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ORTHOPEDIC SURGERY

April 19, 2004

Workers' Compensation Appeals Board

Inj: [redacted]
D/I: 1/6/98
Emp: Brymarc Management
CL#: 20352657
WCAB: MON 234515

AGREED MEDICAL EVALUATION

INTRODUCTION

[redacted] is a 61-year-old male, date of birth October 15, 1942, who was seen in my South Flower Street office on January 15, 2004 for orthopedic agreed medical evaluation. The following is a narrative summary of the history as obtained from the patient via the services of Mr. [redacted] of Christina Arana Interpreting acting as professional Spanish language interpreter, the physical examination and review of submitted records. The records submitted for my review measured 5 1/4-inches in thickness and weighed 13 1/2 pounds. The record review was accomplished in a six-hour time frame. The face-to-face time with [redacted] was 3/4 of one hour. The time taken to prepare this report was 3 1/4 hours. The issues of medical causation and apportionment are addressed in the body of this report.

The factors of complexity involved in this evaluation appropriately characterize it as an extraordinarily complex medical-legal evaluation, ML104, with the modifier –94 for the agreed medical evaluation.

As part of the agreed medical evaluation, x-rays of the cervical spine, lumbosacral spine and both knees were taken on January 15, 2004 at my request, and at an outside facility. The x-ray films were returned to my office unread for my reading. Appended is a copy of a report of my reading of these x-ray films.

CHIEF COMPLAINT

Pain in the neck, left shoulder and low back, and fatigue of both legs.

HISTORY OF INJURY

[redacted] was employed by Brymarc Management as a maintenance worker from 1993 until January of 1998. [redacted] states that on January 6, 1998 at 4:30 p.m., he was standing on a fire escape ladder, which was attached to a wall, removing Christmas lights, at a height of ten feet from the ground. [redacted] states that it had rained the night before and his right foot slipped on one of the ladder rungs. He fell backwards; however, his right leg at the knee became entangled with the ladder and he ended up hanging upside down. [redacted] states that he remained upside down for 20 minutes whilst struggling to free himself. He states that he then slid down the ladder, landing on both feet although as he landed, he lost his balance and fell backwards, striking his neck and entire back against the wall behind the ladder. He sustained abrasions to his neck and back from the wall. He also experienced immediate pain and swelling in his right knee and states that his entire body felt "hot". He remained in a seated position on the ground for the next ten minutes or so until he got up to find his manager. The injury was not witnessed, but was reported to [redacted]s manager. [redacted] states that within the next hour or so, he began experiencing neck and low back pain. He tried to drive himself home, but was not able to do so and had to call for assistance.

The following day, [redacted] was seen at U.S. Healthworks in the City of Vernon. He was examined and x-rays were taken of his back and right knee. Magnetic resonance imaging of the back and right knee was obtained, which revealed "something torn in the knee with fluid". He was prescribed Acetaminophen, Naprosyn, Cyclobenzaprine, Flexeril and Robaxin. He was also treated with physical therapy comprising ultrasound and hot and cold packs, three times per week for 30 days. [redacted] states that he was told that his back was bad, but his knee was worse. Surgery was recommended for his right knee. [redacted] then sought the services of an attorney.

On March 25, 1998, Doctor [redacted], a psychiatrist, evaluated [redacted]. His attorney referred him to Doctor [redacted]. He was examined and prescribed medication although he does not recall the name of the medication. He was seen and treated three times per week for three months. [redacted] states that the treatment he received from Doctor [redacted] helped.

[redacted] was also referred by his attorney to Doctor [redacted] for his right knee. He saw Doctor [redacted] in February of 1998. He was examined and prescribed medications including Tylenol #3. Doctor [redacted] reviewed the previous magnetic resonance imaging investigations, and [redacted] was treated with physical therapy comprising movement and ultrasound, three times per week, which helped a little.

In March of 1998, Doctor [redacted] evaluated [redacted] He was examined and x-rays taken of his entire back, the results of which he is unaware. Magnetic resonance imaging of the back was obtained, which revealed "something wrong in the low back". He was prescribed Vicodin. He was also treated with physical therapy three times per week. [redacted] states that therapy was of no benefit, so in 1999, pool therapy was initiated, three times per week.

On June 15, 1998, [redacted] underwent arthroscopic right knee surgery performed by Doctor [redacted]. He noted no benefit with surgery and states that the inflammation recurred. In 1999, [redacted] underwent a second arthroscopic right knee surgery, which helped to relieve the swelling. He was treated postoperatively with physical therapy comprising hot and cold packs and exercises, three times per week for one year. He was given a brace for his right knee. Doctor [redacted] opined that [redacted] would require a total knee replacement in the future. Doctor [redacted] released [redacted] in 2000.

