well maintained three-story building with patient paid parking (maximum $6.00) located in the back of the building. There is also free 2-hour parking on the adjacent street.

Dr. Scheffels is a board certified orthopedic surgeon who has been in private practice for over forty years. Dr. Scheffels shares office space with several orthopedists and a neurologist. He has available 6 complete examination rooms. Dr. Scheffels estimates that 30 percent of his practice is devoted to patient treatment, while the other 70 percent of his time is devoted to IME evaluations primarily within the workers' compensation systems and another retirement system.

As referenced in his Curriculum Vitae, Dr. Scheffels graduated from New York Medical College, where he also completed an internship and residency. He has served as the former Chairman of the Department of Surgery and on the Credentials and Ethics Committee at Pacifica of the Valley Hospital.

Dr. Scheffels's office was clean with adequate seating. The office and restrooms are handicap accessible and there is a staff of thirteen employees.

Staff reviewed the LACERA Disability Retirement procedures and expectations in its evaluation of County Employees applying for both service-connected and nonservice-connected disability retirements. The importance of preparing impartial and non-discriminatory reports that are clear and concise and address issues of causation and incapacity were discussed with the doctor. He understood that he would adhere strictly to the HIPAA laws that would also apply for LACERA reports. Staff reviewed with Dr. Scheffels the Panel Physician Guidelines for evaluating LACERA applicants and defined the relationship between workers' compensation and disability retirement. Staff discussed the

need to rely on his own objective and subjective findings rather than the opinions of previous physician reports and/or comments.

Dr. Scheffels agreed to adhere to LACERA's standard of having his evaluation reports sent to us within 30 days of examination. Staff confirmed that Dr. Scheffels is agreeable with accepting payment per the Official Medical Fee Schedule (OMFS). Dr. Scheffels was informed that if he is approved by the Board to be on our panel of physicians, he is required to contact the specialist assigned to the case for approval of any special tests or extraordinary charges. He was also informed that a Quality Control Questionnaire is sent to each applicant regarding their visit.

RECOMMENDATION

LACERA has a pressing need to add orthopedic physicians, particularly in the area in which Dr. Scheffels completes examinations. He expressed not only a willingness to be on our panel, but also an enthusiasm for building a relationship with LACERA.

Based on our interview and the need for his specialty, staff recommends Dr. Scheffels' application be presented to the Board for approval as a LACERA Panel Physician.

LACERA

Los Angeles County Employees Retirement Association

300 N. Lake Ave., Pasadena, CA 91101 ■ Mail to : PO Box 7060, Pasadena, CA 91109-706 626/564-2419 • 800/786-6464

GENERAL INFORMATION		Date 6-24-15
Group Name:		Physician Name: Kenneth P. Scheffels MD
I.	Primary Address: 4940 Van Nuys Blvd #302, Sherman Oaks CA 9140	
	Contact Person Marc Bautzer	Title Marketing Rep.
	Telephone: 818-990-4497	Fax 818-990-6045.
II.	Secondary Address See Attached List.	
	Contact Person E. Moss	Title Administrator
	Telephone 818-990-4497	Fax 818-9906045

PHYSICIAN BACKGROUND		
Field of Specialty Orthopedic Surgery	Subspecialty ~~Spine~~	
Board Certification ☒ Yes ☐ No	License # G29461	Expiration Date 8-31-16.

EXPERIENCE
Indicate the number of years experience that you have in each category.

Evaluation Type

I. Workers' Compensation Evaluations

☑ Defense	How Long?	20 yrs.	☑ IME	How Long?	10 yrs
☐ Applicant	How Long?	5 yrs	☑ QME	How Long?	20 yrs.
☑ AME	How Long?	10 yrs			

No hrs

II. ☑ Disability Evaluations How Long? 20 yrs.

For What Public or Private Organizations? Federal Defense Base;

Currently Treating? ☑ Yes ☐ No

Time Devoted to: Treatment 30% Evaluations 70%

Estimated Time from Appointment to Examination	Able to Submit a Final Report in 30 days?
☐ 2 weeks ☑ 3-4 Weeks ☐ Over a month	☒ Yes ☐ No

LACERA's Fee Schedule	
Examination and Initial Report by Physician	$1,500.00 flat fee
Review of Records by Physician	$350.00/hour
Review of Records by Registered Nurse	$75.00/hour
Supplemental Report	$350.00/hour

-OVER-

Other Fees	
Physician's testimony at Administrative Hearing (includes travel & wait time)	$350.00/hour
Deposition Fee at Physician's office	$350.00/hour
Preparation for Expert Testimony at administrative Hearing	$350.00/hour
Expert Witness Fees in Superior or Appellate Court	$3,500.00 half day $7,000 full day

Physician agrees with LACERA's fee schedule? Yes No

Comments

Name of person completing this form:

Kenneth P. Scheffels MD. Title: MD

(Please Print Name)

Physician Signature: [signature] Date: 6-18-15

FOR OFFICE USE ONLY Physician Interview and Sight Inspection Schedule	
Interview Date: 8/17/15	Interview Time: 12:00
Interviewer: Debbie Swanson	

Kenneth P. Scheffels, M.D.
Orthopedic Surgery

CURRICULUM VITAE

EDUCATION:

NEW YORK MEDICAL COLLEGE, NEW YORK - M.D. DEGREE
METROPOLITAN HOSPITAL MEDICAL CENTER IN AFFILIATION WITH NEW YORK MEDICAL COLLEGE, NEW YORK - INTERNSHIP
NEW YORK MEDICAL COLLEGE, NEW YORK - RESIDENCY

LICENSES AND CERTIFICATIONS:

M.D. LICENSE - CALIFORNIA AND NEW YORK
DIPLOMATE, AMERICAN BOARD OF ORTHOPEDIC SURGERY
QUALIFIED MEDICAL EVALUATOR (QME)

MEMBERSHIPS AND SOCIETIES:

LOS ANGELES COUNTY MEDICAL ASSOCIATION - PAST MEMBER OF THE BOARD OF DIRECTORS
CALIFORNIA MEDICAL ASSOCIATION
AMERICAN MEDICAL ASSOCIATION

HOSPITAL APPOINTMENTS:

PACIFICA OF THE VALLEY HOSPITAL - FORMER CHAIRMAN DEPARTMENT OF SURGERY; CREDENTIALS AND ETHICS COMMITTEE

HONORS AND AWARDS:

NEW YORK MEDICAL COLLEGE SURGICAL SOCIETY AWARD - 1969

EXPERIENCE:

PRIVATE PRACTICE OF ORTHOPEDIC SURGERY, (MED HEALTH) 1988-PRESENT
SERRA MEDICAL CLINIC, 1978-2003
ROSS-LOOS, LOS ANGELES, 1975-1978

SAMPLE

KENNETH P. SCHEFFELS, M.D.

Diplomate, American Board of Orthopedic Surgery

630 W. Duarte Road, Suite 203
Arcadia, California 91007
(626) 447-8870

#1

[redacted]

[redacted]

Attn: XXXXXXXXX XXXXXXXX, [redacted]

- and -

[redacted]

Attn: XXXXXXX XXXXX, [redacted]

RE: XXXXXXXXX [redacted] GXXXXXX vs. [redacted]

CLAIMANT : XXXXXXXXX [redacted]
CLAIM NO : XXXXXXXXXX
EAMS NO : ADJXXXXX
EMPLOYER : XXXXXX XXXXX, DDS
ACCT. NO : [redacted]
D/INJURY :
D/EXAMIN :

ORTHOPEDIC PANEL QME EVALUATION REPORT

Dear Ms. XXX and Mr. HXXXXXXX:

Today, I had the opportunity to perform an orthopedic Panel QME evaluation in my Arcadia office on XXXXXX [redacted] a 50-year-old, right-handed female. She gives the following history.

This is a Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances (ML104), of nine and one-half hours in length. This is a QME evaluation and extensive medical records were provided. Six and one-half hours was spent on the combination of review of medical records, reviewing the depositions and in face-to-face time with the claimant. (This counts as two complexity factors). Three

[redacted]

hours spent on preparation of this report. This report addresses the issue of medical causation with written request of the parties. This report addresses the issue of apportionment, again as requested. This report also addresses the issue of, need of or modification of medical treatment.

EMPLOYMENT AT TIME OF INCIDENT:

The patient worked as a registered dental assistant, for Dr. XXXXX XXXXXX, DDS and she would assist him in his dental procedures. She worked for him for four years and worked for the previous owner of that dental office for ten years. She worked for Dr. XXXX from November of [redacted] until she was terminated in [redacted] of [redacted]. In addition to aiding him in the dental procedures, she would also do things such as pulling charts and cleaning the room and mopping the floors. Her job also involved cleaning a masking machine, which apparently is an air abrasion machine. She denied concurrent employment.

Since leaving this job she has worked for XXs, but only for one month as she could not handle the standing required. She subsequently obtained new employment part-time with a dentist in [redacted] and also has been working at XXXXXXXXX since [redacted]

HISTORY OF THE PRESENT INJURY:

The patient alleges an injury to the left hip due to her work with Dr. XXXX. However, she reports that she injured her left hip in a non-industrial slip and fall in [redacted]. Prior to that, she states that her hip was not bothering her significantly, although she had occasional aching. Since the fall, which actually took place in a bowling alley, she states that she had ongoing and increasing pain in her hip. She feels this was due to the prolonged standing at work and the arthritis that she was told that she had in the hip, was also cause by the prolonged standing at work.

She was seen by her private doctor for this hip pain, status post her slip and fall at the bowling alley, and he told her that she had significant hip disease, which the patient states initially started when she was young. She had hip

[redacted]

dysplasia as a child and did have hip surgery. Her private doctor referred her to the hip and pelvic clinic, run by Dr. XXXX. She was told that pelvic surgery would not be beneficial and that eventually, she would need a total hip replacement.

She states at that time, her back started to hurt as well. She feels that the back pain was due to the prolonged standing and when she was sitting at work, she would have to twist to reach and work on the client. She felt that this back pain started about two or three years prior to her termination.

When questioned if the back pain started prior to the hip and the fall, the patient feels she has back pain from a combination of factors, including leaning over and helping the dentist, as well as from the slip and fall from the bowling alley and her altered gait from her total hip replacement.

She reports that she has had right wrist pain for many years and felt that this developed due to her repeated use of her right hand as a dental assistant and the use of tools. She felt this started about four or five years ago.

She complains that her right foot started to hurt her around [redacted]. She feels that this was due to the fact that when she was walking and because of the hip surgery she would place her left foot on top of her right foot to relive pressure on the left hip and that caused the right foot problem.

On the recommendations of Dr. XXXX, she went to her private doctor at XXXXXXX and eventually had a total hip replacement done on [redacted] She admits that she had improvement with the surgery to the left hip, although she still reports some hip complaints.

She was also treated at XXXXXX for the right hand, with medications and therapy.

For the right foot she started treatment in [redacted] and later treated with another doctor her attorney sent her.

[redacted]

For the lumbar spine she was treated by a chiropractor, Dr. XXXX beginning in [redacted] She last treated with Dr. XXXX in [redacted] of this year.

CURRENT COMPLAINTS:

The patient has low back pain, which she indicates is present all the time and so radiation of pain into the upper thighs.

The patient has pain in the right foot with prolonged ambulation.

The patient has right wrist pain worse with repetitive grasping.

The patient has mild aching of the left hip.

Non-orthopedist complaints of stress. She states the stress has developed because Dr. XXXXX will not give her a reference.

CURRENT JOB STATUS:

The patient is working 4-hours per day as a dental assistant for a Dr. XXXXXXXXXX, 5-days per week and she works at DXXXXXXXXX in a ticket booth selling tickets part-time.

PAST MEDICAL HISTORY:

WORK INJURIES:

None prior.

ILLNESSES:

The patient has a history of type II diabetes. The patient denies any history of tuberculosis, pneumonia, or asthma. There is no history of heart disease, hypertension, epilepsy, liver disease, kidney disease, thyroid disease, ulcers, or cancer.

[redacted]

MEDICATIONS:

The patient is taking glyburide, Metformin, clarithromycin, Naproxen, amoxicillin, Tramadol and omeprazole.

ALLERGIES:

The patient is an allergy to latex.

SURGERIES:

The patient had a left hip surgery at 15-months old, as well as a left hip replacement on [redacted]

AUTO ACCIDENTS:

Many years ago, denies residuals.

FAMILY HISTORY:

The patient's mother is alive with diabetes and asthma. The patient's father is deceased from cancer.

SOCIAL HISTORY:

The patient denies the use of tobacco, but admits to drinking alcohol. The patient denies the use of illicit drugs.

REVIEW OF AVAILABLE RECORDS:

[redacted] - Cover letter from defendant's attorney (representing The XXXXXXXXX) reviewed.

UNDATED Cover letter from defendant's attorney (representing TXXXXXXXXX) reviewed.

Her ADL form was completed and reviewed.

Division of Workers Compensation:

[redacted] - Employee's claim for Workers' Compensation benefits - Date of injury listed as [redacted] Hips, back, psyche, and Internal. Signed by the patient.

[redacted]

[redacted] - Application for adjudication of claim - Date of injury listed as CT [redacted] to [redacted]. Job title: Dental Assistant. Continuous trauma injury to hips, back, nervous, and body systems. Repetitive work; overtime.

XXXXXXXXXXXXXXXX Hospital - XXXXXXX Park, California:

[redacted] - Seen for acute bronchitis. Placed on amoxicillin.

[redacted] - Seen for acute bronchitis. Placed on amoxicillin.

[redacted] - Seen for acute bronchitis. Placed on amoxicillin. Noted borderline hypertension. Assessment: Obesity. Told to exercise.

[redacted] Patient called in relating she injured her wrist on Monday, painful and stiff.

[redacted] - Seen at XXXXXX by XXXXXXXXXX XXXX, MD. *Patient fell five days ago*. Presently complains of pain across the dorsal aspect of her right wrist. Physical examination: Minimal tenderness to palpation over the dorsum of the right wrist. Assessment: Right wrist pain. X-rays showed normal right wrist. Prescribed Naprosyn.

[redacted] - X-rays of the right wrist done by B. XXX, MD - Impression: Normal x-rays of the right wrist.

[redacted] - Seen at XXXXX by XXXXX XXXXXXXX, MD for followup of right wrist pain. Recommended physical therapy.

[redacted] - Seen for URI symptoms. Reports using albuterol (Proventil). Reports taking loratadine (Claritin), Naprosyn, and pseudoephedrine.

[redacted] - Patient called in relating difficulty breathing.

[redacted] - Seen for routine eye exam. Reports blurred vision.

[redacted] - Seen for URI symptoms. Went to Las Vegas recently. Takes Naprosyn and loratadine (Claritin).

[redacted] - Seen for right ear pain times six days. Assessment: Otitis externa. Otitis media.

[redacted] - Emergency room report - Seen at XXXXX for left upper chest pain times around three days ago, radiating into her upper back. Describes sharp pain. Takes Naprosyn, loratadine (Claritin), and pseudoephedrine. Assessment: Chest pain. Recommended Baby Aspirin. Discharged in stable and ambulatory condition.

[redacted] Seen for chest pain in the emergency department. States she has been under a lot of stress since [redacted] the company she is working for had been sold. Relates she is taking care of her grandmother's trailer home. Treadmill exercise stress test performed. Pap test came back abnormal; positive for HPV.

[redacted] - Seen for colposcopy secondary to abnormal Pap smear; HPV positive.

[redacted] - Patient called in very upset; states Dr. BXXXXh has not called her with the results of her Pap smear.

[redacted] - Seen for Pap surveillance.

