The original documents posted in support of Disability Procedures and Services Committee, August 1, 2018 Agenda Item IV.A, Consider Application of Robert A. Moore, M.D., as a LACERA Panel Physician, contained confidential information exempt from public disclosure under the Ralph M. Brown Act, the California Public Records Act, and other legal authority.

LACERA has replaced the original documents with a properly redacted version.

For further information, contact:

LACERA

Attention: Public Records Act Requests

300 N. Lake Ave., Suite 620

Pasadena, CA 91101

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, AUGUST 1, 2018 **

The Committee may take action on any item on the agenda, and agenda items may be taken out of order.

COMMITTEE MEMBERS:

William Pryor, Chair
James P. Harris, Vice Chair
Herman Santos
Gina Zapanta-Murphy
Marvin Adams, Alternate

I. CALL TO ORDER

II. APPROVAL OF THE MINUTES

A. Approval of the minutes of the special meeting of July 17, 2018.

III. PUBLIC COMMENT

IV. ACTION ITEMS

A. Consider Application of Robert A. Moore, M.D., as a LACERA Panel Physician

B. Consider Application of Neil S. Ghodadra, M.D., as a LACERA Panel Physician

C. Consider Application of Katalin Bassett, M.D., as a LACERA Panel Physician

D. Request to Contract with Professional Investigation Agencies

V. FOR INFORMATION

A. Blood-borne Infectious Disease Presumption – Presentation by Francis J. Boyd, Senior Staff Counsel

VI. REPORT ON STAFF ACTION ITEMS

VII. GOOD OF THE ORDER

(For information purposes only)

VIII. 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, make a motion, or second 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 SPECIAL 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

TUESDAY, JULY 17, 2018

COMMITTEE MEMBERS

PRESENT: William Pryor, Chair
James P. Harris, Vice Chair
Herman Santos
Gina Zapanta-Murphy
Marvin Adams, Alternate

ABSENT: None

ALSO ATTENDING:

BOARD MEMBERS AT LARGE

Thomas Walsh
Alan Bernstein
Vivian H. Gray
Les Robbins

STAFF, ADVISORS, PARTICIPANTS

Ricki Contreras, Disability Retirement Services Division Manager

Francis J. Boyd, Senior Staff Counsel

The Meeting was called to order by Chair Pryor at 11:22 a.m., in the Board Room of Gateway Plaza.

I. APPROVAL OF THE MINUTES

A. Approval of the minutes of the special meeting of May 10, 2018.

Mr. Harris made a motion, Ms. Zapanta-Murphy seconded, to approve the minutes of the special meeting of May 10, 2018. The motion passed unanimously.

II. PUBLIC COMMENT

There were no requests from the public to speak.

III. FOR INFORMATION

A. Cancer Presumption – Presentation by Francis J. Boyd, Senior Staff Counsel

Mr. Boyd and Ms. Contreras were available to answer any questions.

IV. GOOD OF THE ORDER

V. ADJOURNMENT

With no further business to come before the Disability Procedures and Services Committee, the meeting was adjourned at 11:40 a.m. in memory of Captain David Rosa

July 19, 2018

TO: Disability Procedures & Services Committee
William Pryor, Chair
James P. Harris, Vice Chair
Herman Santos
Gina Zapanta-Murphy
Marvin Adams, Alternate

FROM: Ricki Contreras, Manager
Disability Retirement Services

FOR: August 1, 2018, Disability Procedures and Services Committee Meeting

SUBJECT: **CONSIDER APPLICATION OF ROBERT A. MOORE, M.D., AS A LACERA PANEL PHYSICIAN**

On June 7, 2018, staff interviewed Robert A. Moore, 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 Robert A. Moore, M.D., to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

JJ:RC:mb

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

July 20, 2018

TO: Ricki Contreras, Manager
Disability Retirement Services

FROM: Tamara L. Caldwell, DRS Supervisor
Disability Retirement Services

Maisha Coulter, Sr. Disability Retirement Specialist
Disability Retirement Services

FOR: August 1, 2018 Disability Procedures & Services Committee

SUBJECT: Interview and Office Visit with Neurologist Applying For LACERA's Panel of Examining Physicians

RECOMMENDATION

Based on our interview and an effort to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends Robert A. Moore, M.D.'s application be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

On June 7, 2018, staff interviewed **Robert A. Moore**, **M.D.** at his office, located at 4940 Van Nuys Blvd. #302 Sherman Oaks, CA 91403. As referenced in his Curriculum Vitae, Dr. Moore graduated from University of California, San Diego School of Medicine, with his Medical Degree in 1979. He completed his internship and residencies at University of California, Irvine Medical Center and Long Beach Veterans Administration Medical Center.

Dr. Moore is Board Certified in Neurology and Sleep Disorders, and has been in private practice for over thirty years. Dr. Moore related that as an IME for neurological conditions he primarily evaluates patients for the following conditions: Strokes, Parkinson, Alzheimer's Diseases, Dementia, Multiple Sclerosis, and Migraine Headaches. As an IME for sleep disorders he primarily evaluates for the following conditions: Sleep Apnea, Narcolepsy, Insomnia, and Restless Leg Syndrome

The office is located in a three-story office building with parking behind the building for a maximum fee of $6 and metered parking on the street in front of the building. The Van Nuys office has two examination rooms. He estimates that 50 percent of

his practice is devoted to patient treatment, while the other 50 percent is devoted to IME evaluations for other retirement systems and workers' compensation. Dr. Moore shares office space with Neil Ghodadra, M.D., orthopedist; Kenneth Scheffels, M.D., orthopedist; Linda Waters, Ph.D. Psychologist; and Dr. Michael Parr, M.D., Psychiatrist.

The office was clean with ample seating. Male and female handicap accessible restrooms are located just outside the suite in the hallway and were clean. Dr. Moore has an office administrator who will assist with all LACERA cases and an office assistant. In addition, Dr. Moore has two additional offices located in Paramount and Newport Beach.

Staff reviewed the new LACERA Panel Physician Guidelines with the physician, which included a lengthy discussion regarding the Rules in Evaluating Applicants, Disability Retirement Law Standards, and a thorough explanation of what is expected when preparing Panel Physician's written report for the Board of Retirement. Dr. Moore understood and agreed to the rules set forth in the Guidelines.

Staff also discussed report submission timeframes, fee schedule and billing procedures, additional diagnostic testing request requirements, and advised the physician of the requirement of maintaining a valid medical license, Board Certification, and insurance coverage. He was advised to immediately report any lapses, suspensions or revocation of medical license, Board Certification, or insurance coverage, or be subject to immediate suspension or termination from LACERA Panel of Examining Physicians. Dr. Moore understood and agreed to adhere to the requirements as discussed.

Dr. Moore was informed that a Quality Control Questionnaire is sent to each applicant regarding their visit, which affords the applicant an opportunity to provide feedback concerning their experience during the medical appointment.

IT IS THEREFORE RECOMMENDED THAT YOUR COMMITTEE adopt staff's recommendation to submit the Application of Robert A. Moore, M.D. to the Board of Retirement for final approval to the LACERA Panel of Examining Physicians.

Attachment

RC:tlc:mc

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 5-15-18.
Group Name:		Physician Name: Robert A. Moore MD.
I. Primary Address: 4940 Van Nuys Blvd #302, Sherman Oaks CA 91403.		
Contact Person Elainna Moss		Title Administrator.
Telephone: 818-990-4497		Fax 818-990-6045
II. Secondary Address See Attached.		
Contact Person		Title
Telephone		Fax

PHYSICIAN BACKGROUND		
Field of Specialty Neurology & Sleep Disorder	Subspecialty	
Board Certification ☒ Yes ☐ No	License # G043085	Expiration Date 1/31/20

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

Evaluation Type

I. Workers' Compensation Evaluations

- ☒ Defense — How Long? 20 years
- ☐ Applicant — How Long? ____
- ☒ AME — How Long? 10 years
- ☒ IME — How Long? 10 years.
- ☒ QME — How Long? 20+ years

II. ☒ Disability Evaluations — How Long? 10-15 years

For What Public or Private Organizations? LACERS / LA City Dept of Pensions.

Currently Treating? ☒ Yes ☐ No

Time Devoted to: Treatment 50+ % Evaluations 50 %

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? X Yes No

Comments

Name of person completing this form:

Elaina Moss. Title: Administrator
(Please Print Name)

Physician Signature: E.G. Moss MD Date: 5/15/18

FOR OFFICE USE ONLY Physician Interview and Sight Inspection Schedule	
Interview Date:	Interview Time:
Interviewer:	

ROBERT A. MOORE, M.D.

Diplomate, American Board of Psychiatry and Neurology
Diplomate, American Board of Sleep Disorder Medicine

Locations:

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

16444 Paramount Boulevard, Suite 204
Paramount, California 90723
(562) 408-2247

510 Superior Ave., Suite 280
Newport Beach, California 92663
(818) 990-4497

ROBERT A. MOORE, M.D.

Diplomate, American Board of Psychiatry and Neurology
Diplomate, American Board of Sleep Disorder Medicine

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

Additional Locations:

16444 Paramount Boulevard, Suite 204
Paramount, California 90723
(562) 408-2247

510 Superior Ave., Suite 280
Newport Beach, California 92663
(818) 990-4497

[redacted]

EDUCATION AND DEGREES:

B. S. -- 1970-1975 -- Yale University, New Haven, CONN
Major: Biology

M. D. -- 1975-1979 -- University of California, San Diego
La Jolla, CA
Major: Neuroscience

Internship - 1979-1980 - University of California, Irvine
Medical Center, Orange, CA
Internal Medicine

Residency - 1980-1983 - University of California, Irvine
Medical Center, Orange, CA
Neurology

Long Beach V. A. Medical Center
Long Beach, CA
Neurology

POSITIONS HELD:

Chairman, Dept. of Neurology, Hoag Memorial Hospital, Newport Beach, CA; October 2000 - October 2002

Private Practice: Neurology, Irvine, CA; 1983-present

Adjunct Clinical Faculty Univ. of Calif., Irvine, 1983-present

Asst. Clinical Professor, Univ. of Calif., Irvine, 6/87-6/92

Associate Director Seizure Clinic Univ. of Calif. Irvine Medical Center, Irvine Ca., 1983-1985

Sleep Disorders Center Univ of Calif, Irvine 1984-1985, Interim Director 8/86-1/87, Director 7/1/88-6/1/92

LICENSURE AND AWARDS

California State Board of Medical Quality Assurance
LIC # G043085 1980-present

Drug Enforcement Administration
LIC # AM9455393 1980-present

Diplomate (Neurology) American Board of Psychiatry & Neurology--January 1985

Diplomate National Board of Medical Examiners 1980-present

Accredited Clinical Polysomnographer Certified 5/87

ORGANIZATION MEMBERSHIPS

American Academy of Neurology -- Active member

American Association for the Advancement of Science

American College of Physicians -- Associate member

California Medical Association

Orange Co. Medical Association

Association of Clinical Faculty Univ. of Cal. Irvine

Orange County Neurological Society

TEACHING EXPERIENCE

Winter Quarter -- 1983 and 1982 -- UCI College of Medicine
Instructor: Examination of the Neurological Patient

Winter Quarter -- 1983 -- UCI College of Medicine
Lecturer: Neuroanatomy (for first year medical students)

Summer Quarter -- 1982 -- Saddleback College (North Campus)
Lecturer: Instruction in Intensive Care Nursing

Summer Quarter -- 1982 -- UCIMC -- Department of Neurology
Co-organizer and Instructor -- Emergency Lecture Series

1980-1983 Neurology Grand Rounds UCIMC
Presenter and lecturer

1984 Pulmonary Medicine Grand Rounds Hoag Hospital
Sleep Induced Breathing Disorders

Professional Seminars, Treatment of Sleep Disorders 5/85,6/85

Lecturer, Behavioral Science II UCI School of Medicine 8/86

Lecturer Introductory Course in Sleep Disorders Medicine,
Hoag Hospital 3/87

ADMINISTRATIVE EXPERIENCE

Chief Resident -- 6/82 to 11/82 -- Department of Neurology

Admissions Committee -- 1977 to 1978 -- UCSD School of
Medicine -- Student representative

Alumni Selection Committee, Yale University -- 1983 to
present

Sleep Committee Hoag Hospital 6/86-present

Ethics Committee Hoag Hospital 9/96 - 9/98

Sample - QME.

ROBERT A. MOORE, M.D.

Diplomate, American Board of Psychiatry and Neurology
Diplomate, American Board of Sleep Disorder Medicine

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

[redacted]

[redacted] Suite [redacted]
[redacted] California [redacted]
Attn: [redacted] Esquire

- and -

[redacted], APC
[redacted] Boulevard, Suite [redacted]
[redacted] California [redacted]
Attn: [redacted], Esquire

RE: [redacted] v [redacted]

CLAIMANT : [redacted]
CLAIM NO : [redacted]
EAMS NO : [redacted]
EMPLOYER : [redacted]
ACCT. NO : [redacted]
D/INJURY : [redacted]
D/EXAMIN : [redacted]

NEUROLOGICAL PANEL QME EVALUATION REPORT

Dear Ms. [redacted] and Mr. [redacted]:

The following is a summary report of neurological Panel QME evaluation done today in my Sherman Oaks office. The history and evaluation were performed solely by the undersigned.

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. This report addresses the issue of apportionment.

Ms. [redacted] is a [redacted]-year-old, right-handed [redacted] who was employed by [redacted] as an actress for 5-6 years. She is seen in reference to an injury sustained during the course of her employment on [redacted].

The history is obtained from the patient. The patient is a good historian and relates a pertinent medical history. Submitted medical records are available for review.

HISTORY OF THE PRESENT INJURY:

[redacted] states that she was in her normal condition of health until the day of her injury on [redacted]. On the date of her injury she was a "stand-in", working on an [redacted] episode. She states that she was hit by a sign that fell 30-40 feet. In reviewing medical records, Dr. [redacted] who examined the patient on [redacted], states that the sign fell approximately 15 feet. Dr. [redacted] notes there was no loss of consciousness.

The patient states that she saw a physician on the day of her injury. She states that two teeth were loose, which were subsequently replaced.

The patient has seen multiple physicians and has had multiple diagnostic studies. She has been seen by Dr. [redacted], Dr. [redacted] (neurologist), Dr. [redacted] (orthopedist), Dr. [redacted] (neurologist), Dr. [redacted] (orthopedist), Dr. [redacted] (specialist in dental trauma), Dr. [redacted] (dentist), Dr. [redacted] (oral surgeon), Dr. [redacted] (psychologist), Dr. [redacted] (internist), as well as a pain management doctor, a chiropractor and an acupuncturist.

The patient considers Dr. [redacted], an orthopedist, her treating physician.

She has had neuroimaging studies consisting of a CT scan of the brain and an MRI scan of the brain, both of which were normal.

She has had neuropsychological testing and has been diagnosed as having a major depressive disorder. She had a vestibular autorotation test, which was felt to be consistent with peripheral vestibular pathology. This was performed

[redacted]
Neurological QME Evaluation
[redacted]

on [redacted]

Dr. [redacted], a neurological consultant, felt that she was MMI on [redacted]. She was given a 3% WPI for complaints of pain and a 7% WPI based on Table 13-5 and Table 13-6. It was felt she should be precluded from working at heights.

She remains under the care of a psychiatrist for depression. The use of Zoloft has been recommended, but has not yet been implemented.

The patient has not worked since her injury.

CURRENT COMPLAINTS:

The patient admits to depression. In addition, she feels that she has a tendency to forget things that people tell her. At times, she has difficulty knowing the right word to say. She is able to drive, go out alone, and otherwise perform activities of daily living from a cognitive standpoint.

The patient states that at times she feels that she has a fever, but has never taken her temperature. She feels hot and sweaty. This occurs on a daily basis.

She states that she is scheduled to see an internist in the next couple of days.

The patient states that she experiences headaches on a daily basis. These are holocephalic and aching in nature. They can be associated with photophobia and phonophobia. With her headaches, the patient complains of difficulty focusing.

The patient feels that she has difficulty sleeping.

She complains of left jaw pain.

I cannot elicit complaints of impaired vision or hearing. The patient does complain of bilateral tinnitus. There are no complaints of diplopia, dysarthria or dysphasia.

I cannot elicit complaints of focal limb weakness or distal limb incoordination. There are no complaints of limb paresthesias.

The patient states that when she moves or turns too quickly, and at other times in the absence of any precipitating factor, she feels that her balance is off. She ambulates without assistive devices. She does not stumble or fall.

She denies a prior history of head trauma. She denies a prior history of psychiatric disorders.

PAST MEDICAL HISTORY:

The patient states that her last general check-up was a couple of months ago and her last blood work was over two years ago.

SURGERIES:

Bilateral surgery 6-7 years ago; right wrist surgery 6-7 years ago.

ILLNESSES:

Denied.

CURRENT MEDICATIONS:

Ibuprofen, p.r.n. Vicodin, Tramadol, Flexeril, Nabumetone, Omeprazole, Clonazepam, Adderall, and a medication for migraines. She is awaiting authorization for Zoloft.

ALLERGIES:

Sulfa drugs, Levaquin.

FAMILY HISTORY:

Noncontributory.

SOCIAL HISTORY:

The patient smokes a pack of cigarettes a day. She drinks alcohol socially.

[redacted]
Neurological QME Evaluation
[redacted]

REVIEW OF SYSTEMS:

HEENT:

There is no history of sinusitis.

CARDIOPULMONARY:

There is no history of coronary artery disease.

GASTROINTESTINAL:

The patient complains of diarrhea.

REVIEW OF MEDICAL RECORDS:

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

[redacted] – Cover letter from defendant's attorney reviewed.

There are handwritten dental progress reports from [redacted], DDS in June and July 20

[redacted] Occupational Health Center:

[redacted] MD:

[redacted] – Work status report done by Dr. [redacted] – Date of injury listed as [redacted] Diagnoses: Subluxed left upper tooth crown. Concussion without loss of consciousness. Cervical sprain/strain. Ordered MRI. Referred for dental consult. The patient is placed on temporary total disability.

There are physical therapy progress reports in July and [redacted] 20 from [redacted] Physical Therapy.

[redacted] MD:

[redacted]
Neurological QME Evaluation
[redacted]

Orthopedic evaluation report – Seen by Dr. [redacted]. Date of injury listed as [redacted] Reiterates the history and mechanism of injury. Presently complains of constant neck pain, back pain with numbness & tingling, as well as left knee pain. Also reports jaw pain, head pain, pain in her teeth, as well as numbness & tingling in her hands and legs. Previous industrial injuries: History of work-related injury to her left shin. Prior fractures: Gives history of bilateral ankle fracture some years ago while performing ballet; underwent surgery to both ankles and recovered fully. Right wrist fracture approximately years ago, underwent surgery to her right wrist (in and fully recovered. Diagnoses: Cervicothoracic spine myoligamentous sprain/strain. Cervical disc protrusion with annular tear at C6-7. Closed head injury. Concussion by history. Dental injury. Recommended physical therapy modalities 3x4 with strengthening and stretching exercises. Referred for neurological examination as well as reevaluation with a dentist. Given prescription for Relafen. The patient is placed on temporary total disability.

– Progress report done by – Same complaints. Same diagnoses. Same treatment plan. Still off work.

– Orthopedic progress report – Seen by for persistent neck pain, mid back pain, and low back pain. Date of injury listed as Medical records reviewed: MRI scan of the cervical spine dated showed mild disc space narrowing at c56and C6-7 with mild neuroforaminal narrowing at C6-7. there was reversal of cervical lordosis. There was mild disc bulge with annular ear at C6-7. MRI scan of the brain on was normal. CT scan of the cervical spine on 7/1[redacted]/1[redacted] showed no fracture. There was mild reversal of the normal cervical lordosis. CT scan of the head dated showed no acute intracranial hemorrhage. Diagnoses: Cervicothoracic spine myoligamentous sprain/strain. Cervical disc protrusion with annular tear at C[redacted]. Closed head injury. Concussion by history. Dental injury. Continue physical therapy. Awaiting MRIs of the thoracic spine and lumbar spine. Referred for neurological examination regarding post concussion syndrome. The patient is placed on temporary total disability. Still off work.

– MRI scan of the brain done by MD – Impression: Normal study. No intracranial hemorrhage or contusion. No hemosiderin deposition or blood products.

– MRI scan of the lumbar spine done by , MD – Impression: Mild facet arthropathy at L4-5 and L5-S1 without compromise of the neural elements.

[redacted], MD:

– Neurological examination report done by MD – Date of injury listed as A sign fell from height of 15 feet and struck the patient's head. Patient fell to the ground and experienced headache, dizziness, and pain to her body. She had a bump on her head and two broken teeth. Presently complains of headaches, dizziness, vertigo, blurred vision, nausea, memory problems, tinnitus, loss of balance, anxiety, sleep difficulty, as well as sensitivity to light and sound. Also complains of low back pain radiating down her legs with numbness, tingling, and weakness; neck pain radiating up into her head; as well as bilateral upper extremity pain with numbness, tingling and weakness. Medical records reviewed: MRI scan of the brain dated was normal. Impression: Status post blunt head trauma with concussion. Post concussion syndrome. Cervical spine and lumbosacral spine musculoligamentous sprain/strain. Work status deferred to the PTP. Recommended electronystagmogram as well as cognitive neuropsychological evaluation.

There are several physical therapy progress reports from [redacted] in October and November

Orthopedic progress report – Seen by Dr. Same complaints. Will start physical therapy this week. Dental surgery scheduled for Same diagnoses. Still on temporary total disability.

– Normal ENG testing done by , MD. Vestibular autorotation testing was consistent with peripheral vestibular pathology (recommended vestibular rehabilitation).

There are several physical therapy progress reports from Physical Therapy in November and December

– CT scan of the head done by , MD – Impression: Unremarkable

study.

[redacted] Doctor's first report of occupational injury or illness – Date of injury listed as [redacted] (*Patient uses the name, [redacted]*) Patient was seen in the emergency department at [redacted] St. [redacted] Medical Center by [redacted] MD for persistent headache, nausea, emesis, and dizziness; worsening. Also reports left-sided facial numbness. Takes oxycodone (Norco). Smoking history: Admits to smoking cigarettes. Impression: Post concussion syndrome. Patient was discharged in good condition. Follow up with Dr. [redacted] Given prescription for tramadol.

[redacted] – Progress report done by Dr. [redacted] – Same complaints. Same diagnoses. Same treatment plan. Still off work.

[redacted] – Neurological progress report done by [redacted] – Same complaints. Reports having a bump on her head; states she underwent oral surgery about two weeks ago and was put on pills. Reports she may have had fallen during sleep while alone at home. Same complaints of lethargy, anxiety, nausea, and headache. Same diagnoses. Work status deferred to the PTP. Ordered CT scan of the head.

[redacted] – Neurological progress report done by Dr. [redacted] – Date of injury listed as [redacted] Seen for followup of headache and palpitations. CT scan was normal. Presently complains of continued concentration problems, dizziness, palpitations, sleep difficulty, neck pain, and low back pain. Diagnostic Impression: Status post blunt trauma to head with concussion. Post concussion syndrome. Cervical spine and lumbosacral spine musculoligamentous sprain/strain. Work status deferred to the PTP. Given prescription for clonazepam (Klonopin). Recommended cognitive neuropsychological evaluation for memory assessment.

[redacted] – Orthopedic progress report done by Dr. [redacted] – Same complaints. Physical therapy did not help. Recently had dental surgery; states she had broken teeth and had implants placed. Sees her neurologist for followup of her head trauma. Recommended chiropractic treatment 2x6. Still off work.