Sometime in 2000, [redacted] saw a pain management physician at the Southland Pain Management Center. He was examined a discogram was performed, the results of which he is unaware. He was also given a TENS unit, which he used on a daily basis, with no benefit.

In 2000, [redacted] underwent low back fusion with implantation of a spinal cord stimulator. He states that that stimulator bothered him and he noted no benefit with the fusion. Approximately five to six months later, the stimulator was removed. He was treated with physical therapy for one year, at which time he underwent a second fusion surgery. He again noted no benefit with surgery.

Sometime around mid 2003, Doctor [redacted], an internist, evaluated [redacted] secondary to diabetes, high blood pressure and skin rash. He was prescribed Ranitidine. He has continued to see Doctor [redacted] on a monthly basis.

[redacted] last saw Doctor [redacted] on December 23, 2003. He has continued to receive pool therapy three times per week, but just recently stopped therapy because he developed a rash on his torso area, which he states appeared after he received a cortisone injection in November of 2003. He noted that he has received a total of 20 injections to areas including his neck, shoulder and low back. He states that the injections helped a bit, but caused itching. [redacted] states that the pool therapy was "the only thing that helped". He is scheduled to return to Doctor [redacted] on January 27, 2004.

[redacted], following the injury on January 6, 1998, stopped working that same day. He has not worked since that time.

[redacted] reports having sustained a previous industrial injury to his neck around 1991 whilst employed by "4 Cities". He was working as a maintenance worker. [redacted] states that he was pulling on a refrigerator when he injured his neck. The injury was reported to his

manager and he was seen at a clinic in Los Angeles. He was examined and treated with hot packs, once weekly for one month. He noted benefit with treatment. He did not miss any time from work. He received a financial settlement of $1,000. He recovered fully.

CURRENT COMPLAINTS

[redacted] complains of intermittent stabbing paracervical pain, felt "on the bone", occurring daily. On a scale of 0 to 10, 0 being no pain and 10 being the worst pain imaginable, [redacted] characterizes his usual pain as a level 5 to 6. At the time of the agreed medical evaluation on January 15, 2004, [redacted] characterized his pain as a level 7. He states his current maximum lifting capacity is less than ten pounds. Vicodin and pool therapy help to relieve the pain. He complains of intermittent pain radiating into the right upper extremity to the wrist as well as into the left shoulder with difficulty raising his arms, occurring daily, lasting five to six hours at a time. There is no numbness or tingling in the upper extremities. He does not experience a headache, but notes nausea, dizziness and blurred vision. He does not experience vomiting or tinnitus. There is no hoarseness or dysphagia. There is pain with Valsalva maneuver. Overall, [redacted] believes his neck condition has been deteriorating.

[redacted] complains of nearly constant stabbing mid and low back pain. On a scale of 0 to 10, 0 being no pain and 10 being the worst pain imaginable, [redacted] characterizes his usual pain as a level 8. Medication and pool therapy help to relieve the pain. The most comfortable position is lying prone. He complains of intermittent pain radiating into the right buttock and lower extremity posteriorly to the great toe and into the left buttock and lower extremity posteriorly to the heel, more so on the left than the right, occurring daily, lasting five hours at a time. There is no numbness or tingling in the buttocks or lower extremities. [redacted] reports experiencing bowel problems. There is no report of bladder or sexual potency dysfunction. There is aggravation of pain with Valsalva maneuver. [redacted] believes he can walk 1/2 a block. He does not use a cane because doing so causes shoulder pain. He does, however, use a walker when using the restroom. He avoids stairs. Overall, [redacted] believes his mid and low back condition has been unchanged since his first low back surgery.

[redacted] complains of intermittent aching right knee pain, felt "below the kneecap", occurring twice daily especially with walking, lasting one hour at a time. On a scale of 0 to 10, 0 being no pain and 10 being the worst pain imaginable, [redacted] characterizes his usual pain as a level 4 to 5. He notes clicking, popping, weakness and giving way. He wears a knee brace. Elevation helps to relieve the pain. [redacted] states that although the inflammation in his right knee resolved, he believes overall that his right knee condition has been unchanged since undergoing surgery.

[redacted] experiences difficulty getting off to sleep. He believes he gets three to four hours of sleep per night. He also takes a 1+-hour nap during the day. He awakens from sleep twice nightly. He does not feel refreshed upon awakening in the morning.