[redacted] - Emergency room report - Seen at XXXXX for Z-shaped laceration to volar aspect of the left index finger while cutting an avocado. Active problem list: Obesity. Abnormal Pap smear. Takes valacyclovir (Valtrex) and Naprosyn. Assessment: Status post repair of laceration. Placed on cephalexin (Keflex) and Motrin. Given wound care instructions.

[redacted] - Emergency room report - Seen at XXXXXX removal of sutures. Sustained left index finger laceration 11 days ago. Physical examination: Wound CDI. Bacitracin and Bandaid applied to left index finger. Current medications: Valacyclovir (Valtrex), Naprosyn, ibuprofen (Motrin), and cephalexin (Keflex). Given wound care instructions. Patient is discharged to home.

[redacted] - Seen by XXXXXXX XXXXXXX, MD for chronic left hip pain *for quite some time*. Had left hip surgery at 13 months

[redacted]

old; described pins were placed. Denied having surgery at age 12 or 13; states she was asymptomatic at that time. Gives history of being involved in a motor vehicle accident in 1989. Patient also complains of back pain with pain radiating from the left hip down the left leg. *Prolonged walking at XXXXXXXXXX worsens the pain.* Pain level today at 9/10. Laboratory tests showed low MPV and low vitamin D. Assessment: Left hip pain. Osteoarthritis of the hip. Status post left hip surgery at 13 months old. States pain was worse after the motor vehicle accident of [redacted] Ordered x-rays of the hip and back. Referred for orthopedic evaluation. Prescribed Vicodin. Continue Naprosyn.

[redacted]- X-rays of the left hip done by XXXXXXX XXXXXXX, MD - Impression: Osteophytes and facet hypertrophy seen in the lumbar spine. Disc space narrowing noted at L4-5 and L5-S1. Degenerative changes and disc disease of the lumbar spine.

[redacted]- Seen for followup of left hip pain times *three to four years;* worse in the past few months. States she had surgery to her hip at age [redacted] old because head of femur was not developing. *There is questionable congenital hip dysplasia.* Assessment: Obesity with BMI 33.67. Abnormal Pap smear. Prescribed Mobic. Recommended cortisone injection for the hip with XXXXXXX XXXXXXXXXXXXX, MD. Apply heat to affected areas. Told to lose weight.

[redacted] - Seen for vitamin D deficiency. Takes ergocalciferol, vitamin D2.

[redacted] - Seen for followup of hip osteoarthritis. Prescribed Celebrex.

[redacted] - Orthopedic evaluation report - Seen at XXXXXXXXXXXXXXXX XXXXXXXXX, MD for chronic left hip pain. Has had three surgeries to her hip as well as multiple episodes of casting and bracing by age [redacted] Reiterates history of motor vehicle accident approximately [redacted] years ago with increased hip pain and back pain. She did in her adolescent life; describes she was active in karate, skateboarding, and others, however she has had more pain *in the past* [redacted] *years*. Currently weighs [redacted] pounds; BMI 33.67. Describes pain in her groin and thigh. Takes Vicodin, ergocalciferol, vitamin D2, Celebrex, as well as

[redacted]

valacyclovir (Valtrex). X-rays showed left hip coxa valga with approximately 25% lateral uncovering. Moderate joint space narrowing of the left hip. Assessment: Left DDH. Congenital hip dysplasia. Hip osteoarthritis. Arthralgia of hip or thigh. Told to lose weight and minimize impact on hips. Advised high likelihood of total-hip arthroplasty. Follow up with Dr. XXXXX for possible periacetabular osteotomy. Recommended use of cane.

[redacted]- Patient called in very upset because she did not get the DMV handicap placard she requested and tomorrow she will be out of town.

[redacted]- Seen at St. XXXXXX Health Center by [redacted]XXXXX, MD for increasing left hip pain times several months, causing her to use a cane. Job title: Dental Assistant. Describes being on her feet at times at work. Past medical history: Left hip dysplasia. Past surgical history: Hip surgeries at age [redacted]months as well as [redacted]years secondary to developmental dysplasia of the hip. X-rays showed significant degree of acetabular dysplasia with a center edge angle of approximately 15° as well as evidence of moderate arthritis with decreased superior joint space, wear, and osteophytes on the femoral head with sclerosis, osteophytes, cysts, and wear of the acetabulum. Assessment: Acetabular dysplasia with arthritis of the left hip. Recommended surgery in the form of anterior-approach left total-hip replacement. Periacetabular osteotomy is not recommended.

[redacted]- PA-C spoke with patient on the phone: Patient states she cannot wait [redacted]months for surgery. Requests to have surgery with Dr. Matta. Patient will be placed on the waiting list for total-hip arthroplasty with AXXXX XXXXXXXXXXXX , MD. Patient feels she is unable to perform her job anymore.

[redacted]- Work status report - The patient is placed on total temporary disability.

[redacted]- AXXXXX KXXXXXXXXXXX, MD spoke with the patient on the phone: Same complaints of severe left hip pain greatly affecting her activities of daily living. Patient is very frustrated with the pain; declined injections and would like

[redacted]

to have her hip replaced.

[redacted]- Seen at KXXXX by AXXXXX KXXXXXXXXXXXXXXX, MD for same complaints. Dr. Matta did not recommend periacetabular osteotomy because of the degree of arthritis present; rather recommended total-hip arthroplasty. Current medications: Valacyclovir (Valtrex), Vicodin, Naprosyn, ergocalciferol, vitamin D2, and Celebrex. Same diagnoses: Left DDH with significant degenerative joint disease. Osteoarthritis of hip. Hip dysplasia, congenital. Recommended left total-hip arthroplasty.

[redacted]- Seen at XXXXXX by CXXXXXXXXX XXXX, MD for severe left hip pain as well as sleep difficulty. X-rays showed moderate to severe joint space loss with DDH of the left hip. Assessment: Left hip DDH with advanced degenerative joint disease changes. Obesity. Osteoarthritis of hip. Recommended left total-hip arthroplasty. Noted that patient is both overweight and young.

[redacted]- Seen for URI symptoms. Prescribed Medrol Dosepak and Phenergan.

[redacted]- Seen by N.P. for low back pain times six days. Gives history of motor vehicle accident in the[redacted] Last week she got up the chair and experienced back discomfort which got worse after sexual activity. Takes Vicodin for her hip and Naprosyn for her tendinitis. Assessment: Low back pain. Continue medications. Prescribed cyclobenzaprine (Flexeril).

[redacted]- Seen by XXXXXXXXXX XXXXXXXXX, MD for low back pain. Patient states she hurt her back [redacted]go while having sexual intercourse. Assessment: Back sprain/strain. Prescribed Medrol Dosepak. Continue Flexeril, Naprosyn, and Vicodin. Recommended physical therapy. Apply heat to affected areas.

[redacted]- Seen by PA-C for left hip pain times a few years. Given today injection of Kenalog, lidocaine, and Marcaine into the *right* hip joint.

[redacted]- Seen for Mxxxx KXXXXXXX, MD for followup of left hip degenerative joint disease due to DDH. Here for

[redacted]

injection #3, administered without complication. Injection #1 helped for four months. Injection #2 did not work.

[redacted] - Given prescription for Vicodin.

[redacted] - Patient called in regarding work restrictions. She had hip injection done by Dr. MXXXXX under x-ray guidance. Describes being on her feet eight hours a day at work. Patient wants to make sure the hip injection is effective and would last long enough until January at which time she may consider surgery. If she will be placed on modified duties she would like this to be dated starting [redacted] She is currently on vacation and will return to work on [redacted]

[redacted] - Seen by MXXXX KXXXXX, MD for followup of left hip DDH status post surgery as a child; now with progressive arthrosis with severe pain. BMI [redacted]. Currently weighs [redacted] pounds. Recommended total-hip arthroplasty.

[redacted] - Seen by [redacted] KXXXXX, MD for popping in her knee with a lot of pain. Also reports popping and pain in her left hip and left thigh after injection administered on [redacted] Assessment: Left hip dysplasia with cartilage loss. The patient is placed on total temporary disability.

[redacted] - Seen at XXXXXX by [redacted] XXXXXX, MD for left hip pain. Scheduled for left hip replacement surgery with Dr. KXXXXX. Active problem list: Obesity. Abnormal Pap smear. Hip osteoarthritis. Vitamin D deficiency. Congenital hip dysplasia. Vital signs: Height is [redacted] and weighs [redacted] pounds. BMI [redacted] Assessment: Left hip osteoarthritis. The patient is placed on total temporary disability.

[redacted] - Work status report - The patient is placed on total temporary disability.

[redacted] - Given instructions regarding occupational therapy and physical therapy.

[redacted] - Progress report - Seen by GXXXXX KXXXXX, MD for left groin pain; diagnosed with left hip degenerative joint disease. Patient wishes to proceed with left total-hip arthroplasty. Assessment: Left hip dysplasia. Scheduled

[redacted]

to undergo surgery on [redacted]

[redacted] - Emergency room report - Seen at Kaiser for severe degenerative joint disease of the left hip, worse, has failed to respond to conservative treatment. Also reports left groin pain. Active problem list: Obesity. Abnormal Pap smear. Osteoarthritis of hip. Osteoarthritis. Vitamin D deficiency. Congenital hip dysplasia. Vital signs: Height is [redacted] and weighs [redacted] pounds. Assessment: Left hip dysplasia. Recommended left total-hip replacement.

[redacted] - Operative report done by [redacted] XXXXXXX, MD - Seen at [redacted]. Pre- and postoperative diagnoses: Left hip degenerative joint disease secondary to developmental dysplasia of the hip (DDH). Procedures performed: Left total-hip arthroplasty.

[redacted] - Inpatient physical therapy hip consultation report - Seen at KXXXXXX.

[redacted] - Postoperative x-rays of the left pelvis done by [redacted] XXXXXXX, MD - Seen at [redacted]. Impression: Left total-hip replacement with components in satisfactory position. Postsurgical changes seen within the surrounding soft tissues.

[redacted] - Physical therapy evaluation report - Seen at [redacted].

[redacted] - Discharge summary report - Seen at KXXXXX. Prescribed Norco, aspirin, and Colace. Continue taking ferrous sulfate and oral zinc acetate. Given instructions regarding and discharged to home.

[redacted] - Patient called in complaining of difficulties with sleep as well as anxiety since the surgery.

[redacted] - Given prescription for Valium for her anxiety.

[redacted] - Physical therapy evaluation report done by [redacted] XXXX, MSPT - Patient is status post left total-hip arthroplasty.

[redacted] - Physical therapy progress report.

[redacted] - Work status report - Wound is healing nicely. Prescribed tramadol (Ultram). The patient is placed on total temporary disability.

[redacted] - Physical therapy progress report.

[redacted] - Physical therapy progress report.

[redacted] - Physical therapy progress report.

[redacted] - Physical therapy progress report.

[redacted] - Physical therapy progress report.

[redacted] - Physical therapy progress report.

[redacted] - Seen by [redacted] KXXXXX, MD. Patient is very satisfied with the surgery. Still suffers from insomnia. Receives physical therapy. The patient is placed on total temporary disability.

[redacted] - Physical therapy progress report.

[redacted] - Seen by [redacted] KXXXXX, MD. Patient states she did 15 minutes of bicycle in the gym and two laps in the pool. The following day she felt soreness along her left lower lumbar region.

[redacted] - Postoperative progress report - Seen by [redacted] XXXXX, MD for back pain. Gives history of sciatica. States exercising increased her sciatic pain times six days; felt she had left leg paresthesias. Given instructions regarding exercises and hip precautions.

[redacted] - Physical therapy progress report.

[redacted] - Seen by [redacted] MD. Patient wants to return back to work on [redacted] inquires regarding work restrictions.

[redacted] - Physical therapy progress report.

[redacted] - Seen by PA-C. The patient is placed on total

[redacted]

partial disability; modified duties. May return to work with posterior hip precautions and perform work duties seated in a chair. Patient states her employer is giving her a hard time regarding work restrictions.

[redacted] - Work status report - The patient is placed on total partial disability; modified duties.

[redacted] - Patient called in and spoke with GXXXXX KXXXXX, MD. Patient states she returned to work as a Dental Assistant and her employer could not accommodate her work restrictions and terminated her. *Patient's posterior hip precautions must be observed at all times*: No bending of hip past 90° angle. No crossing of legs. No twisting of hip inwards. Must keep knees and toes pointed upwards. Hip is restricted from bending due to risk of dislocation. Apply ice to affected areas. Continue use of antiinflammatory.

[redacted] Surgery Group:

[redacted] - Orthopedic evaluation report - Seen by Manuel [redacted], MD. Date of injury listed as CT [redacted] Patient began to experience left hip pain at work in around [redacted] In around [redacted] she slipped-and-fell on her left side while bowling. She presented to Kaiser Permanente in [redacted] with ongoing left hip pain. Presently complains of left hip pain, increased with walking or standing. Describes the recent onset of low back pain. Complains of neck pain radiating into the shoulders. Also reports suffering from depression and anxiety. Past medical/surgical history: Underwent left hip surgery as an infant [redacted] to address developmental dysplasia of the hip (DDH). Hardware was subsequently removed at age four. Patient had a motor vehicle accident in [redacted] and received chiropractic treatment for her back. She settled her case and received Award of [redacted] In [redacted] she slipped and fell while bowling. Vital signs: Height is [redacted] and weighs [redacted] pounds. Diagnoses: Lumbar spine sprain/strain. Status post left total-hip arthroplasty with residual symptoms. Residual leg-length discrepancy, left shorter than right. Psychological sequelae secondary to industrial injury. The patient is placed on total temporary disability. Recommended x-rays of the hips bilaterally.

[redacted]

[redacted] - PR-2 - Seen by [redacted]. XXXXX, MD. Date of injury listed as CT [redacted] Seen for left hip pain and low back pain radiating down the lower extremity. Physical examination: Tenderness, decreased range of motion, decreased strength, and decreased sensation. Diagnoses: Lumbar spine sprain/strain. Status post total-hip arthroplasty. Residual leg-length discrepancy, left shorter than right. Ordered x-rays of the hip and pelvis. Referred for psych consult. The patient is placed on total temporary disability.

[redacted] - PR-2 - Seen by M. XXXXX, MD. Date of injury listed as CT [redacted] Presently complains of stiffness and pain in the left hip and lumbar spine with left lower extremity weakness. Recommended land-based physical therapy as well as aquatic therapy 2x6. The patient is placed on total temporary disability.

[redacted] - PR-2 - Seen by [redacted] XXXXX, MD. Same complaints. Same diagnoses. Residual leg-length discrepancy with left leg shorter than the right leg. Same treatment plan. Awaiting psychiatric evaluation. Still off work. Still temporarily totally disabled.

[redacted] - Progress report done by GXXXXX KXXXXX, MD - Patient is very satisfied postoperatively. Continue physical therapy, range of motion, and quadriceps strengthening.