[redacted] – Psychological evaluation report done by [redacted] –

[redacted]
Neurological QME Evaluation
[redacted], 201[redacted]

Presently complains of ongoing head pain. Feels fatigued. Suffers dizziness. Has sensitivity to light and sound. Still has low back pain, neck pain, and left jaw pain causing difficulty chewing. ROS: Dizziness. Problem with balancing. Sensitivity to light and noise. Positive blurred vision. Ringing in both ears. Reports GI complaints. Psychological complaints include ongoing sadness, depression, anger, worry, hopelessness, crying spells, weight gain, and anxiety. Smoking history: Patient smokes half pack of cigarettes per day. Patient started working with [redacted] on . Date of injury listed as . Mechanism of injury: A sign weighing about 10 pounds fell from height of about 15 feet and hit the patient on top of her head causing her to fall down and lose consciousness. The impact caused a dent to the 10-pound sign. Patient remained dazed when she regained consciousness. The impact also caused her to clamp her jaw and crack two teeth on the left side of her jaw. Medical records reviewed. Diagnoses: Axis 1: Major depressive disorder, single episode, moderate. Cognitive disorder, not otherwise specified. Axis 2: NO diagnosis. Axis 3: Per medical records. Axis 4: Financial. Occupational. Axis 5: GAF score is 56. Recommended up to 16 sessions of psychotherapy. Referred for medication management sessions with a psychiatrist. Reevaluation in six months.

[redacted] Medical Group:

[redacted] MD:

. Orthopedic evaluation report – Seen by Dr. _____. Date of injury listed as . Reiterates the history and mechanism of injury. Presently complains of head pain, memory loss, left jaw pain, neck pain, upper back pain, mid back pain, and low back pain radiating down both legs. Takes Motrin. Past surgical history: Right wrist surgery and bilateral ankle surgery in Social history: Smokes tobacco. Diagnoses: Post-traumatic headaches. Jaw contusion; dental trauma. Cervical and lumbar sprain/strain with radicular complaints. Recommended acupuncture 2x4. Given prescription for nabumetone (Relafen), cyclobenzaprine (Flexeril), and omeprazole. The patient is placed on temporary total disability.

– Neurological progress report done by Dr. [redacted] – Same complaints. Same diagnoses. Work status deferred to the PTP. Ordered EMG/NCV of the bilateral lower extremities. Awaiting MRIs of the cervical

spine and lumbar spine. Continue medications. Reevaluation in four weeks.

[redacted] – Orthopedic progress report done by Dr. [redacted] – Same complaints. Same diagnoses. Same treatment plan. Continue chiropractic treatment 2x4. Awaiting MRI scan of the lumbar spine.

[redacted] – Neurological progress report done by Dr. [redacted] – Same complaints. Same diagnoses. Work status deferred to the PTP. Same treatment plan.

[redacted] – Neurological MMI evaluation report done by Dr. [redacted] – Date of injury listed as [redacted]. Reiterates the history and mechanism of injury. Diagnostic Impression: Status post blunt head trauma with concussion. Post concussion syndrome. Lumbosacral musculoligamentous sprain/strain. **The patient has reached maximal medical improvement status.** AMA Impairment Rating: Given 3% whole person impairment for pain per page 573 of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition. Given 7% whole person impairment for post-traumatic head syndrome per Tables 13-5 and 13-6 on page 320. Using the Combined Values Chart on page 604, the patient has *final whole person impairment of **10%*** from a neurological standpoint. Work restrictions: Precluded from working at heights. Causation: Industrial. Apportionment is not an issue. Future medical care: Medication for headache. Outpatient neurological doctor visits. Additional testing including electrodiagnostic tests as well as neuropsychological doctor visits.

[redacted] – Orthopedic progress report done by Dr. [redacted] – Same complaints. Same diagnoses. Same treatment plan. Continue chiropractic treatment. Continue acupuncture treatment. Awaiting MRI scan of the lumbar spine as well as EMG/NCV.

[redacted] – Orthopedic progress report done by Dr. [redacted] – Same complaints. Same treatment plan. Still on temporary total disability.

[redacted] – Orthopedic progress report done by Dr. [redacted] – Same complaints. Awaiting psychotherapy. Same treatment plan. Continue medications, clonazepam (Klonopin).

[redacted] – Orthopedic progress report done by Dr. [redacted] – Same complaints

of neck pain, painful cervical range of motion, headaches, memory problems, low back pain radiating down the legs with numbness & tingling, as well as GI complaints including constipation and abdominal discomfort. Physical therapy and acupuncture help temporarily. Same diagnoses: Post-traumatic headaches. Jaw contusion; dental trauma. Cervical and lumbar sprain/strain with radicular complaints. Still as well as lumbar MRI. Continue acupuncture treatment, 2x4. Referred for Internal Medicine consult. Still on temporary total disability. Off work until [redacted].

[redacted] – MRI scan of the lumbar spine done by [redacted], M[redacted] – Impression: Mild-to-moderate diffuse degenerative facet arthropathy from L1 to S1, right worse than left.

This concludes the review of medical records.

PHYSICAL EXAMINATION:

GENERAL EXAMINATION:

The patient is a well-nourished female who appears to be depressed. She is otherwise in no acute distress.

NEUROLOGICAL EXAMINATION:

MENTAL STATUS:

The patient was alert and oriented to person, place and time. She recalled two of three objects after five minutes of distraction. Calculation ability was intact.

The patient was able to follow three separate commands without difficulty and repeat two reverse digits. No apraxias or agnosias were noted. Her general fund of knowledge is good. The patient is quite specific in relating a medical history as it relates to physicians seen and dates.

SPEECH:

The patient's speech was normal. There was no difficulty naming objects.

CRANIAL NERVES:

The pupils were equal, round and reactive to light and accommodation. The discs were flat bilaterally. EOMs were full and without nystagmus. There was no facial asymmetry. Facial sensation was intact to soft touch. Uvula and tongue were in the midline and the gag was normal.

COORDINATION:

Rapidly alternating movements were normal in the upper and lower extremities. Finger-nose-finger and heel-shin testing revealed no dysmetria or transverse tremor.

GAIT:

The patient walks mildly slowly. She is able to walk on her heels and toes. Her tandem gait was minimally impaired with a tendency to fall to either direction.

STRENGTH:

There was normal tone in the upper and lower extremities. No fasciculations or atrophy were noted. Upper extremity strength was 5/5 and symmetrical. Lower extremity strength was 5/5 and symmetrical.

SENSORY:

The patient was intact to soft touch.

REFLEXES:

The biceps, triceps and brachioradialis jerks were 1/4 and symmetrical. The knee and ankle jerks were 1/4 and symmetrical. The toes were downgoing bilaterally.

IMPRESSIONS:

1. History of minor head trauma with residual post-concussive syndrome.

2. Major depression with psychological factors affecting a physical condition.

DISCUSSION:

I am seeing the patient as a Qualified Medical Examiner in neurology. The patient is seen in reference to an injury sustained during the course of her employment as a stand-in on [redacted].

Briefly, the patient was in her normal condition of health until the day of her injury. A sign apparently fell, causing the patient to fall. She required replacement of two loose teeth. According to submitted medical records, she did not lose consciousness.

The patient has seen a multitude of physicians since her injury and has had a multitude of diagnostic studies.

At the current time, I will address this patient strictly from a neurological standpoint. Issues related to the patient's multiple other complaints, including orthopedic and psychiatric complaints, should be addressed by appropriate examiners.

From a neurological standpoint, the patient's current subjective complaints as outlined in the original pages of this report include:

1. Difficulty focusing and some memory problems.

2. Daily headaches.

3. Poor balance with periods of intermittent vertigo.

Current objective findings include:

1. The patient's neurological examination is entirely nonfocal, except for a mild decrease in her ability to tandem walk.

2. The patient has had normal neuroimaging studies of the brain.

3. The patient had vestibular autorotation test performed revealing evidence of peripheral vestibular pathology.

I feel the patient suffered a minor head injury. Her injury was not associated with loss of consciousness or any neuroradiographic abnormalities. However, it was apparently of sufficient force to cause loosening of two teeth requiring replacement.

At the current time, I would note that the patient has been diagnosed as having a major depressive disorder and feel that her depression and underlying psychiatric disorder is contributing to her current physical complaints and symptomatology.

From a neurological standpoint, the patient is at Maximum Medical Improvement.

As it relates to her complaints of headaches, these are felt to be entirely attributable to her work injury. According to Table 18-3, based on a combination of intensity and frequency of pain and the pain being mildly aggravated by performing activities of daily with her ability to perform them with few modifications, I would assign a 2% WPI.

100% of her disabilitv associated with her headaches is apportioned to the work incident of [redacted].

I would recommend avoiding the use of narcotic analgesic medications in treating her complaints of headaches. It is felt that her residual complaints of headaches can be treated with use of medication such as Ibuprofen. Additional diagnostic testing and treatment is otherwise not felt to be indicated.

The patient's complaints of vertigo are also felt to be directly related to her work injury. It is noted that when she was considered MMI by Dr. [redacted], her gait was described as normal, including a tandem walk. However, today, she exhibited a minor decrease in her ability to tandem walk. In addition, the patient had vestibular testing performed in November, [redacted], as described, which did reveal abnormalities. According to Table 11-4, the patient has symptoms and signs of vestibular dysfunction with supporting objective findings. She is assigned a Class II impairment and a 5% WPI.

100% of her disability associated with her vertigo is apportioned to the work incident of [redacted].

The patient is not felt to require further diagnostic testing or treatment of this condition. I would concur with Dr. [redacted] that the patient should not balance or work at unprotected heights.

As it relates to the patient's cognitive complaints and sleep disorder, this is felt to be the result of an underlying depressive disorder and not the result of cognitive impairment related to direct trauma from the patient's injury. As such, I would not assign a rating under Table 13-5 or 13-6.

From a neurological standpoint, the patient's memory is loss is slight and she is fully oriented. She solves everyday problems and has independent function in shopping and other activities. She is fully capable of self-care.

If it is determined that the patient has an underlying work-related psychiatric condition then these complaints should be included in assigning a GAF, but I do not feel that she requires a separate rating under Table 13-4, Table 13-5, or Table 13-6.

If you have any questions or if I can be of any further assistance, please do not hesitate to contact me.

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, that I believe it to be true.

Yours sincerely,

Robert A. Moore M.D.

ROBERT A. MOORE, M.D.
Diplomate, American Board of
Psychiatry and Neurology

Signed in County on this date [redacted]

RAM/[redacted]

cc: [redacted]
Attn: [redacted]

Sample - IME.

ROBERT A. MOORE, M.D.

Diplomate, American Board of Psychiatry and Neurology

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

[redacted]

Department [redacted]
[redacted] Street, Suite [redacted]
[redacted], California [redacted]

Attention : [redacted] Claims Officer

CLAIMANT : [redacted]
CLAIM NO : [redacted]
EMPLOYER : [redacted]
ACCT. NO : [redacted]
D/EXAMIN : [redacted]

NEUROLOGICAL IME EVALUATION - DISABILITY PENSION

Dear Mr. [redacted]

The following is a summary report of neurological evaluation done today in my office at your request. The purpose of this evaluation is to address her "brain injury/stroke". Ms. [redacted] identification was verified by her [redacted] badge.

The patient was interviewed and examined in the presence of her sister. The history is obtained from the patient and her sister by the undersigned. The patient had some difficulty relating a medical history because of her aphasia, as will be described. A pertinent history is obtained. Medical records are reviewed.

Ms. [redacted] is a [redacted]-year-old, right-handed female, who was employed by the [redacted] Department for years, beginning in . She was working in the position of sergeant at the time of her stroke. She is seen in reference to disability retirement.

[redacted]
Neurological IME Evaluation
[redacted], 201[redacted]

HISTORY OF THE PRESENT INJURY:

The patient has a history of hypertension. In [redacted] 20[redacted], she was seen by Dr. [redacted] for follow-up of hypertension. She was on a cholesterol drug. She had not been diagnosed as being diabetic at the time. She was diagnosed as having diabetes in [redacted], 20[redacted].

The patient was seen in the emergency room in October, [redacted] with a diagnosis of unstable angina.

In a [redacted], [redacted] report, Dr. [redacted] states that the patient's high blood pressure is out of control and the patient is morbidly obese. She is anemic.

The patient was otherwise in her normal condition of health until she suffered a stroke on [redacted]. She states that she was hospitalized at [redacted] She was discharged on [redacted], and apparently from rehab on [redacted].

When initially examined by a neurologist, the patient had right-sided weakness and difficulty speaking. She was diagnosed as having an acute CVA. An MRI scan of the brain on [redacted] revealed a very large acute infarct involving most of the territory of the left middle cerebral artery. Carotid imaging studies were otherwise unremarkable. An EEG was abnormal. On [redacted], it was noted that the patient could not speak.

At the time of her discharge from inpatient rehab on [redacted], the patient still was noted to have a severe aphasia and could not answer questions fully with complete sentences. She had oropharyngeal dysphagia.

The patient subsequently received speech therapy, occupational therapy, and physical therapy. The patient had an Agreed Medical Examination by an internist in [redacted], 20[redacted]. She was referred for neurological evaluation.

The patient has not worked since the time of her stroke.

CURRENT COMPLAINTS:

At the current time, the patient states her symptoms have improved since the time of her acute infarction. She continues, however, to complain of mild right leg weakness. She tends to drag it when she walks, especially if she is tired. She feels that her balance is a bit off. She ambulates without assistive devices. There are no complaints of left leg weakness.

The patient also complains of some mild distal weakness in the right hand and complains of some difficulty doing such things as buttoning buttons and picking up coins because of poor coordination. There are no complaints of left arm weakness or distal limb incoordination.

The patient states that when she tries to write, she is not able to write the correct words.

The patient's sister notes that she continues to have difficulty speaking. She tends to speak in short sentences and frequently says "the wrong word." The patient reports no complaints of dysarthria. There are no current complaints of dysphasia.

The patient denies any problems with vision or hearing. There are no complaints of diplopia. The patient states that she feels that her memory is fine. The patient is able to drive. She is handling her own finances.

PAST MEDICAL HISTORY:

SURGERIES:

Denied.

ILLNESSES:

As stated above, history of hypertension, high cholesterol and diabetes.

CURRENT MEDICATIONS:

According to the last medical record available for review in February, , the

patient was taking Amlodipine, aspirin, betamethasone, HCTZ, Metformin, Januvia, and Glimepiride.

ALLERGIES:

None known.

FAMILY HISTORY:

Noncontributory.

SOCIAL HISTORY:

The patient does not smoke cigarettes or drink alcohol.

REVIEW OF SYSTEMS:

HEENT:

There is no history of sinusitis.

CARDIOPULMONARY:

There is no current complaints of chest pains, palpitations, or syncope.

GASTROINTESTINAL:

There are no current GI complaints.

REVIEW OF MEDICAL RECORDS:

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

I have reviewed all of the documents contained in the medical file as identified by page numbers B1-B5; D1-D178; and E1-E432.

PHYSICAL EXAMINATION:

GENERAL EXAMINATION:

The patient is a well-nourished female in no acute distress. Effort during the examination was good.

NEUROLOGICAL EXAMINATION:

MENTAL STATUS:

The patient was alert and oriented to person, place and time. Calculations were intact. Object recall was intact. The patient followed three separate commands. She had difficulty performing reverse digit testing; this was likely related to aphasia. Her general fund of knowledge appeared to be good.

SPEECH:

The patient's speech was non-dysarthric and fluent. She tended to speak slightly slowly in short sentences. There was moderate difficulty naming objects with frequent paraphasic errors.

CRANIAL NERVES:

The pupils were equal, round and reactive to light and accommodation. The discs were flat bilaterally. Confrontation testing was intact. EOMs were full and without nystagmus. There was a minimal right facial droop. Facial sensation was intact to soft touch. Uvula and tongue were in the midline. Hearing was intact to whisper.

COORDINATION:

Rapidly alternating movements were mildly decreased in the right fingers and toes; normal on the left. Finger-nose-finger testing bilaterally revealed no dysmetria or transverse tremor. Heel-shin testing bilaterally revealed no dysmetria or transverse tremor.

GAIT:

The patient exhibited a mild right leg circumduction. She had difficulty walking on her heels and toes. Her tandem gait was mildly to moderately impaired with a tendency to fall to the right.

STRENGTH:

There was normal tone in the upper and lower extremities. No fasciculations or atrophy were noted. Left upper and left lower extremity strength was 5/5 in all groups tested. In the right upper extremity, deltoid, biceps, and triceps were 5/5; wrist flexors, extensors and interossei were 5-/5. In the right lower extremity, physiologic extensors were 5/5; hip and knee flexors and right foot dorsiflexors were 5-5.

SENSORY:

There were scattered dysesthesias over the right side of the body.

REFLEXES:

The right biceps, triceps and brachioradialis jerks were 2/4; they were 1/4 on the left. The right knee jerk and ankle jerk were 2/4; they were 1/4 on the left. The toes were downgoing bilaterally.

IMPRESSION:

Hemispheric infarct with residual right-sided weakness and aphasia.

DISCUSSION:

Briefly, the patient had multiple cerebrovascular risk factors, including hypercholesterolemia, hypertension, and diabetes.

In [redacted], the patient suffered a hemispheric infarct involving the territory of the middle cerebral artery on the left.

The patient completed physical therapy, occupational therapy, and speech

therapy.

The patient's current subjective complaints as outlined in the original pages of this report include:

1. Mild right-sided weakness and right upper extremity incoordination.

2. Gait disturbance.

3. Difficulty talking.

Current objective findings include:

1. There is mild distal weakness on the right.

2. There is a gait disturbance.

3. The patient exhibits a moderate fluent aphasia.

4. Hyper-reflexia on the right.

5. The patient had an MRI scan consistent with left middle cerebral artery infarct.

INCIDENT(S) CAUSING IMPAIRMENT:

There was no specific incident that caused the current impairment. Rather, it was related to multiple chronic vascular risk factors, including hypertension, diabetes, and hypercholesterolemia. The patient's blood pressure had been difficult to control, according to the records. These conditions were the predominate cause of the stroke.

PRESENT IMPAIRMENT:

The patient has an existing impairment. The patient's endurance is affected. She is able to stand and walk only 2-4 hours out of an 8 hour day. She would have difficulty walking on uneven surfaces. She would be unable to climb, balance, or work at heights. She would be unable to run. She would not be

able to fire a weapon or be involved in an altercation. Lifting and carrying would be limited to 25 pounds. With the right arm, the patient could occasionally, not frequently continuously push and pull up to 25 pounds. She would have at least slight difficulty operating hand controls and using tools. She would have difficulty performing frequent simple gripping and fine coordinated movements with the right hand and fingers.

In addition, the patient exhibits elements of a fluent aphasia. She would have significant difficulty verbally communicating with coworkers and with members of the public.

MEDICAL REHABILITATION AND TREATMENT:

The patient is now over one year status post event and it is not felt that additional therapeutic modalities will result in any significant change in the patient's functional status.

Her current impairments are felt to be permanent in nature.

It is not felt that any additional treatment will change her impairment at this time and no reevaluations are necessary.

If you have any questions or if I can be of any further assistance, please do not hesitate to contact me.

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, that I believe it to be true.

Yours sincerely,

Robert A. Moore M.D.

ROBERT A. MOORE, M.D.
Diplomate, American Board of
Psychiatry and Neurology

Signed in [redacted] County on this date [redacted]

July 19, 2018

TO: Disability Procedures & Services Committee
William Pryor, Chair
James P. Harris, Vice Chair
Herman Santos
Gina Zapanta-Murphy
Marvin Adams, Alternate

FROM: Ricki Contreras, Manager
Disability Retirement Services

FOR: August 1, 2018, Disability Procedures and Services Committee Meeting

SUBJECT: **CONSIDER APPLICATION OF NEIL S. GHODADRA, M.D., AS A LACERA PANEL PHYSICIAN**

On June 7, 2018, staff interviewed Neil S. Ghodadra, 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 Neil S. Ghodadra, M.D., to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

JJ:RC:mb

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

July 20, 2018

TO: Ricki Contreras, Manager
Disability Retirement Services

FROM: Tamara L. Caldwell, DRS Supervisor
Disability Retirement Services

Maisha Coulter, Sr. Disability Retirement Specialist
Disability Retirement Services

FOR: August 1, 2018 Disability Procedures & Services Committee

SUBJECT: Interview and Office Visit with Orthopedist Applying For LACERA's Panel of Examining Physicians

RECOMMENDATION

Based on our interview and an effort to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends Neil S. Ghodadra, M.D.'s application be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

On June 7, 2018, I interviewed **Neil S. Ghodadra**, **M.D.** at his office, located at 4940 Van Nuys Blvd. #302 Sherman Oaks, CA 91403. The office is located in a three-story office building with parking behind the building for a maximum fee of $6 and metered parking in front of the building.

Dr. Ghodadra is a Board Certified orthopedist, and has been in private practice for over five years. Dr. Ghodadra's office has two examination rooms. He estimates that 70 percent of his practice is devoted to patient treatment and the other 30 percent of his time is devoted to IME evaluations for insurance companies. Dr. Ghodadra shares office space with Robert Moore, M.D., neurologist; Kenneth Scheffels, M.D., orthopedist; Linda Waters, Ph.D. Psychologist; and Dr. Michael Parr, M.D., Psychiatrist.

As referenced in his Curriculum Vitae, Dr. Ghodadra graduated from Duke University School of Medicine with his Medical Degree in 2009. He completed his internship, residency, and fellowship at Rush University Medical Center in Chicago, Illinois.

The office was clean with ample seating. Male and female handicap accessible restrooms are located just outside the suite in the hallway and were clean. Dr. Ghodadra has an office administrator who will assist with all LACERA cases and an office assistant. In addition, Dr. Ghodadra has four additional office locations in Arcadia, Los Angeles, Paramount, and Thousand Oaks.

Staff reviewed the new LACERA Panel Physician Guidelines with the physician, which included a lengthy discussion regarding the Rules in Evaluating Applicants, Disability Retirement Law Standards, and a thorough explanation of what is expected when preparing Panel Physician's written report for the Board of Retirement. Dr. Ghodadra understood and agreed to the rules set forth in the Guidelines.

Staff also discussed report submission timeframes, fee schedule and billing procedures, additional diagnostic testing request requirements, and advised the physician of the requirement of maintaining a valid medical license, Board Certification, and insurance coverage. He was advised to immediately report any lapses, suspensions or revocation of medical license, Board Certification, or insurance coverage, or be subject to immediate suspension or termination from LACERA Panel of Examining Physicians. Dr. Ghodadra understood and agreed to adhere to the requirements as discussed.

Dr. Ghodadra was informed that a Quality Control Questionnaire is sent to each applicant regarding their visit, which affords the applicant an opportunity to provide feedback concerning their experience during the medical appointment.

IT IS THEREFORE RECOMMENDED THAT YOUR COMMITTEE adopt staff's recommendation to submit the Application of Neil S. Ghodadra, M.D. to the Board of Retirement for final approval to the LACERA Panel of Examining Physicians.

Attachment

RC:tlc:mc

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 5-11-18.

Group Name:

Physician Name: Neil S. Ghodadra, M.D.

I. Primary Address: Mailing 4940 Van Nuys Blvd #302, Sherman Oaks CA 91403.

Contact Person Elainna Moss | Title M.D.

Telephone: 818-990-4497 | Fax 818-990-6045

II. Secondary Address See Attached CV. -

Contact Person E. Moss. | Title Administrator Med Health Services

Telephone | Fax

PHYSICIAN BACKGROUND

Field of Specialty Orthopedic Surgery. | Subspecialty

Board Certification ☒ Yes ☐ No | License # A116163 | Expiration Date 1/31/19.