EMPLOYMENT HISTORY

[redacted] was employed by Brymarc Management as a maintenance worker from 1993 until January of 1998. He states his usual job at the time of injury involved working five days per week, eight+ hours per day with one hour for lunch. His job duties involved checking air conditioning units and stoves, fixing doors and handling plumbing and electrical repairs. He lifted appliances and tools with the heaviest weight lifted without assistance being 100+ pounds.

Prior to this time, [redacted] was employed by "4 Cities" as a maintenance worker from 1986 until 1992 or 1993. He was also employed by Wilshire Mortgage as an apartment maintenance worker from 1973 until 1986.

PERSONAL MEDICAL HISTORY

[redacted] states he does not have a personal physician. He reports a personal history high blood pressure and skin rash. He also reports a ten-year history of diabetes. He denies having sustained any non-work injuries or accidents. He reports having allergies to Cortisone and other similar substances. Current medications include Vicodin taken twice daily, Glyburide, Ranitidine, Enalapril Maleate, Sucralfate, Omezaprole and Docusate Sodium. He has had the following surgical procedures: late 2000, implantation and subsequent removal of a spinal cord stimulator performed by Doctor [redacted]; 1998 and 1999, arthroscopic right knee surgery performed by Doctor [redacted]; 2000 and 2002, low back fusion performed by Doctor [redacted].

FAMILY HISTORY

Nil of note.

SOCIAL HISTORY

[redacted] is married. He has two sons and one daughter between the ages of 45 and 29; all are well. He does not smoke. He does not drink alcohol. He has had an elementary school education. He is a native of Mexico and came to the United States in 1963 or 1964. He served in the Mexican Army from 1961 until 1962. His hobbies and special interests previously included playing baseball.

PHYSICAL EXAMINATION

General: [redacted] does not appear to be in any acute distress. He has black hair. He has a physical appearance consistent with his chronological age of 61 years. He is 5 feet 10 inches tall and weighs

219 pounds. He believes his pre-injury weight was 238 pounds. He is right-hand dominant.

Examination of the Cervical Spine and Upper Extremities: On inspection, there is no obvious swelling, skin breaks, skin contusion, asymmetry or scoliosis of the cervical spine. There is no atrophy or asymmetry of either upper extremity.

To palpation, there are no patient complaints of tenderness, nor is there muscle spasm palpable in the cervical spine, either trapezius, either shoulder or either upper extremity.

Range of Motion of the Cervical Spine and Upper Extremities: [redacted] forward flexes cautiously to chin to within one fingerbreadth of the chest. There is 30 degrees of cervical spine hyperextension. There are complaints of neck pain to the extremes of flexion and extension of the cervical spine. Lateral flexion left and right is 30 degrees bilaterally. Rotation left and right is 50 degrees bilaterally. There is crepitus to range of motion testing of the cervical spine. Spurling's testing is negative bilaterally for radicular pain, but produces complaints of neck pain.

There appears to be equal and symmetrical motion of the shoulders, elbows, wrists and fingers. The shoulder apprehension tests are negative bilaterally.

Upper limb circumferences are as follows:

	R	L
Upper arms	12 1/2"	12 1/2"
Elbows	11 1/2"'	11 1/2"
Forearms	12"	12"
Wrists	7"	7"

Motor Examination: To testing the major muscle groups of both upper extremities, there appears to be no obvious motor loss. Motor power of the muscle groups tested is MRC grade 5/5.

Grip Strength: Grip strength using the Jamar dynamometer as a guide is as follows:

R (major)	L (minor)
0/10/5	10/5/10

[redacted] did not appear to be making a maximal effort to Jamar testing.

Sensory Examination: Sensory testing using the modality of light touch appears to show no loss in either upper extremity.

Deep Tendon Reflexes: The biceps, triceps and brachioradialis jerks are bilaterally present and equal, 1+. Phalen's and Finkelstein's tests are negative bilaterally.

Vascular Examination: The radial, ulnar and brachial pulses are bilaterally present and palpable, 2+. Capillary refill to the finger pulps of the digits of both hands appear normal. There is no edema present in either lower extremity, and skin temperature appears normal.

Examination of the Spine and Lower Extremities: [redacted] is noted to walk with a normal heel-toe progression, equal stride length and equal stance time. He walks slowly. He has a slight limp favoring the right lower extremity. He does not use any walking aids. He is able to heel-walk and toe-walk; he does so awkwardly. He completes 50% of a normal squat, accompanied by patient complaints of right knee pain.