XXXXXXXX XXXX Multi-Specialty Medical Group & Therapy:

[redacted] - Handwritten Chiropractic Doctor's first report of occupational injury or illness - Seen by *XXX XX*, DC - Body parts injured: Left hip, low back, and right wrist/hand. Date of injury listed as CT [redacted] Recommended chiropractic treatment modalities. Return to work on modified duties. No lifting, pushing, pulling over 25 pounds. No standing more than one-half hour. No walking more than 20 minutes. No repetitive bending or stooping. No squatting. Date of injury listed as CT [redacted]

[redacted] - Chiropractic evaluation report done by *JXXXX LXXX*, DC - Seen at XXX XXXXXX Multi-Specialty Medical Group & Therapy. Date of injury listed as CT [redacted]

[redacted]

Patient states she developed pain in her right wrist, low back, left hip, and right heel/foot. Also reports she developed stress, anxiety, depression, sleep difficulty, and headaches. Sustained right clavicle fracture in around [redacted] nonindustrial. Past medical history: Arthritis. Past surgical history: Left hip replacement on [redacted] industrial. Left hip surgery at age [redacted] months because her hip did not grow. Diagnoses: Posttraumatic stress disorder. Headache. Sleep difficulty. Difficulty walking. Lumbar ligament laxity. Lumbar neuritis/radiculitis. Rule out carpal tunnel syndrome, right wrist. Right hand joint effusion. Postoperative left hip total replacement. Post complication right plantar fasciitis. Insomnia. Not yet MMI. Recommended to amend patient's claim to include right hand and wrist as well as right foot/heel. Also added sleep difficulty. Recommended physiotherapy modalities as well as chiropractic care 3x8. Recommended home exercise program, work conditioning program, as well as acupuncture treatment. Recommended EMG/NCV of the bilateral lower extremities. Referred for psychological, orthopedic, Internal Medicine, as well as Pain Management consults. Return to work on modified duties. No forceful gripping with the right upper extremity. No lifting over 25 pounds. No squatting. No prolonged standing. No walking more than 20 minutes.

[redacted] - Chiropractic progress report.

There is chiropractic treatment log sheet indicating patient's regular attendance in February and [redacted]

[redacted] - MRI of the right wrist with flexion/extension done by XXXXXX KXXXXXXX, MD - Impression: Subchondral cyst of the capitate and head of the third metacarpal. Normal flexion and extension images. No other abnormalities.

[redacted] - MRI of the lumbar spine with flexion/extension done by SXXXXX KXXXXX, MD - Impression: T11-12 showed broad-based central disc protrusion encroaching the subarachnoid space. Disc measurements: 1.9 mm in neutral, extension, and flexion. L2-3 showed a broad-based central disc protrusion compressing the thecal sac and bilateral transiting nerve roots with bilateral neuroforaminal stenoses, encroaching to the bilateral exiting nerve roots. Disc measurements: 4.0 mm in neutral and 3.0 mm in

[redacted]

flexion/extension. L3-4 showed a broad-based central disc protrusion effacing the thecal sac and bilateral transiting nerve roots with left neuroforaminal stenosis, encroaching to the left exiting nerve root. Noted facet arthrosis. Disc measurements: 2.7 mm in neutral and extension; and 1.9 mm in flexion. L4-5 showed bilateral facet degeneration; facet arthrosis. L5-S1 showed diffuse disc bulge effacing the thecal sac and bilateral transiting nerve roots. Noted facet arthrosis. Disc measurements: 1.9 mm in neutral and 3.0 mm in flexion/extension. Multilevel degenerative disc disease. Disc desiccation at L2-3, L3-4, and L5-S1.

[redacted]- MRI of the left hip without and with contrast done by SXXXXX KXXXXX, MD - Impression: Several fatty and cystic changes of the superior aspect of the uterus. Clinical and historical correlation recommended. Recommended GYN referral. Right femoroacetabular arthrosis. Surgical metallic artifact overlying the left hip, consistent with previous left hip replacement surgery, limiting evaluation of the left hip. CT scan and/or x-rays of the left hip recommended. Metallic artifact extends through the pelvic brim and acetabulum which may represent medial migration of the surgical hardware however x-ray study or CT scan of the left hip is suggested. No contrast enhancement seen. No other abnormalities.

[redacted]- Physical therapy progress report.

[redacted] - Anatomical impairment measurements (AiM) report done by SXXX KXXXX, MD - Body parts injured: *Right wrist.*

[redacted] - Anatomical impairment measurements (AiM) report done by SXXXX KXXXX, MD - Body parts injured: *Left hip.*

[redacted] - Anatomical impairment measurements (AiM) report done by Sana Khan, MD - Body parts injured: *Lumbar spine.*

[redacted] - Psychological evaluation report done by AXXXX DXXX, PhD - *Seen and examined actually on* [redacted] Date of injury listed as CT [redacted] Diagnostic impression: Axis 1: Adjustment disorder, not otherwise specified. Primary insomnia. Axis 2: Deferred. Axis 3: Deferred to appropriate examining physicians. Axis 4: Occupational, economic, as well as problems related to

[redacted]

interaction with the legal system. Axis 5: Current GAF score is 66; *corresponding whole person impairment is 6%*. Recommended psychotherapy as well as cognitive-behavioral therapy.

[redacted] - Physical therapy progress report.

[redacted] - Chiropractic PR-2 - Seen by XXX XXX, DC. Same complaints. Same diagnoses: Rule out cubital tunnel syndrome. Rule out carpal tunnel syndrome. Gait abnormality. Myofascitis. Status post left hip replacement, stable. Stress. Headaches. Insomnia. Pain in the lumbar spine, right wrist, right ankle, and right foot. Lumbar spine disc syndrome/radiculitis. Right plantar fasciitis. Same treatment plan. Continue acupuncture and physical therapy 3x6. Still on modified duties. Same work restrictions. Recommended ThermoCool compression system at 30 minutes per day time 60 days; DME trial; ESWT for the right foot; as well as EMG/NCV of the bilateral lower extremities. Follow up with Pain Management and Psychology. Referred for FCE evaluation.

[redacted] - Autonomic nervous system function testing report with interpretation - Seen by XXXXX XXXXX, MD. Referred by XXX XXXXX, DC.

There is chiropractic treatment as well as physical therapy log sheet indicating patient's regular attendance in March and [redacted]

[redacted] - Psychotherapy progress report done by SXXXXXX XXXXXX, PsyD.

[redacted] - Computerized range of motion and muscle strength study performed by [redacted] DC. Referred by [redacted] DC.

EXXXXXXXX XXXXXXXXX, MD:

[redacted] - Pain Management evaluation report - Seen at XXXXXXX XXXXXX Stop Multi-Specialty Medical Group & Therapy by XXXXXXX XXXXXXX, MD. Referred by XXXXXXXX XXXXX, DC. Present complaints: Right foot pain; left thigh pain; left buttock pain; and low back pain. *Low back pain started in*

[redacted]

the early [redacted] intermittently; attributed to prolonged standing, walking, and sitting at work; did not report her injury to her employer. *Right wrist pain started in around* [redacted] attributed to repetitive grasping, pushing/pulling, and carrying charts and supply boxes at work weighing around 25 pounds; did not report her injury to her employer; went to Kaiser and diagnosed with tendinitis. *She continued working from* [redacted] *with persistent pain in her right wrist and low back*. In around [redacted] she began to experience stress, anxiety, depression, and headaches; attributed to change of ownership of the practice she worked for; did not report her symptoms and continued working. Past medical history: Arthritis. Takes Naprosyn. Medical records were reviewed. Diagnostic impression: Axial low back pain. Lumbar facet arthropathy. Status post left hip replacement. Right foot tenosynovitis. Given today injection of Kenalog and lidocaine into the right foot with relief of discomfort. Recommended lumbar diagnostic facet block due to very little discopathy. Prescribed Naprosyn, tizanidine (Zanaflex), Ultracet, as well as topical creams. Work status per primary treating physician.

[redacted] - Chiropractic Supplemental report done by Phu La, DC - Medical records were reviewed.

[redacted] - Extracorporeal shockwave therapy report done by MXXXXXXX XXXXXX, DO - Procedure #1. Diagnoses: Right wrist/hand tenosynovitis/tendonopathy. Patient received 1000 shocks at the initial level 5 at a force of 1.1.

[redacted] - Psychotherapy progress report done by SXXXXXX XXXX, PsyD.

[redacted] - Internal Medicine evaluation report - Seen at XXX XXXXXX Multi-Specialty Medical Group & Therapy by Michael RXXXX XXX, MD for insomnia and headaches. Referred by XXX XX , DC. Impression: Insomnia. Headache. Prescribed topiramate (Topamax).

[redacted] Chiropractic Supplemental report done by PXXX XXX, DC - Medical records were reviewed.

[redacted] - Handwritten Chiropractic PR-2 - Seen by PXXX XXX me complaints. Same diagnoses. Same treatment plan. Still

[redacted]

on modified duties. Same work restrictions. No lifting over 25 pounds. No carrying over 20 pounds. Limited standing to no more than one-and-a-half hours. No repetitive bending, stooping, power gripping/grasping, or squatting.

[redacted] - Psychotherapy progress report done by SXXXXX XXXXXX, MD

There is chiropractic treatment as well as physical therapy log sheet indicating patient's regular attendance in [redacted]

[redacted] - Handwritten Chiropractic PR-2 - Seen by XXX XX, DC. Same complaints. Same diagnoses. Same treatment plan, added Biofreeze. Still on modified duties. Same work restrictions.

[redacted] - EMG/NCV of the bilateral upper extremities done by XXXXX XX, MD - Impression: Normal EMG. Abnormal NCV with findings suggestive of right carpal tunnel syndrome. Follow up with XXX XX, DC.

[redacted] - Physical therapy progress report.

There is chiropractic treatment log sheet indicating patient's regular attendance in [redacted].

[redacted] - Handwritten Chiropractic PR-2 - Seen by XXX XXX, DC. Same complaints. Same diagnoses. Same treatment plan. Still on modified duties. Same work restrictions.

[redacted] - Chiropractic progress report.

[redacted] - Internal Medicine progress report done by [redacted], MD - Continue topiramate (Topamax). Prescribed Ambien.

[redacted] - Chiropractic Supplemental report done by XXXXXX XXXXX, DC - Medical records were reviewed.

[redacted] - Chiropractic progress report.

There is chiropractic treatment log sheet indicating

[redacted]

patient's regular attendance in September and [redacted]

DEPOSITION OF XXXXXXXX [redacted], VOLUME 1:

[redacted] - Pages 1 through 71 - The patient had an auto accident in the [redacted] wherein she was a driver and he sustained injury to her low back. She eventually settled his case; does not remember how much he received. Denies any residuals. Goes through her family and living situation as well as her educational attainment. Started working for Dr. XXXX in [redacted]. Explains that she actually started working for Dr. [redacted] in [redacted] and then Dr. [redacted] owned the practice in [redacted] He job duties included ordering; doing chair side, charts, front office, OSHA, setting and breaking up rooms, sterilization, x-rays, four- to six-handed dentistry, impressions, fixing things, *waterlase*, air abrasion, corner polishing, bleaching teeth, treatment plans, treatment conferences, temporary crowns, checking insurance, banking, computers, as well as scheduling and confirming appointments. She was placed off work from [redacted] through [redacted]. Underwent left total-hip replacement at XXXXXXX XXXXXX [redacted] She last worked on [redacted]; states *she was fired*. Explains that Dr. DXXXX just showed her a list of patients (all of whom were personal friends of his) who had complaints against her. Dr. DXXXXX told her he had many patient complaints and fired her. *Patient testifies she would have continued working had she not been fired.* Had concurrent employment while working for Dr. DXXXX. Goes through her prior employment (prior to Dr. DXXXX). There was discussion about her Workers' Compensation claim in [redacted] against XXXX [redacted] Corporation; described she was held up at gun point. She received counseling for about six months. She obtained an attorney and eventually received a Settlement. Patient described working at XXXXXXX Dental Care as a Registered Dental Assistant (subsequent to her employment with Dr. DXXXX) but she had to stop because she was being asked to do tasks which exceeded her work restrictions as a result of her hip surgery which included no lifting over 10 pounds; no standing pigeon-toed; no crossing of legs; no bending more than 90°. Patient is currently not working; states she is looking for work as a Dental Assistant; *had sent out* [redacted] *resumes* to dental offices. Patient explains that she actually had been hired

[redacted]

by [redacted] and scheduled to start working on the [redacted]th ([redacted] doing vacation planning as well as ticket selling. Gives history of fractured right clavicle at around age [redacted] while riding a skateboard, received treatment at WXXXX XXXXX Hospital, no residuals. There was discussion about her left hip surgery at age [redacted] secondary to a birth defect. She had an emergency room visit in [redacted] due to work-related stress; described Dr. [redacted] was taking her duties away from her when he overtook the practice; also cut her work hours. States Dr. [redacted] put his sister as the Head Assistant. She was working on charts more and cleaning rooms. At one time she had to go to the emergency department due to work-related anxiety and stress. She did not get back her old duties. There was discussion about her present Workers' Compensation claim: Body parts injured include her left hip and sciatic nerve status post hip replacement; right wrist tendonitis (on Naprosyn); and right foot on a compensatory basis (wears Velcro brace). Patient underwent left hip surgery as an infant and followed by hardware removal at [redacted] She is not sure when her left leg became shorter than her right leg. She noticing problems with her left hip since she fell in [redacted] while bowling. She landed on her buttocks. She went to Kaiser for medical treatment and was referred to Dr. [redacted]. In [redacted] Dr. [redacted] told her arthritis had set in and hip replacement is needed. Dr. KXXXXXX (Kaiser) gave her an injection on [redacted] which helped. She received a total of four injections (including one injection into her left thigh in [redacted] which did not work). She finally underwent surgery on [redacted] Denies any sciatic symptoms prior to her surgery. Patient testifies that *prior to her bowling/falling incident she was on her feet at work eight hours a day and was not having pain.* Patient states that at the present time she does not have any pain in her hip or sciatic nerve, zero pain level. There was discussion about her psychiatric symptoms including anxiety and depression. Upon further questioning, the patient describes she is presently having intermittent pain in her low back, left hip, and left leg. Her low back pain was worst in [redacted] (postoperative). She is also having problems with her right foot. She still has tendonitis in her right wrist. Her hip pain increased in the last year she was working for Dr. [redacted] and her right wrist pain worsened, attributed to work activities.

[redacted]

Also describes her left leg pain worsened in the past year. She is able to do her activities of daily living including personal hygiene. She is seeing Dr. [redacted] XX tomorrow. Dr. [redacted] told her left leg is shorter than her right leg. She still experiences weakness on her left side. She performs her home exercises.