EXPERIENCE

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

Evaluation Type

I. Workers' Compensation Evaluations

- ☒ Defense How Long? 4 years
- ☐ Applicant How Long? ____
- ☒ AME How Long? 1 year.
- ☒ IME How Long? 4 years
- ☒ QME How Long? 4 years

Did QME for 2 years - stopped and returned for 2 yrs at SCOA in 2016

II. ☒ Disability Evaluations How Long? 5 years

For What Public or Private Organizations? 156 -

Currently Treating? ☒ Yes ☐ No

Time Devoted to: Treatment 70 % Evaluations 30 %

Estimated Time from Appointment to Examination

- ☒ 2 weeks Depending upon Location
- ☒ 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? [X] Yes [ ] No

Comments

Name of person completing this form:

Elainna Moss (Please Print Name) Title: Administration

Physician Signature: _____ Date: 5/11/18

FOR OFFICE USE ONLY Physician Interview and Sight Inspection Schedule	
Interview Date:	Interview Time:
Interviewer:	

NEIL S. GHODADRA, MD

Diplomate, American Board of Orthopedic Surgery
MAILING ADDRESS:
4940 VAN NUYS BLVD, SUITE 302, SHERMAN OAKS, CA 91403
Appointments – (QME/AME/IMEs): (818)990-4497
Additional Appointment Locations:

DR. GHODADRA IS AVAILABLE FOR IME/QME/AME's AT THE FOLLOWING LOCATIONS:

10780 Santa Monica Blvd, Suite 210
Los Angeles, CA 90025

4940 Van Nuys Blvd, Ste 302
Sherman Oaks, CA 91403

16444 Paramount Blvd, Ste 204
Paramount, CA 91403

110 Jensen Court, Unit 1C
Thousand Oaks, CA 91360

NEIL S. GHODADRA, MD

Diplomate, American Board of Orthopedic Surgery
MAILING ADDRESS:
4940 VAN NUYS BLVD, SUITE 302, SHERMAN OAKS, CA 91403
Appointments – (QME/AME/IMEs): (818)990-4497
Appointment Locations:

10780 Santa Monica Blvd, Suite 210
Los Angeles, CA 90025

16444 Paramount Blvd, Ste 204
Paramount, CA 91403

4940 Van Nuys Blvd, Ste 302
Sherman Oaks, CA 91403

110 Jensen Court, Unit 1C
Thousand Oaks, CA 91360

CURRICULUM VITAE

EDUCATION

Fellowship:
Rush University Medical Center, Chicago, IL
Sports Medicine

Residency:
Rush University Medical Center, Chicago, IL
Orthopaedic Surgery

Internship:
Rush University Medical Center, Chicago, IL
General Surgery

Medical School:
Duke University School of Medicine, Durham, NC
Doctor of Medicine

College:
Duke University, Durham, NC
Bachelor of Science: Biology
Minor: Economics, Chemistry, Hindi

LICENSES/CERTIFICATIONS

Medical License
State of California — License#A116163 Active

Board Certification
American Board of Orthopedic Surgery — July 2013 to present

WORK EXPERIENCE/PRACTICE

Practice
Los Angeles, CA — 2013-present
Private Practice Treatment and Evaluation
Med Health Services – QME/IME/AMEs-Evaluation — 2016-present
Southern California Orthopedic Institute-SCOI — 2011-2013
Treatment and Evaluation/QMEs/IMEs

Societies
American Academy of Orthopedic Surgeons
Arthroscopic Association of North America
American Orthopedic Society for Sports Medicine

Publications
Multiple publications available upon request

Past Positions

Medical Director Utilization Review for Adminsure	2015-present
Director Of Cartilage Restoration Snibbe Ortho	2013-present
Medical Director STAR Surgical Center	2014-present
Medical Director Advanced Surgical Treatment	2016-present
Chief Resident Rush Medical Center	2009-2010

HOSPITAL AFFILIATIONS/APPOINTMENTS

Suburban Medical Center
Los Robles Hospital
Cedars-Sinai Medical Center

AWARDS AND HONORS

2014	Selected Honorary Orthopedic Surgeon for the Southern California Arthritis Foundation
2012	Selected by peers as "Best Doctors of 2013" in Orthopedic Surgery
2010	AAOS Best Scientific Exhibit Award. *Recurrent Shoulder Instability: Current Concepts in Evaluation and Management of Glenoid Bone Loss.* Ghodadra N, Grumet R, Bach BR Jr, Romeo AA, Provencher MT.

Sample QME.

NEIL S. GHODADRA, MD

Diplomate, American Board of Orthopedic Surgery

16444 Paramount Boulevard, Suite 204
Paramount, California 90723
Phone (818)990-4497

FILE COPY

January 20..

CONFIDENTIAL

XXXXX AND ASSOCIATES
xxxxx Blvd, Suite x
San xxxxxxxxx, CA xxxxx
Attn: xxxxxxxxxx Esq.

and

LAW OFFICES OF XXXXXXXXXXX
XXXXXX Avenue
xxxxxx, CA xxxxx
Attn: xxxxxxxxxxxxxxx, Esq.

RE: Hxxxxxxx Oxxxx VS. xxxxxxxx Mxxxxx LTD

CLAIMANT	:	xxxxxxxx Oxxxxxxx
CLAIM NUMBER	:	xxxxxxxxxxxx
WCAB NUMBER	:	ADJxxxxxx
EMPLOYER	:	xxxxxxxxxxxx LTD.
DATE OF INJURY	:	01/xx/xx
OUR ACCT. NO	:	
D/EXAMINATION	:	

ORTHOPEDIC PANEL QME EVALUATION

Dear xxxxxxxxxx:

I had the opportunity to perform an Orthopedic Panel QME Evaluation in my office on Mr. Hxxxxxx O, a -year-old, right-handed male. He is 'xx" tall and weighs xx pounds. He was interviewed today with the assistance of Mrxxxxxxx of Xxxxxxxxxxxx Interpreting. He gives the following history.

This is a Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances

(ML104), of eight and three-quarters hours in length. Six and three-quarter hours was spent on the combination of review of medical records and deposition (six hours) and in face-to-face time (forty-five minutes) with the claimant. (This counts as two complexity factors). Two 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.

JOB DESCRIPTION/EMPLOYMENT AT TIME OF INCIDENT:

Mr. xxxxx worked as a packer for Rxxxxxx Mxxxxxxx LTD for seven years prior to his injury. His job duties included packing cushions of different types of furniture into bags, tying the bags, and taking the bags into a room. His job required a lot of heavy lifting, pushing, pulling, and bending. His injury occurred on xz/22/1x. He is not currently working and has not worked since x/2x/xx.

HISTORY OF INJURY/INCIDENTS:

On the date of his injury, xxxx xxxxxxx was squatting down to pick up a bag which weighed approximately 50 pounds. As he was standing up, he felt pain in his neck and upper, mid, and lower back. He also felt pain in his left shoulder radiating down the entire left arm to his hand and fingers.

He first sought medical attention on the date of injury. His employer sent him to ... He was given anti-inflammatory medication and x-rays were taken of the left shoulder.

Since that he has been treated with pain medication, epidural steroid injections, and physical therapy. He has had MRI's of the neck, left hand, left shoulder, and spine.

Additionally, he had EMG testing of the upper extremities. He was sent to Dr. Axxxxx and Dr. Yxxxxx. Dr. Yxxxxxxxxx has recently referred him for xxxxxxxxx.

He last received treatment for his injury in xxxxxxxx, 20xx, when he saw Dr. xxxxxx.

He states he is awaiting surgery.

CURRENT ORTHOPEDIC COMPLAINTS:

He states the left side of his head and neck are in constant pain. He has pain in his left shoulder, left arm, left hand, and left fingers constantly. He has a numbness and tingling sensation in his left arm radiating into his left hand.

He also has constant upper, mid, and lower back pain.

As a result of his symptoms, he is not able to lift heavy objects. Standing and walking for long periods of time are also troublesome for him.

Medication and rest help alleviate his symptoms. His symptoms are aggravated by excessive movement.

With regard to activities of daily living, he reports much difficulty with dressing himself (including shoes), washing and drying himself, working outdoors on flat ground, standing, sitting, reclining, running errands, feeling what he touches, opening previously opened jars, and sleeping. He has some difficulty taking a bath, getting on and off the toilet, lifting a full cup to his mouth, making a meal, typing a message on a computer, using a telephone, climbing up one flight of stairs, rising from chair, doing light housework, opening car doors, turning faucets on and off, getting in and out of a car, and engaging in sexual activity. He performs the following activities without difficulty: Brushing his teeth, cutting his food, writing a note, seeing a television screen, speaking clearly, and smelling and tasting the food he eats.

PAST MEDICAL HISTORY:

ILLNESSES/MEDICAL CONDITIONS:

None.

MEDICATIONS:

Celecoxib, Hydrocodone, Cyclobenzaprine, Pantoprazole, Dextromethorphan, and Flurbiprofen.

PRIOR WORK INJURIES:

None.

SURGERIES:

None.

AUTO ACCIDENTS:

None.

SOCIAL HISTORY:

The patient does not smoke cigarettes or drink alcohol.

FAMILY HISTORY:

Noncontributory.

REVIEW OF MEDICAL RECORDS:

XXXXXX & Associates:

11/28/1x: Sxxxx xxxxxx, Esq. Defense cover letter noting I am to evaluate this applicant. Applicant alleged specific injury date of 01/xx/xx with injuries to neck and x shoulder , and later added additional body parts.

State of California/WCAB:

03/31/1x: State of California, Department of Industrial Relations, Division of Workers Compensation, Employee's Claim for Workers Compensation Benefits. Claimed are injuries to neck, left shoulder, left arm, left hand, fingers, back from injury on while at work.

01/22/1x: Employer's First Report of Occupational Injury or Illness. While tying bags of pillows for packing, employee felt pulling sensation in neck and upper back.

Xxxxxxxxxxxxxxxx xxxx:

01/22/1x: xxxxxxxxx xxxxx, M.D. Doctor's First Report of Occupational Injury or Illness. Pulling sensation in neck and upper back while tying pillows. Diagnoses: 1) Cervical spine strain. 2) Strain, thoracic spine. Plan: 1) Nabumetone 750 mg and cyclobenzaprine 7.5 mg. 2) Cervical pillow. 3) Heat therapy moist/thermaphore. Work Status: Return to modified duty.

01/26/1x: xxxx xxxxxxxx, M.D. PR-2. Continued neck pain in left cervical area x 4 days, 7/10. Felt a little better but the pain continued. On examination cervical spine ranges of motion were within normal limits. There was mild tenderness at the scapular border and infraspinatus muscle. Range of motion caused discomfort. Diagnoses: 1) Cervical spine strain. 2) Strain, thoracic spine Plan: Continue the ongoing medications. Physical therapy to be requested. Work status: Return to modified work. Note: X-ray of the cervical spine was reported to have been performed by xxxxxxx xxxxxxxxxx, M.D. on this date with impression of being within normal limits, but this note is not present in the records received.

02/02/1x: Dr. xxxxxxx. PR-2. Continued intermittent pain to the left paracervical region x 20 days. Diagnoses remained unchanged. Plan: Patient d'ced from nabumetone. He was prescribed Medrol dose pack for the radicular complaints in his left arm. Pending authorization for physical therapy.

02/09/1x: Dr. xxxxxxx. Pain now to left lower cervical, base of neck radiating to left shoulder for more than 2 weeks, rated as 4/10, better with rest and medications. Neck pain had decreased and the pain in the upper back had resolved. There was no thoracic spine pain, but now was tenderness to palpation at the left lower third of the cervical spine with decreased spasm. Diagnoses: 1) Cervical, strain, improved. 2) Thoracic spine strain, resolved. Plan: Patient had decreased pain in the neck and resolved in upper back. He was tolerating modified work well. Physical therapy was pending approval. Cyclobenzaprine refilled to decrease muscle spasm. Patient to return in one week to evaluate for discharge. Work status: Return to regular work.

02/16/1x, xxxxxxxxxxxx. PR-2. Patient complained of intermittent, left lower cervical pain at the base of neck radiating to left shoulder and left upper extremity, rated as 4/10. He felt pain had decreased but not resolved. Was tolerating regular work with some discomfort. Had had one out of the 6 scheduled physical therapy sessions. Diagnoses: Cervical sprain, improved. Plan: Continue with therapy and regular work. Discharge was anticipated in the next visit.

03/02/1x: Dr. xxxxxxxxxx. PR-2. Now with constant pain to the left cervical paravertebral muscles x one month. He rated the pain at 10/10; worse by turning to, looking up left. Appeared to have gone to ER and received injection which made pain better. Diagnosis: Cervical radiculopathy. Plan: Patient given a 60 mg Toradol injection to help decrease his pain. Patient to continue medications prescribed at ER, naproxen and Flexeril. A MRI was requested to rule out herniated nucleus pulposus.

03/06/1x: Dr. xxxxxx. PR-2. Continued constant pain to left cervical paravertebral muscles pain x one month, rated as 8-9/10, with frequent, stabbing, throbbing pain radiating down the left arm and left portion of the chest. He was better with use of heat, and worse by turning to the right. Also complained of moderate left arm radicular pain, especially when it was "hanging" for long periods of time with upper extremity numbness to fingers. No improvement from last visit. Discussion: Same degree of radiculopathy in left arm. Prescribed arm sling to be used when left arm too painful. Asked to continue with medications and moist heat. Toradol injection given for pain. Continue now with modified work.

03/15/1x: xxxxxxx xxxxxxx M.D. PR-2. Continued constant left shoulder pain, rated as 10/10, made worse with any neck movement and better by medications and injection. Patient now out of medications. Also complained of associated weakness, numbness, and tingling radiation from the neck to the left arm. No longer wore arm sling as did not help pain. Now complaining of thoracic pain at T1-12, rated as 10/10, worse with moving the right arm and neck, better with medications. Neck noted to be tilted to right on presentation. Diagnoses: 1) Cervical strain. 2) Thoracic strain. 3) Cervical radiculopathy. Plan: 1) Continue conservative treatment while awaiting MRI of cervical spine. 2) Hydrocodone 5/325 mg one tablet at night. Work status: Off rest of the shift and then modified work next day.

03/16/1x: Dr. xxxxxxxx. Seen at after-hours clinic for increased pain. Frequent pain, left base of neck, radiating to left trapezius, radiating to left shoulder down to left hand. Associated with radiation of pain down left upper extremity. Plan: MRI had been approved and scheduled. At this time given injection Toradol and hydrocodone. Work Status: TTD until next visit.

03/24/1x: Dr. xxxxxxx. PR-2. Continued frequent pain radiating down the left arm. A little better and rated the pain at 8/10. Stated had not been given modified duty. MRI had

been done and reviewed. Diagnoses remained unchanged from the previously reviewed reports. Plan: Continue medication and moist heat, referral to pain management. Follow-up in 1 week. Work status: Modified duties.

03/31/1x: Dr. xxxxx. PR-2. Complained of upper back and neck pain with frequent radiation down the left hand to the left shoulder, rated at 9/10, felt worse than before. Associated with numbness down left arm to hand. No improvement in the neck pain and radiculopathy to left arm. Plan: Norco 5 mg for pain, nabumetone 750 and cyclobenzaprine 7.5 were given. Continue moist heat and modified duty. Pain management referral still pending. Follow-up in 1 week.

04/07/ Dr. xxxxxx. PR-2. Constant sharp, burning pain in the cervical spine radiating to left shoulder down to the right arm, rated at 9/10 and associated with moderate swelling, paresthesia, weakness of the left side. No improvement since the previous visit. No change in diagnoses. Plan: Pain management was approved and first appointment was scheduled. Work Status: Tolerating modified duty well. No climbing ladders and pushing, pulling or lifting over 20 lbs.

February -June xxxxx xxxxx, P.T. Several physical therapy notes for right shoulder.

Fxxxxxxx Medical Group, Inc.-xxxxxxxxx xxxxxxx, M.D. :

0x/22/1x: Doctor's First Report of Occupational Injury or illness. Patient's injury tossing bag of pillows noted. Diagnoses: 1) Cervical spine strain/sprain; rule out herniated cervical disc with radiculitis/radiculopathy. 2) Lumbar spine sprain/strain; rule out herniated lumbar disc with radiculitis/ radiculopathy. 3) Left hand sprain/strain; rule out tendinitis, carpal tunnel syndrome. 4) Left shoulder sprain/strain; rule out internal derangement. 5) Left elbow sprain/strain; rule out internal derangement, tendinitis. Plan: 1) EMG/NCV of bilateral upper extremities. 2) MRI of cervical spine, lumbar spine, left shoulder, and left wrist. 3) Physical therapy to cervical spine, lumbar spine, and left upper extremity. Work Status: Temporarily totally disabled for 6 weeks.

0x/22/1x: Primary Treating Physician's Initial Orthopedic Comprehensive Report. The claimant presented for orthopedic evaluation of his work-related injury. He had been employed with ---- ---------- Ltd. since ~ as a packer. His job function was to pack pillows into bags, approximately 500 pillows per day and would bend down to pick up the

pillows off the floor and put into bags. He felt the job required him to lift and carry 20-180 lbs. Worked in a standing position. Chief Complaints: 1) Constant pain in left shoulder, rated as 9-10/10. 2) Constant aching pain in neck with numbness and tingling, rated 9-10/10. 3) Left hand pain, rated 9/10 with radiation to fingers. 4) Complained of headaches, intermittent, as well as depression, anxiety and insomnia. Past surgery: Hernia operation, fully recovered. Diagnoses: 1) Cervical spine strain/sprain; rule out herniated cervical disc with radiculitis/radiculopathy. 2) Lumbar spine sprain/strain; rule out herniated lumbar disc with radiculitis/ radiculopathy. 3) Left hand sprain/strain; rule out tendinitis, carpal tunnel syndrome. 4) Left shoulder sprain/strain; rule out internal derangement. 5) Left elbow sprain/strain; rule out internal derangement, tendinitis. Plan: 1) EMG/NCV of bilateral upper extremities. 2) MRI of cervical spine, lumbar spine, left shoulder, and left wrist. 3) Physical therapy to cervical spine, lumbar spine, and left upper extremity.

0x/20/1x: PR-2. Pain radiating arms, left greater than right in the, form of numbness, tingling and weakness. Pain in lumbar spine which radiated to the legs. Pain in the left shoulder continued, increased with overhead activities, pushing, pulling, and lifting. Pain in the left hand along with numbness, tingling and burning. No change in diagnoses. Plan: 1) Request for authorization ultrasound guided corticosteroid injection to the left shoulder and left wrist. 2) Authorization requested for cervical and lumbar epidural based steroid therapeutic pain management procedure at the level of C5-6, C6-7 and L4-5, L5-S1 with procedure modification as indicated. 3) Authorization requested for post-operative laboratory test. 4) Authorization requested for physical therapy twice a week for 6 weeks.

0x/17/1x: PR-2. Complaints of pain in spine, left shoulder and left wrist pain as well as numbness left upper extremity and intermittent numbness in the left leg. Awaiting ultrasound guided injection and epidural steroid injections. No change in diagnoses: Plan: 1) Request for authorization ultrasound guided corticosteroid injection to the left shoulder and left wrist. 2) Authorization requested for cervical and lumbar epidural based steroid therapeutic pain management procedure at the level of C5-C6, C6-C7 and L4-L5, L5-S1 with procedure modification as indicated. 3) Continue physical therapy twice a week for 6 weeks. Work status: Remain off work. Temporarily totally disabled until 07/29/2015.

0x/31/1x: PR-2. Continued pain in he left shoulder which radiated into the left upper extremity. Complained of numbness and tingling in the left index finger. Pain level 8/10. Was now awaiting left shoulder surgery as all conservative treatment had failed. No change in diagnoses. Plan: 1) Request for authorization left shoulder scope arthroscopic surgery with subacromial decompression. 2) Internal Medicine evaluation for surgical

clearance including laboratory studies. 3) Post-operative treatment would be required. 4) Post-operatively would need Hot/cold contrast unit, and abduction sling. 5) Urine screening for drug toxicology done. Work status: Temporarily totally disabled.

1x/02/1x: PR-2. Complained of continuing pain in the left shoulder which radiated into the left upper extremity, rated at 8/10. Numbness and tingling in the left index finger and now had noticed the same symptoms in the left middle finger. Complained of swelling in left middle finger. Cold temperatures made his pain more constant. He also complained of insomnia, headaches and symptoms of anxiety & depression. Diagnoses unchanged. Plan: 1) Continued request for authorization left shoulder scope arthroscopic surgery with subacromial decompression. 2) Continued request for internal medicine evaluation for surgical clearance including laboratory studies. 3) Also continued note that post-operative treatment would be required. 4) Continued note that post-operatively would need hot/cold contrast unit, and abduction sling.

1x/30/1x: PR-2. Continued left shoulder pain. Diagnoses: 1) Cervical spine strain/sprain; rule out herniated cervical disc with radiculitis/radiculopathy. 2) Lumbar spine sprain/strain; rule out herniated lumbar disc with radiculitis/ radiculopathy. 3) Left hand sprain/strain; rule out tendinitis, carpal tunnel syndrome. 4) Left shoulder sprain/strain; rule out internal derangement. 5) Left elbow sprain/strain; rule out internal derangement, tendinitis. Plan: Awaiting surgical authorization.

0x/27/1x: PR-2. No change. Patient noted to be lifting his shoulder which he said is for pain relief.

06/01/1x: PR-2. Continued pain in left shoulder, upper back, neck pain, without change. No change in diagnoses. Request for shoulder surgery denied. Second opinion requested from Dr. Fait per recommendation of QME.

07/25/1x: PR-2. No change. Continuing to request second opinion on shoulder surgery.

09/19/1x: PR-2. No change in symptoms. No change in diagnoses. Awaiting authorization for second opinion surgical consult. Authorization requested for left wrist forearm brace. Patient to be given wrist support for relief and soft pad and comfortable elastic material to mold around wrist for support. Refill tramadol 50 mg, Prilosec 20 mg and Voltaren XR 100 mg.

10/17/1x: PR-2. Only accepted body parts noted to be upper back and trunk. Otherwise no change. Awaiting authorization for second opinion, left elbow sleeve, left wrist forearm brace.

1x/14/1x: PR-2. Review of Dr. xxxxxxx's reports. Dr. Axxxxx disagreed with non-surgical recommendation for left shoulder, noting MRI results of left shoulder demonstrating partial rotator cuff tear, clinical findings positive for impingement syndrome. The patient has failed all conservative treatment.

01/16/1x: PR-2. No change in symptomatology or diagnoses. Refill of medications. Remains TTD.

02/22/1x: PR-2. Continued constant left shoulder pain radiating to upper back. Diagnoses for Accepted Body Parts: 1) Herniated cervical disc with left C7 radiculopathy, positive MRI and positive EMG. 2) Lumbar spine strain/sprain, herniated lumbar disc, with radiculitis, positive MRI Other Diagnoses: 1) Left wrist/hand strain/sprain, TFCC fraying, internal derangement, 2) Left shoulder strain/sprain, tendinitis impingement, partial cuff tear, positive MRI. 3) Left elbow strain/sprain. Plan: 1) Temporary Handicap Placard due to difficulty in ambulating. 2) Medications refilled: Tramadol 50 mg, Prilosec 20 mg and Voltaren XR 100 mg, ketoprofen/cyclobenzaprine/Lidocaine 10/3%/5%, flurbiprofen 10%, capsaicin 0.025%, menthol 2% and camphor 1%. Work Status: TTD.

0x/05/1x: PR-2. The patient continued to complain of pain in the neck, upper back, and lower back with radiation into the legs and feet associated with burning sensation. He also complained of a left shoulder pain as well as numbness and tingling in the hands.
He had recently had a re-evaluation with Dr. xxxxxxx, who recommended consult with a spine surgeon for possible C5-C6 and C6-C7 anterior cervical discectomy and interbody fusion. The patient currently was taking only pain medications and was resting. Accepted Body Parts: 1) Herniated cervical disc with left C7 radiculopathy, positive MRI and positive EMG. 2) Lumbar spine sprain/strain, herniated lumbar disc, with radiculitis, positive MRI. Other Diagnoses: 1) Left wrist/hand sprain/strain, with TFCC fraying, internal derangement. 2) Left shoulder sprain/strain, tendinitis impingement, partial cuff tear, positive MRI. 3) Left elbow sprain/strain. Plan: 1) Authorization for spine consultation with Dr. for possible ACDF at C5-C6 and C6-C7 as recommended by Dr. . 2) Authorization for psychological evaluation as well as internal medicine evaluation for surgical procedure requested. 3) Refill medications. Work Status: Continued TTD.