Inspection of the Spine and Lower Extremities: There is no obvious asymmetry of the spine. There are noted a number of surgical scars related to the low back including a midline surgical scar measuring 5 1/2 inches in length. There is a parallel surgical scar to the left of the midline in the region of the posterior iliac crest measuring 1 1/2 inches in length, and there is an anterior abdominal surgical scar to the left of the umbilicus extending to the inferior hypogastrium measuring 7 inches in length. [redacted], additionally, is noted to have an erythematous rash over the right side of his chest anteriorly, extending from the upper rib cage into the upper abdomen and towards the right flank. There is no atrophy or asymmetry of either lower extremity.

To palpation, there are patient complaints of low back pain from L1 to S1 without muscle spasm present. There is tenderness to palpation of both buttocks. There is no tenderness or muscle spasm in either lower extremity.

Range of Motion of the Spine and Lower Extremities: [redacted] moves his spine and lower extremity joints slowly and cautiously. He forward flexes in a guarded fashion to fingertips to knee level. There is 15 degrees of spine hyperextension. There are complaints of back pain to the extremes of flexion and extension of the lumbar spine. Lateral flexion left and right is 15 degrees bilaterally. Rotation left and right is 30 degrees bilaterally.

There appears to be equal and symmetrical motion of the hips, ankles and feet. With regard to the knees, range of motion of the right knee is from 7 to 125 degrees. Range of motion of the left knee is from 5 to 130 degrees. There is moderate patellofemoral and femoral tibial crepitus to ranging both knees. There is 1 1/2+ valgus laxity to stress testing the right knee, 1+ valgus laxity to stress testing the left knee, 1+ anterior drawer on the right and left, and 1/2+ Lachman on the right and negative Lachman on the left. McMurray and Pivot shift tests produce complaints of pain in the right knee, and there are patient complaints of pain to patellar compression in the right knee.

Limb lengths are 35" each, measured from the anterior superior iliac spines to the medial malleoli.

	R	L
Thighs 4" above superior poles of patellae	18"	18 1/2"
Knees at midpatellar level	16 1/2"	16 1/2"
Calves 6" above tibial tubercles	13"	13"

Straight Leg Raising: With the patient lying spine, straight leg rising is limited to 50 degrees by patient complaints of back pain without leg pain present. Foot dorsiflexion tests increase the patient's complaints of Cram testing is negative. In the sitting position, straight leg rising is 60 degrees bilaterally without complaints of low back or leg pain and negative foot dorsiflexion tests.

Motor Examination: To testing the major muscle groups of both lower extremities, there appears to be no gross motor loss. Motor power of the muscle groups tested is MRC grade 5/5.

Sensory Examination: Sensory testing using the modality of light touch appears to show no loss in either lower extremity.

Deep Tendon Reflexes: The knee jerks and ankle jerks are present and equal, 1+. Ankle clonus is absent bilaterally, and plantar responses are down going.

Vascular Examination: The dorsalis pedis and posterior tibial pulses are bilaterally present and palpable, 2+. The popliteal pulses are bilaterally present and palpable, 1+. Capillary refill to the toe pulps of the digits of both feet appear normal. There is no edema present in either lower extremity, and skin temperature appears normal.

REVIEW OF SUBMITTED RECORDS

The submitted records were reviewed and taken into account in the preparation of this report. Listed below are those portions of the record review that were thought relevant to [redacted]'s work-related injury. The listing below is not meant to represent a comprehensive summary of all records submitted. A schedule of all the records reviewed is appended.

There is a report from [redacted], M.D. dated May 20, 1992 entitled Doctor's First Report of Occupational Injury or Illness noting a continuous trauma injury from May of 1991 to April 15, 1992. [redacted] indicated that he believed he had been unfairly treated and reprimanded and unjustly terminated. He also complained of cumulative physical injury to his low back in the course of his employment. Diagnosis was depressive disease not otherwise specified.

On June 16, 1992, [redacted], M.D. saw [redacted] He noted a date of injury of April 15, 1992. [redacted] indicated he developed symptoms sometime in 1991 in the course of his employment. He recalls installing a dishwasher in 1991, following which he noted low back pain and later neck pain. Current complaints were of low back pain, numbness and tingling, and an electric paresthesias in the left buttock and posterior left thigh. He complained that his head felt "too heavy". Diagnosis was chronic cervical myofascial strain, nonindustrially related, and chronic lumbar spine myofascial strain. Recommendation was for a MRI of the lumbar spine. On July 23, 1992, Doctor [redacted] noted that a MRI of the lumbar spine had been performed and was reviewed by [redacted] Doctor [redacted] reported the MRI as showing, at L5-S1, a 3.5 to 4 mm. very broad-based disc protrusion at L5-S1 with mild central and mild proximal bilateral neural foraminal stenosis. According to Doctor [redacted] had work restrictions of no very heavy work. With respect to the cervical spine, the complaints were considered by Doctor [redacted] not to be related to industrial trauma.