DEPOSITION OF BXXXXXX [redacted], VOLUME 2:

[redacted] - Pages 72 through 148 - The patient takes naproxen and a pill to help her sleep. Goes through her family and living situation. She started working at XXXXXX on [redacted]. Her job duties include vacation planning and selling tickets in the ticket booth. Her job there entails sitting. She works around 20 hours per week. Has difficulty doing her job because of her wrist and right foot. Has constant right foot pain. Describes working at a computer her whole work shift. She is also currently working part-time at a dental office (Dr. [redacted]). She started working there on [redacted] as a Dental Assistant, works around [redacted] hours per week. Her job duties include assisting the doctor, doing chair side, performing x-rays, pouring up models, sterilizing instruments, computer work, as well as talking to patients. Has difficulty doing her job because of her wrist, hand, and foot, also her back. Has pins & needles in her right hand as well as stiffness in her right index finger. She wears her wrist brace but not at work. She experiences needles in her right foot especially when standing up. She wears her boot when she sleeps. She works at the dental office on [redacted] and [redacted] She works at XXXXXX on [redacted], [redacted] Describes she has an assistant at the dental office who does the cleaning. Her current work restrictions include no bending; no standing over half an hour; no stooping; no lifting over 25 pounds; no carrying over 20 pounds; no power gripping; no squatting, or stooping. She informed the doctor about her restrictions when she started working and *they are being honored*. Her hip pain began in around [redacted] following a bowling incident. Right after that she began experiencing pain in her right foot because she was compensating all her weight onto her right foot; explains she would take her left foot and put it on top of her right foot and bear all her weight on her right foot. A podiatrist at XXXXX gave her a boot as well

[redacted]

as insoles for her shoes. Dr. XXX gave her a cortisone injection to her foot a few months ago which helped temporarily. Relates she was performing her exercises at one time and her *sciatic* went out placing her back to using the cane. She feels stabbing pain in her right foot when she stands up, flexes her right foot, or lies down. Has discomfort in her hip. Patient states that after her surgery, she returned back to work only after *two and a half days* (sic). At one time she was asked to work on a machine (air abrasion) which was beyond her restrictions. She went home with pain in her hip and back. She was afraid to tell or remind her employer about her restrictions due to fear of losing her job; her employer ended up firing her two days later anyway. Dr. XXX stopped the acupuncture treatment to her left hip, low back, right foot, and right hand because it was not helping. Shock wave treatment was done once. She currently has problems walking with her right foot and limps with her left leg. There was discussion about her psychiatric symptoms: Patient relates she was previously working for Dr. [redacted] as the Head Assistant and then Dr. [redacted] took over the practice and took away her job duties and gave it to his sister which caused her a lot of stress. Dr. [redacted] did not change the job duties of the other employees. He made her sister the Head Assistant. Patient relates experiencing harassment from the front desk (XXXX). She is still on her 90-day probation with Dr. [redacted] Dr. [redacted] referred her to Dr. LXXXXXXXXX for employment. Dr. [redacted] took over the practice in [redacted] and in around [redacted] her boyfriend rushed her to the XXXXXX emergency room secondary to anxiety and stress. Her EKG was normal. No therapy or biofeedback was requested. She could not recall if she was given any medication. Patient described receiving harassing text messages from XXXX. MXXX could be nice one day and a snake another day. One text message she received from MXXXX stated, ''*If you're not resting, I'm going to come and kidnap you and kill you.*'' Patient took it as a joking matter. There was further discussion about her work relationship with [redacted] especially regarding her Disability, surgery schedule, the surgery itself, as well as her postoperative course. Patient mentions filing a wrongful termination claim against Dr. XXXXX which had been restricted and settled. Patient states [redacted] was the Office Manager and has the power to hire or fire anybody and that was why she was fired.

[redacted]

This concludes the review of available records.

PHYSICAL EXAMINATION:

GENERAL:

The patient is a well-developed, well-nourished, 50-year-old, right-handed female in no acute distress. She appears her stated height of 5'XX tall and weight of XXX pounds.

GAIT/STANCE:

The patient ambulates independently with a normal heel-toe gait without the aid of any assistive devices.

In the examining room, the patient stands straight with the spine erect. The pelvis and shoulders are level to the floor.

RIGHT WRIST:

There is no deformity, heat, swelling or erythema. There is mild tenderness to palpation. The radial and ulnar joints are nontender.

There is full range of motion of the wrists.

Tinel's sign is questionable positive on the right, Phalen's test, and Finkelstein's tests are negative bilaterally.

UPPER EXTREMITY MEASUREMENTS:

	RIGHT	LEFT
Forearms (Largest circumference):	26 cm	26 cm
Arms (Mid biceps):	34 cm	34 cm

LUMBAR SPINE:

There is a normal lumbar lordotic curvature. There is no

[redacted]

paralumbar spasm. There is no paralumbar tenderness. There is mild tenderness in the midline. There is mild left SI joint tenderness.

She is able to stand on her heels and toes without difficulty.

After adequate warm-up, the patient is able to forward flex the lumbosacral spine so that the tips of her fingers reach the knees and arise to the erect position without difficulty.

HIPS:

There is full and painless range of motion of the right hip.

The left hip has a well healed surgical scar that is nontender with no sign of infection. It is not adherent to underlying tissue.

The patient can flex her left hip to 80 degrees and extend it to 0 degrees. There if full abduction, adduction, there is limitation in internal to 10 degrees and external rotation to 20 degrees.

The greater trochanters are nontender bilaterally.

LOWER EXTREMITIES:

Reflexes: Knees 2+ and symmetrical; ankles 2+ and symmetrical.

There is no ankle clonus.

There is a negative Babinski sign.

There is no motor deficit of either lower extremity as evidenced by a strong tibialis anterior, extensor hallucis longus, quadriceps femoris and gastrocnemius muscles.

There is no sensory deficit to the Wartenberg pinwheel.

There is no vascular deficit.

[redacted]

Peripheral pulses are full and intact.

LOWER EXTREMITY MEASUREMENTS:

	RIGHT	LEFT
Calves (at the widest point):	25 cm	25 cm
Thighs (10 cm above the superior pole of the patella):	56 cm	56 cm
Leg Lengths	91 cm	89.5 cm

RIGHT FOOT:

There is no deformity and full range of motion. There is no tenderness noted at this time. She says his is a good day.

DIAGNOSIS:

1. Left hip degenerative joint disease secondary to acetabular dysplasia as a child aggravated and exacerbated by a slip and fall accident at the bowling alley, status post total hip replacement.

2. Lumbosacral sprain/strain.

3. History of mild inflammation of the right foot, non-industrial in nature.

4. Tendinitis of the right hand, resolved.

DISCUSSION:

After reviewing the records supplied to me, taking a history of the patient, as well as doing the examination, it is my opinion that this patient did not sustain any industrial injury her left hip. The problems with the hip are due to the acetabular dysplasia as a child, resulting in the need surgery and resulting in pin removal. The hip arthritis that she developed was a normal progression with the acetabular dysplasia that she had as a child and is a common

[redacted]

consequence. That dysplasia was aggravated by a non-industrial slip and fall in the bowling alley. In my opinion, it is not due to any employment while working for Dr. [redacted] as that job did not involve standing all day and the patient could sit at times during the day. I feel that her work played no role at all in her left problem, disability and need for treatment.

The patient during her history to me seems very bitter towards Dr. [redacted] due to her termination, but that does not mean she had any significant continuous trauma injury to the hip while working for him. She spent a great deal of time today complaining of stress and problems with obtaining jobs and references.

It should be noted that while she is now claiming a continuous trauma injury working for Dr. [redacted] she made no such claim at the time of her hip surgery and all of that surgery was done on a non-industrial basis.

With regard to the hip she has done fairly well since the surgery. She clearly is at MMI status.

She also reports lumbar spine pain. There was some indication in the records of so low back complaints. I feel the low back pain is a combination of leaning over assisting the dentist in his office and the result of altered gait from her total hip procedure. There is no sign of lumbar disc disease and no lower extremity radiculopathy. She is also at MMI status in this regard.

She also complaints of right foot pain, which she actually relates to the hip in that she would stand more on the right to take pressure of the left hip. Today, I really see nothing that needs treatment for the right foot and I cannot see how this could be related to her job with Dr. [redacted] In fact she admits this did not even begin until [redacted]

Her other complaint is a history of right wrist pain for many years. She feels this is due to her work and the repeated use of her right hand and wrist as a dental assistance. It appears this began during the time she worked for Dr. [redacted] and it is reasonable she could have some tendonitis, but this is also considered to be at MMI

[redacted]

status.

AMA IMPAIRMENT:

The patient is rated using the AMA Guides, 5th Edition:

For the left hip, she is rated using Pages 546 and 548. Using Table 17-34 for a hip replacement, she had a fair result, with 79 points. Using Table 17-33 this is a 20% whole person impairment.

For the lumbar spine, using Table 15-3 she is a DRE Category II, with some decreased range of motion and radicular complaints, but no true radiculopathy. She has a 7% whole person impairment.

For the right wrist, I would take this into consideration with her ADLs and pain and provide her with a 2% whole person impairment.

There is no impairment for the right foot.

Her total whole person impairment combined is 27%.

WORK PRECLUSIONS:

For the left hip she is precluded from prolonged standing or walking, very limited climbing, and no lifting, pushing or pulling more than 20 pounds.

The same restrictions would be in place for the lumbar spine.

For the right wrist, she should wear the wrist brace, and must take a break after 30 minutes of use of her hands.

FUTURE MEDICAL CARE:

None for the left hip on an industrial basis.

For the lumbar spine, she should be allowed follow-up visits, use of non-steroidal anti-inflammatories, non-narcotic pain medications, such as Ultram, and short courses of therapy or acupuncture, not to exceed two courses a year.

[redacted]

For the right wrist, the use of a right wrist brace, the use of anti-inflammatories is all that is required.

CAUSATION & APPORTIONMENT:

I addressed causation earlier in my discussion. The left hip was in no way caused or aggravated by her work. This problem began as a child and progressed to the point she needed surgery. There was some aggravation due to the bowling alley incident, not her work. 100% of her left hip disability is due to the non-industrial factors.

The low back pain is due to a combination of assisting at Dr. [redacted] and office and the result of altered gait from her total hip procedure. I would apportion 60% to the hip surgery and the remaining 40% to her work at Dr. [redacted] office on a cumulative trauma basis.

The right foot is unrelated to her work at Dr. DXXXX.

The right wrist is secondary to overuse on her job. I would apportion this 100% to the cumulative trauma.

DISCLOSURE:

This patient was interviewed and examined by the undersigned; the medical records were reviewed; and this dictation was done solely by the undersigned.

The attached statement for billing for the services of this evaluation and report are true and correct to the best of my knowledge.

There has not been a violation of Sec. 139.3 in conjunction with this evaluation to the best of my knowledge.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein,

[redacted]

that I believe it to be true.

Sincerely,

KENNETH P. SCHEFFELS, M.D.
Diplomate, American Board of
Orthopedic Surgery

Signed in Los Angeles County on _____

KPS/fm/mte

cc: TXXXXXXX
XXXXXXXX [redacted]
Attn: [redacted]
P.O. Box XXXX
WXXXXX XXXXX, California XXXXX

LAW OFFICES [redacted] XXXXXXXX (REPRESENTING THE [redacted]
Attn: [redacted] HXXXXXX, Esquire
P.O. Box XXXX
XXXXX, California XXXXX

SAMPLE.

KENNETH P. SCHEFFELS, M.D.

Diplomate, American Board of Orthopedic Surgery

4940 Van Nuys Boulevard, Suite 302
Sherman Oaks, California 91403
(818) 990-4497

#2

[redacted]

[redacted]

Attention: xxxxx xxxxxx, Claims Representative

CLAIMANT : [redacted]
CLAIM NO :
REQUESTOR: XXXXXXXX XXXXX
COVENTRY#: [redacted]
COVERAGE : DEFENSE BASE ACT
ACCT. NO : XXXX
D/INJURY : [redacted]
D/EXAMIN :

ORTHOPEDIC IME EVALUATION REPORT

Dear Ms. XXX:

Today, I had the opportunity to perform an orthopedic IME evaluation in my Sherman Oaks office on Ms. [redacted] a 59-year-old, right-handed female. Ms. XXXX gives me the following history.

She is seen today with regard to her claim of shoulders, upper arm, neck and head.

EMPLOYMENT AT TIME OF INCIDENT:

Ms. [redacted] worked as a flight attendant for XXXXXXXX [redacted] She worked for this employer for [redacted] She worked about 80 hours per month. She performed standard flight attendant duties, but reports at the end o[redacted]er job involved working more in the galley, cooking meals in an overhead oven and serving food. This required repeated overhead reaching with both upper extremities. She

[redacted]

denies concurrent employment. She last worked in [redacted].

HISTORY OF THE PRESENT INJURY:

Ms. [redacted] states that during the course of her employment she performed repeated overhead reaching with both upper extremities, right side more than left. As a result, she developed pain and limitation of motion in both shoulders. This began in about [redacted], and progressively worsened until she obtained medical care under her private insurance in [redacted] She was then taken off work.

She saw Dr. [redacted] three times, and was then referred to a rheumatologist for blood tests. She was found to be ANA positive. She also had MRI's of both shoulders, but is not clear about the results. She was seen by a rheumatologist Dr.XXXX.

Due to continued shoulder pains, she eventually went to Human Resources and officially filed a workers' compensation claim.

Due to continued shoulder pain, she saw an orthopedist, Dr. [redacted] XXXXX and due to the positive MRIs, she underwent right shoulder arthroscopy on [redacted] and left shoulder arthroscopy on [redacted]

She had extensive post-operative physical therapy on the right shoulder and is currently doing home exercises for her right shoulder. She continues to receive physical therapy, two times per week, for her left shoulder.

CURRENT ORTHOPEDIC COMPLAINTS:

1. Left shoulder pain and stiffness, worse with motion, especially overhead reaching. She states she has a "frozen shoulder".

2. Right shoulder stiffness and pain exacerbated by overhead reaching and motion.

She does not describe any neck pain either on her questionnaire or verbally to me today.

CURRENT JOB STATUS:

Ms. [redacted] is not working. She is collecting workers' compensation disability.

[redacted]

She last worked in [redacted], but is unclear on the date.

PAST MEDICAL HISTORY:

WORK INJURIES:

None prior.

ILLNESSES:

The patient denies any history of tuberculosis, pneumonia, or asthma. There is no history of heart disease, hypertension, diabetes, epilepsy, liver disease, kidney disease, thyroid disease, ulcers, or cancer.

ALLERGIES:

Denied.

SURGERIES:

[redacted] breast reduction; [redacted] right shoulder arthroscopy; [redacted] eft shoulder arthroscopy.

AUTO ACCIDENTS:

[redacted] no injuries.

FAMILY HISTORY:

Mother and grandmother had cancer. Father had diabetes.

SOCIAL HISTORY:

The patient denies the use of tobacco or alcohol. She does not use illicit drugs.

REVIEW OF MEDICAL RECORDS:

Ms. [redacted] completed an ADL form today and this was reviewed.

[redacted] – Cover letter from [redacted] reviewed.

[redacted]

[redacted] XXXXX& [redacted] XXXXXXX [redacted]

[redacted], MD:

[redacted] Work status report - Seen for sudden onset of low back pain. Off work for two weeks. Return to work on [redacted]

[redacted] - Work status report - Seen for sudden onset of low back pain. The patient is placed on total temporary disability. Off work until [redacted]

[redacted] Work status report – *Seen at XXXXXX XXXXX Medical Center* by [redacted] XXXX, MD secondary to ongoing back symptoms. Patient is unable to perform her job duties. The patient is placed on total temporary disability times six weeks.

[redacted] Work status report – Still temporarily totally disabled. Receives physical therapy. Off work until [redacted]

[redacted] X-rays of the right shoulder and humerus done by [redacted] XXXX, MD – *Impression*: Unremarkable x-rays of the right shoulder and right humerus. No fracture. Intact articular surfaces.

[redacted] – X-rays of the left shoulder and humerus done by [redacted] XXXX, MD – *Impression*: Unremarkable x-rays of the left shoulder and left humerus. No fracture. Intact articular surfaces.

[redacted] Seen by [redacted] MD at XXXX XXXX Health Center for bilateral arm pain radiating from deltoid muscles. Patient works as a Flight Attendant. Describes doing lifting at work. Physical examination: Bilateral upper extremities nontender with full ranges of motion. Assessment: Bilateral arm pain. URI symptoms. Fatigue. Ordered x-rays as well as various laboratory tests.

[redacted] – Seen by [redacted], MD. Laboratory tests came back with positive ANA (1:80). Assessment: Myalgia. Referred for Rheumatology consult. Follow up with Dr. XXXXX. FMLA forms filled out for two months' leave.

[redacted] – Seen by [redacted] XXXXXX, MD for followup of migraines, osteoporosis (lumbar spine), and low vitamin D. Current medications: alprazolam (Xanax), oxycodone-acetaminophen, and eletriptan (Relpax). Same complaints of significant bilateral arm pain, attributed to her work activities. States her surgeon believes her positive ANA is partly due to her silicone breast implants which were already removed. Presents tearful when discussing her pains. Diagnoses: Bilateral

[redacted]

shoulder joint pains. Bilateral arm pain. Osteoporosis. Low vitamin D, lumbar spine. Migraine. Referred for Workers' Compensation evaluation. Prescribed Advil. Recommended MRIs of the cervical spine and bilateral shoulders. Continue physical therapy. Injections to biceps tendon offered but patient declined.