0x/03/1x: PR-2. Authorization received for spine surgery consult with Dr. Kxxxxx. Referral for psyche evaluation. Medications refilled. He remained TTD.

0x/31/1x: PR-2. Authorization received for both psyche and surgical consults. Internal medicine requested.

0x/12/1x: PR-2. Patient evaluated for psyche clearance on . . . . . Awaiting report.

0x/09/1x: PR-2. Patient suffered laceration on left 3rd distal phalanx on (and had stitches. Sutured removed on this date. Surgical consult pending.

0x/13/1x: PR-2. No change in symptoms or diagnoses. Awaiting scheduling for spine surgical consult. Norco now prescribed for pain as well as topical creams. Return for follow-up in 6 weeks.

Mxxxxxxxx xxxxx Center:

0x/20/1x: xx xxxx, M.D. MRI of Cervical Spine without Contrast. Impression: 1) Moderate levoscoliosis with tip at C5-C6. 2) C3-C4: Grade 1 anterolisthesis, moderate canal stenosis and moderate left and mild right neuroforaminal narrowing. 3) C4-C5: Moderate canal stenosis and mild bilateral neural foraminal narrowing. 4) C5-C6: Disc protrusion, moderate to severe canal stenosis and moderate right and mild left neuroforaminal narrowing. 5) C6-C7: Left paracentral disc protrusion, moderate to severe canal stenosis and severe left neural foraminal narrowing. Note that findings could be associated with left C7 radiculopathy.

0x/12/1x: Dr.xxxxxxxx. Follow-up MRI of Cervical Spine. Impression: 1) C5-C6 and C6-C7 showed increasing disc protrusion resulting in worsening canal stenosis and neuroforamina stenosis. Otherwise multilevel degenerative findings were unchanged. 2) C3-C4: Mild canal stenosis, moderate left and mild right neuroforaminal narrowing. 3) C4-C5: Mild canal stenosis and mild left neural foraminal narrowing. 4) C5-C6: Left paracentral disc protrusion, severe canal stenosis with cord compression and moderate left neuroforamina narrowing. 5) C6-C7: Left paracentral disc protrusion, severe canal stenosis with cord compression and severe left neuroforamina narrowing. Findings could be associated with left C7 radiculopathy. 6) C7-TI: Mild left neuroforaminal narrowing.

0x/13/1x: Dr. xxxxx: MRI of Lumbar Spine. Impression: 1) L4-L5: Disc protrusion with

annular tear, mild bilateral neuroforaminal narrowing. 2) L5-S1: Posterior disc protrusion with annular tear and moderate bilateral neuroforaminal narrowing. 3) No nerve impingement or canal stenosis seen.

0x/13/1x: [illegible] xxxxx xxxx, M.D. MRI Upper Extremities Joint without Contrast. Impression: 1) Triangular fibrocartilage thinning and mild frayed centrally, without full thickness perforation and with adjacent mild subcortical cystic change at the ulnar aspect of the lunate, raising the possibility of ulnocarpal abutment. 2) Extensor carpi ulnaris mild tendinosis. 3) Median nerve mild enlargement, flattening and signal alteration within the carpal tunnel which could be seen in the setting of carpal tunnel syndrome.

0x/13/1x: Dr. xxxxx. MRI of Upper Extremities Joint without Contrast. Impression: 1) Mild supraspinatus and infraspinatus tendinosis. Superimposed 3 mm low grade articular sided partial-thickness tear at the junction of the supraspinatus and infraspinatus tendons at the footprint, age-indeterminate. 2) Type 11 acromion and trace amount of subacromial/subdeltoid bursal fluid.

0x/22/1x: Dr. xxxx. MRI of the Upper Extremity without Contrast, Left Hand. Impression: Probable chronic sprain of ulnar collateral ligament of 2nd MCP joint.

xxxxxxx xxxxxxx Medical Group/xxxxx xxxxx, M.D.:

0x/18/1x: EMG/NCV Studies of Bilateral Upper Extremities. Impression: 1) Abnormal EMG of the left upper extremity with findings of acute C7 nerve root involvement. Cannot rule out superimposed component of acute C6 nerve root involvement. 2) Normal EMG of right upper extremity without electrodiagnostic evidence of acute or chronic right cervical nerve root involvement. 3) Normal bilateral median motor and sensory nerve conduction studies without electrodiagnostic evidence of median nerve neuropathy across the wrists. 4) No electrodiagnostic evidence of upper extremity peripheral polyneuropathy.

0x/19/1x: EMG/NCV Studies of Bilateral Lower Extremities. Impression: 1) Normal bilateral lower extremity electrodiagnostic studies. 2) Normal EMG of bilateral lower extremities without electrodiagnostic evidences of, acute or chronic lumbar Si nerve root involvement. 3) Normal bilateral lower extremity nerve conduction studies without electrodiagnostic, evidence of bilateral lower extremity peripheral polyneuropathy.

xxxxx [illegible] xx, M.D.:

RE: Hxxxxxxxx xxxxxxxxx
ORTHOPEDIC PANEL QME EVALUATION
DATE OF EXAM: JANUARY 1x, 20xx

0x/18/1x: Orthopedic Qualified Medical Evaluation. History of injury on was reviewed. His one surgery was for an inguinal hernia in 19 He denied any problems with his back, neck, arm, hand or shoulder before the incident. Prior MRIs and electrodiagnostic studies were reviewed. Diagnoses: 1) Cervical musculoligamentous sprain/strain syndrome. 2) Left shoulder sprain/strain syndrome. 3) Somatic conversion disorder, noted as claimant's problem at the time of this QME evaluation. 4) Pre-existing cervical spondylosis. 5) Pre-existing tendinosis conditions supraspinatus and infraspinatus portions of the rotator cuff, left shoulder, with 3 mm partial articular surface tear of uncertain age. 6) Pre-existing lumbar spondylosis condition L4-L5 and L5-S1 levels not related to the January xx, 201x incident. 7) No evidence of carpal tunnel syndrome. Discussion: The claimant's current medical conditions were not deemed permanent and stationary. Causation was felt more probable than not to be directly related to the claimant's incident of January 2x, 201x at which time he was lifting and tossing filled plastic bags with cushions as his usual and customary job for diagnoses 1 and 2 above. However, diagnoses 4, 5, 6 and 7 were felt to be unrelated to the injury. Additionally, with diagnosis #3, which was the somatic conversion disorder, Dr. xxxxx reached this diagnosis after "a thorough review of the records and careful examination." He noted that abnormal physical findings were present on examination including the claimant holding his shoulder in an abnormal elevated position constantly, which "did not correspond to any shoulder pathology or cervical disc or nerve root disorder." The patient also had non-anatomical pain response on general shoulder palpation not corresponding to anatomic pathology. He further held his left index finger in an outstretched position, without any history of injury and stated he had "pinprick hypesthesia to the entire left hemithorax is a nonanatomic event." Recommendation: 1) Psychiatric QME evaluation recommended at this time. 2) Second opinion review of the claimant's MRI studies involving the cervical spine, left shoulder, left wrist and lumbar spine suggested. 2) No indication for surgery for the left shoulder or other areas as related to the incident of

0x/2x/1x: Supplemental Report. Review of deposition. No change in position.

0x/22/1x: Orthopedic xxxxxxxxxx xzxxxxxxx Re-Evaluation. Interval History: Patient had continued to be treated with medication only which include three pain pills per day plus local creams at areas of maximal soreness (lateral clavicle, trapezius and AC joint regions of the left shoulder). There had been no change in his complaints. It was noted that the patient had been advised shoulder by Dr. xxx, which the insurance carrier denied. He continued to see Dr. xxxxx once a month for medication refills. At this time the patient at been

terminated by xxxx xxx. He had not worked since then. Current symptoms: 1) Left shoulder pain with radiation down radial aspect of left arm into thumb and index fingers. 2) Ongoing numbness of left upper extremity. 3) Occipital headaches and posterior neck pain. 4) Residual weakness in left upper extremity, particularly the left hand. Additionally, he had a "temporary" episode of left posterior thigh, calf and heel pain.

Of note, the review of records in this report appears to pertain to another patient, identified as a female with knee and ankle problems. Diagnoses: 1) Per previous QME examination, cervical and left shoulder sprain/strain syndrome. 2) Multilevel cervical spondylosis condition from C3-C7, worsened at the lower two levels. 3) MRI scan cervical spine of that showed evidence of worsening canal stenosis and disc protrusion, the taller at the left C6-7 area mainly and to a lesser extent the C5-C6 area. 4) MRI evidence of of lumbar spine showing bilateral neural foraminal narrowing and mild posterior disc protrusions at L4-L5 and L5-S1. No nerve impingement was seen. 5) Left shoulder is showing evidence of continued restrictive motion associated with inactivity called adhesive capsulitis of mild-to-moderate degree. 6) No evidence of carpal tunnel syndrome. 7) Persisting mild voluntary inhibition of shoulder and left index finger movement. Dr. wrote that while his previous QME diagnosis included somatic conversion disorder characterized by severe inhibition of motion about the shoulder and left hand, he found on this exam that these symptoms were significantly diminished such that there were no longer "excessive response reactions to testing stimuli" as had been exhibited at the original QME examination. Discussion: The main finding for the claimant on this re-examination related to his C5-6 and C6-7 cervical spondylosis with left-sided disc herniation and foramina] narrowing. His left hand sensory deficit was now consistent with the C5-C6 disc herniation shown in the MRI scan. Additionally, the patient now had absent reflexes in the left biceps and triceps levels on the left side and 1+ brachialis reflex also on the left side compared to the normal 2+ on the opposite side. At this time, the objective findings were felt no longer masked by the functional overlay. Recommendation: Dr. Berg felt that new recommendations should be made with the absence now of the significant serious functional overlay. He believed that the patient should have referral to a spine surgeon for consideration of C5-C6 and C6-C7 anterior cervical diskectomy and interbody fusion or other surgical treatment as that surgeon may advise. Work Status: He was TTD as to "performance of remunerative labor," which Dr. xxx added was a "disability period ... expected to remain for an indefinite time." In answering specific questions stated as being posed in the cover letter sent to him, Dr. xxx stated that the claimant was not yet permanent and stationary. He did have pre-existing cervical spondylosis conditions throughout the cervical spine from C3-C7 that were present at the time of this claimant's

employment. However, the precipitating cause of his current status appeared to be herniated cervical discs, as noted on the latest MRI scan. If he did not have surgical treatment, then permanent work restrictions can be expected. The conservative treatment he had received had been seen as necessary and related to the injury but "has not been curative in nature."

Deposition of Hxxxxx Oxxxxxx:

51-page deposition of the applicant. Admonitions of the deposition were given. He was currently on medications, names of which were not recalled. These were from Dr. xxx. He did not recall when he first saw Dr. xxxx. He took medication for pain 3 x a day and also thought he took a muscle relaxant and a stomach protector. Identification questions are asked. He lived in for years. He was single but lived with his brother and his brother's wife, their two children and his mother. He did not remember where he went to high school. He never attended any vocational schools. He was currently not working. He last worked at xxxx xxx. He thought he had applied for unemployment although he said he applied through EDD, which was identified as state disability. He did not know when he started to receive money from this. This was his only source of income. He denied having food stamps. He had a car that he was able to drive. He was driven to the deposition by his sister-in-law. He said that she often drove him to doctor appointments. He agreed that this was his first Workers Compensation claim. He had never made any other claims against his employer. He denied having any injuries outside of work. He had no injuries in any restaurants or at home. He had not received any treatment from any hospitals.

At this time his doctor said he needed surgery to the left shoulder and back. He said he wanted to have the surgery. He had never had any past surgeries. He denied any physical conditions. He denied making any psychiatric claims. He had never been involved in any motor vehicle accidents. He never had any pedestrian or bicycle accidents. He said his injury occurred on at 6:30 a.m. He was lifting sofa cushions. There was no witness to his injury. He told his work and he was sent to a doctor that day. He continued working for two more months until Dr. xxxxx took him off work. During the time he worked after the injury he said he could not work properly. His job was to bag parts according to style and color. The bags contained sofa cushions and backing. Sometimes he worked overtime. When he saw the doctor, he complained of his neck, back, shoulder and hand. All of them bothered him equally. A break was taken. At the resumption, he was asked what hurt him now. He said, "Everything." He described his neck pain as being on the left side that was a throbbing. He had pain running through his back and left shoulder,

which he also described as throbbing. The pain ran down to his fingers. He felt a stabbing pain in the back. He rated his pain as 8/10. When he took his medications, it "stabilized" the pain, but it did not go away. He said that the pain then went down to a 6/10.

When the injury happened, he did not fall but heard a pop "everywhere." It was all on his left side. He said he could hardly use his left upper extremity now. He had been off work for 11 months and nothing had gotten any better. When asked what he did while at home and not working, he said, "I haven't done anything at home. I'm resting absolutely."
He denied any prior injuries to his neck, left shoulder, left arm or back. He estimated 150 people worked for xxxxxxx xxxxxx. He denied any concurrent employment. He denied owning his own business. Before working for he worked at a warehouse driving a forklift and disassembling merchandise. He did this for two years. He left when he was offered work at xxxxx xxxxxxx. He denied any injuries at that job. Before that job he worked making frames for chimneys as a painter's helper. He painted the frames for the chimneys. He denied any injuries from that position. He did not remember when he came to the United States. He was born in . While there he worked at a tortilla manufacturer for 20 years. He would lift tortillas and put them on tables. Another person would come "and pack them up." He worked from 7 a.m. to 2 p.m. At times he also packed the tortillas into bags. He felt that he was still considered employed by xxxxx xxxxx. His supervisor was xxxx. His job duties were to pack, make a bag and mark it with a marker as to what style it was. This was if it were a sofa or a loveseat. He denied having any problems at work. He said he had had three MRIs performed on his left side, specifically his back, his shoulder and his neck. He denied having any pets or going on any trips. He rarely went outside He was asked what his day was like. He said he would get up at 7 and have breakfast that his mother made for him. He would then watch TV. This could not be too long as sitting or lying in one position hurt. He said, "I have to be in constant motion so that it doesn't hurt me." After watching TV, he took a shower. He could brush his teeth but had trouble doing this. He took a shower with difficulty because he had problems holding onto the soap. He reiterated his left hand was "useless." However, he could perform his personal toilet without problems. Otherwise he would watch TV the whole day. He never did any chores. He would go to bed at 9 p.m.

He said he had prepared with his attorney for 45 minutes prior to the deposition.

On questioning by the applicant attorney, he said that his pain radiated from the back down the left leg to the ankle. This occurred on a daily basis.

At this time the lawyers confer, and the deposition ends.

This concludes the review of medical records.

PHYSICAL EXAMINATION:

GENERAL:

On examination, the patient is alert and oriented x 3. He is in no acute distress with a normal gait pattern.

CERVICAL SPINE/UPPER EXTREMITIES:

There is point tenderness over C3-C4, C4-C5, and C5-C6, as well as positive paraspinal muscular tenderness over this region.

There is limited range of motion with flexion to 50 degrees, extension to 25 degrees, right rotation to 25 degrees, left rotation to 20 degrees, right lateral bending to 30 degrees, and left lateral bending to 20 degrees.

There is tenderness over the left greater than right side. There is tenderness over the left trapezius and left sternocleidomastoid.

Spurling's test is positive in the left upper extremity in the C7 distribution. Spurling's test in the right upper extremity is negative.

There are no upper motor neuron signs and no signs of myelopathy.

Reflexes are decreased on the left in the brachioradialis reflex.

There is decreased motor strength in the left triceps with 4/5 strength; otherwise, there is 5/5 motor strength in the bilateral upper extremities.

Neurovascular is intact to two-point discrimination with decreased sensation in the left C7 distribution.

LEFT SHOULDER:

The patient holds the left shoulder at an elevated position. There is extensive tightness and tenderness of the left trapezius. The patient has a scapula which is held superiorly, as well.

There are no masses or lesions.

There is limited range of motion of the left shoulder with forward flexion to 95 degrees. External rotation is to 40 degrees, internal rotation is limited to 55 degrees, and abduction is to 80 degrees.

There is positive tenderness over the anterior and lateral deltoid.

There is 4/5 cuff strength with mild pain on resisted cuff testing.

Neer's, Hawkin's, Speed's, Yergason's signs are positive.

O'Brien's test is positive.

Bellypress test is negative.

GRIP STRENGTH TESTING:

Jamar dynamometer testing was performed and repeated three times on each hand.

The right side was noted to be 80 pounds/75 pounds/62 pounds.

The left side was noted to be 24 pounds/20 pounds/22 pounds.

LUMBAR SPINE/LOWER EXTREMITIES:

Examination of the low back shows no gross deformity. There are no open wounds, masses, or lesions. There are no visible rashes or atrophy. There is tenderness over L4-L5 and L5-S1. There is positive paraspinal muscular tenderness.

Neuromuscular examination is intact in the bilateral lower extremities. Range of motion reveals 80 degrees forward flexion, 20 degrees extension, 25 degrees right and left rotation, and 30 degrees right and left lateral bending.

Straight leg raising is negative.

The patient has no difficulty performing toe walk and heel raise.

There are no upper motor neuron signs and no evidence of myelopathy.

DIAGNOSES:

1. Pre-existing multilevel cervical spondylosis, C3-C7, with aggravation at C5-6 and 6-7 due to the work-related injury.

2. Left C7 disc herniation with radiculitis related to the work injury.

3. Left shoulder adhesive capsulitis and left shoulder partial-thickness rotator cuff tear and rotator cuff tendinosis, work-related.

4. Lumbar neural foraminal narrowing with disc protrusions at L4-5 and L5-S1, non-industrial

DISCUSSION:

The patient had worked as a packer for seven years for xxx xxxxx LTD. He reports that his job duties involved lifting heavy objects and squatting down to pick up bags which weighed approximately 50 pounds. With regard to his injury, he noted a specific injury on He noted that once he picked up a heavy bag and got up he had extensive pain in the neck, spine and left shoulder.

From reviewing the records, his primary complaints since the injury have involved the left shoulder, neck and left upper extremity. From the records there was no indication that he developed lower back complaints, based upon the records several months post the incident.

He had a previous QME by Dr. who reported a pre-existing lumbar spondlylosis unrelated to the 1/22/15 work incident. However, he felt the patient needed further care for the neck and left shoulder on an industrial basis, and was not MMI.

He has had extensive conservative treatment and has had adequate conservative measures to

date. He has been seen by pain management and has had extensive therapy, as well. He did have multiple MRI's, as well. He notes continued pain and difficulty.

Mr. xxxxx continues to have pain in the cervical and lumbar spine and left shoulder. He has an elevated left shoulder upon exam.

In regards to his cervical spine, he does have pre-existing cervical spondylosis. However, the patient has had an aggravation at C5-C6 and C6-C7 with left C7 radiculitis due to his work injury. His work duties, within reasonable medical probability, caused a left disc herniation and now the patient has symptoms consistent with left C7 radiculitis. At this point, he requires a spine surgeon referral for possible ACDF of the cervical spine. He has weakness and numbness, consistent with left C7 radiculitis which is consistent with both the physical exam findings and the MRI findings. At this point, given the patient's symptoms and muscle weakness, he will require operative intervention.

With regards to the lumbar spine, his MRI reveals multilevel disc protrusions. I do not feel that these are really due to his mechanism of injury that the patient states he sustained on . Again, these symptoms were not reported initially in the records. I would have to agree with Dr. Bxxx in this regard.

With regards to the left shoulder, the patient has adhesive capsulitis due to his left shoulder partial-thickness rotator cuff tear with continued pain and difficulty with range of motion activities. At this point, the patient has been tried on conservative therapy and continues to have pain. He does have a partial-thickness tear of the rotator cuff and he will require a cortisone injection to the left shoulder for pain relief. If he fails conservative management which includes physical therapy and cortisone, he would then be a candidate for left shoulder subacromial decompression.

CAUSATION:

1. The aggravation of pre-existing spondylosis with C7 disc herniation is work-related. His injury at work on and corresponds to the patient's symptoms and the pathology of the MRI.

2. The left shoulder partial-thickness rotator cuff tear is work-related.

3. With regard to the x/xx/1x specific injury and his lumbar spine, due to the lack of

complaints involving the lumbar spine around the time of the injury or first treatment, I cannot clearly relate this to the specific incident of . I would agree with Dr. in this regard. No records from his first two months of treatment mention any lumbar spine complaints. The mechanism of injury does not correspond.

DISABILITY STATUS:

For the cervical spine and left shoulder, the patient is temporarily disabled. As light duty work is not longer available he is TTD at this time. Given his cervical pain and left shoulder pain he is unable to perform his work activities. I expect he will come to surgery and will not be MMI until nine months to one year post surgery.

At this point, the patient is off of work. If light duty again becomes available, he should not do any repetitive lifting, squatting, climbing, kneeling or lifting greater than 10 pounds with the left arm.

Regarding the alleged lumbar spine injury, he is considered at MMI status.

AMA IMPAIRMENT:

Only the lumbar spine is MMI and can be rated.

For the lumbar spine, he would be a DRE Category II, using Table 15-3 of the guides. He has some degenerative disc disease and herniation, but has good motion and no neurological deficit. He has a 6% whole person impairment for the lumbar spine.

FUTURE MEDICAL CARE:

He will likely need referral to a spine surgeon for his cervical spine for multilevel ACDF. He has symptoms consistent with a left C7 disc herniation with radiculitis. This will need to be treated surgically as he has failed conservative management to date.

In regards to the left shoulder, the patient does have a partial-thickness rotator cuff tear. For immediate pain relief, the patient would benefit from a muscular cortisone injection. If this fails to provide long term relief, the patient will need to have physical therapy two times a week for six weeks. He may need to be seen by an orthopedic surgeon to undergo left

shoulder arthroscopy and decompression. He will need extensive therapy afterwards, two times a week for at least 8-10 weeks for strength and muscle recovery.

For the lumbar spine, none on an industrial basis.

APPORTIONMENT:

The patient has pre-existing spondylosis of the cervical spine. However, the left C7 disc herniation and aggravation of his C5-C6 disc are due to the work injury. When he reaches MMI status, I would expect to apportion some percentage to the underlying pathology.

The left shoulder disability will be 100% apportioned to the work injury.

His lumbar spine disability is 100% apportioned to is underlying degenerative changes and there is no injury to the lumbar spine on 1/2x/1x to apportion.

DISCLOSURE:

This patient was interviewed and examined by the undersigned, with the assistance of a certified interpreter. Interpreting assistance was provided by xxxxx xxxxx of xxxxxx. The medical records and deposition 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, that I believe it to be true.

Sincerely yours,

NEIL S. GHODADRA, M.D.
Diplomate, American Board of
Orthopedic Surgery
State of California License _____

Signed in _____ County on _____

NSG/xx/xx

cc: xxxxxxx xxxGROUP
PO Box 5xxxxx
Sxx xxxxx, 9xxxx
Attn: Axxxxx Esxxxx, Claims Examiner

Sample - IME.

NEIL S. GHODADRA, MD

Diplomate, American Board of Orthopedic Surgery
Sherman Oaks Office
4940 Van Nuys Blvd, Suite 302
Sherman Oaks, CA 91403
Phone: (818)990-4497

CONFIDENTIAL

October XX, . 1X

FILE COPY

LAW OFFICE OF ZXXXX & XXXXX
1XXXXXXXXXX XXXXXXXX
Mission XXXX, CA 9XXX
Attn: CXXX KXXX, Esq.

RE: EXXXX XXXXXXX VS. AX XXXXXXXXX, ET AL

CLAIMANT	:	EXXX GXXXX
CLAIM NUMBER	:	BXXXX
DATE OF LOSS	:	0X/01/1X
OUR ACCT. NO	:	2XXXX
D/EXAMINATION	:	XX/1X/1X

ORTHOPEDIC IME EXAMINATION

Dear Mr. KXXX:

Today, I had the opportunity to perform an Orthopedic IME Evaluation in my office on Mr. EXXX GXXXXX.