On April 26, 1993, [redacted], M.D. performed a qualified medical evaluation for a continuous trauma injury from May of 1991 through April 5, 1992. Diagnosis was chronic residuals of soft tissue injury cervical spine, and lumbar musculoligamentous strain. There was x-ray evidence of degenerative disc disease at C5-6, and history of diabetes. [redacted] was considered to be permanent and stationary. He was able to perform his usual and customary work duties and, according to Doctor [redacted], 100% of [redacted] complaints were nonindustrial.

On July 28, 1993, there is a Compromise And Release for AOE/COE as a maintenance supervisor from April 17, 1991 through April 17, 1992. This was settled for the sum of $8,000 on July 28, 1993.

[redacted], M.D., internal medicine physician, saw [redacted] from April 26, 1995 through December 1, 1998, principally for type II diabetes mellitus and, in addition on July 22, 1996, [redacted] complained of pain in the right index finger. He was noted to have a puncture wound in the metacarpal phalangeal joint of the right index finger. On January 29, 1998, [redacted] was noted to have fallen off a ladder in the course of his employment. This appears to have been on or around January 16, 1998, according to Doctor [redacted]. Assessment was right knee traumatic effusion at work.

On January 7, 1998, [redacted], M.D. from U.S. Healthworks authored a Doctor's First Report of Occupational Injury or Illness noting a date of injury of January 6, 1998. Employer was Alexio. [redacted] slipped from a ladder on the last four steps. He hit his back against a wall. Current complaints were of right knee, neck and back pain. His right knee throbbed a lot. Diagnosis was upper back contusion and abrasion, lumbar spine strain, and right knee contusion and abrasion.

On January 8, 1998, there is a report from U.S. Healthworks. [redacted] was not improving significantly. He was seen through January 19, 1998.

On March 5, 1998, [redacted], M.D. noted that [redacted] has his knee tapped by Doctor [redacted] and 15 cc. of serous fluid obtained. [redacted] had been tried on a Medrol Dose pack. Diagnosis made by Doctor [redacted] was lumbar strain on the right, rule out lumbar disc herniation at L5-S1, and rule out internal derangement right knee. Recommendation was for a MRI of the lumbar spine and right knee.

On February 12, 1998, MRI of the lumbar spine was performed. [redacted], M.D. reviewed the films and reported multilevel disc desiccation changes and mild spondylotic changes worse at L3-4, L4-5 and L5-S1. Also on February 12, 1998, MRI of the right knee was performed. Doctor [redacted] reviewed the films and reported mild to moderate right knee joint effusion and partial near complete radial tear of the posterior horn of the medial meniscus, which was also noted to be partially macerated. There was a possible partial tear of the posterior horn of the lateral meniscus.

On February 24, 1998, [redacted], M.D. noted current complaints that were partially illegible, but included pain and swelling and locking and giving out and buckling of the right knee. [redacted] was not able to fully straighten out his knee, and he limped. On March 10, 1998, Doctor [redacted] noted that [redacted] was off work, and Doctor [redacted] requested authorization for surgery to the right knee.

On April 13, 1998, [redacted] Ph.D. made an axis I diagnosis of adjustment disorder with mixed emotional features.

On May 28, 1998, Doctor [redacted] documented complaints of severe back and right thigh and leg pain. Diagnosis was lumbar radiculopathy.

On June 15, 1998, Doctor [redacted] performed video arthroscopy and partial medial meniscectomy of the right knee for a diagnosis of medial meniscus tear right knee. On August 11, 1998, Doctor [redacted] noted that [redacted] was going to physical therapy, but was not very happy with his progress. The pain was somewhat improved, but was still significant.

On September 14, 1998, MRI of the lumbar spine was performed. [redacted], M.D. reviewed the films and reported, at L4-5 and L5-S1, a small broad-based central protrusion. There was no mass effect on the central canal or neural foramina at these levels or elsewhere.

On October 6, 1998, [redacted], M.D. noted current complaints of symptoms related to the anterior parapatellar and medial aspect of the right knee, low back pain and right groin pain, and twitching and tingling of the right thigh, right neck and trapezius and upper back pain. Diagnosis was history of contusion and musculoligamentous strain lumbar spine, and right knee internal derangement, status post surgery with persistent symptoms. [redacted] was considered to be permanent

and stationary with regard to the neck and low back, no very heavy work; with regard to the right knee, no running, jumping, prolonged standing or walking or any significant squatting, kneeling and climbing. [redacted] was considered to be a qualified injured worker. Doctor [redacted] opined that [redacted] did not appear to need additional surgery to his knee and did not appear to be a surgical candidate with respect to his neck and low back.