[redacted] – MRI of the right shoulder done by XXXXXXX XXXXXXX, MD – *Findings*: Focal area of low signal on T1 and T2 weighted images within the supraspinatus tendon measuring 8.0 mm in diameter, consistent with calcific tendinosis of the supraspinatus tendon. Mild right acromioclavicular joint degenerative changes. Mild degenerative changes of right greater tuberosity. There is a tear of the right superior labrum anteriorly with tendinosis versus partial tear of attachment of the tendon of long head of biceps. Noted thickening and edema of right superior glenohumeral ligament and joint capsule and to a lesser extent the inferior joint capsule (either result of prior trauma or adhesive capsulitis). Clinical correlation advised. Small joint effusion seen. *Impression*: Edema of the superior glenohumeral ligament and the joint capsule and also inferior joint capsule which can be seen as a result of prior trauma or adhesive capsulitis. Calcific tendinosis of the supraspinatus tendon. Tear of the superior labrum anteriorly and tendinosis of the attachment of the tendon for long head of biceps. Joint effusion. Mild acromioclavicular joint degenerative changes with no evidence of impingement.

[redacted] – Orthopedic evaluation report – Seen by XXXXXXX XXXXX, MD at XXXX XXXXXX [redacted]. Job title: Flight Attendant. Work activities include repetitive reaching, lifting, and overhead activities which caused constant chronic bilateral shoulder pain and neck pain. Past surgical history: Bilateral breast reconstruction surgeries. Current medications: *Valacyclovir (Valtrex)*, eletriptan (Relpax), Xanax, and Advil. Noted the MRI findings of the cervical spine and shoulders. Assessment: Cervical stenoses. Bilateral acromioclavicular joint arthroses, impingement syndrome. Right shoulder calcific tendinitis and labral tear. Causation: Industrial. Recommended right subacromial decompression, right acromioclavicular joint arthroplasty, removal of calcium deposit, rotator cuff repair, and superior labral treatment.

[redacted] – Operative report done by XXXXXXXX XXXXX, MD – Pre- and postoperative diagnoses: Right shoulder rotator cuff tear, calcific tendonitis, acromioclavicular joint arthrosis, impingement syndrome, synovitis, and adhesive capsulitis. *Procedures performed*: Right shoulder arthroscopic repair of rotator cuff tendon tear. Arthroscopic right acromioclavicular joint arthroplasty, extensive debridement, lysis of adhesions, and subacromial decompression. *Findings*: Right glenohumeral space showed significant synovitis in the anterior and posterior compartments with minimal articular changes to the right humeral head or glenoid.

[redacted]

Noted adhesions across the anterior and posterior aspect of the shoulder. Some fraying of the right superior labrum. 90% partial-thickness undersurface tear of the anterior attachment site of the right supraspinatus tendon. Right subacromial space showed extensive bursitis in the subacromial space. Release of the right coracoacromial ligament exposed a 7.0 mm anterolateral subacromial bone spur.

[redacted] – Postoperative physical therapy evaluation report done by XXXXX XXXXX PT.

[redacted] Physical therapy progress report.

[redacted] – Letter from XXXXX XXXXXX, MD indicating patient was on FMLA leave from work since her job duties were felt to be exacerbating her symptoms.

Further physical therapy progress reports from XXXX XXXXXXX, PT dated [redacted]

[redacted] Acupuncture evaluation report done by [redacted]

[redacted] – Acupuncture progress report done by [redacted]

[redacted] Acupuncture progress report done by [redacted]

[redacted] Physical therapy progress report done by [redacted] PT.

[redacted] – Acupuncture progress report done by [redacted]

Further physical therapy progress reports from [redacted] *PT dated* [redacted]

[redacted] – MRI of the left shoulder done by JXXXX XXXXX, MD – Referred by [redacted] XXXXXXX, MD. *Findings*: Minor degenerative changes in the left acromioclavicular joint with tiny bursal effusion. Type 2 acromion. Tiny zones of undersurface tearing. Focus of presumed calcification in the left supraspinatus near its insertion; recommended correlation with conventional film. *Impression*: Minor insertional tearing of the footprint of the left supraspinatus. There may be a focus of calcification in the distal supraspinatus tendon. Correlation radiography is recommended.

[redacted]

[redacted] – Physical therapy progress report done by [redacted] XXXXXX, PT.

[redacted] – Physical therapy progress report done by [redacted] XXXXXX, PT.

[redacted] – Operative report done by [redacted] XXXXXX, MD – Pre- and postoperative diagnoses: Left shoulder impingement syndrome, acromioclavicular joint arthrosis, synovitis, and adhesive capsulitis. *Procedures performed*: Left shoulder arthroscopic acromioclavicular joint arthroplasty. Arthroscopic extensive debridement, lysis of adhesions, and subacromial decompression. *Findings*: Fraying of the anterior labrum with some synovitis in the left glenohumeral joint space. Left subacromial space showed extensive bursitis and adhesions throughout the subacromial space. Release of the left coracoacromial ligament exposed a 6.0 mm anterolateral subacromial bone spur. Left acromioclavicular joint showed extruded disc with stenotic acromioclavicular joint.

[redacted] – Postoperative physical therapy evaluation report done by [redacted], PT.

Further physical therapy progress reports from EXXX XXXXXXa, PT dated [redacted], and [redacted]

[redacted] – MRI of the left shoulder done by [redacted] XXXX, MD – Referred by [redacted] XXXXXX, MD – *Findings*: Surgical changes including resection of the left acromioclavicular joint and the undersurface of the left acromion. Noted fluid present in the operative bed; small amount of fluid seen in the bursa. Mild signal changes in the left rotator cuff consistent with tendinosis but no rotator cuff tear. Mild changes including left subscapularis tendinosis. *Impression*: Since the prior study of [redacted] the patient has had surgery at the left acromion and left acromioclavicular joint. No evidence of rotator cuff tear. Since the prior exam, mild changes of subscapularis tendinosis have appeared.

Further physical therapy progress reports from EXXXX OXXXXX, PT dated [redacted] and [redacted]

UNDATED letter from the patient indicating she suffers from extreme pain in her shoulders, upper arms, and neck. Three doctors she had seen all agreed her pain is caused by her work activities including reaching and bending. She cannot bend her arms behind to hook her bra or put a shirt over her head. Lying down on either side is painful. She feels weak in her arms and hands. She started working the galley in

[redacted]

[redacted] *having the carts, supplies, and meals ready; and filling the bins when there were extra supplies. In* [redacted] *she worked most of her off days and worked in the galleys a lot. Described taking in and out and moving heavy oven racks several times to cook the meals evenly. Described doing a lot of reaching and stretching when getting bins for sodas, water, and other supplies. Her bilateral arm pain progressed in around early* [redacted] *She continued working; rested as much as possible in between flights. Reiterates she worked straight from* [redacted] *through* [redacted] *without days off right into* [redacted] *She constantly reported her bilateral arm pains to her Supervisors and coworkers. She last worked on* [redacted] *States she was in so much pain, fatigue, and distress that she started crying in the doctor's office.*

This concludes the review of medical records.

PHYSICAL EXAMINATION:

GENERAL:

The patient is a well-developed, well-nourished, 59-year-old, right-handed female who appears younger than her stated age. Her stated height is [redacted] stated weight [redacted] pounds.

GAIT/STANCE:

The patient ambulates independently with a normal heel-toe gait without the aid of any assistive devices.

In the examining room, the patient stands straight with the spine erect. The pelvis and shoulders are level to the floor.

CERVICAL SPINE:

There is full and painless active and passive range of motion of the cervical spine in all planes. There is no paracervical spasm. There is no paracervical tenderness. There is no tenderness in the midline. There is no trapezius tenderness or spasm.

UPPER EXTREMITIES:

Biceps and triceps reflexes are 2+ and symmetrical.

[redacted]

There is no motor deficit of either upper extremity.

The patient is able to oppose the tips of her thumbs to the heads of the fifth metacarpals.

She is able to flex all fingers so that they reach the mid-palmar crease.

The patient is able to oppose the tips of her thumbs to the tips of all of her digits.

She has full abduction and adduction of all of her digits.

There is no intrinsic atrophy.

There is no hypothenar or thenar atrophy.

There is no sensory deficit to the Wartenberg pinwheel.

There is no vascular deficit.

Peripheral pulses are full and intact. There is good capillary filling of all digits.

SHOULDERS:

There are well-healed arthroscopic portal scars about both shoulders. The scars are nontender and not adherent to underlying tissue. There is no keloid formation or sign of infection.

Examination of the right shoulder reveals abduction to 90 degrees and flexion to 140 degrees. Remaining motions are full. There is only mild pain with abduction and flexion. There is no strength deficit.

Examination of the left shoulder reveals abduction to 80 degrees and flexion to 130 degrees. There is significant pain with attempt to do range of motion of the left shoulder.

There is no point tenderness at the biceps grooves, subacromial bursae, or AC joints bilaterally.

Impingement sign is negative bilaterally.

[redacted]

ELBOWS:

Examination of the elbows reveals full, painless range of motion; 0 degrees extension, 140 degrees flexion, 90 degrees pronation, and 90 degrees supination.

There is no tenderness at the medial or lateral epicondyles.

There is a negative Tinel's sign at the cubital tunnels.

WRISTS/HANDS:

The radioulnar joints are nontender.

There is full range of motion of the wrists.

Tinel's sign, Phalen's test, and Finkelstein's test are negative bilaterally.

UPPER EXTREMITY MEASUREMENTS:

		RIGHT	LEFT
Forearms (Largest circumference)	:	24 cm	24 cm
Arms (Mid biceps):		29 cm	29 cm

DIAGNOSES:

1. Continuous trauma/repetitive trauma injury, bilateral shoulders, secondary to work as a flight attendant; status post arthroscopy bilateral shoulders, right shoulder AC joint arthroplasty and rotator cuff repair [redacted] left shoulder debridement and subacromial decompression on [redacted]

2. History of prior neck pain in records, no industrial injury to the cervical spine.

DISCUSSION:

At this time, it is within reasonable medical probability that this patient sustained a continuous trauma injury to both shoulders as a result of her work as a flight attendant. She describes the overhead activities and use of the arms that would be

[redacted]

consistent with the development of symptoms due to her job. This has resulted in internal derangement bilaterally with the need for shoulder arthroscopies.

She had right shoulder surgery on [redacted] and has completed all postoperative therapy. I believe she has reached maximum medical improvement for the right shoulder.

The left shoulder surgery was performed on [redacted] and she remains in the rehabilitation phase for the left shoulder. I anticipate an MMI status for the left shoulder in approximately 3-4 months.

While there was a claim for neck pain, she does not give me a history to support a cervical spine injury. There is no indication of any treatment for the neck in the records from the last year. The treatment has been for the shoulders only. She gives no neck complaints today. She gives no history of headaches to me today.

Ms. [redacted] has been seen by a rheumatologist and has a positive ANA. While I can see how she injured her shoulders due to the work described, I cannot relate any other complaints to the job.

FUTURE MEDICAL CARE:

The patient should be provided with future medical care for the left shoulder consisting of physical therapy to improve range of motion.

For the right shoulder, she should continue her home exercise program.

STATUS:

Ms. XXXXXX has reached maximum medical improvement for the right shoulder only.

AMA IMPAIRMENT:

Using the AMA Guides, 5th Edition, Figure 16-40 on page 476, she has a 3% upper extremity impairment. Using Figure 16-41 on page 477, abduction to 90 degrees equals a 4% upper extremity impairment. Her total right upper extremity impairment is 7%. There is no impairment for internal or external rotation. Using Table 16-3 on page 439, the upper extremity impairment of 7% converts to a 4% whole person impairment.

[redacted]

The left shoulder is not yet at maximum medical improvement and is not rated at this time.

WORK CAPACITY:

She would be precluded from use of the arms above shoulder level. She is also precluded from lifting, pushing or pulling more than 20 pounds.

CAUSATION & APPORTIONMENT:

Ms. [redacted] bilateral shoulder complaints are consistent with a continuous trauma work injury.

100% of the patient's present right shoulder disability is apportioned to her employment activities of repetitive overhead reaching. Her prior x-rays did not show any significant degeneration. At this time I feel there is no prior disability or other causation to apportion.

I see nothing to support any injury to the cervical spine. She also gives me no history of headaches or migraines due to neck pain. Any complaints other than to the shoulders I feel is more medical reasonably related to her positive ANA.

DISCLOSURE:

Ms. [redacted] was interviewed and examined by the undersigned. The medical records were reviewed and this dictation was done solely by the undersigned.

Sincerely,

KENNETH P. SCHEFFELS, M.D.
Diplomate, American Board of
Orthopedic Surgery

Signed in Los Angeles County on _____

KPS/fm/cce

September 23, 2015

TO: Disability Procedures & Services Committee
Vivian H. Gray, Chair
William de la Garza, Vice Chair
William R. Pryor
Les Robbins
Yves Chery, Alternate

FROM: Ricki Contreras, Manager
Disability Retirement Services Division

FOR: October 7, 2015, Disability Procedures and Services Committee Meeting

SUBJECT: **CONSIDER APPLICATION OF THOMAS W. FELL, JR., M.D., AS LACERA PANEL PHYSICIAN**

On August 17, 2015, Debbie Semnanian interviewed Thomas W. Fell, Jr., M.D., a physician seeking appointment to the LACERA Panel of Examining Physicians.

Attached for your review and consideration are:
- Staff's Interview Summary and Recommendation
- Panel Physician Application
- Curriculum Vitae
- Sample Report(s).

IT IS THEREFORE RECOMMENDED THAT THE COMMITTEE accept the staff recommendation to submit the application of Thomas W. Fell, Jr., M.D., to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

JJ:RC/sc

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

Date: 9/24/15

August 17, 2015

TO: **Ricki Contreras, Division Manager**
Disability Retirement Services

FROM: **Debbie Semnanian, WCCP** DS
Supervising Disability Retirement Specialist

SUBJECT: **INTERVIEW OF ORTHOPEDIC SURGEON APPLYING FOR LACERA PHYSICIAN'S PANEL**

On August 17, 2015, I interviewed **Thomas Fell**, M.D. at his office at 4940 Van Nuys Blvd., Suite 302, Sherman Oaks, CA 91403. The office space is located in an older but well maintained three-story building with patient paid parking (maximum $6.00) located in the back of the building. There is also free 2-hour parking on the adjacent street.

Dr. Fell is a board certified orthopedic surgeon who has been in private practice for over forty years. Dr. Fell shares office space with several orthopedists and a neurologist. The office has 6 complete examination rooms. Dr. Fell estimates that 50 percent of his practice is devoted to patient treatment, while the other 50 percent of his time is devoted to IME evaluations primarily within the workers' compensation systems and other retirement systems.

As referenced in his Curriculum Vitae, Dr. Fell graduated from New Jersey College of Medicine with his medical degree in 1969. He completed an internship at North Carolina Hospital in 1974, and residencies at North Carolina Memorial Hospital in 1974 and North Carolina Orthopedic Hospital in 1973. Dr. Fell served as Chairman Quality Assurance Committee and Chief of Staff at Pacifica of the Valley Hospital.

Dr. Fell's office was clean with adequate seating. The office and restrooms are handicap accessible and there is a staff of thirteen employees.