He gives the following history directly to this examiner. Please note that Mr. GXXXX was accompanied by a nurse who took notes and recorded the examination.

HISTORY OF INJURY:

Mr. XXXX presents as status post an X/X/1X auto accident. He notes that he had a previous history of right knee pain and meniscus pathology that was treated with arthroscopy and debridement. He noted 90% relief in his right knee. He states he still has some pain and symptoms along the anterior aspect of the knee with activities. However, he stated that prior to the X/1/1X accident he liked to play soccer and worked as a computer technician for his company. He states that the job

involved sitting and walking. He notes that he works at a computer and he states that he is able to fix most problems with just the use of a phone.

He states that he had no left knee issues prior to the X/X/1X accident.

Regarding the description of the X/1/1X accident, he notes that he was driving when a truck collided into him causing his car to roll over three or four times. He sustained extensive injury to his head and multiple contusions, including the left knee. He states the dashboard hit both of his knees.

He was air-lifted to XXXX XXX Hospital, at which time he had multiple films taken. He states that after the accident he was off work for approximately 1½ weeks.

Due to continued left knee pains, he did go to see Dr. XXX XXXXXXX, who had been his previous doctor. Upon an MRI review of the left knee, it was noted that he did have a medial meniscus tear. He states that once he knew he had a medial meniscus tear as well as concomitant symptoms of instability and pain, it was decided that he would undergo a left knee arthroscopy and medial meniscectomy.

Mr. XXXX did undergo left knee surgery and states that he had approximately 70% relief after he had taken six weeks off of work to do physical therapy exercises. He states that he continued to try home exercises to get better, but states he continues to have pain. He states that he never got better than 70% and notes similar symptoms now in the lateral aspect of the knee.

He states that after the surgery he was trying to coach soccer more and go back to normal activities, he had increasing pain in the lateral aspect of the left knee. He did receive a new MRI, at which point it was noted that he had a tear of the lateral meniscus. He subsequently saw Dr. XXXXXXX, at which time Dr. XXXXXXX advised him that he could pursue surgical intervention or non-operative treatment. He discussed the risks, complications, and benefits of each. Mr. XXXX is at the point now where he is trying to decide what he wants to do.

He did state that he is no longer playing extensive soccer, but rather is coaching in limited duty, given that he cannot perform some of the moves that are required to be able to coach at a higher level. He states he avoids repetitive bending and stooping and twisting activities due to pain.

CURRENT ORTHOPEDIC COMPLAINTS:

Left knee pain, with feeling of giving away at times and intermittent swelling.

PAST MEDICAL HISTORY:

ILLNESSES/MEDICAL CONDITIONS:

None.

PRIOR WORK INJURIES:

None.

SURGERIES:

Right knee surgery, as noted in history above.

AUTO ACCIDENTS:

None.

REVIEW OF MEDICAL RECORDS:

SXXX SXXXXXX, M.D.:

20\ ..

Notes include rash and labs.

20(

: Right knee with swelling on right lateral side of right knee. Tenderness to palpation. Impression: Right knee sprain/strain. Advised to rest, use ice, compression, elevation and to discontinue exercises for 10 days. Motrin p.r.n.

Continued knee pain. Swelling for a few months. Labs taken. Patient to have knee x-ray. Take Motrin 800 mg p.r.n.

Continued with lateral knee pain, slight improvement. Rash noted. Request MRI.

Also notes on urticaria, fatigue. Labs.

:

: Right knee pain increased. Outer portion of right knee. Give-way. Plan: MRI of knee and Motrin.

): Noted MRI showed torn medial menicus. Referral to Dr. XXXXX.

Notes on asthma, labs.

20

: Patient status post right knee meniscectomy. Stitches removed.

1: Note appears to give in diagnoses "arthritis." Appeared to have headache complaints.

: Feeling better. No headache.

Notes on rash, asthma, fatigue, joint pain from strep throat.

20

Notes on fatty liver, asthma, hypertension, swollen glands.

20

Notes on allergies, fatigue. Losing weight.

20

Headache complaint.

MVA. Complaining of headache, neck pain, knees, body aches and anxiety. Scalp wound with cellulitis. Off work.

Complaining of neck pain, right shin pain, knee hurts. Left elbow pain. Had returned to work. On Flexeril.

PCP and Specialist Request for Services. Severe left knee pain. Requesting Dr. XXXXX.

: Headache, left knee pain as well as asthma and fatigue.

Diabetes diagnosed.

: Complaining of knee pain post-surgery. Authorization to see Dr. XXXXX again.

: Left knee still hurting. MRI requested.

20 -20

Notes on hyperlipidemia and hypertension, asthma, viral infections, fungal infection areas of alopecia

XXXXXX Radiology Medical Group

): XX XXXXXX, M.D. X-ray of Right Knee. Impression: Within normal limits.

): XXX XX, M.D. MRI of Right Knee. Impression: 1) Tear near junction of posterior horn and body of lateral meniscus with degeneration in posterior horn of medial meniscus. 2) Small joint effusion and edema and/or bursitis anterior to patella and patellar tendon. 3) Ossicle above attachment of patellar tendon on proximal tibia.

SXXXXX XXXXXXXX Orthopedic / XXXXXX XXXXX, M.D.

Consult. Referral for history of right knee pain without specific trauma. One year history of right knee pain without specific injury or trauma. Pain started gradually and increased in severity pain focused on lateral side of right knee. X-rays: 4 view x-rays today, including weight-bearing views. Impression: No evidence of acute bony structure injury, significant degenerative changes, or soft tissue swelling. It should be noted in the peripatellar tendon there does appear to be a loose body, which may indicate old Osgood-Schlatter condition. MRI: MRI showed a tear to the lateral meniscus. Some mild arthritic changes noted in all compartments. The above noted loose body is found in the inferior patellar tendon. Assessment: Right knee lateral meniscus tear. PLAN: Patient recommended to consider partial lateral meniscectomy. Agreed and will be scheduled for surgery. Patient to use ice, heat, and anti-inflammatories as necessary in meantime.

Follow-up. Impression: 1) Right knee pain. 2) Lateral meniscal tear.

Scheduled for diagnostic and operative arthroscopy.

XXXX X. XXXXX, M.D. History of Present Illness. Exam: Focused examination of the patient's right knee shows tenderness along the lateral joint line. Range of motion is zero to 125 degrees. Muscle strength is 4/5. No instability. Distal vitals are intact. Assessment: Right knee lateral meniscal tear. Continue to schedule surgery.

Mr. XXXXX. Certification of Disability. Patient to be disabled from to for lateral meniscal tear surgery.

Patient now status post right knee arthroscopy. Doing reasonably well. Start physical therapy. Prescription given.

: Patient noting some discomfort and soreness in knee. Assessment: Lateral knee pain. Patient to continue with physical therapy, stretching and rehab. Injection discussed. He would like to hold off. Prescription for Voltaren 75 mg b.i.d.

: Consult. Patient presented with history of sudden onset, constant, aching, throbbing pain to the left knee secondary to a motor vehicle accident sustained on August 20 Patient was driving his automobile when a semi cut him off. The patient's vehicle was struck and rolled 4 times. He was air-lifted to Hospital in , were he was seen in the emergency room and then discharged. Since that time, the patient has had chronic pain in the medial side of the left knee. No prior history of problem with the left knee in the past. He describes the pain as an aching pain to sharp pain. The pain is worse with activity. Currently on Tylenol with codeine and Voltaren. Physical examination: Left knee muscle strength 5-/5, positive McMurray's sign to the medial side. Impression: 1) Left knee medial side pain. 2) History of motor vehicle accident with significant mechanism of injury. Plan: MRI of left knee to evaluate medial meniscus.

Follow-up. MRI was reviewed showing tear to posterior horn medial meniscus. Assessment: 1) Left knee medial meniscus tear. 2) History of previous right knee lateral meniscus tear with excision of parameniscal cyst. Plan: Surgery for left knee. Patient may meanwhile use ice, heat and anti-inflammatory medications until surgery.

Follow-up. Patient has had no improvement with conservative therapy to the left knee condition. Impression: Medial meniscus tear, left knee. Preoperative evaluation for medial meniscectomy, chondroplasty and intra-articular shaving. Plan:

Scheduled for surgery.

. Follow-up. Post-op #1 visit. Incisions healing well. Walking with antalgic gait. Impression: 1) Diagnostic arthroscopy. 2) Medial meniscectomy. 3) Debridement. 4) Chondroplasty. Patient to start physical therapy, encourage home exercise program. Off work at this time.

: Follow-up. Six weeks status post left knee arthroscopy. Good progress in physical therapy. Continued weakness noted. Assessment: Post-op visit #2, status post left knee arthroscopy with partial medial meniscectomy. On Motrin, which was refilled today.

: Follow-up. Mild swelling around knee mainly around portals. Strength 5-/5. Slightly weak on exam. Patient to continue home exercise. Can use gym. Continue to use ice, heat and anti-inflammatory medications.

Follow-up. Patient stated symptoms improved with therapy but did not completely resolve. Left knee locking with specific movement. No change noted on physical examination from April visit. X-rays: Slight joint space narrowing only seen on left knee. Assessment: Status post left knee arthroscopy with partial medial meniscectomy, persistent pain. MRI of left knee recommended. Patient having more pain than Dr. liked. Probable scar, incomplete healing or recurrent tear to be ruled out.

: Follow-up. Stated better when using brace. MRI reviewed. Noted not to have recurrent major tear. Option of living with pain or injection or repeat arthroscopy given. Will try to live with it. Consider injection in 2-3 months.

Follow-up. Patient stated pain tolerable. Using Motrin and knee brace. No change in diagnoses. Discussion: Patient wishes to live with pain with Motrin controlling pain.

: Follow-up. <u>While playing soccer</u> with daughter developed pain on lateral side of left knee. Improved with rest. Denied prior problem with lateral side of knee. On physical examination, positive McMurray's noted. X-rays of both knees were taken and were within normal limits. Diagnoses: 1) Left knee lateral pain, possible lateral meniscal tear. 2) Left knee recurrent medial meniscus tear. 3) Left knee previous medial meniscectomy . Plan: MRI recommended with intra-articular contrast. If there is lateral meniscal tear, recommend surgery.

Follow-up. MRI reviewed and noted to show lateral meniscal tear with

some mild degenerative changes noted in all three compartments. Assessment: 1) Left knee lateral meniscus tear. 2) Degenerative joint disease. Discussion: Patient wished to defer surgery at this time to see if can live with pain. Follow-up on as-needed basis only.

XXXXXXXX Surgery Center:

XXXXXX XXXXX, M.D. Operative Report. Pre-operative Diagnoses: 1) Right knee pain. 2) Lateral meniscal tear. 3) Interarticular cyst, lateral joint. Post-operative Diagnoses: Right knee pain. 2) Lateral meniscal tear. 3) Parameniscal cyst arising from inferior meniscal tear.

. Operative Report. Pre-operative Diagnoses: 1) Left knee pain. 2) Medial meniscal tear. Post-operative Diagnoses: Left knee pain. 2) Medial meniscal tear. 3) Discoid lateral meniscus, non-pathologic.

XXXXX Therapy-Fitness,

: Illegible signature. Note of physical therapy evaluation for right knee. Soreness noted over lateral knee and right side of leg.

Intake Functional Status Summary. Patient with moderate pain, post-meniscectomy. Status post motor vehicle accident in 2(and left knee surgery on 5. Several physical therapy notes attached and reviewed.

XXXXX XXXXX Medical Group :

XXXXX XXXX, M.D. Ultrasound of the Liver. Impression: Fatty changes in liver.

XXXX XXXXX, M.D. Ultrasound of Scrotum/Testicles. Impression: 1) Small bilateral hydroceles. 2) Small left varicocele.

XXXX XXX. Within normal limits.

: XXXX XXXX, M.D. MRI of Left Knee. Indication: Left knee pain. Impression: Complex medial meniscus tear.

. XXXX XXXX M.D. Chest X-ray. Impression: Normal study.

:)XX XXXXX, M.D. Fluoroscopically Guided Injection of Intra-

Articular Contrast for MRI of Left Knee. Conclusion: Successful left knee intra-articular injection for MRI.

: Dr. XXXX. MR of the Left Knee with Intra-Articular Contrast. Conclusion: 1) Discoid lateral meniscus: "Congenital variant morphology maybe symptomatic and may cause locking or stability issues. A discoid meniscus is also more prone to tearing than a meniscus with normal morphology. The lateral meniscus is currently intact." 2) Post-surgical signal abnormality in the medial meniscus and evidence of partial meniscectomy resulting in a diminutive body with a slightly blunted free edge. No evidence of residua or recurrent meniscal tear.

: Dr. XXXX. MR of the Left Knee with Intra-Articular Contrast. Conclusion: 1) Horizontal cleavage tear of the mid-body of the lateral meniscus with extension to the inferior articular surface. 2) 6 x 5 mm para-meniscal cyst along the lateral joint line. 3) Lateral patellar tilt. 4) Evidence of prior medial partial meniscectomy.

XXXXX XXXXX Memorial Hospital:

: Emergency Summary Report. Trauma/Traffic accident. Impression: Blunt head trauma with laceration.

: Trauma/Resuscitation Flowsheet. Checked was restrained driver. Rollover of vehicle 4 times. Patient complained of headache, left elbow pain. Noted to have temple laceration.

: HXXXX LXXXXX, M.D. Patient brought in by helicopter a code trauma. Patient was driver of car involved in a rollover motor vehicle accident. Patient had loss of consciousness. Was wearing seatbelt. Complained of headache. Multiple lacerations on scalp and swelling right temple region. No neck or chest pain. No shortness of breath. No abdominal pain. Superficial abrasions on extremities. CT of head within normal limits. However foreign body noted, which was removed in the right parietal region. Multiple small puncture wounds on right side of scalp, largest injected with lidocaine and when explored large piece of glass removed. Impression: 1) Blunt head trauma. 2) Multiple abrasions and contusions. 3) Multiple scalp lacerations and abrasions. 4) Evaluation after motor vehicle accident. Disposition: To home.

LXXXX XXXXXXX, M.D. Trauma Consultation. On physical examination swelling noted on right side of scalp, multiple lacerations noted. No midline tenderness at back. Pelvis stable. CT scan of head negative with parietal

scalp foreign body identified and removed in ER. CT of face, cervical spine, chest and abdomen/pelvis negative. Assessment: No acute injuries clinically or radiographically that would warrant further intervention or admission to trauma service.

XXXX GXXXXX, M.D. CT Examination of Head without IV Contrast. Impression: Normal unenhanced CT examination of the head for age. Right parietal scalp foreign body.

Dr. XXXX. CT of Face. Within normal limits.

Dr. XXXX. CT of Cervical Spine without IV Contrast with Multiplanar Reconstructions. Impression: No evidence of cervical spine fracture or dislocation.

Dr. XXXX. CT of Chest with IV Contrast. Impression: Within normal limits.

Dr. XXXX. CT of Abdomen and Pelvis with IV Contrast. Impression: Normal CT examination.

Several labs attached and reviewed.

XXXXXXX XXXX Fire Department Emergency Medical Services:

Poorly copied form. Appears to state patient was restrained driver in vehicle which rolled over 4 times.

Deposition of XXX XXXXX:

132-page deposition of the applicant. Admonitions of the deposition are given. He had not taken any medications in the last 24 hrs. Identification questions were asked. He had lived first in before moving to He graduated from XXX with a degree in business education. He was employed as a social worker at the help desk for the County XXXX. He stated he was making a claim for lost wages. He had worked for the employer since 2C He described the accident in XXXXXX 201X. He was coming from after a vacation returning home to I Questions are asked about the car and the environmental conditions when the accident occurred. As he was passing a truck in the #3 lane, being in the #2 the truck moved into his lane, causing him to collide with hit. He felt that the car flipped immediately and rolled over three or four times before landing right-side up. He was removed from the vehicle by the paramedics. He was not clear

what was occurring at that time but remembered his arm and head were bleeding "profusely". He felt he had hit the windshield and that both knees hit the dash. He might have hit his head on the roof of the car. He was briefly knocked unconscious. He was taken by helicopter to XXXXXX XXX. He was in the ER for four to five hours. He felt an MRI and x-rays were done. He had the glass taken from his arm and head. He felt that more glass came out on its own from his head over the next six months. A break is taken. When the deposition resumes, questions were asked about the accident statement. Mr. XXXX did not remember speaking with the officer who wrote the report. He remembered x-rays and perhaps MRIs being taken at XXXX XXXX. He said he left with bandages on his head and arm. He never returned for any further treatment at XXXXX XXXX. He went to see his primary care physician, Dr. XXXXXX. She referred him to see Dr. XXXXX at XXXXX. While in XXXX XXXXX, he had a headache and his whole body hurt. He noted that these complaints continued when he saw Dr. XXXX, who gave him Motrin 800 mg. Dr. XXXX referred him to Dr. XXXX because of his knee. It was noted at that time that Mr. XXXXX had prior knee issues, this to the right knee for damaged lateral meniscus. He did not know how the knee had been damaged. During the motor vehicle accident, the right knee was not injured. Dr. XXXXX took x-rays and MRI of the left knee. Ultimately he had surgery on the left knee.

Mr. XXXXX stated he continued to have body aches but these resolved with the Motrin. He still had headaches which occurred about once a week. He said his primary doctor "did some stuff" to determine why, but there was never an answer. He had not been referred to other doctors for this. When he got a headache now he would take Advil and go to bed. If it happened at work he would "tough it out." He felt that the headache made him have to take breaks more often. He did not feel however that the computer made things worse. He had never had any complaints from his supervisors about the breaks.

At the time he went for follow-up after the accident, he noted that his left knee was hurting. He said, "I couldn't control the movement, couldn't go upstairs, downstairs. It gave out when walking." He never completely fell. He would try to be near walls to lean against. He never used crutches. He had been doing coaching and then had to coach from the sidelines.

He had had surgery for the left knee at the XXXXX Surgery Center early in 20__. However the knee had continued pain and a second MRI had been ordered. He now needed another surgery on the other side of the left knee. He had not gone ahead with the surgery because he felt that there was a chance that after the surgery "the meniscus will flatten out, and I will be bone on bone. And at that time knee replacement is the only fix." He did not want bone surgery at his age. He had been

advised the surgery about 8 months prior.

At this time he had called a pain management specialist who told him to take the Motrin 800 mg as needed. He would take the Motrin 2 to 3 times a week.

He had continued coaching for a while but said it was not "hands on", but more on an instructional basis. About a year ago he had tried to play soccer but when he tried it "I couldn't move. They had to help me to my car." That was he last time. Prior to that he had an injection for the pain. He would go to I _ : gym now where he would work on the bike and the elliptical. He would go two to three times a week. He did not have any doctor appointments currently.

After the injury he was off work for a couple of weeks, and then was off again when recovering from surgery and for physical therapy. This happened twice, once for the right knee and once for the left. At this time he was not doing physical therapy. He did the exercises which he learned from physical therapy at the gym. He said he was active hiking prior to the injury but could not do it now. He no longer ran. He did some gardening but nothing that required lower body strength. He said that he had fallen once or twice, but "you learn. Things that hurt you, you don't do anymore." At this time he did not use an assistive device, but he had used a cane for six months after the surgery. It had been a year since he had used the cane. He noted that his son and daughter both had back pain after the injury but that these went away. His wife had shoulder pain but was not treating for this.

At this point he said that his doctor told him it was inevitable that he would have another surgery for the left knee. He wanted to put it off as long as he could. He only had pain that required him to bend his knee.

The next lawyer to speak for him represented the plaintiff in the case. Mr. XXX said that he did not have a clear memory of the incidence. Several questions were asked about Mr. XXXXX's condition on driving the car. Many questions were asked about the various cars in the area and the sequence of events.

The next attorney asked him physically what else had occurred to him. As part of his lawsuit he was claiming his injuries and the vehicle. His insurance covered his luggage claims. Looking at himself in the mirror, he did not feel bad about his scars either on the head or arm.

The surgery he had was on the inside of the knee. What pained him know was the outside of the left knee.

He was asked what was the difference between his first and second surgeries. He felt the extent of the damage. He felt that the right knee was "minor" compared to what had to be done on the left. He admitted that this was his own perception in viewing the MRIs and that Dr. XXXXXXX had not told him this. His doctor had told him to go back to his regular life. At that time he tried to play soccer. The pain was significant from this and he returned to Dr. XXXX. He noted that Dr. XXXXXX had given him an injection to see if it helped. He commented, "It hurts." After the second surgery he was on crutches for two weeks and then used the cane steadily for four months and then on a sporadic basis. At this point Dr. XXXXXXX was doing blood work to check for any abnormalities because of his headaches. Questions are asked about the types of athletics his children were in.

Mr. XXXXX said again that he had heard from Dr. XXXXXX that there was a risk of the meniscus flattening out and that he would have bone on bone if he had the lateral meniscus surgery done. He would then require a total knee replacement.
Mr. XXXX reported increased symptoms "After I returned to regular movement." This included going to the gym "volunteering and doing more stuff." Prior to the car accident he was going to [illegible] 4 to 5 times a week. He was very active in it. At the time of the injury he was taking phentermine for weight loss. He had done that for one month.

At this time all of the lawyers confer and the deposition end.

PHYSICAL EXAMINATION:

Mr. Xxxx was accompanied to the exam room by the nurse. She was taking notes throughout the entire exam.

BILATERAL KNEES:

On gait inspection, it is noted that there is no altered gait. There is no evidence of antalgia or gait avoidance pattern. He is able to toe walk and heel raise without difficulty in the bilateral lower extremities.

Inspection: On visual exam of the bilateral knees, there is noted to be swelling and 1+ effusion of the left knee with no swelling of the right knee. Visual exam showed no gross deformity, no open wounds, no masses, and no visible rash, lesions, or atrophy. Arthroscopy portals are visualized in the knees. These have healed over very well.

Palpation: On examination of the right knee, the patient has tenderness over the

medial joint line. There is no tenderness over the lateral joint line. There is no tenderness of the quadriceps or tibia.

On palpation of the left knee, the patient has tenderness over the medial joint line and extensive tenderness over the lateral joint line. There is mild tenderness over the patella tendon, as well.

Range of Motion: Using a Goniometer, right knee range of motion was measured from approximately 2-125 degrees. Left knee range of motion measured using the Goniometer was approximately 3-120 degrees.

Tests: On examining the right knee, he had positive patella crepitation and positive patella grind. There was no lateral patella tilt. There was excellent tracking. J-sign was negative. There is a normal Q-angle. McMurray's test was negative. The knee is stable to varus and valgus testing from 0-120 degrees. Lachman's test is Grade 1. Posterior Drawer is negative. Posterior lateral spin is negative. Pivot shift test is negative. Apley's test is negative.

On examining the left knee, he had positive patella crepitation and positive patella grind. McMurray's test was positive. Apley's test was positive. Lachman's test is Grade 1. Pivot shift test is normal. The knee is stable to varus and valgus stress testing at 0-120 degrees. Posterior Drawer is negative. Posterior lateral spin is negative. Q-angle is normal. J-sign is negative. There is normal patella tracking. Patella quadrant movements are normal.

LOWER EXTREMITIES:

Visual inspection of the lower extremities reveals no open wounds, lesions, or masses. There is no visible rash or atrophy of the bilateral lower extremities.

Measurements: Evaluation of the quadriceps muscle mass, 10 cm proximal to the patella tendon, is 45 cm bilaterally. Evaluation at 10 cm distal to the distal pole of the patella shows 36 cm bilaterally.

Neurovascular: Neurovascular examination is intact in the bilateral lower extremities to proprioception and pinprick sensation. Vibration test is normal.