On October 9, 1998, Doctor [redacted] noted no improvement. The patellar tendon region had been injected at the last office visit, without improvement. On October 27, 1998, Doctor [redacted] noted that [redacted] had been making progress in physical therapy. He was ambulating with crutches. He was supplied with a knee brace.

On November 17, 1998, Doctor [redacted] opined that [redacted] was permanent and stationary with complaints of neck and upper and lower back pain with pain radiating to the right leg. Diagnosis was right S1 radiculopathy and cervical strain. [redacted] was permanent and stationary with regard to the cervical spine, subjective factors only; with regard to the lumbar spine, light work and no prolonged sitting and standing. Apportionment was slight to moderate pain with very heavy lifting due to the injury in the 1980's.

On January 22, 1992, Doctor [redacted] administered a lumbar epidural steroid injection.

On January 28, 1999, MRI of the right knee was performed. [redacted] M.D. reviewed the films and reported findings consistent with a tear of the posterior horn of the medial meniscus. There was noted a signal within the posterior horn of the lateral meniscus, which was a questionable tear. There was lateral facet patellofemoral chondromalacia.

On January 29, 1999, Doctor [redacted] administered a lumbar epidural steroid injection.

On February 12, 1999, Doctor [redacted] administered a lumbar epidural steroid injection.

On February 25, 1999, Doctors [redacted] and [redacted] noted that [redacted] had had three lumbar epidural steroid injections and had had several days of pain relief with each, but no long-term benefit.

On March 19, 1999, MRI of the lumbar spine was performed. [redacted], M.D. reviewed the films and reported, at L5-S1, a 5 mm. annular bulge with moderate bilateral neural foraminal encroachment; at L4-5, a 4 mm. diffuse annular bulge with mild to moderate neural foraminal encroachment; at L3-4, a 3 mm. annular bulge with slight neural foraminal encroachment.

On April 13, 1999, Doctor [redacted] noted that [redacted] was eight days status post surgery to the right knee. Sutures were removed.

On April 23, 1999, Doctor [redacted] performed discography at L2-3, L3-4, L4-5 and L5-S1. Doctor [redacted] reported, at the L4-5 level, the discogram was positive with severe concordant pain.

On May 4, 1999, Doctor [redacted] noted that [redacted] was about one month after partial medial meniscectomy to the right knee.

On May 11, 1999, Doctor [redacted] performed an internal medicine consultation. Doctor [redacted] diagnosed a peri-rectal abscess and noninsulin dependent diabetes mellitus, under poor control. Doctor Patel recommended immediate referral to a surgeon.

On May 13, 1999, Doctor [redacted] documented complaints of severe back pain. He diagnosed discogenic low back pain and a positive discogram at L4-5 and recommended fusion surgery at the L4-5 level.

On September 24, 1999, Doctor [redacted] documented current complaints of right knee pain. Doctor [redacted] opined [redacted] was permanent and stationary with a work restriction of no repetitive bending, kneeling, stooping, climbing, prolonged walking, standing, and repetitive heavy lifting. Doctor [redacted] opined that [redacted] would possibly need a total knee replacement in the future.

On January 10, 2000, MRI of the lumbar spine was performed. [redacted], M.D. reviewed the films and reported, at L3-4, L4-5 and L5-S1, disc desiccation and bilateral L5 foraminal stenosis, right side greater than left.

On February 8, 2000, Doctor [redacted] documented complaints of significant problems with the right knee. There was said to be significant quadriceps and vastus medialis obliquus atrophy. Doctor [redacted] opined [redacted]'s major problem with probably significant patellofemoral arthritis and that [redacted] was headed for a total knee replacement. Doctor [redacted]'s recommendation was to try to live with the knee the way it is.

On May 26, 2000, [redacted], M.D. performed a cervical epidural steroid injection.

On June 16, 2000, Doctor [redacted] performed a cervical epidural steroid injection.

From August 8, 2000 to August 12, 2000, [redacted] was an inpatient at the Coast Plaza Doctor's Hospital. On August 8, 2000, Doctor [redacted] performed posterolateral spinal fusion at L4-5 with spine LINK fixation system and implantation of an EBI bone stimulator and right iliac crest bone graft for a diagnosis of discogenic pain. On September 28, 2000, Doctor [redacted] noted some pain in the right buttock. The right leg was said to give way.

On October 10, 2000, Doctor [redacted] opined [redacted] was permanent and stationary. [redacted] complained of pain aggravated by going up and down stairs, kneeling and crawling. The pain was anterolateral. Work

restrictions considered appropriate by Doctor [redacted] were no repetitive squatting, kneeling, crawling, climbing, repetitive lifting of greater than 25 pounds, and no prolonged walking and standing greater than four hours out of an eight-hour day.