Staff reviewed the LACERA Disability Retirement procedures and expectations in its evaluation of County Employees applying for both service-connected and nonservice-connected disability retirements. The importance of preparing impartial and non-discriminatory reports that are clear and concise and address issues of causation and incapacity were discussed with the doctor. He understood that he would adhere strictly to the HIPAA laws that would also apply for LACERA reports. Staff reviewed with Dr. Fell the Panel Physician Guidelines for evaluating LACERA applicants and defined the relationship between workers' compensation and disability retirement. Staff discussed the need to rely on his

own objective and subjective findings rather than the opinions of previous physician reports and/or comments.

Dr. Fell agreed to adhere to LACERA's standard of having his evaluation reports sent to us within 30 days of examination. Staff confirmed that Dr. Fell is agreeable with accepting payment per the Official Medical Fee Schedule (OMFS). Dr. Fell was informed that if he is approved by the Board to be on our panel of physicians, he is required to contact the specialist assigned to the case for approval of any special tests or extraordinary charges. He was also informed that a Quality Control Questionnaire is sent to each applicant regarding their visit.

RECOMMENDATION

LACERA has a pressing need to add orthopedic physicians, particularly in the area in which Dr. Fell completes examinations. He expressed not only a willingness to be on our panel, but also an enthusiasm for building a relationship with LACERA.

Based on our interview and the need for his specialty, staff recommends Dr. Fell's application be presented to the Board for approval as a LACERA Panel Physician.

LACERA

Los Angeles County Employees Retirement Association

300 N. Lake Ave., Pasadena, CA 91101 ■ Mail to : PO Box 7060, Pasadena, CA 91109-706 626/564-2419 • 800/786-6464

GENERAL INFORMATION		Date 6-8-15
Group Name:		Physician Name: Thomas W. Fell JR. M.D.
I. Primary Address: 4940 Van Nuys Blvd #302 Sherman Oaks CA 91403		
Contact Person E. Moss		Title Administrator
Telephone: 818-990-4497		Fax 818-990-6045.
II. Secondary Address See Attached Listing.		
Contact Person		Title
Telephone		Fax

PHYSICIAN BACKGROUND

Field of Specialty Orthopedic Surgery	Subspecialty	
Board Certification ☒ Yes ☐ No	License # G26187	Expiration Date 10-31-16

EXPERIENCE

Indicate the number of years experience that you have in each category.

Evaluation Type

I. Workers' Compensation Evaluations

No liens

- ☒ Defense — How Long? 25 years.
- ☒ Applicant — How Long? 8 years
- ☒ AME — How Long? 8 years
- ☒ IME — How Long? 20 years.
- ☒ QME — How Long? 20 years.

II. ☒ Disability Evaluations — How Long? 20 years City of LA

For What Public or Private Organizations? Dept of Fire & Police Pensions (5 years → CAL PERS)

Currently Treating? ☒ Yes ☐ No

Time Devoted to: Treatment 50 % Evaluations 50 %

Estimated Time from Appointment to Examination

- ☐ 2 weeks
- ☒ 3-4 Weeks
- ☐ Over a month

Able to Submit a Final Report in 30 days?

☒ Yes ☐ No

LACERA's Fee Schedule

Examination and Initial Report by Physician	$1,500.00 flat fee
Review of Records by Physician	$350.00/hour
Review of Records by Registered Nurse	$75.00/hour
Supplemental Report	$350.00/hour

-OVER-

Other Fees	
Physician's testimony at Administrative Hearing (includes travel & wait time)	$350.00/hour
Deposition Fee at Physician's office	$350.00/hour
Preparation for Expert Testimony at administrative Hearing	$350.00/hour
Expert Witness Fees in Superior or Appellate Court	$3,500.00 half day $7,000 full day

Physician agrees with LACERA's fee schedule? Yes No

Comments

Name of person completing this form:

THOMAS W FELL, 5R MD (Please Print Name) Title: _____

Physician Signature: Thomas W Fell MD Date: 6-15-15

FOR OFFICE USE ONLY Physician Interview and Sight Inspection Schedule	
Interview Date: 8/17/15	Interview Time: 12:00
Interviewer: Julie Simmons	

CURRICULUM VITAE

THOMAS W. FELL, JR., M.D.

Diplomate, American Board of Orthopedic Surgery

MAIN OFFICE:
Sherman Oaks
4940 Van Nuys Blvd.#302
Sherman Oaks, CA 91403
(818)990--4497

OTHER LOCATIONS:

Beverly Hills
50 N. La Cienega Blvd.#205
Beverly Hills, CA 90211
(323)966--4566

Arcadia
630 W. Duarte Road #203
Arcadia, CA 91007
(626)447-8870

Palmdale
819 Auto Center Drive
Palmdale, CA 93551
(661)266-0993

Paramount
16444 Paramount Blvd.#204
Paramount, CA 90723
(562)408-2247

Education:

Tufts University, Medford, Ma. B.S. 1964
Boston College, Chestnut Hill, Ma. Chemistry 1965
New Jersey College of Medicine, Newark M.D. 1969

Internship:

North Carolina Memorial Hospital Chapel Hill, N.C.
July 1969 - June 1970

Residency:

North Carolina Memorial Hospital Chapel Hill, N.C.
July 1970 - June 1974
North Carolina Orthopaedic Hospital Gastonia, N.C.
(Children's Orthopaedics) Jan-Dec 1973)

Practice:

Ross-Loos, Los Angeles July 1974 - August 1978
Serra Medical Clinic, Sun Valley 1978-May, 2004
Med Health (Workers Compensation - Treatment and Evaluations),
Sherman Oaks, Palmdale, Arcadia, Beverly Hills, Paramount
1988-Present

Hospital Affiliations:

Pacifica of the Valley Hospital, Sun Valley

Past Positions:

Director Scoliosis Clinic Ross-Loos(Cigna) 1974-84
Vice President Medical Staff Ross-Loos Hospital 1974
Chairman Utilization Review Ross-Loos Hospital 1973-74
Chairman Quality Assurance Committee Pacifica of
the Valley Hospital 1980-85, 1988-1989, 1994
Chief of Staff Pacifica of the Valley Hospital
1985-1987
Member Board of Directors Serra Medical Clinic 1979-1990
Chairman Department of Surgery Pacifica of the Valley Hospital 1989-91

Certification:

American Board of Orthopaedic Surgery, September 1975

Societies:

American Academy of Orthopaedic Surgeons
Western Orthopaedic Association

Licenses:

California, North Carolina

Publications:

Preston, E.T., and Fell, T.W.: Congenital Idiopathic Clubfoot, Clinical Orthopaedics 122:102, 1977

Sample

THOMAS W. FELL, JR., M.D.

Diplomate, American Board of Orthopedic Surgery

50 N. La Cienega Blvd., Suite 205
Beverly Hills, California 90211
(323) 966-4566

[redacted]

[redacted]

XXXX, CA XXXXX
Attn : [redacted]

RE: LXXXXXXX JXXXXXX VS [redacted]

CLAIMANT : LXXXXXX [redacted]
CLAIM NO : XXXXXXXXXXXX
WCAB NO : [redacted]XXXX
EMPLOYER : XXXXXXXXXXXXXXX
ACCT NO : XXXXXXX
D/INJURY : [redacted]
D/EXAMIN :

ORTHOPEDIC DEFENSE QME EVALUATION

Dear XXXXXXXXXXXXX:

Today, I had the opportunity to perform an orthopedic Defense (ADR) QME evaluation on [redacted]XXXXXX [redacted]XXXXXXX, in my Beverly Hills office. He gives me the following history with the assistance of an interpreter, XXXXXXXXXXXX with [redacted]XXXXXXXXXX [redacted].

This is a Complex Comprehensive Medical-Legal Evaluation (ML103) with the following three complexity factors being met: Four hours was spent on a combination of reviewing the medical records and in face-to-face time with the claimant. This report addresses the issue of medical causation with written request.

EMPLOYMENT AT TIME OF INCIDENT:

Mr. [redacted]XXXXXXX is a 64-year-old right hand dominant male employed by XXXXXXXXXXXXXXX [redacted] as a janitor for he thinks about one year and two months prior to his injury. However, for at least 20 years prior to that he has worked for the same building doing maintenance, but working for

[redacted]

another owner, he thinks that company was XXXXXXXXX. All the time he has been there, he has been doing building cleaning and maintenance.

HISTORY OF THE PRESENT INJURY:

The patient's first accident occurred in [redacted]. Prior to that, he did not have any back pain. At that time, he was lifting some heavy garbage bags. He had low back pain and treated at [redacted]. He was off work for at least seven to eight weeks. He believes his employer was XXXXX at that time. He has had back pain ever since then. He states that he takes medications to try to control his back pain. He states that the patient was going down both legs. He states that at that time, surgery was advised, but he declined it. He was given a back brace, which he has worn ever since.

In [redacted], he was lifting a heavy garbage bag, which was heavier than usual. The low back pain significantly increased. He again went to XXXXX. He was evaluated and had x-rays. He had chiropractic treatment, acupuncture treatment and physical therapy.

He had an epidural steroid injection at XXXXXX, which helped.

He continued working light duty up until the time he was seen by an attorney. In [redacted] the attorney sent him to a doctor who placed him off work.

He was then given various physical therapy and medications until the present time.

He states he is a little better than he was in January.

He states that they talked about surgery, but he is afraid of the surgery due to his diabetes as how he is walking and afraid he will not walk after surgery.

He has not returned to work since [redacted].

PRESENT COMPLAINTS:

The patient has mid and lower back pain with twisting,

bending, reaching and squatting. He is overall better with sitting. The pain radiates to both legs down to the calves and feet, particularly with walking over one to two hours. The pain can be in the right or left leg. There is no numbness, but occasional tingling in the legs. With walking, the pain in the hips/buttocks is the greatest pain. Coughing and sneezing does not cause any pain.

PAST MEDICAL HISTORY:

WORK INJURIES:

The patient had a prior work related injury in [redacted], as noted in the history, also to the low back with continued pain.

ILLNESSES:

The patient has a history of diabetes. The patient denies arthritis, cancer, heart or lung disease.

MEDICATIONS:

The patient is taking omeprazole and ibuprofen. He also takes medication for his diabetes.

ALLERGIES:

None.

SURGERIES:

None.

AUTO ACCIDENTS:

Denied.

SOCIAL HISTORY:

The patient denies smoking cigarettes, but admits to drinking alcoholic beverages.

[redacted]

FAMILY HISTORY:

The patient's mother is alive with diabetes. The patient's father is deceased due to kidney problems.

REVIEW OF MEDICAL RECORDS:

Mr. [redacted] completed an ADL form today and this was reviewed.

XXXXXXXXXXXXXXXXXXXXXX:

[redacted] XXXXXXXXXXXXX, Esq. Cover letter thanking me for the evaluation of the applicant as defense QME evaluator.

State of California/WCAB:

[redacted] State of California, Division of Workers Compensation/Workers Compensation Appeals Board Application for Adjudication of Claim. Claimed was injury to back while lifting bags on XXXXXXXX as a Janitor for XXXXXXXXXXXXXXXX [redacted].

XXXXXXXX XXXXXXXXXXXXXXXX:

[redacted]: XXXXXXXXX XXXXXXXXXXXXXXX, M.D. Patient presented with back pain for 2 days with no history of trauma and no pain radiation. On examination there was a 1 x 1 cm subcutaneous soft tissue mass in lumbar area. Assessment: 1) Backache 2) Diabetic foot exam. Patient to have CT of lumbar spine without contrast. Ibuprofen 600 mg. Follow-up in 2 weeks with primary medical doctor.

[redacted]: XXXXXXXXXXX XXXXXXXXXXXXXX, M.D. CT of Lumbar Spine. Impression: 1) Moderate central canal stenosis at L4-L5 with lateral recess stenosis at L5 on the left and intraforaminal nerve root compression of the L4 nerve root on the left, secondary to combined effects of hypertrophic degenerative facet disease at L4-L5 and Grade 1 anterolisthesis at L4-L5. 2) Hypertrophic degenerative facet disease L5-S1 bilaterally. 3) No evidence of demonstrable mass in paraspinous soft tissue. Findings noted axial images noting bilateral severe hypertrophic degenerative facet disease with bilateral hypertrophic facet disease at

[redacted]

L5-S1 more pronounced on left.

[redacted]: XXXXXXXXXXX XXXXXXXX, M.D. Called patient's home and spoke with [redacted]. Doing better. Suspect recent pain was muscle spasm. Offered physical therapy as did lifting at work. Patient to consider. Follow-up with Dr. Daly in October.

[redacted] XXXXXX XXXXXXXXX, M.D. Patient seen for diabetes mellitus. Noting cough for 2 weeks from dust. Said walks a lot at work and likes to exercise. CT of lumbar spine reviewed. Physical examination noted minimal tenderness at paraspinal area. Diagnosis: Spinal stenosis, lumbar area.

[redacted] XXXXXX XXXXXXXX, P.T. Physical therapy evaluation. Noted 6 months of low back pain. Felt related to work from using heavy machines and heavy lifting. Physical therapy modalities reviewed.

[redacted] XXXXXXX XXXXXXX, R.N. Complaining of severe back pain x 2 months. Appointment made to see Dr. AXXXXXXX.

[redacted]: XXXXX XXXXXXX. Patient stated that no pain when not working. Pain came on after a couple of hours at work. Worse when having to lift trash into container, each bag weighing 60-70 lbs with many trash bins to fill. Worse with walking on hard surfaces rather than soft/carpeted. Did not like wearing brace because gets too hot wearing it. Discussed use of TENS for pain management.

[redacted] XXXXXXXXX XXXXXXXXXXX, M.D. Progress note. Presenting with back pain to lower extremities for 2 months. Pain in right lumbar more than left. Better with rest and physical therapy. Associated numbness and tingling in feet. Meloxicam and ibuprofen did not help. Patient said asked supervisor to change his duties but need's doctor's note. Assessment: Lumbar spinal stenosis. Plan: 1) Modified duty for next 2 months. 2) Tramadol 50 mg. 3) Consider epidural steroid injection.

[redacted]. Dr. XXXXXXXXXX. Recent flare-up of back pain recently. Rarely ill but had episodes of intense pain that currently have halted ability to work on regular basis.

[redacted]

Physical examination noted tenderness to palpation at paraspinal muscle musculature region, especially on right. Patient with left lateral flexion and rotation. Assessment: Spinal stenosis, lumbar region. Advised temporary disability with time off work.

[redacted]: XXXXXXXXX XXXXXXXXX. Referred by Dr. XXXXXX. Two months chronic back pain now worsening. Assessment: Lumbar radiculopathy. 2) Essential hypertension. Plan: Methylprednisolone 4 mg oral dose pack ordered.

[redacted]: XXXXXXXXX XXXXXXXXX, N.P. Referred by Dr. XXXXXXX. Pain seen low back pain. Acute and intermittent low back pain with pain radiation to right lower extremity to right calf over past 3 months aggravated by lifting work as janitor. Assessment: 1) Arthropathy of lumbar facet. 2) Essential hypertension. 3) Lumbosacral radiculitis. Plan: Epidural steroid injection. Patient given instruction for pre-injection of no aspirin for one week and no blood thinners as well as instructions for his diabetes.

[redacted]: XXXXXXXXX XXXXXXXXXX, M.D. History and Physical for scheduled epidural steroid injection. Patient with history of low back pain, right greater than left leg pain.

[redacted] Dr. XXXXXXXXX. Pre- and Post-Operative Procedure: 1) Spinal stenosis of lumbar spine. 2) Lumbosacral radiculitis. Procedure: 1) Injection into epidural space of lumbar steroid. 2) X-ray fluoroscopic guidance for spine injection.

[redacted]: Dr. XXXXXXXXXX. Follow-up evaluation. Pain had progressed and now into buttocks and both legs where previously only in right leg. Began having pain in both legs 2 months ago. Pain described as cramping 5/10.