Motor/Reflexes: Motor strength is 5/5 in the bilateral lower extremities, including hip flexors, quadriceps, EHL, dorsiflexion, and plantar flexion. There are no upper motor neuron signs and no signs of myelopathy. Reflexes are normal in the bilateral lower extremities, including patella and Achilles reflexes.

DIAGNOSES:

1. Left knee medial meniscus tear related to the x/x/1x accident with reasonable medical probability. Status post left knee arthroscopy and medial meniscectomy.

2. Left knee lateral meniscus tear related to the x/1/1x accident with reasonable medical probability.

3. History of prior right knee arthroscopy, unrelated to x/x/1x incident.

DISCUSSION:

Mr. XXXX had an auto accident on X/1/1X. At that time he had multiple injuries and contusions and states his knees hit the dashboard and he had ongoing left knee pain.

He does admit to previous pathology of the right knee, which involved arthroscopy and meniscectomy. He states that after that surgery he had 90% relief of his right knee pain. At this point, he states that his right knee has remained at the 90% mark and that he has had no ill effects in the right knee from the X/1/1X accident.

With regards to the left knee, he had no previous left knee injury, trauma, or surgeries. After the accident on X/1/1X, he had an MRI of the left knee which showed a medial meniscal tear that was treated with arthroscopy and meniscectomy. Even after the surgery, he noted continued pain and had only 70% relief. A new MRI of the left knee did reveal a lateral meniscus tear.

Of note, Mr. XXXX does have a discoid lateral meniscus which is a congenital meniscus shape found in some patients. This does make the patient more prone to tearing. The original MRI after the X/1/1X accident showed a medial meniscus tear. The lateral meniscus tear was seen on the second MRI. The weakness and the fact that he had surgery on the medial meniscus of the left knee caused increased pressure on the left knee leading to a tear of the lateral meniscus with reasonable medical certainty.

At this point, Mr. XXXX is deciding between operative intervention and conservative treatment.

I have been asked to address specific questions:

CAUSATION:

Within reasonable medical probability, the x/1/1x automobile accident was the cause of the left knee medial and lateral meniscus tears and subsequent need for operative intervention. He noted mechanical symptoms and left knee pain after the accident, at which time an MRI was taken, showing medial meniscus pathology. He subsequently had to have a medial meniscectomy and debridement. The causation of the lateral meniscus tear is due to the fact that he has weakness and had surgery in the medial aspect of the knee, causing more pressure in the lateral aspect of the knee, thus leading to altered mechanics with increased pressure and a tear of the lateral meniscus. Of note, he does have a discoid lateral meniscus, which is a congenital meniscus shape that is seen in few patients. This does make the patient more prone to tears, but the surgery on the medial meniscus also could lead to increased weakness as well.

There was no new injury to the right knee in the x/1/1x accident of concern. There was a prior right knee injury, but no increase or change in his knee secondary to the auto accident of concern.

PROGNOSIS:

At this time Mr. Exxxx has not had operative intervention for the left knee lateral meniscus tear. If he continues with conservative treatment, he is at increased risk for early chondromalacia and arthritic changes of the knee, as he will have decreased function of the meniscus. Given that there is a tear in the meniscus, the cushioning effects of the meniscus have been dramatically lessened and the compression forces across the knee will exacerbate the tear.

In my opinion, Mr. Exxxxx will have a good prognosis if he undergoes a left knee arthroscopy and lateral meniscectomy. He does have another tear on MRI, as well as mechanical symptoms and physical exam findings that are consistent with lateral meniscus pathology. Given his age and activity level, it is within reasonable medical probability that a lateral meniscectomy would decrease his chances of osteoarthritis and allow him to get back to performing his activities of daily living and recreational activities, as well.

FUTURE MEDICAL CARE:

If he treats conservatively, he will likely require injections which include cortisone and Hyaluronic acid injections. Cortisone can be given three times a year if he has at

least three months of relief from each injection. Otherwise, he will have to undergo Hyaluronic acid injection. This could be given as a series of three injections or as a one-time injection. Of note, the Hyaluronic injections can be given once every six months. If he does not achieve six months of relief with this injection, then he should not be receiving these injections.

Mr. xxxx will most likely require a left knee arthroscopy and lateral meniscectomy. This would require operative intervention, as well as six weeks of post-operative rehab that includes two times per week for six weeks. He would need to be off of work for approximately six weeks time, as well. At that point he would be able to go back to full duties and full activities.

If he does undergo a left knee arthroscopy and lateral meniscectomy, and undergoes appropriate post-operative rehabilitation in a timely manner, it would be within reasonable medical probability that he would no longer need the additional future medical care and injections for the left knee.

DISCLOSURE:

Mr. xxxxx was interviewed and examined by the undersigned and this dictation was done solely by the undersigned.

Sincerely yours,

NEIL S. GHODADRA, M.D.
Diplomate, American Board of
Orthopedic Surgery
State of California License

Signed in _____ County on _____

July 19, 2018

TO: Disability Procedures & Services Committee
William Pryor, Chair
James P. Harris, Vice Chair
Herman Santos
Gina Zapanta-Murphy
Marvin Adams, Alternate

FROM: Ricki Contreras, Manager
Disability Retirement Services

FOR: August 1, 2018, Disability Procedures and Services Committee Meeting

SUBJECT: **CONSIDER APPLICATION OF KATALIN BASSETT, M.D., AS A LACERA PANEL PHYSICIAN**

On June 7, 2018, staff interviewed Katalin Bassett, 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 Katalin Bassett, M.D., to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

Attachments

JJ:RC:mb

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

July 20, 2018

TO: Ricki Contreras, Manager
Disability Retirement Services

FROM: Tamara L. Caldwell, DRS Supervisor
Disability Retirement Services

Maisha Coulter, Sr. Disability Retirement Specialist
Disability Retirement Services

FOR: August 1, 2018 Disability Procedures & Services Committee

SUBJECT: Interview and Office Visit with Psychiatrist Applying For LACERA's Panel of Examining Physicians

RECOMMENDATION

Based on our interview and an effort to provide a diverse panel of examining physicians in several geographic locations throughout Los Angeles and surrounding counties, staff recommends Katalin Bassett, M.D.'s application be presented to the Board of Retirement for approval to the LACERA Panel of Examining Physicians.

BACKGROUND

On June 12, 2018, staff interviewed **Katalin Bassett**, **M.D.** at her office, located at 1401 N. Tustin Ave. #120 Santa Ana, CA 92705. Dr. Bassett is a Board Certified psychiatrist, and has been in private practice for over thirty years. As referenced in her Curriculum Vitae, Dr. Bassett graduated from Semmelweis Medical University with her Medical Degree in 1977. She completed her internship at the Long Beach Veterans Administration and residencies at St. Stephen's Hospital and U.S.C Medical Center. She completed her fellowship with U.S.C. Medical Center.

Dr. Bassett estimates that 65 percent of her practice is devoted to IME evaluations for other retirement systems and workers' compensation and the remaining 35 percent is devoted to patient treatment.

The office is located in a three-story office building with free parking all around the office building. Dr. Bassett's office has two examination rooms. The office was clean with ample seating. Male and female handicap accessible restrooms are located just outside the suite in the common area and were clean. Dr. Bassett has an office administrator who will assist with all LACERA cases. In addition, Dr.

Bassett has three additional offices located in Long Beach, San Bernardino, and Carlsbad. She does not share office space with any other doctors, but has a neuro-psychologist available to provide testing as needed.

Staff reviewed the new LACERA Panel Physician Guidelines with the physician, which included a lengthy discussion regarding the Rules in Evaluating Applicants, Disability Retirement Law Standards, and a thorough explanation of what is expected when preparing Panel Physician's written report for the Board of Retirement. Dr. Bassett understood and agreed to the rules set forth in the Guidelines.

Staff also discussed report submission timeframes, fee schedule and billing procedures, additional diagnostic testing request requirements, and advised the physician of the requirement of maintaining a valid medical license, Board Certification, and insurance coverage. She was advised to immediately report any lapses, suspensions or revocation of medical license, Board Certification, or insurance coverage, or be subject to immediate suspension or termination from LACERA Panel of Examining Physicians. Dr. Bassett understood and agreed to adhere to the requirements as discussed.

Dr. Bassett was informed that a Quality Control Questionnaire is sent to each applicant regarding their visit, which affords the applicant an opportunity to provide feedback concerning their experience during the medical appointment.

IT IS THEREFORE RECOMMENDED THAT YOUR COMMITTEE adopt staff's recommendation to submit the Application of Katalin Bassett, M.D. to the Board of Retirement for final approval to the LACERA Panel of Examining Physicians.

Attachment

RC:tlc:mc

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
Group Name:		Physician Name: Katalin Bassett, MD
I. Primary Address: 1401 N. Tustin Ave, #120 Santa Ana, Ca 92705		
Contact Person Maria		Title office manager
Telephone: (714) 550-0508		Fax (714) 550-0344
II. Secondary Address 4000 Long Beach blvd, #222, Long Beach 90807		
Contact Person		Title
Telephone Same		Fax

PHYSICIAN BACKGROUND		
Field of Specialty Psychiatry	Subspecialty —	
Board Certification ☑ Yes ☐ No	License # A 42851	Expiration Date 03/31/20

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

Evaluation Type

I. Workers' Compensation Evaluations

☐ Defense	How Long? ____		☒ IME	How Long? ____	
☐ Applicant	How Long? ____		☒ QME	How Long? ____	
☒ AME	How Long? ____				

II. ☒ Disability Evaluations How Long? ____

For What Public or Private Organizations? Pers,

Currently Treating? ☒ Yes ☐ No

Time Devoted to: Treatment 35 % Evaluations 65 %

Estimated Time from Appointment to Examination	Able to Submit a Final Report in 30 days?
☒ 2 weeks max ☐ 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:

Katalin Bassett (Please Print Name) Title: M.D.

Physician Signature: [signature] Date: 4/20/18

FOR OFFICE USE ONLY Physician Interview and Sight Inspection Schedule	
Interview Date:	Interview Time:
Interviewer:	

KATALIN BASSETT, M.D., INC.

GENERAL AND LEGAL PSYCHIATRY

MAIN OFFICE AND MAILING ADDRESS:

☐ 1401 N. TUSTIN AVE., SUITE 120
SANTA ANA, CA 92705
PHONE (714) 550-0508
FAX (714) 550-0344

☐ 4000 LONG BEACH BLVD., SUITE 222
LONG BEACH, CA 90807
(562) 592-5580

☐ 198 N. ARROWHEAD AVE., # 2A
SAN BERNARDINO, CA 92408
(909) 888-8489

☐ 701 PALOMAR AIRPORT RD., # 300
CARLSBAD, CA 92011
(760) 805-7800

CURRICULUM VITAE

EDUCATION

High School:	Graduated 1970
College/University	Medical School - 1971-77 Integrated Pre-Medical - Medical Program Semmelweiss Medical University Budapest, Hungary Degree and year granted: M.D. - 1977
INTERNSHIP	Flexible Internship - 1976-77 Budapest, Hungary (as part of a 6 year medical school) Psychiatric Internship - 1985-86 Long Beach Veterans Administration Long Beach, California
RESIDENCIES	Ear, Nose and Throat - 1978-82 St. Stephen's Hospital Budapest, Hungary Psychiatry - July, 1986 - July, 1989 U.S.C. Medical Center Los Angeles County
FELLOWSHIP	Psychiatry and Law - July, 1989-90 U.S.C. Medical Center Los Angeles County
LICENSURE	State of California Medical License - 1986 (A042851) Qualified Medical Examiner 1991 (#001619) Agreed Medical Examiner 1992

BOARD STATUS

Board Certification:	E.N.T. Hungary - 1982 Board Certified, American Board of Psychiatry and Neurology - 1997 Re-Certification, American Board of Psychiatry and Neurology - 2008

ACADEMIC APPOINTMENT	Clinical Instructor in Psychiatry and the Behavior Sciences - U.S.C. 1990
EXPERIENCE	
1990 - Present	Private Practice in the Field of Psychiatry specializing in early intervention, medical management, goal-oriented, brief course of psychotherapy, of depression, anxiety/panic disorder and post-traumatic stress disorder.
FORENSIC EXPERIENCES	Agreed Medical Examiner and Qualified Medical Examiner in the Field of Psychiatry Psychiatric Expert Witness, Orange County Superior Court, 1990-2000
PROFESSIONAL REFERENCES	Available upon request

SAMPLE REPORT

KATALIN BASSETT, M.D., INC.

GENERAL AND LEGAL PSYCHIATRY

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CARLSBAD, CA 92011
(760) 805-7800

AGREED MEDICAL EXAMINATION IN PSYCHIATRY

September

Re: ** versus , Inc.
Claim Number: **
WCAB Number: **
Date of Injury: **
Date of Exam: September

To Whom It May Concern:

This psychiatric report should be handled as privileged information. The data in these reports can be misinterpreted and misunderstood. If the applicant/client requests access to this report, I recommend that the report be released to a qualified professional, preferably a mental health professional, who would be willing to assume clinical responsibility for the report and discuss relevant findings with the applicant/client in a summary form.

** was seen for Initial Comprehensive Psychiatric AME Evaluation in my office on , 20 in my capacity as an Agreed Medical Examiner. The entire history was taken by Katalin Bassett, M.D.

This is a Psychiatric Medical-Legal Evaluation (ML-104).

I verify under penalty of perjury that the total time I spent on the following activities is true and correct:

The face-to-face interview time was 2.0 hours.
Dictation, formulation and final review time was 3.0 hours.
Medical record review time was 4.5 hours.
This resulted in a total evaluation time of 9.5 hours.
(which took place over a period of three weeks)

I declare under penalty of perjury that the name and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than clerical preparation, are as follows:

Medical records available for my review at the time of preparation of this report were reviewed by . The records were then re-reviewed by the undersigned, Katalin Bassett, M.D. There is an attached record review at the end of this report.

Cognitive testing was administered and interpreted by a licensed clinical psychologist, Ph.D., , to provide objective data for assessment of the cognitive elements of the applicant's psychiatric impairment.

Psychological testing included a Minnesota Multiphasic Personality Inventory-2 and a Millon Clinical Multiaxial Inventory-III. In addition, the applicant completed the Beck Depression Inventory and Beck Anxiety Inventory, and the Epworth Sleepiness Scale, which were reviewed with the applicant and interpreted by this examiner.

The applicant was advised of the purpose and issues of this psychiatric evaluation. The history, mental status examination, formulation and conclusions of this report were performed and dictated by this examiner.

IDENTIFYING INFORMATION

** is a year old, who had been employed at Inc. since November . She reports an injury on November , resulting in right upper extremity complaints.

She had a carpal tunnel release in April . She eventually stopped working in 20 when she was terminated from her job, presumably because the employer could not accommodate her orthopedic limitations.

The applicant reports a great deal of complaints in the right hand. She also reports becoming depressed because of the hand injury and her limitations.

She is treating with Dr. , a pain management specialist, and more recently she was sent to treat with Dr. , a psychiatrist, who placed her on Zoloft.

DESCRIPTION OF APPLICANT AT TIME OF INTERVIEW

The applicant is a . She came to the evaluation with her and . She was cleanly attired. Her appearance was slightly unusual as she wore a very low-cut t-shirt showing a large amount of cleavage and had small holes cut out of it. Her lower front teeth were missing, but it was barely visible. She had clean brown hair. She wore prescription glasses and silver dangling earrings. She had a white elastic wrist brace on the right that was not very clean.

She spoke pretty good English, as she has been in the U.S. for about 40 years, but we had a certified Spanish/English interpreter for our aid and we used the interpreter, which was reasonable for an AME.

She had no indication of acute physical or emotional distress. She was somewhat histrionic and a rather difficult historian. She was likeable and was cooperative. It was relatively easy to establish rapport with her.

HISTORY OF PRESENT ILLNESS

** began her employment at , Inc. in 19 . She states that for about years she worked as a packer. She would have to weigh candy using her hands and put it in boxes that weighed up to five pounds. She then worked in a different area where she would have to close the lids of boxes and for the last to years she cleaned the premises. She worked about eight hours a day. Recently, she did not have any overtime. When she last worked she was paid every two weeks.

She states that her supervisor was difficult and put pressure on her and all the workers to work hard. She would check on them and point out where they needed to clean. She feels that the work was distributed unevenly sometimes.

She then sustained an injury on November , when she was washing the floor with a machine and the machine somehow "jerked and flipped" and pulled her right hand. She had a swollen right wrist and reported the injury.

The applicant was then sent to where she was evaluated by , M.D. He thought the patient had a sprain/strain of right hand. She was placed on modified duties and was sent to physical therapy.

On January , the applicant was seen by , D.O., for a hand surgical consultation. The doctor noted that the patient had right carpal tunnel syndrome and right wrist flexor carpi radialis (FCR) tendinitis. The condition was felt to be industrial. She was placed on restrictions.

She then began to treat with Dr. . It was noted by Dr. that by March , her physical pain was worsening.

On April , the patient underwent a right carpal tunnel release by Dr. . The records show that after the surgery she had some sensitivity around her scar. The applicant was described with hypersensitivity on her right wrist.

By December , Dr. found the applicant permanent and stationary with the diagnosis of status post right carpal tunnel release and right wrist FCR tendinitis, resolved. She felt the patient did not have permanent impairment and she was able to return to her usual and customary duties.

The applicant states that she continued to see Dr. in 20 and she was also followed at U.S. Healthworks. The records indicate that she stated on April , 20 that her condition had worsened and she was placed back on modified duties. Ms. ** states that she was on light duty for a period of time.

By May Dr. had noted that the patient had a right wrist neuroma and needed occupational therapy and desensitization.

Eventually her case was transferred from Dr. to Dr. in about July .

On August , 20 Dr. issued an initial report noted that the patient was on light duty continuing with right wrist pain. She was diagnosed with neuroma, right hand and hypersentitivity; status post carpal tunnel release. The doctor thought that the patient had a rateable impairment because of her dysestasia and hypersensitivity and her disability needed to be re-addressed by Dr. . She may need additional surgery but in the meantime she could work on light duty.

On January , 20 the applicant was seen by Dr. , a hand specialist. He noted right carpal tunnel release and injury to the palmar cutaneous branch of the median nerve with hypersensitivity. A possible second surgery may be necessary. She

was not yet permanent and stationary and likely could not return to her regular duties.

The applicant tells me that in August of , her supervisor, , sent her home. Up until that time, she had continued to do some packing and cleaning work, although she admitted that her hand was painful and swollen.

On January , 20 there was an orthopedic AME by , M.D., who concluded that the patient had reached maximum medical improvement. She had work restrictions. She was a Qualified Injured Worker. She needed future treatment and possibly surgery. She was left with 9% whole person impairment of the right wrist, including 2% for pain.

In March the applicant's orthopedic care was taken over by Dr. . He thought that the patient may have complex regional pain syndrome of the right hand.

Apparently, there was a QME evaluation by Dr. , who thought the patient should be in pain management and surgery would not help her. **Comment: This report was not available for my review.**

By November 7, Dr. noted that the patient's attorney advised her to request a psychiatric consultation and he agreed that referral should take place.

The applicant was found permanent and stationary by Dr. on July , with carpal tunnel syndrome; status post surgery; complex regional pain syndrome due to painful neuroma of palmar cutaneous nerve. Patient did not want to have surgery. She was found with a 14% whole person impairment for the right upper extremity which was apportioned 81% industrial and 19% non-industrial, as far a causation goes, but apportionment of final impairment was 99% due to complications of treatment. She may need additional surgery.

On April , the applicant was evaluated by Dr. , a psychiatrist. He noted the applicant's depression, worry, sleep and anxiety problems, feeling like crying. She also had pain in her neck shoulders and bilateral wrists. She was described as tearful. She was diagnosed with Major Depressive Disorder, Single Episode. She was felt to be psychiatrically TTD and was started on Zoloft.

Subsequently, the applicant was seen by Dr. a couple of times in May and June of . Dr. documented that the applicant's depression and tearfulness improved with medications.

The applicant saw Dr. until about early 20 . She now sees Dr. for her general medical issues. She goes to the Clinic, where she sees her family physician, Dr. .

She states that she remains somewhat depressed, cries easily. She is desperate. She has money problems. She tends to ruminate over her issues. She reports pain and swelling in her hand; her fingers burn and the palmar side of her wrist is sensitive. The pain radiates to her shoulder and neck.

At the time of this evaluation, the applicant states she is sad and discouraged about her future. She feels guilty but not punished. She denies problems with her self-esteem but cries easily. She is restless and irritable. She has fatigue and decreased energy. She has difficulty making decisions. She reports decreased concentration. She has decreased sleep, increased appetite and complete lack of sex drive.

She endorsed mild to moderate anxiety symptoms, including difficulty relaxing, fear of the worst happening, rapid heartbeats, trembling, abdominal discomfort and feeling hot.

SOCIAL HISTORY

The applicant was born in Mexico on April , 19 . She has been in the She states that her father was a brick layer who died between age 60 and 70 from a heart attack. Her mother was a housewife. She raised 14 children and the applicant is one of nine girls and five boys. She is the fifth child age-wise. Her mother died at age 72 from diabetes. She states that three of her siblings live in and the rest of them are in the She reports a good upbringing.

She states that her parents had an "okay" marriage and they got along reasonably well. Her mother would hit the kids with a wooden spoon as a form of discipline. Her father was never abusive.

She denies any developmental delays or disciplinary problems, including truancy, fear of going to school, nail biting, nightmares, running away, bedwetting, suspensions from school or repeated clashes with authority.

She denies exposure to any physical, emotional or sexual abuse as a child or to any violence as an adult.

She has : The oldest, , is studying and has a boyfriend or a husband who supports her. The applicant was with 's father for a year and then they separated. She then had kids, , age , and , age . She states that they are housewives. She was together with their father for five years and then he left her.

She then was in a year relationship with the father of her year old He cheated on the applicant and they separated. Her does not work and is supported by his girlfriend.

The applicant has now been with her husband for years. He is years old and is a . He has hypothyroidism and hypercholesterolemia. She says they have a good relationship.

She lives with her husband. She gets up at 6:00 a.m. and makes lunch for her husband. She often goes back to bed until 8:00 or 9:00 a.m. She then has breakfast and takes her medications. She makes her bed. She does some cleaning. She runs errands and pays her bills. She then sits on the sofa and watches television. She sometimes dozes off. When her husband comes home they have dinner and she takes her medicine.

She goes to bed between 7:00 and 8:00 p.m. She does not sleep well because she wakes up several times at night to go to the bathroom and sometimes it is difficult to go back to sleep.

She has decreased appetite and no sex drive. She states that because of her hand problem it is difficult for her to dress herself and take a shower. She cannot grab onto anything strong because it causes pain in her right hand. She is able to drive herself.

EDUCATIONAL HISTORY

The applicant finished

OCCUPATIONAL HISTORY

Ms. ** has been employed at since 19 . Before that she was on

MILITARY HISTORY

The applicant has never been in the military.

LEGAL HISTORY

The applicant denies arrests, criminal record, previous workers' compensation or personal injury claims, bankruptcy, foreclosure or being a party to any civil lawsuits.

MEDICAL HISTORY

The applicant was diagnosed with years ago and she has blood sugar readings between and

She had one miscarriage and four live births.

She denies any head trauma, seizures, loss of consciousness, acute or chronic medical conditions, including high blood pressure, asthma, ulcers, arthritis, etc.

MEDICATIONS

Ms. ** is taking Metformin, 5 mg two a day, Glipizide, 20 mg two a day, Amlodipine 10 mg a day, Benazepril, 10 mg a day, Atorvastatin, one a day, and Fenofibrate, one a day. She also takes Synthroid, 100 mcg and Sertraline, 100 mg.

PAST SURGERIES

The applicant underwent right carpal tunnel release in April and years ago she had a tubal ligation.

PSYCHIATRIC HISTORY

She denies any history of anxiety, depression or panic attacks, manic symptomatology or psychosis. She denies any psychiatric treatment as an outpatient or psychiatric hospitalization prior to this injury.

HABITS

The applicant denies excessive drinking or using street drugs. She does not smoke cigarettes.