On November 28, 2000, Mr. [redacted] and Doctor [redacted] noted that [redacted]s main complaint was of the left leg. He had ongoing back and right elbow and right shoulder pain. Diagnosis was status post spinal fusion at L4-5, and right elbow numbness. Another diagnosis made was cubital tunnel syndrome on the right. On January 25, 2001, Mr. [redacted] and Doctor [redacted] noted some benefit from surgery. X-rays showed "good bone growth in the lateral gutters", appears fusion was present. Recommendation was for authorization for removal of the bone stimulator. On March 20, 2001, Mr. [redacted] and Doctor [redacted] indicated "intense pain" over the bone stimulator. Recommendation was for removal. On May 14, 2001, Doctor [redacted] removed the EBI bone stimulator battery; however, on July 5, 2001, Mr. [redacted] and Doctor [redacted] indicated that [redacted] believed his back pain was worse. The pedicle screws in the left side showed a large halo at the L5 level. Recommendation was for a MRI with Gadolinium enhancement and a CT scan of the lumbar spine. [redacted] was temporarily totally disabled.

On July 12, 2001, MRI of the lumbar spine was performed with and without IV contrast. [redacted], M.D. reviewed the films and indicated that there was pedicle screw fixation in place.

On September 4, 2001, Doctor [redacted] documented complaints of intense back pain radiating to the right leg, and increase in neck pain radiating to the arms. Diagnosis was failed L4-5 fusion with loose pedicle screws and cervical radiculopathy. MRI of the cervical spine was performed, and further low back surgery recommended.

On September 16, 2001, MRI of the cervical spine was performed. [redacted] M.D. reviewed the films and reported, at C3-4, a 3 mm. central posterior disc protrusion/extrusion; at C4-5, a 2 mm. protrusion with moderate encroachment on the left C5 root; at C5-6, moderate decrease in disc height and desiccation of the C5-6 disc with a 3 mm. protrusion, and moderate to severe encroachment of the right neural foramen and mild left C6 encroachment. At C6-7, there was desiccation and a 2 mm. posterior bulge with mild to moderate left neural foraminal narrowing. There was no direct cord compromise noted at any level.

On October 25, 2001, Mr. [redacted] and Doctor [redacted] noted that [redacted] had a motor vehicle accident on September 7, 2001, which was said to have occurred whilst [redacted] was driving to physical therapy and this resulted in a significant increase in neck and back pain. On March 11, 2002, Doctor [redacted] performed surgery, exploration of the fusion at L4-5, removal of pedicle screws at L4-5 and re-instrumentation, and an anterior intervertebral fusion with BAK cage system and iliac crest bone graft for a diagnosis of failed fusion at L4-5. On March 21, 2002, Mr. [redacted] and Doctor [redacted] noted that

[redacted] was walking with a walker. On March 28, 2002, Mr. [redacted] and Doctor [redacted] noted significant benefit from surgery. X-rays showed good placement of the left pedicle screws at L4-5. There were two BAK cages anteriorly. There were not screws in the right side. On April 4, 2002, Mr. [redacted] and Doctor [redacted] noted drainage from the umbilicus area. On September 3, 2002, Mr. [redacted] and Doctor [redacted] documented complaints of ongoing leg pain. EMG and nerve conduction studies said to have been performed on August 12, 2002 showed evidence of chronic longstanding bilateral L4-5 radiculopathy. Recommendation was for MRI with Gadolinium enhancement.

On September 12, 2002, a CT scan of the lumbar spine was performed. Doctor [redacted] reviewed the films and reported very likely fusion ongoing at L4-5 with prominent degenerative changes at L5-S1 with bony ridges encroaching on the neural foramina, with mild degenerative changes at L3-4 and only mild annular bulges above and below the fusion.

On November 5, 2002, Doctor [redacted] documented complaints of persistent back pain and some numbness in the right leg. MRI of the lumbar spine showed evidence of disc desiccation at L5-S1 with some right L5 neural foraminal narrowing. Recommendation was for urological evaluation by Doctor [redacted] and discography at L3-4 and L5-S1.

On December 5, 2002, Ms. [redacted] and Doctor [redacted] noted complaints of persistent severe low back pain radiating to the right lower extremity. Discography of the lumbar spine of November 12, 2002 was said to be negative at L3-4 and L5-S1, and [redacted] indicated he did not want to have lumbar epidural steroid injections.