Said [redacted] lumbar epidural steroid injection gave only little benefit. Assessment: Low back and bilateral leg pain. L4-L5 spinal stenosis. Recommend second epidural steroid injection which he agreed to. Patient to continue with meloxicam and tramadol p.r.n. basis.

[redacted]: Dr. XXXXXXX. Patient seen prior to scheduled epidural steroid injection. Dietary indiscretions due to

[redacted]

back pain, leg cramps and stress. Paxil for increased frustration over back condition. Dr. Daly felt that patient's better control of his blood sugar would help pain. Possible surgery if no relief with injections.

[redacted]: Dr. XXXXXXX. Pre- and Post-Operative Procedure: 1) Spinal stenosis of lumbar spine. 2) Lumbosacral radiculitis. Procedure: 1) Injection into epidural space of lumbar steroid. 2) X-ray fluoroscopic guidance for spine injection.

[redacted]: XXXXXXXXXXX XXXXXXXX, L.V.N. Note. Patient brought form for bus pass to fill out regarding spinal stenosis. Primary care physician not available.

[redacted]: CXXXXXXXX XXXXXXXs. Patient dropped off Metro Application form for Dr. XXXXXXX to sign. Dr. XXXXXXX made referral for him to Spine Surgery.

[redacted]: Dr. XXXXXX. Noting leg cramps often at night. Diagnoses include spinal stenosis.

[redacted] XXXXXXXXX XXXXXXXX, M.D. Sent for surgical consultation by Dr. [redacted] Patient has had limited responses to epidurals. Temporary help with physical therapy, multiple different medications and epidural steroid injections. X-rays: Mild narrowing noted at L4-L5 disc space associated with slight spondylolisthesis. L5-S1 disc space may be slightly narrowed, but not well visualized. Discussion: The patient was noted to have severe lateral recess stenosis L4-L5 bilateral secondary to degenerative spondylolisthesis and milder left L5-S1 lateral recess stenosis. He was offered hemilaminotomies and medial facetectomies of the bilateral L4-L5 and left L5-S1. This was felt to be better than a fusion as primary complaint was leg pain. Also fusion could be considered at later date. Patient to consider and to let us know if he wants to proceed with surgery.

[redacted]: XXXXXXX XXXXXXXXXXX, M.D. X-ray of Lumbar Spine. Impression: Mild narrowing noted at L4-L5 disc space associated with slight spondylolisthesis. L5-S1 disc space may be slightly narrowed, but not well visualized.

[redacted]

[redacted]: Dr. XXXXXX. Dr. Daly noted that the patient had follow-up at the Spine Clinic. Period of disability considered but patient holding off for now.

[redacted]: XXXXXXXXX XXXXXX, LVN. Phone call with daughter. Patient stated did not want to apply for disability anymore.

[redacted]: XXXXXXX XXXXXXX. Patient called and wanted to cancel disability as already has upcoming appointment with a back specialist.

[redacted]: Dr. XXXXXg. Patient complaining of pain in bilateral legs from hips to ankles with numbness and feeling of tightness. Assessment: 1) Low back and bilateral leg pain. 2) L4-L5 spinal stenosis. Plan: Discussion with patient on options. Patient having difficulty deciding if should have surgery. Hesitant to proceed with more injections. To titrate nortriptyline to 50 mg qhs.

[redacted]: **XXXXX XXXXXXXX, M.D. Back pain from picking up trash on this date.** Relevant Past Medical History: The patient was noted to have had a CT of the lumbar spine on [redacted] for low back pain. Scout radiographs of the spine at that time noted very mild Grade I anterolisthesis of L4 on L5. CT and lumbar x-rays reviewed. Impression: 1) Lumbosacral radiculitis. 2) Lumbar facet arthropathy. Plan: Norco p.r.n. severe pain. Continue meloxicam. Refer to physical therapy. Repeat of x-ray of spine today. May require lumbar epidural steroid injection. Work Status: Modified duty, with lifting, pushing and pulling up to 25 lbs.

[redacted]: XXXX XXXXXXXXXXX, M.D. Complaint of low back pain. Patient currently working. Diagnosis: Lumbar radiculitis. Plan: MRI of lower back without contrast. Rule out herniated disc. Continue on modified duty.

[redacted] Dr. XXXXXXXX. PR-2. Patient said he was constantly on his feet and had severe back pain at work. Diagnoses: 1) Lumbar spondylosis. 2) Lumbar radiculopathy. Plan: 1) Sacrolumbar support. 2) Lab testing. 3) Continue with medications.

[redacted]

[redacted]: Dr. XXXXXXX. PR-2. Diagnoses: 1) Lumbar facet arthropathy. 2) Low back pain. 3) Lumbar radiculitis. Plan: Continue medication. Finish physical therapy. Refer to Pain Management for lumber epidural steroid injection.

[redacted]: Dr. XXXXXXXX. Pain Medicine Consult. Worsening back pain. Dr. CXXXXXXXXXX noted that he had seen this patient in [redacted] for low back and leg symptoms. Assessment: 1) Low back pain with leg fatigability. 2) L4-L5 spinal stenosis. Discussion: The patient previously had epidural steroid injection with benefit. Patient to be scheduled when authorization from Workers Compensation received.

[redacted]: Dr. FXXXXXXXX. No change in diagnoses. Continue Norco and meloxicam. Lumbar epidural steroid injection scheduled. Work Status: No lifting, pushing or pulling over 6 lbs.

[redacted] Dr. XXXXXX. Procedure Note. Pre- and post-operative diagnosis: Lumbar spinal stenosis. Procedure: 1) Injection steroid/anesthetic epidural, lumbar or caudal 2) X-ray fluoroscopy up to one hr.

[redacted] Dr. FXXXXXXX. PR-2. The patient's symptoms were improved. No change in diagnoses. Medications were refilled.

Also noted are reports on treatment for diabetes mellitus, type 2, erectile dysfunction, hypertension, eye exams, laboratory work-ups, and viral illnesses.

XXXXXXXX XXXXXXXXXXX:

[redacted]: Physical therapy evaluation and treatment

XXXXXXXX Radiology:

[redacted]: XXXXXXXXX XXXXXXXXX, M.D. MRI of the Lumbar Spine. Impression: 1) 6 mm disc bulge at L4-5 which together with mild to moderate facet arthropathy results in moderate spinal stenosis as well as moderate severe left and mild to moderate right neuroforaminal narrowing. 2) 3 mm broad posterior disc protrusions at L3-4 and LS-S1 without

[redacted]

evidence of spinal stenosis or neuroforaminal narrowing. 3) 4-5 mm anterolisthesis of L4 on L5. This is likely on the basis of facet arthropathy. 4) Mild to moderate bilateral facet arthropathy at L4-L5. 5) Disc desiccation at T11-T12, T12-L1, L3-L4, L4-L5 and LS-S1 with mild to moderate disc height loss at L4-L5.

Industrial XXXXXXXX XXXXXXXXXX:

[redacted]: XXXXXXXX XXXXXXXXXXXXX, M.D. Primary Treating Physician's Initial Comprehensive Medical Evaluation Report. The patient's injury was described. He presented with low back pain. He was currently TTD. Relevant Past Medical History: Type 1 diabetic. The patient injured his back 4 years ago while working for the employer and had self-procured treatment with injection and physical therapy (at Kaiser). He did not file a Workers Compensation claim at that time. Diagnosis: Lumbar spine myofascitis with radiculopathy. Plan: Omeprazole 20 mg q.d., Tylenol #3 300/30 mg 1-2 p.o. q 8-12 hrs, ibuprofen 800 mg 2-3 x daily. Physical therapy 2 x a week for 4 weeks. Functional Capacity Evaluation requested. DNA testing-CYP450 Pharmacological ASSAY for medication therapy ordered. Patient to have internal medicine consult for diabetes. Work Status: TTD.

[redacted]: XXXXXXXX XXXXXXXX, M.D. Internal medicine consult. Chest x-ray ordered.

[redacted]: Dr. XXXXXXXXXXXX. PR-2. No change in diagnoses. Labwork reviewed. Plan: EMG/NCV. Physical therapy 2-3 x a week for 4 weeks.

[redacted]: Dr. XXXXXXXXXXX. PR-2. No change. Patient referred for orthopedic consult.

[redacted] AXXXXXXX XXXXXXXXX, M.D. Secondary Treating Physician's Initial Comprehensive Orthopaedic Spine Evaluation. Chief Complaint: Low back pain following work injury with radiculopathic numbness and tingling of the lower extremities. The patient had been treated by Dr. De La Llanos conservatively. Diagnosis: 1) Lumbar disc herniation with discogenic disease and spondylolisthesis of L4-L5 with lytic lesions and pars defect. 2) Rule out

[redacted]

lumbar radiculopathy. Discussion: Dr. YXXXXXXXXXX requested all MRI reports. He considered the applicant to be a surgical candidate but wished to have nerve conduction studies of the lower extremity first.

This concludes the review of medical records.

PHYSICAL EXAMINATION:

GENERAL:

The patient appears to be his stated height of [redacted]'' tall and [redacted] pounds.

GAIT:

The patient walks without a limp.

STANCE:

On stance, the pelvis is level, the back is straight and the head is balanced over the midline.

CERVICAL SPINE:

Examination of the cervical spine reveals no tenderness in the midline. Paraspinal muscles are nontender without spasms.

There are no fascial nodules.

Trapezii are nontender without spasms.

Range of motion of the cervical spine reveals rotation to 60/60 degrees; lateral tilt to 30/30 degrees; extension to 30 degrees; and forward flexion - chin to the chest. All ranges of motion are without pain.

SHOULDERS:

Examination of the shoulder girdles reveals no tenderness to palpation. There is no evidence of atrophy or swelling.

Range of motion of the shoulders reveals abduction to

[redacted]

180/180 degrees; adduction to 50/50 degrees; forward flexion to 180/180 degrees; external rotation to 90/90 degrees; internal rotation to 80/80 degrees; and extension to 50/50 degrees.

Impingement, apprehension and biceps stress tests are negative.

Shoulder motor strength in flexion, extension, abduction, adduction, internal rotation, and external rotation are all 5/5.

ELBOWS:

Examination of the elbows reveals no tenderness or swelling.

Cubital tunnels are nontender.

Range of motion of the elbows reveals extension to 0/0 degrees; flexion to 150/150 degrees; pronation to 80/80 degrees; and supination to 90/90 degrees.

Elbow motor strength in flexion and extension is 5/5.

WRISTS/HANDS:

Forearms are nontender.

Examination of the wrists reveals no evidence of tenderness or swelling.

Range of motion of the wrists reveals dorsiflexion to 70/70 degrees and palmar flexion to 70/70 degrees.

Wrist motor strength in dorsiflexion and palmar flexion is 5/5.

Tinel's, Phalen's, and Finkelstein's tests are negative.

There is no evidence of thenar or hypothenar atrophy.

Abduction strength is strong.

He is able to bring all of his fingers to the mid-palmar

[redacted]

crease and his thumb to the fifth metacarpal head.

Reflexes: Biceps 1+/1+; triceps 1+/1+.

Pinprick sensation in the upper extremities is intact.

UPPER EXTREMITY MEASUREMENTS:

	RIGHT	LEFT
Forearms :	24.5 cm	24.5 cm
Biceps :	27 cm	27 cm

LUMBAR SPINE:

The patient complains of mild left and right paraspinal tenderness. The sacroiliac joints are nontender.

There are no spasms. There are no fascial nodules.

Range of motion of the lumbar spine reveals the patient bends forward to the level of the ankles. Lateral tilt is to 20/20 degrees. Extension is to 10 degrees. With extension and lateral tilt, he has lateral radiating leg pain.

LOWER EXTREMITIES:

Reflexes: Knees 2+/2+; ankles 2+/2+.

Pinprick sensation in the lower extremities is intact.

The extensor halluces longus is strong.

The motor examination, including extensor halluces longus, hamstrings, quadriceps and hip flexors, are all 5/5.

Straight leg raising to 70/70 degrees.

Sciatic tension test is negative.

KNEES:

Examination of the knees reveals no evidence of swelling or localized tenderness.

Range of motion is without pain.

LOWER EXTREMITY MEASUREMENTS:

	RIGHT	LEFT
Calves :	36.5 cm	36.5 cm
Quadriceps (4'' above The superior pole of The patella) :	40 cm	40 cm

DIAGNOSIS:

Lumbosacral sprain/strain aggravating underlying degenerative arthritis with stenosis.

DISCUSSION:

This patient has underlying preexisting degenerative arthritis of the lumbar spine with Grade I anterolisthesis at L4-L5 with canal and foraminal narrowing, with stenotic symptoms. He first injured his back in [redacted]. The pain was aggravated by work at that time. His symptoms were stenotic at that time with pain going down the leg. His diagnosis was lumbar spinal stenosis. In spite of his diabetes, he was given a Medrol Dosepak. He was given epidural steroid injections, which did not help that much. Following the 2010 injury, due to the ongoing pain, he was sent for surgical consultation and surgery was advised. The patient declined surgery at that time and he is still declining it at this time.

The patient has had ongoing pain since [redacted]. He then clearly suffered a new injury of [redacted]. It does appear that the back pain increased at that time, although it does not really appear his leg pain increased. With the epidural steroid injection he did improve somewhat. With not working since December, he has improved a little bit also.

Since the patient does not want surgery, nothing more can be

[redacted]

done for this patient and he is at maximum medical improvement.

FUTURE MEDICAL CARE:

The patient should be allowed to use non-steroidal anti-inflammatory medications permitted by his diabetic and hypertension condition. Allowance should be made for one to two more lumbar epidural steroid injections show the symptoms increase. The option for decompressive surgery as suggested by XXXXXXX XXXXX in [redacted] should be left open since he is having very stenotic symptoms since [redacted]. The need for surgery has been present since the [redacted] injury and would be indicated absent the [redacted] injury.

AMA IMPAIRMENT:

Using the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition:

For completeness, I would recommend electrodiagnostic studies be obtained of the bilateral lower extremities to be sure the patient does not have any true radiculopathy. I expect that the EMG would be negative and if so, he would be rated according to the DRE method Table 15-3, he would be DRE category II with 8% whole person impairment.

WORK STATUS:

The patient could return to limited duty with no lifting over 25-pounds, no repetitive bending or stooping at the waist. The patient should be allowed to sit periodically and avoid very prolonged standing. He should be allowed just to sit for 5-10 minutes every hour or so just to relieve the stenotic symptoms in his legs.

CAUSATION & APPORTIONMENT:

The patient aggravated pre-existing symptomatology and pathology in the episode of [redacted] at XXXXXXX XXXXX [redacted] However, he already had significant stenotic symptomatology with radiating leg pain. He was taking medications prior to August of [redacted]. He had increased symptoms since his prior injury of [redacted]. Absent the episode

[redacted]

of [redacted] he was able to continue working on light duty indicating a worsening of his back pain. I would apportion 20% to the episode of [redacted] and 80% to the combination of prior injury of [redacted] and preexisting pathology. To make clear, the need for surgery existed since [redacted] and still exists at this time, and would have existed absent the episode of August of [redacted]. The patient's stenotic symptoms were present in [redacted] and have persisted ever since then. The reason for surgery is decompression of the lumbar spine due to the stenotic symptoms. These stenotic symptoms were present in [redacted] and persist at this time.

DISCLOSURE:

This patient was interviewed and examined by the undersigned, with the assistance of professional interpreter, XXXXXX XXXXXXX with XXXXXXX Interpreting. The medical records were reviewed; and this dictation was done in its entirety by the undersigned.

The attached statement for billing for the services of this evaluation and report are true and correct to the best of my knowledge. There has not been a violation of Sec. 139.3 in conjunction with this evaluation to the best of my knowledge.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under 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.