SUMMARY OF MEDICAL RECORDS

For a detailed summary, please see the Medical Records Review attached at the end of this report.

SUMMARY OF PSYCHOLOGICAL TESTING

A **Minnesota Multiphasic Personality Inventory-2** and **Millon Clinical Multiaxial Inventory - III** were administered and interpreted. Please see a copy of the scores included in the psychological testing attached to this report.

The **Beck Depression and Anxiety Inventories** are each a 21-question self-report inventory which asks the applicant to choose from a hierarchy of levels of depression or anxiety-related symptomatology for each question. Each question is scored from zero to three, with a maximum score of 63 for the test. The higher the score, the higher the self-rating by the applicant as a measure of depression or anxiety-related symptoms.

The following is a description of approximate correlation of range of scores on the Beck Depression and Anxiety Inventories to levels of subjective depression or anxiety:

1 - 10	Within normal limits
11 - 16	Mild mood disturbance
17 - 20	Borderline clinical depression or anxiety
21 - 30	Moderate depression/anxiety
31 - 40	Severe depression/anxiety
Over 40	Extreme depression/anxiety

The applicant's **Beck Depression Inventory** score was **21.** The applicant's **Beck Anxiety Inventory** score was **22.** These scores are consistent with her mental status and mild anxiety and depression.

NOTE: These are descriptive terms of levels of symptoms of depression and anxiety which are not in any way equivalent to descriptive terms of psychiatric disability utilized by the psychiatric guidelines for describing Workers' Compensation psychiatric disability. In addition, subjective symptoms of depression and anxiety do not directly correlate to levels of impairment. The description of levels of depression and anxiety is based on the self-report of the applicant and does

not correct for exaggeration or denial of symptoms. The level of depression indicated on the Beck Depression Inventory and the level of anxiety indicated on the Beck Anxiety Inventory must be assessed in conjunction with other objective data of the psychiatric evaluation.

The **Epworth Sleepiness Scale** score of **11** is borderline for some excessive sleepiness.

Cognitive Testing: The applicant's cognitive testing was overall in the borderline to low average range with borderline auditory concentration, visual spatial reasoning and rapid visual learning. She has average short auditory memory and low average visual recognition. She was able to perform simple visual scanning in the low average range. She was unable to perform simultaneous multiple visual tasks. Her Reys score of 12 did not show malingering of cognitive deficits. Her projective drawings suggested instability and eccentric thought processes.

The applicant's **MMPI-2** was extremely exaggerated and, therefore, the test was invalid.

The **MCMI-III** was also exaggerated and invalid.

These test results were considered when I addressed the patient's psychiatric medical legal issues.

MENTAL STATUS EXAMINATION

The applicant's appearance was described in detail at the outset of this report, under the 'Description of the Applicant at the Time of Interview' heading.

She was alert and oriented to time, place and person with a clear sensorium. She did not have any involuntary movements or tics.

She spoke Spanish without dysarthria, aphasia or word finding difficulties. She was interviewed with the aid of a certified Spanish/English interpreter. Her speech style was unremarkable.

Her mood was mildly dysphoric. Her affect was appropriate to content.

Her cognitions were unimpaired. Her thought processes were logical. She did not have loose associations, delusions or ideas of reference. She denied hallucinations.

She did not have any obsessions, compulsions, phobias or avoidance behaviors. She denied homicidal or suicidal ideations. Her insight, judgment and impulse control were unimpaired.

DIAGNOSTIC IMPRESSION

Axis I: Adjustment Disorder with Anxiety and Depression, somewhat chronic.

Axis II: Deferred.

Axis III:
1. Per Orthopedic AME, Dr. 's Report.
2. Diabetes, preexisting.
3. Hypothyroidism, preexisting.
4. Obesity, non-industrial.

Axis IV: Psychosocial Stressors: Orthopedic complaints.

Axis V: GAF Score: **61**

SUMMARY OF HISTORY

In summary, Ms. ** is a year old who is originally from . She has been in the for close to years. She reports a reasonable upbringing, coming from a large family, but states that her parents were decent providers. She denied any exposure to adversities as a child.

She has children from three different relationships. She raised her children mostly on her own. Now she has been with her husband for years. She says her kids between ages and are doing reasonably well. She states that they get along well.

She had a long employment history at since 19 , mainly as a and then doing cleaning. Prior to working at she was on and, according to my records, she was periodically laid off from but then was rehired.

She has had s for the last years and she is also morbidly obese.

Ms. ** sustained an injury on November , to her right hand during the regular course of her employment with . After a brief period of conservative treatment, she underwent carpal tunnel release surgery which did not turn out very well. She developed a neuroma, and possibly chronic regional pain syndrome. After the surgery, she went back on modified duties briefly, but eventually she was terminated because the employer could not provide her with light duty work. She has not been working since around 20 .

She has now been off work for close to three years. She describes chronic physical pain, as well as development of anxiety and depressive symptoms due to her physical pain, her physical limitations and inability to continue to work.

Her psychiatric symptoms were most likely initially consistent with an Adjustment Disorder with Anxiety and Depression. The condition has remained relatively chronic. She is somewhat anxious and depressed but I do not believe that she meets diagnostic criteria for a Major Depressive Disorder.

For her orthopedic issues, she was seen Dr. , the AME, on January 20 . He found her right hand/wrist disability was 100% apportioned to continuous trauma of her job-related duties. She was given 9% whole person impairment, including 2% for pain.

For her psychiatric issues, she has been treating with Dr. , who thought the patient had a Major Depressive Disorder and was TTD. I believe that the patient's diagnosis is an Adjustment Disorder with Anxiety and Depression, Chronic.

She has been treating with a psychiatrist, Dr. , since April 20 . She was placed on Zoloft, which seems to have improved her symptoms. She remains with mild chronic low-grade symptoms, which are outlined at the outset of this report.

DISABILITY STATUS/CAUSATION/APPORTIONMENT The apportionment is addressed pursuant to Labor Code Section §4663 and §4664. The opinions are made with a reasonable medical probability. Opinion regarding causation is based upon the applicant's history, mental status, psychological testing and medical records I have received by the time of issuing the report. I considered significant causative factors, including prior documented psychiatric injuries,

permanent disability, or impairment, as well as preexisting conditions, which in the natural progression would have resulted in permanent psychiatric impairment. I took into consideration other factors, which may have contributed to this applicant's current condition/ disability/impairment.

I have taken into consideration the Almaraz Guzman Decision regarding an accurate impairment rating and allowing impairment rating based upon the four corners of AMA Guides to the Evaluation of Permanent Impairment, 5th Edition.

The applicant is symptomatic but her symptoms are not severe enough to cause her to be psychiatrically TTD. She meets diagnostic criteria for an Adjustment Disorder with Anxiety and Depression. This condition is predominantly industrial and caused by her orthopedic injury that she sustained in 20 .

Ms. ** did not have any periods of psychiatric TTD but she remains symptomatic. She has been receiving a few months of psychotropic medications from Dr. She was placed on Zoloft, which has improved her symptoms. It sounds like she received close to six months worth treatment since she began to see Dr. and at this point the applicant probably should be considered permanent and stationary psychiatrically with a **GAF score of about 61.**

Causation of the onset of her Adjustment Disorder is predominantly industrial. I do not see any indication of preexisting psychiatric disability or the presence of a psychiatric disorder which in its natural progression would have left her with any permanent psychiatric impairment or any subsequent psychiatric stressors.

The orthopedic AME found her orthopedic issues 100% industrial, therefore, her permanent psychiatric impairment is not apportioned. There is 0% apportionment to non-industrial factors.

The applicant's evaluation took place in full accordance with the standards defined by the Division of Workers' Compensation of the State of California and the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition.

Disability Rating per AMA Guidelines:

1. <u>Ability to perform activities of daily living</u>:
   Impairment: **Class II/Mild.**

2. Social functioning:
   Impairment: **Class II/Mild.**

3. Concentration, persistence and pace:
   Impairment: **Class II/Mild.**

4. Deterioration or decompensation in work or work-like setting/adaptation:
   Impairment: **Class II/Mild.**

TREATMENT CONSIDERATIONS

The applicant should remain on an antidepressant for about another 9 to 12 months because of the chronicity of her symptoms. She should receive six to eight session of supportive therapy with a Spanish speaking therapist. This should be part of future medical treatment.

The treatment she has received so far with Dr. should be considered industrial.

VOCATIONAL REHABILITATION

Within her physical limitations, from a strictly psychiatric point of view, the applicant would be able to work. Psychiatrically, she is not eligible for retraining.

Thank you for allowing me the opportunity to participate in this psychiatric evaluation of ** I hope that I may continue to be of service to you. Please do not hesitate to contact me if I can be of further assistance.

DISCLOSURE

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.

I further declare under penalty of perjury that I personally performed the evaluation of the applicant on at nd that, except as otherwise stated herein, the

evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

I further declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this applicant or the preparation of this report.

I declare under penalty of perjury that this bill for my services is true and correct to the best of my knowledge.

Signed this ____ day of October , at County,

Katalin Bassett, M.D.
Diplomate, American Board
of Psychiatry and Neurology

KB:cr

cc:

July 19, 2018

TO: Disability Procedures and Services Committee
William Pryor, Chair
James P. Harris, Vice Chair
Herman Santos
Gina Zapanta-Murphy
Marvin Adams, Alternate

FROM: Ricki Contreras, Division Manager
Disability Retirement Services

Tamara L. Caldwell, DRS Supervisor
Disability Retirement Services

FOR: August 1, 2018 Disability Procedures & Services Committee

SUBJECT: Request to Contract with Professional Investigation Agencies

RECOMMENDATION

That the Disability Procedures and Services Committee accept staff's recommendation to approve the issuance of service agreements to American Employer Defense and MV Investigations for the purpose of providing professional investigation services to LACERA's Disability Retirement Services and Disability Litigation Division and submit to the Board of Retirement for final approval to the LACERA Panel of Service Providers.

EXECUTIVE SUMMARY

A LACERA member applies for disability retirement benefits when they believe they are permanently incapacitated from performing the duties of their current position with the County. If granted, the member is entitled to a lifetime benefit from LACERA. It is the responsibility of the Disability Retirement Services Division (DRS) to impartially investigate all disability retirement applications to ensure that applicants have a valid claim for benefits. Occasionally, there are claims that require a more in-depth investigation due to discrepancies evident in the record or information obtained from the employer or other witnesses. When such a situation arises, DRS may require the use of private investigation agencies.

LEGAL AUTHORITY

The Board of Retirement has the plenary authority and fiduciary responsibility to administer the retirement system, and it holds executive, legislative, and quasi-judicial powers. It has the sole authority to determine eligibility for a disability retirement. In

administering its duties, the Board has the authority to contract with investigative services necessary to carry out the purpose of this article.[1]

DISCUSSION

DRS currently has one investigation agency under contract. Historically, we have employed up to 4 agencies at any given time. Over the past five years, we have lost three of the four agencies once contracted with LACERA due to retirements and closure of the agencies. To ensure that we maintain a diverse panel of professional investigative agencies, DRS seeks to hire 2 replacement agencies.

Staff leveraged our relationships with Los Angeles County Counsel and Third Party Administrators to solicit referrals for private investigation agencies used by their departments. As a result of our inquiry, recommendations for two firms were provided, American Employer Defense and MV Investigations. Staff conducted interviews with both firms to determine what services were available. Both agencies bring a wealth of experience and knowledge in the field of investigations, and both have a long standing relationship with the County of Los Angeles, as well as other government entities, insurance companies, law firms, and third party administrators. Each agency is able to provide professional investigative services including background investigations, surveillance, AOE/COE investigations, criminal and civil records searches, medical canvasses, and social media searches. Additionally, their investigators are available to testify during any administrative hearings as needed. The services offered will be used by both Disability Retirement Services and Disability Litigation Divisions.

SUMMARY

Enclosed for your consideration are promotional materials from American Employer Defense and MV Investigations.

IT IS THEREFORE RECOMMENDED THAT YOUR COMMITTEE accept the staff recommendation to submit the applications of American Employer Defense and MV Investigations, to the Board of Retirement for final approval to the LACERA Panel of Service Providers.

Attachment

RC:TLC:mb

NOTED AND REVIEWED:

JJ Popowich, Assistant Executive Officer

[1] Cal. Const., art. XVI, § 17, subd. (a) and (b); Gov. Code Sec. 31725; *Preciado v. County of Ventura, et al.* (1982) 143 Cal.App.3d 783, 789; and Gov. Code Sec. 31732.

AMERICAN EMPLOYER DEFENSE

President's Message 2018

In 1988, guided by an absolute commitment to ethics and standards, I founded Ted Koerner Investigations which by 1997 had grown into **A**merican **E**mployer **D**efense, Inc. From the beginning our strength has come from providing superior results. Now in our thirtieth year it is inspiring to be at the helm of such a savvy, experienced group of dedicated professionals.

Building on our primary commitment to be the best at what we do, this past year has seen the addition of several more top investigative professionals as well as the implementation of distinctive technological advances. I seized the opportunity to add Bart Daly to our management team. Bart brings fifteen years experience as a Workers Compensation Claims Manager of high-risk, high-volume accounts and another fifteen years as a knowledgeable, respected investigation case manager. Bart has immediately proved himself a valuable strategist capable of guiding operatives to seemingly miraculous results in the most difficult and complex cases. Bart is a great character in the office; I am sure you will find him to be a valuable resource for strategizing.

Our service groups of investigators now represent more than 250 years of distinguished, often memorable service to insurers, administrators, public agency employers and private industry. Our results are well known to the State of California Department of Insurance Fraud Divisions. Many District Attorneys have won convictions for the crimes of insurance fraud, grand theft, embezzlement and perjury using evidence produced by **AED**. Our Mission Statements are:

"Delay Equals Exposure" and "Findings Based on Facts."

With confidence in our methods, tactics, and results, we restate our commitment to reducing losses from a wide range of exposures. I am confident AED will become a primary resource worthy of your trust. It is with great pride that I introduce our staff of dedicated professionals and our various service groups.

American **E**mployer **D**efense, Inc.
Ted Fulton Koerner
Chief Executive Officer

A E D

AMERICAN EMPLOYER DEFENSE, INC.

INVESTIGATIVE SERVICES

CA LIC: PI 13322

P.O. BOX 267
ALTADENA, CA 91003

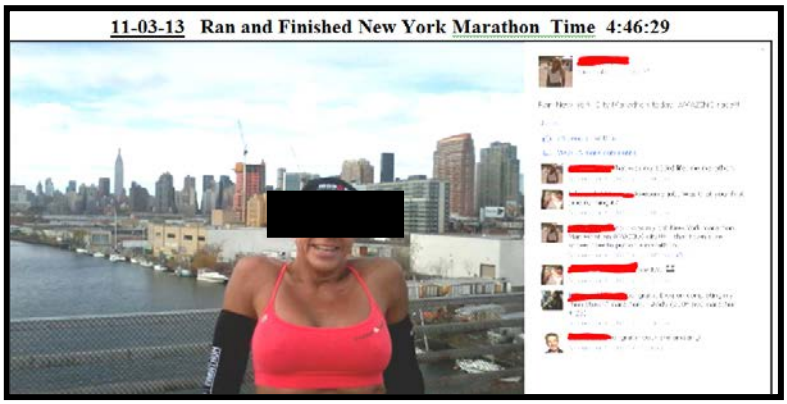
TEL (800) 795-4451
FAX (626) 791-4677

tkoerner@aedfirst.com

"Disabled L.A. City firefighter YouTube Videos

Camarillo Angels Baseball Club's Photos - Buena 4/11

Facebook Postings Reveal Injured Dispatcher Running 100 Marathons



Initial discovery of internet based evidence is often accidental and frequently reveals just a small fraction of what can be found by a skilled specialist.

AED internet and public records specialists have a keen understanding of digging in the 3-D "Spider Web" of Social Media, automated records databases and the internet. Judges have found our evidence to be self-validating and immiscible. We have preserved hundreds of internet videos, images, and web pages as high-value evidence proven to be strongly motivational to physicians reporting on status of disability and discrepancies in Applicant presentations.

Aspects of daily living withheld from med\legal evaluators but frequently exposed in social media include: tips about travel plans, relocating out of area, participation in organized sports or strenuous high-risk activities, playing in a band, performing as an entertainer, unreported concurrent employment/business ownership and professional licensing.

A E D

AMERICAN EMPLOYER DEFENSE, INC.

INVESTIGATIVE SERVICES

CA LIC: PI 13322

P.O. BOX 267
ALTADENA, CA 91003

TEL (800) 795-4451
FAX (626) 791-4677

tkoerner@aedfirst.com

June 21, 2018

LACERA
300 North Lake Avenue
Pasadena, California 91101

Re: AED 2018 Service Rates

Dear Gentlepersons:

Thank you for this opportunity to introduce services provided by **A**merican **E**mployer **D**efense. For thirty years AED has been developing a reputation as a leading provider of results to the insurance industry, and directly to public agency and self-insured employers and their administrators.

As a full-service defense oriented investigations agency, **A**merican **E**mployer **D**efense has been involved in numerous insurance fraud convictions and high exposure litigation successes. Following assignments through to maximize effectiveness is our hallmark. Each of our investigators is an industry leader with decades of service in their respective specialties; our core group of veteran specialists represent over 250 years of Insurance Defense experience. The following is a brief synopsis of our service groups and fees:

1. Subrosa with Video $80/per hour – Includes activity checks and surveillance supported with high quality video picture evidence often used to verify claims of injury and permanent disability ratings. Color prints of specific video frames will be included in our daily reports.
2. AOE/COE and Witness Interviews $80/per hour – Includes on-site, employer-level interviews, record retrieval and incident site inspection. Bi-lingual specialists are used whenever necessary.
3. Public Record, In-Depth Internet\Social Media searches $80/per hour plus source fees. Includes automated searches of state and local indices, accident report locating, vehicle registration and driver's histories and skillful Internet and Social Media activity captures.
4. Hearing/Trial Appearance by the investigator of record at trial for testimony and video evidence presentation are billed at the flat daily rate of $350.00.

5. Litigation Support – witness location, confirmation of witness cooperation, specialty service of process, witness transportation, skillful pursuit of documentary evidence, and testimony at trial. 80/per hour
6. Miscellaneous Expenses
    a. Per Diem expenses are based on actual expenses sustained as room rates in some areas are seasonally affected. An average figure is $110.00 per day including food. Per Diem charges will be applied only to assignments requiring overnight stays.
    b. Video picture evidence duplication to DVD is calculated at 35.00 per hour.
    c. Transportation expenses are calculated at .65 per mile.

Accurate, concise final reports are available within hours of assignment completion. Claims personnel a Counsel can be granted electronic access to surveillance video picture evidence for immediate review.

Our operations manager's e-mail addresses are: tkoerner@aedfirst.com; vadams@aedfirst.com and bdaly@aedfirst.com

Sincerely,
American **E**mployer **D**efense, Inc.
Ted F. Koerner
President & CEO

Putting Claims in REVERSE

TEL: 1.800.358.6133
FAX: 714.388.3642
10808 FOOTHILL BLVD, STE 160
RANCHO CUCAMONGA, CA 91730

INFO@MVINVESTIGATIONS.COM
WWW.MVINVESTIGATIONS.COM

California Lic. PI-25356 Arizona Lic. 1693318

MV INVESTIGATIONS
Professional Investigations Agency

Thank you for taking the time to review the enclosed material.
MV Investigations is a professional investigative agency established in 2006. Our staff holds an excellent reputation in investigating Workers' Compensation Claims. Our main goal is to assist our clients reduce exposure to risk and monetary liability.
We are your insurance defense Investigators. From start to finish, your defense begins with material evidence. We conduct AOE/ COE, surveillance, backgrounds, social media, medical canvass and other possible contributing factors. We also offer risk management, threat assessment and employer level investigations.

Our clients include Corporations, Government entities, Insurance companies, Law firms, Self-Insured firms, Third Party Administrators and Small Businesses.

Our Vision

People employ individuals with the greatest ability & potential, the highest integrity and an unwavering commitment to excellence. Therefore, our clients are our first priority. We always strive to build and maintain a long-term relationship by always understanding our clients' needs; while effectively responding with services and products that reflect the changing industry and dynamics.

We are committed to providing businesses and individuals with information they can trust and rely on to make well-informed decisions. Our vision, mission and expertise demonstrate this commitment.

What We Believe

Values: Integrity, professionalism, discretion and dedication are four key concepts that are at the core of what we believe will lead us to excellence and growth.

Key Growth Initiatives: MV Investigations is committed to achieving leadership in each of its business sectors. To accomplish this goal, our business strategy centers on four key growth initiatives:

- Customer Focus: Customer focus means that everything we do provides value to our clients
- Excellence in Service: Excellence is measured in terms of investigative results, responsiveness and quality of work
- Staff Development: We hire the best and brightest investigative professionals because we know that our future growth depends on them
- Technical Innovation: We believe in technical innovation as key to achieving performance in our work and value for our clients

By this time, you have acquired other agency services and have realized that you have not been provided the required results to conclude your claim.

We have a proven track record with our clients, that our evidence gathering has resulted in successful denial, prosecution/ arrests and a decrease of the settlement amount as well as permanent disability percentage.

Through previously established working relationship with the local District Attorney's office, the Department of Insurance and the National Insurance Crime Bureau; has allowed potential fraud claims to be expedited and properly presented for prosecution and restitution.

MV Investigations provides superior service and support. Each case is given individual attention, and is conducted within your instructions and guidelines.
Important findings and/or significant developments are reported as they occur. Cases requiring frequent status reports are handled as requested.

We are confident that our investigative expertise and results obtained will exceed your expectations. Rest assured that our team is fully knowledgably of Workers' Compensation laws and procedures. We are always up-to-date with any changes in laws governing the industry.

- Surveillance
- AOE/ COE Investigations
- Risk & SIU Assessment
- Employer Level Investigations

Background Investigations

With each Background Investigation, you receive a detailed and professionally written report. The report includes all investigative findings and copies of database records.

We can also validate the employee's SSN whether they are lawfully eligible to work in the United States. This information is necessary for compliance with the INS and may help prevent future fraudulent claims. Please refer to our price guide, in the event a manual search is needed at the local county or law enforcement. We will notify your office and provide you with a quote. Turn-around is 72 hours and volume discounts are available.

Criminal & Civil History

7-year criminal and civil record search in subject's current county of domicile

Statewide moving violation records search

Statewide department of correction criminal search

Nationwide Wants & Warrants search

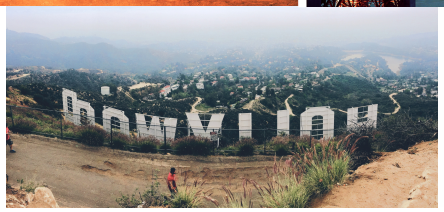
Medical Canvass

We contact up to 20 facilities to determine possible past medical history or pre-existing conditions. This includes pharmacies and possible upcoming medial appointments.

Social Media

Online check for claimant/ employees activity and social media accounts which can assist in pre-surveillance. This also may identify side business, exaggerated or fraudulent injuries.





General Fee Schedule

Interviews; Interview report preparation, surveillance, travel time and stand-by time are billed in 15-minute increments at $85.00 per hour; per Investigator.

- Travel mileage is billed at $.75 per mile, per vehicle used
- Rental of special equipment necessary to complete an assignment is billed at cost.
- Other expenses are billed as incurred (toll roads, parking, etc.)
- Terms: Net due in 15 days or as agreed.

Individual Fee Schedule

AOE/ COE Investigations	Mileage applied	Hourly	85.00
Activity Check	Mileage applied	Hourly	85.00
Surveillance/ Local Area	Mileage applied	Hourly	85.00
Surveillance/ Out of /Area	Mileage applied	Hourly	95.00
Court Appearance	Mileage applied	Hourly	85.00
Admin/ Report Preparation		Hourly	85.00

Travel Time and Mileage applied to all assignments

Video Production	Hourly	85.00
(Includes Four DVD copies)	Each additional	35.00
Background Investigation		250.00 & up
(Includes: Social Media, database intel, criminal, civil, etc.)		