Sincerely,

THOMAS W. FELL, JR., M.D.
Diplomate, American Board of
Orthopedic Surgery

Signed in Los Angeles County on _____

TWF/rb/mte

cc: XXXXXXXXXX XXXXXXXX
PO Box XXXXX
SXXXXXXXXX, XX XXXXX
Attn: LXXX HeXXXX

Sample Report #2 Pension

THOMAS W. FELL, JR., M.D.

Diplomate, American Board of Orthopedic Surgery

4940 Van Nuys Boulevard, Suite 302
Sherman Oaks, California 91403
(818) 990-4497

[redacted]XXXX

CITY OF XXXXXXXXXXXX
[redacted] XXXXXXXXXXXXX[redacted]
XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX

Attn: XXXXXXXXXXXX,[redacted]

CLAIMANT : XXXXXXXXX XXXXXXXX
CLAIM NO : FLA-XXXX
EMPLOYER : XXXXXX
ACCT NO : [redacted]
D/EXAMIN :

ORTHOPEDIC EVALUATION –[redacted]

Dear Mr. XXXXXXX:

Today, I had the opportunity to perform an orthopedic evaluation on [redacted]XXXXXX, in my Sherman Oaks office. He gives the following history.

He is seen for evaluation of his "right knee, elbows, feet, back and neck".

EMPLOYMENT AT TIME OF INCIDENT:

Mr. XXXXXXX is a 63-year-old right hand dominant male employed by the XXXX for 16-years. He joined the [redacted] in [redacted] working patrol for three to four years. After that he worked in a special unit of firearm tracking for approximately five years. In [redacted] he became a detective and worked in that position until [redacted]. He became a sergeant on patrol for two years, which was mainly supervisory. He tried not to participate, but occasionally had to participate. He went back to detective work for his last year of employment, last working in [redacted] One year later he took his retirement.

[redacted]

HISTORY OF THE PRESENT INJURY:

Mr. XXXXXXX tells me he stopped working in [redacted] mainly due to a combination of his right knee and his heart problems.

Mr. XXXXXXX has had problems with the cervical spine (neck) for seven to eight years. It was insidious in onset. He feels this is related to his job. He states he was wearing a helmet monthly for the last three to four years when he was on patrol and as a sergeant and for the first three to four years.

The bilateral elbow pain specifically began in [redacted] when his unit had a large gun recovery of 17+ tons. He had to constantly move the inventory over a three month period. During that time, he developed bilateral elbow pain. This pain became so severe he could not even lift a cup of coffee.

He was treated with physical therapy and injections.

Eventually in [redacted] he had bilateral elbow surgery by Dr. ZXXXXX. He had postoperative physical therapy. The surgery helped, but never took away all of his pain. He was told by Dr. ZXXXX that he might need more surgery due to the amount of scar tissue that built up over the years. However, since then, he has had no more treatment other than medications.

The lumbar spine (back) has no specific injury and just insidious pain over time. He states the low back radiates to the right buttocks, and down to the right leg, as well as left sided lower back pain at times.

In [redacted] or [redacted] he began treatment with Dr. GXXXX for his back. He had physical therapy and x-rays. He is not sure if he had an MRI, but he was told he had bulging discs.

Injections in the back were offered, but he declined them. He was worried about his heart.

He first injured his right knee in [redacted], prior to XXXX, when he twisted it. He had two surgeries. He had surgeries for bone chips and torn cartilage. The chips were apparently laterally and pinned back in place. He had a second surgery to take out the pins and then a third surgery to scrape out the excess calcium. He states that he did okay until [redacted] when he was working and stepping out of a car into a hole and the knee popped. He had three days off work at that time. He was told he had a sprain and always since then has had some swelling and pain.

[redacted]

In [redacted] he further injured his right knee. In [redacted] he stepped on something in a parking lot and twisted his knee and fell. About a month later he was running and stubled and again injured the right knee. Ever since then, he has had more knee pain. He had x-rays and an MRI and was told his cartilage was gone and that it was bone on bone. Synvisc did not really help. He found that he was allergic to it.

He has had no further surgeries on the right knee. He was told that the only thing that will help his knee is a total knee replacement when the knee becomes bad enough.

He also has bilateral feet plantar fasciitis pain. He states that this began in [redacted] when he went from boots to a shoe as detective. He has had x-rays. No injections have been offered. He has had tape and orthotics by a podiatrist.

PRESENT COMPLAINTS:

He reports cervical spine pain, left greater than right, when turning his head. He is okay with forward motion. Looking over his shoulder to drive is what gives him the most trouble. There is no radiating pain. He gets numbness in the ulnar two fingers right and left episodically with a lot of use. This is not a constant pain.

The bilateral elbows - left equal to right have lateral pain. There is tenderness over the scar. The pain increases with a lot of use and cold weather. Lifting particularly away from his body causes pain.

Lower back pain. The left lower back pain is greater, but he has right greater than left buttocks pain that radiates to the knee posteriorly and to the groin anteriorly. This occurs with bending, squatting, lifting and cold weather, as well as twisting, vacuuming and sweeping and sitting without support. He gets numbness in the anterior lateral thigh at times. Coughing and sneezing causes pain up and down spine from his heart surgery, but also causes some lower back pain.

The right knee has swelling, stiffness and pain medial greater than lateral, increased with any use of the leg. The right knee locks and buckles. He has marked difficulty with stairs, squatting and kneeling. He lacks full motion of the knee.

There is left greater than right plantar heel pain with walking over one half hour. He describes a burning pain that is better when he soaks them in cold water.

[redacted]

PAST MEDICAL HISTORY:

WORK INJURIES:

As noted above with the XXXXX as well as the right knee injury in the XXXXX.

ILLNESSES:

He has a history of coronary artery disease, atrial fibrillation, hypertension, sleep apnea, a hiatal hernia, and arthritis of the right knee, hearing loss, gastrointestinal problems, Barrett's syndrome. He denies diabetes or cancer. He has a pacemaker.

MEDICATIONS:

He is taking Arcapta, Benazepril, hydrochlorothiazide, Bystolic, Crestor, Cymbalta, Levothyroxine, Nexium, Advair, Amiodorone, Cidaflex, CoQ10, Lovaza, Xopenex HFA, aspirin, Finasteride, Montelukast, Lunesta, Temazepam, Valtrex, Xodol, Welchol and Amoxicillin.

ALLERGIES:

None.

SURGERIES:

He has had a replacement of the aortic valve in [redacted] He also had bilateral elbow surgery, as noted in the history. He also had a fractured left clavicle in [redacted] requiring surgery. He had right knee surgery in [redacted] and [redacted], as noted in the history.

AUTO ACCIDENTS:

Denied any with injuries.

SOCIAL HISTORY:

The patient denies smoking cigarettes or drinking alcoholic beverages.

[redacted]

FAMILY HISTORY:

The patient's [redacted] is decease from an abdominal aneurysm and the patient's father is deceased from stroke.

REVIEW OF MEDICAL RECORDS:

[redacted] XXXXXXXXXX, [redacted] Cover letter reviewed.

Extensive records were also submitted and review as follows: B1-B9; D1-D17; E1-E1303.

PHYSICAL EXAMINATION:

GENERAL:

XXXXXXX appears to be his stated height and weight of [redacted]" tall and [redacted] pounds.

GAIT:

The patient has an antalgic gait on the right side. He is wearing a right knee brace.

STANCE:

On stance, the pelvis is level, the back is straight and the head is balanced over the midline.

CERVICAL SPINE:

The patient complains of right and left paraspinal tenderness.

There are no fascial nodules.

Trapezii are nontender without spasms.

Range of motion of the cervical spine reveals rotation to 50/50 degrees; lateral tilt to 20/20 degrees; extension to 20 degrees; and forward flexion -1 fingerbreadth chin to the chest.

Foraminal compression test is negative.

[redacted]

SHOULDERS:

Examination of the shoulder girdles reveals no tenderness to palpation. There is no evidence of atrophy or swelling.

Range of motion of the shoulders reveals abduction to 180/180 degrees; adduction to 50/50 degrees; forward flexion to 180/180 degrees; external rotation to 90/90 degrees; internal rotation to 80/80 degrees; and extension to 50/50 degrees.

Shoulder motor strength in flexion, extension, abduction, adduction, internal rotation, and external rotation are all 5/5.

ELBOWS:

There are well healed lateral scars that are diffusely tender.

There is a mildly positive Cozen's test bilaterally. There is negative reverse Cozen's test. Tinel's is negative at the elbow.

Cubital tunnels are nontender.

Range of motion of the elbows reveals extension to 0/0 degrees; flexion to 150/150 degrees; pronation to 70/70 degrees; and supination to 70/70 degrees.

Elbow motor strength in flexion and extension is 5/5.

WRISTS/HANDS:

Forearms are nontender.

Examination of the wrists reveals no evidence of tenderness or swelling.

Range of motion of the wrists reveals dorsiflexion to 70/70 degrees and palmar flexion to 70/70 degrees.

Wrist motor strength in dorsiflexion and palmar flexion is 5/5.

Tinel's, Phalen's, and Finkelstein's tests are negative.

There is no evidence of thenar or hypothenar atrophy.

Abduction strength is strong.

He is able to bring all of his fingers to the mid-palmar crease and his thumb to the fifth metacarpal head.

Reflexes: Biceps 1+/1+; triceps 1+/1+.

To the Wartenberg wheel he had slight decreased sensation in the right index and left 5th fingers. However, he has 5 mm two-point discrimination in all fingers.

Jamar Grip Strength Testing

Right/Left= 30/22; 26/26; 29/26

UPPER EXTREMITY MEASUREMENTS:

		RIGHT	LEFT
Wrists	:	19 cm	19 cm
Forearms	:	32 cm	32 cm
Biceps	:	39 cm	32 cm

LUMBAR SPINE:

The patient complains of left and right paraspinal tenderness. The sacroiliac joints are nontender.

There are no spasms. There are no fascial nodules.

Range of motion of the lumbar spine reveals the patient bends forward to the level of -2" above the ankles and back to the erect position quickly and easily. Lateral tilt is to 20/20 degrees with ispilateral pain. There is no radiating pain in the lower extremities. Extension is

[redacted]

to 20 degrees.

LOWER EXTREMITIES:

Reflexes: Knees 2+/2+; ankles 2+/2+.

Pinprick sensation is slightly decreased on the anterolateral nerve distribution on the right.

The extensor halluces longus is strong.

The motor examination, including extensor halluces longus, hamstrings, quadriceps and hip flexors, are all 5/5.

Straight leg raising to 60/60 degrees.

Sciatic tension test is negative.

LEFT KNEE:

The left knee is entirely nontender with mild patellofemoral crepitus on range of motion.

Range of motion of the knee reveals extension to -2/0 degrees and flexion to 125/135 degrees.

RIGHT KNEE:

There is a long para-medial scar and a shorter lateral scar. The knee rests in approximately 7-degrees of valgus. There is moderate effusion of the knee.

The knee is stable to anteroposterior and mediolateral stressors. With valgus stress there is pain.

McMurray's, jerk and patellar apprehension tests are all negative.

BILATERAL FEET:

There is mild plantar fascial tenderness bilaterally.

[redacted]

LOWER EXTREMITY MEASUREMENTS:

	RIGHT	LEFT
Calves :	38 cm	39 cm
Knees (mid-patella) :	44 cm	43 cm
Quadriceps (4" above The superior pole of The patella) :	54 cm	55 cm

DIAGNOSIS:

1. Degenerative arthritis of the right knee, status post surgery times three.

2. Cervical spine degenerative disc disease.

3. Lumbar spine degenerative disc disease.

4. Bilateral lateral epicondylitis, status post extensor release and debridement.

5. Bilateral plantar fasciitis.

DISCUSSION:

Mr. XXXXXXX has multiple problems that he relates to his work with XXXXX.

He does have problems with the bilateral elbows as a result of his bilateral traumatic epicondylitis that is still symptomatic.

The major problem at this point is his right knee. He had lesser problems with the cervical spine and lumbar spine. In regard to the cervical spine and lumbar spine, this is an insidious onset with some mild age related degenerative arthritis.

He also brings in some slight numbness in the anterior lateral aspect of the right thigh. This is Meralgia paresthetica due to obesity and not related to employment.

[redacted]

With regard to the feet he has bilateral plantar fasciitis that he states developed in [redacted] having treatment in [redacted], while he was on desk duty.

In regard to the right knee, he injured his right knee in the [redacted] in the [redacted] and damaged his cartilage at that time. He has had a progression of arthritis of the right knee that stayed relatively asymptomatic until the injury of [redacted] At that time he lit his arthritis up a little bit. He significantly lit up his underlying arthritis in the injury of [redacted]

The bilateral elbows were injured in the specific episode in [redacted] and somewhat improved with the surgeries, but are still symptomatic and I expect to be ongoing with symptoms due to the lack of complete recovery in spite of the surgery.

INCIDENTS CAUSING IMPAIRMENT:

The cervical spine and lumbar spine have no specific incident causing impairment. He has normal degeneration expected with his age. I would expect a mild aggravation of the cervical spine and lumbar spine due to the work activities, particularly when he was on patrol. However, the predominant cause of the cervical and lumbar complaints is normal degenerative arthritis with time.

The elbows are entirely due to the work episode of [redacted]. There is no evidence of preexisting pathology.

The right knee is due to a combination of the degeneration and due to the injury in the [redacted] and surgeries of the [redacted] with significant aggravation due to his employment in the episodes of [redacted] and further in the two episodes of [redacted] The episode of [redacted] aggravated preexisting arthritis. The episodes of [redacted] further aggravated the preexisting arthritis that would have existed without his employment. However, the significant arthritis seen is due to the cartilage damage in the [redacted]

With regard to his feet, I cannot see where working as a detective would have caused bilateral plantar fasciitis. Changing from boots to walking shoes would not be expected to cause plantar fasciitis. The records that have been supplied to me showed him being treated in [redacted] with taping of the right foot. The records that I have do not show his symptoms beginning with a change in shoes in [redacted] but show the symptoms probably beginning in [redacted] r [redacted] while he was working a sedentary job as a detective.

PRESENT IMPAIRMENT:

As a result of the right knee, he is precluded from anything more than one half hour of standing or walking at one time. He cannot do any type of repeated squatting, kneeling or climbing. He can only do very minimal stair climbing. This is based upon the objective findings found at the time of my examination, as well as the findings in the medical records.

For the bilateral elbows, he cannot do any heavy gripping or grasping without significantly aggravating his bilateral elbow symptomatology. He also cannot do lifting more than 25 pounds. He cannot do prolonged typing. I would not allow him to type for more than one half hour at a time without a 10-15 minute break and no more than 3-4 hours in one day. Typing is an activity with repetitive flexion and extension that will aggravate his elbows.

The cervical spine and lumbar spine has no additional preclusions beyond that already given for his elbows and his knee.

No other preclusions beyond what was already given for the right knee are needed for the bilateral feet.

MEDICAL REHABILITATION:

In regard to the elbows, I do not expect any further change with time.

For the neck and low back, I do not expect a change with time.

For the feet, he may improve slightly with some injections in the feet.

For the right knee, the symptoms will stay the same. When the symptoms become severe enough, he will need a total knee replacement. The total knee replacement will not significantly change his level of disability.

DISCLOSURE:

Mr. xxxxxxxxxx was interviewed and examined by the undersigned; the medical records were

[redacted]

reviewed; and this dictation was done in its entirety by the undersigned.

Sincerely,

THOMAS W. FELL, JR., M.D.
Diplomate, American Board of
Orthopedic Surgery

Signed in Los Angeles County on _____

TWF/rb/mte