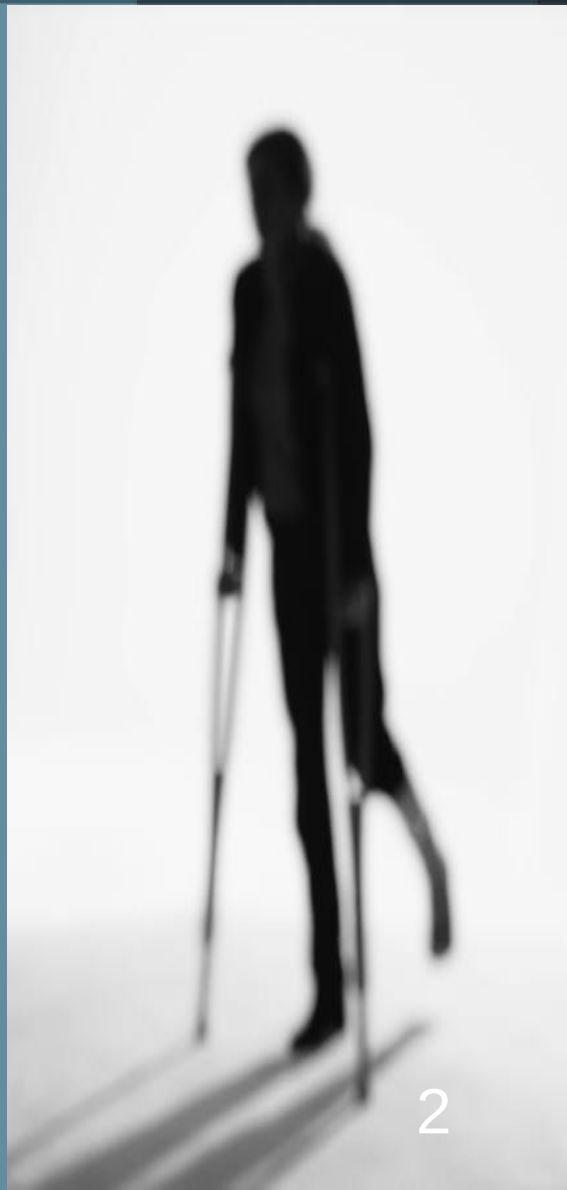
BLOOD-BORNE INFECTIOUS DISEASE PRESUMPTION

Government Code section 31720.7

SERVICE CONNECTION IN NON-PRESUMPTION CASES

- After proving permanent incapacity, service connection will be established only if the member's incapacity arose out of and in the course of the member's employment, and such employment substantially contributed to the incapacity.
- Gov. Code section 31720

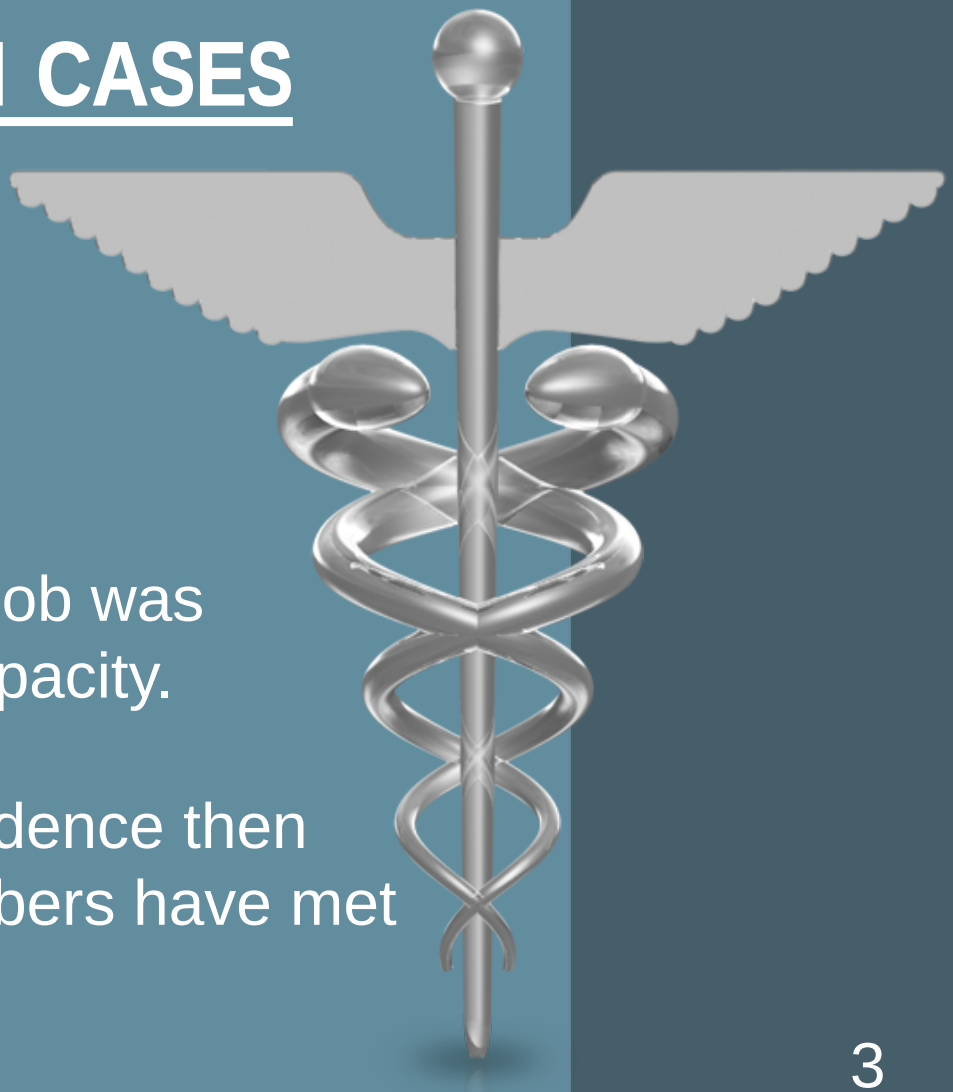
- Substantial contribution: There must be a "real and measurable" connection between the employment and the incapacity.
- *Bowen v. Board of Retirement* (1986) 42 Cal.3d 572.



BURDEN OF PROOF IN NON-PRESUMPTION CASES

NON-PRESUMPTION CASES

- Causation is established by a medical opinion from a physician.
- Physician describes the mechanism by which the job was a causal factor in the incapacity.
- The Board weighs the evidence then determines whether members have met their burden of proof.



BURDEN OF PROOF IN PRESUMPTION CASES

PRESUMPTION CASES

- In a presumption case, the applicant is relieved of the burden of proving that the injury or illness arose out of and in the course of employment and that the employment substantially contributed to the incapacity.

- Once certain prerequisite facts are established, the connection between the incapacity and employment is presumed to exist.

WHAT IS A PRESUMPTION?

DEFINITION:

It is an assumption of fact the law requires to be drawn from one or more other facts already established in the action.

Evidence Code section 600.

TYPES

1. **Rebuttable Presumption:** Establishes the existence of a fact unless evidence is introduced which would support a finding that the presumed fact does not exist.

   Evidence Code sections 604 and 606.

2. **Conclusive Presumption:** A finding of fact that the law requires to be made once prerequisite facts are established, even if there is evidence that would establish that the presumed fact is not true.

   See Evidence Code section 630 *et seq.*

BLOOD-BORNE PRESUMPTION

Government Code section 31720.7:

(a) If a safety member, a firefighter, a county probation officer, or a member in active law enforcement develops a blood-borne infectious disease or a methicillin-resistant Staphylococcus aureus skin infection, the disease or skin infection so developing or manifesting itself in those cases shall be presumed to arise out of, and in the course of, employment. The blood-borne infectious disease or methicillin-resistant Staphylococcus aureus skin infection so developing or manifesting itself in those cases shall in no case be attributed to any disease or skin infection existing prior to that development or manifestation.

(b) Any safety member, firefighter, county probation officer, or member active in law enforcement described in subdivision (a) permanently incapacitated for the performance of duty as a result of a blood-borne infectious disease or methicillin-resistant Staphylococcus aureus skin infection shall receive a service-connected disability retirement.

(c)(1) The presumption described in subdivision (a) is rebuttable by other evidence. Unless so rebutted, the board is bound to find in accordance with the presumption.

BLOOD-BORNE PRESUMPTION

(2) The blood-borne infectious disease presumption shall be extended to a member following termination of service for a period of three calendar months for each full year of the requisite service, but not to exceed 60 months in any circumstance, commencing with the last date actually worked in the specified capacity.

(3) Notwithstanding paragraph (2), the methicillin-resistant Staphylococcus aureus skin infection presumption shall be extended to a member following termination of service for a period of 90 days commencing with the last day actually worked in the specified capacity.

(d) "Blood-borne infectious disease," for purposes of this section, means a disease caused by exposure to pathogenic microorganisms that are present in human blood that can cause disease in humans, including, but not limited to, those pathogenic microorganisms defined as blood-borne pathogens by the Department of Industrial Relations.

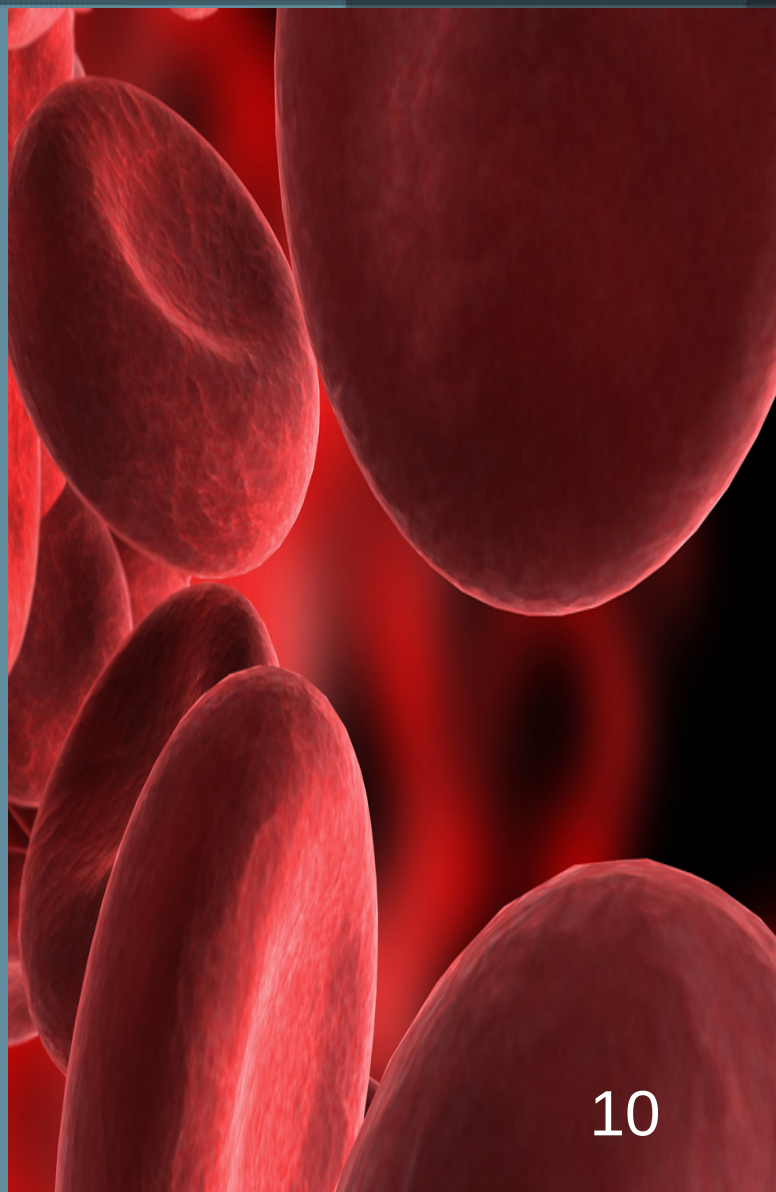
BLOOD-BORNE PRESUMPTION

(e) “Member in active law enforcement,” for purposes of this section, means members employed by a sheriff’s office, by a police or fire department of a city, county, city and county, district, or by another public or municipal corporation or political subdivision or who are described in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code or who are employed by any county forestry or firefighting department or unit, except any of those members whose principal duties are clerical or otherwise do not clearly fall within the scope of active law enforcement services or active firefighting services, such as stenographers, telephone operators, and other office workers, and includes a member engaged in active law enforcement who is not classified as a safety member.

BLOOD-BORNE PRESUMPTION

Requirements:

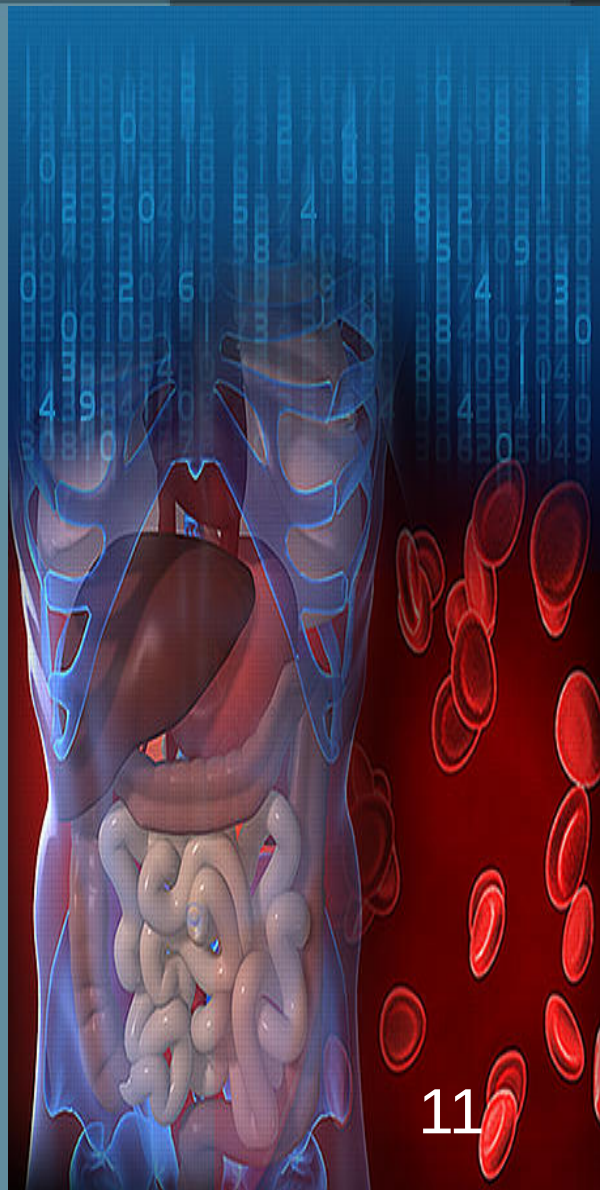
1. Designated occupation
   a.) Safety members
   b.) Firefighters
   c.) County Probation Officers
   d.) Members in active law enforcement
2. Develops blood-borne infectious disease



BLOOD-BORNE PRESUMPTION

Requirements:

3. Permanent incapacity for duty due to blood-borne infectious disease
4. Time for application
5. What does the presumption establish?
6. The presumption is rebuttable



BLOOD-BORNE PRESUMPTION

1. DESIGNATED OCCUPATION

- Safety Member
- Firefighter
- County Probation Officer
- “Members in Active Law Enforcement” means members engaged in “active law enforcement” who are not classified as safety members and are:
  - employed by a sheriff’s office
  - employed by a police or fire department of city, county, city and county, district, or by another public or municipal corporation or political subdivision

BLOOD-BORNE PRESUMPTION

"Members in Active Law Enforcement" (cont.)

- employed by any county forestry or firefighting department or unit, except those whose principal duties are clerical or not within the scope of active law enforcement services or active firefighting services

- Members defined as "peace officers" in Chapter 4.5 of Title 3 of Part 2 of the Penal Code

Note: Contrary to other statutes, the Legislature included members engaged in active firefighting who are not classified as safety members in the definition of "members in active law enforcement."

BLOOD-BORNE PRESUMPTION

Active Law Enforcement

- Member in “active law enforcement” even if not a safety member.

– *Ames v. Board of Retirement*:
  - Contact with prisoners on a regular basis
  - Exposure to hazards from prisoner conduct
  - Risk of injury from the necessity of being able to cope with potential dangers inherent in the handling of prisoners
  - Primary duty is to maintain security

Ames v. Board of Retirement (1983) 147 Cal.App.3d 906, 916.

BLOOD-BORNE PRESUMPTION

2. **Develops blood-borne infectious disease or Methicillin Resistant Staphylococcus Aureus (MRSA)**

   Blood-borne infectious disease must *develop* or *manifest itself* in the applicant.

BLOOD-BORNE PRESUMPTION

3. **Member must be permanently incapacitated as a result of a blood-borne infectious disease or methicillin-resistant Staphylococcus aureus skin infection.**

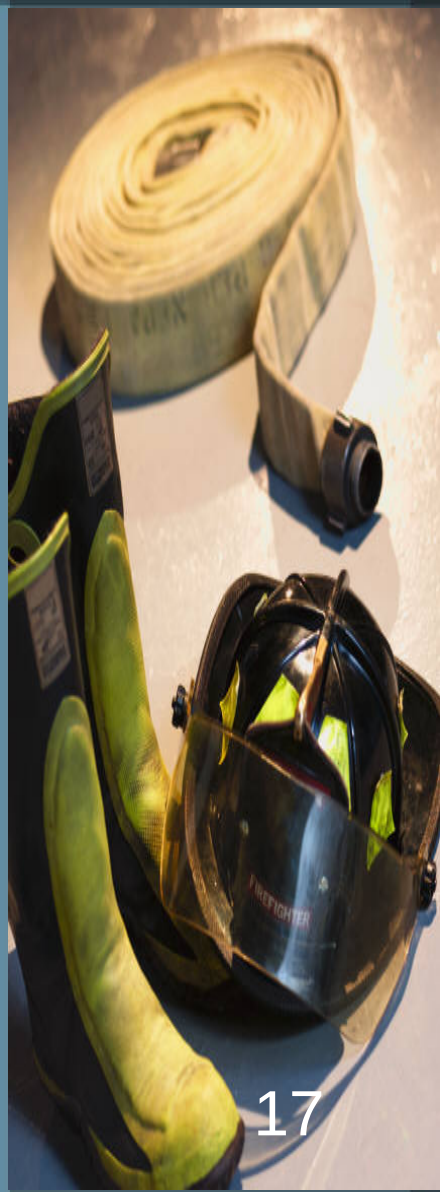
The presumption only addresses **causation**, it does not establish incapacity.

BLOOD-BORNE PRESUMPTION

4. Time for application

The application shall be made while the member is in service, within four months after his or her discontinuance of service, **within four months after the expiration of any period during which a presumption is extended beyond his or her discontinuance of service,** or while, from the date of discontinuance of service to the time of the application, he or she is continuously physically or mentally incapacitated to perform his or her duties.

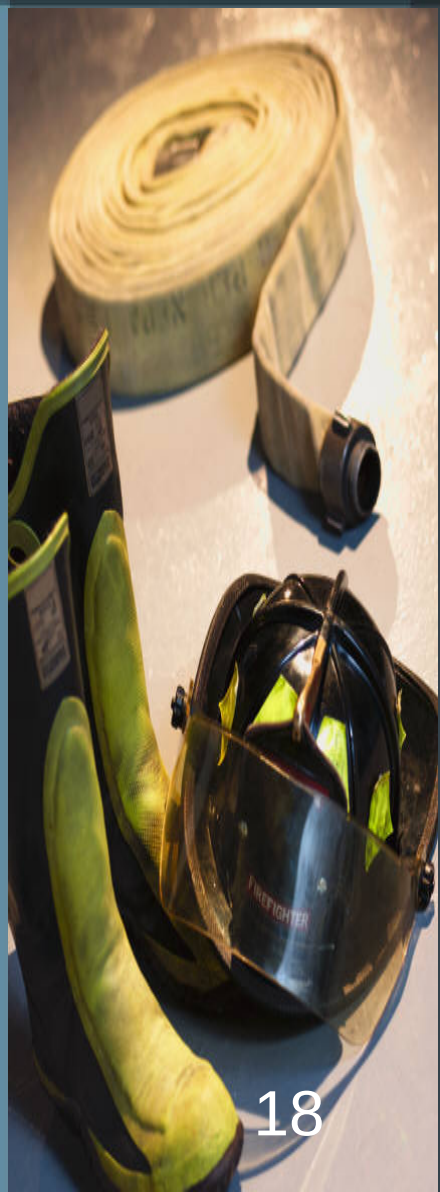
Gov. Code section 31722



BLOOD-BORNE PRESUMPTION

Time for application (cont.)

- **Extension:** ". . . This presumption shall be extended to a member following termination of services for a period of three calendar months for each full year of the requisite service, but not to exceed 60 months in any circumstances, commencing with the last day actually worked in the specified capacity."

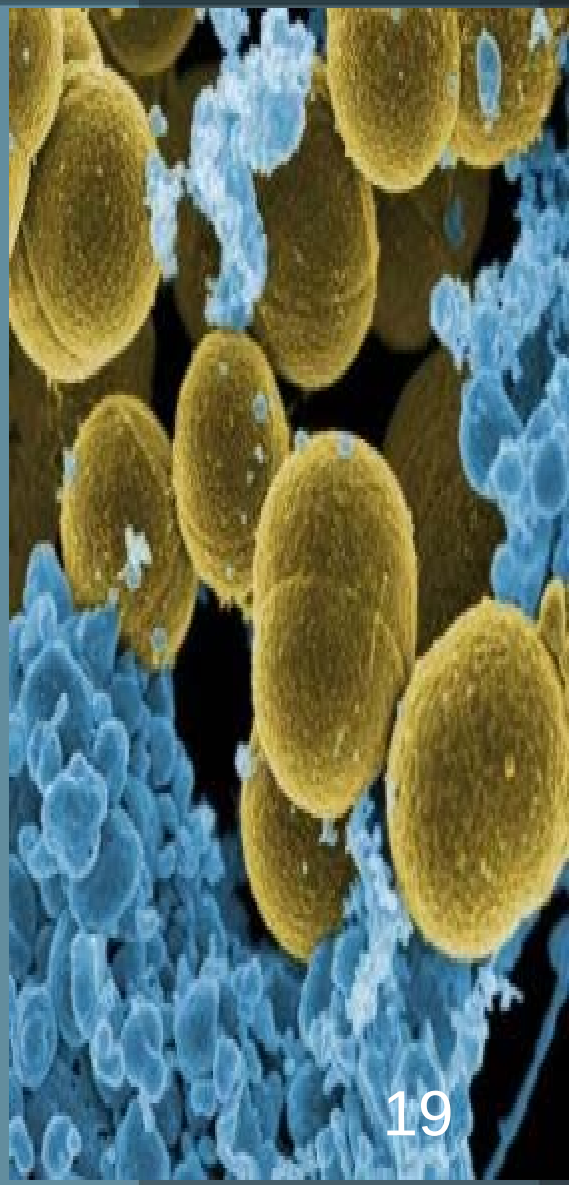


BLOOD-BORNE PRESUMPTION

Time for application (cont.)

MRSA Extension (90 days)

- The MRSA presumption is extended to a member following termination of service for a period of **90 days** commencing with the last day actually worked in the specified capacity. **It is not extended for up to 60 months like other blood-borne infectious diseases.**



BLOOD-BORNE PRESUMPTION

5. What does the presumption establish?

The disease shall be:

- presumed to arise out of and in the course of employment and
- the permanently incapacitated member receives a service-connected disability retirement pension.

BLOOD-BORNE PRESUMPTION

6. The presumption is rebuttable. . .

but the illness cannot be attributed to any illness existing prior to the development or manifestation.

QUESTIONS?