On January 7, 2003, [redacted], M.D., urologist, indicated that [redacted] was complaining of problems with potency after the second spine operation. He had been a diabetes since 1977. A bladder ultrasound showed complete bladder emptying after voiding. Diagnosis was organic impotence on a vascular diabetic basis, and Doctor [redacted] recommended treatment outside of workers' compensation.

On March 12, 2002, Doctor [redacted] noted increased complaints of neck pain. The back pain was said to be relatively stable.

On April 17, 2003, a cervical epidural steroid injection was administered.

On May 24, 2003, Doctor [redacted] indicated persistent neck greater than back pain. There was no long lasting benefit from epidural injections. MRI of the cervical spine and lumbar spine with Gadolinium enhancement and pool therapy was recommended. On June 26, 2003, Ms. [redacted] and Doctor [redacted] noted complaints of severe neck and low back pain.

MRI of the cervical spine, on June 17, 2003, shows, at C3-4 and C4-5, 2-3 mm. bulges; at C5-6, 3 mm. bulges; and at C6-7, 2 mm. bulges.

A CT scan of the lumbar spine performed on June 17, 2003 was reported by Ms. [redacted] and Doctor [redacted] as showing, at L3-4, a 2 mm. broad-based bulge; at L5-S1, 2-3 mm. broad-based bulge with arthritic changes in the facet joints bilaterally. Recommendation was for facet joint injections. On August 14, 2003, Ms. [redacted] and Doctor [redacted] noted that two facet joint injections with Doctor [redacted] had not resulted in any improvement after the second injection. Doctor [redacted] wanted to perform epidural injections to the neck and low back.

On September 29, 2003, Doctor [redacted] noted that [redacted] perceived his back to be worse. Recommendation was for continued pool therapy.

DIAGNOSIS

1. Musculoligamentous strain cervical spine, cervical spondylosis and degenerative disc disease cervical spine, with complaints of radiating pain to the upper extremities.

2. Musculoligamentous strain lumbosacral spine, lumbar spondylosis and degenerative disc disease lumbar spine, treated surgically on three occasions, on August 8, 2000 with posterolateral spinal fusion at L4-L5 with pedicle screws and iliac crest bone graft, on May 14, 2001 with removal of an EBI bone stimulator battery, and on March 11, 2002 with exploration of the fusion at L4-5 and anterior lumbar intervertebral fusion with BAK cages and iliac crest bone graft.

3. Contusion and sprain right knee, medial meniscus tear right knee, degenerative arthritis right knee treated surgically on two occasions: on June 15, 1998 with partial medial meniscectomy and debridement, and in April of 1999 with medial meniscectomy and debridement.

4. Chronic pain syndrome.

5. Type II diabetes mellitus, nonindustrially related.

DISCUSSION

The following are appropriate responses to questions posed in the jointly submitted cover letter dated December 10, 2003:

1. [redacted] has a high level of subjective complaint and perceives that he has major physical disability resulting from the incident of January 6, 1998. [redacted] has had extensive nonsurgical, and surgical treatment over a protracted period of time, but despite this, when seen on January 15, 2004, some six years after the date of his injury and six years after he had last worked, [redacted] believes that he is overall the same or worse compared to the date of injury. In my opinion, this is at least in part explicable on the basis of a chronic pain syndrome. The above has been taken into account in the discussion that follows.

1. [redacted] is at a permanent and stationary state. He may be considered to have reached a permanent and stationary state for all body parts involved at the present time.

1. With respect to the lumbosacral spine with complaints of radiating pain down both lower extremities, [redacted] has the following subjective factors: Patient complaints stabbing pain in the low back and down both lower extremities which I would characterize as frequent and minimal at rest, becoming constant and slight with activities of daily living, reaching constant and moderate with any more than semi-sedentary work. [redacted] has the following objective factors: He is noted to have painful restricted volitional motion of the lumbar spine, there are complaints of back pain to terminal flexion and extension of the lumbar spine, there is painful restriction of supine straight leg raise testing bilaterally with positive foot dorsiflexion tests, there are complaints of tenderness to palpation in the low back and both buttocks. [redacted] is status post three surgical procedures to his low back including anterior and posterior fusion at L4-5. The results of diagnostic testing are noted.

[redacted], with regard to the lumbosacral spine, is able to work with the prophylactic restriction to semi-sedentary work with the proviso that [redacted] should not have to stand or walk for more than 15 minutes without a 15-minute period off his feet.

With respect to the right knee, [redacted] has the following subjective factors: Patient complaints constant aching pain in the right knee which I would characterize as constant and minimal at rest, becoming constant and slight with activities of daily living, reaching constant and moderate with lifting and carrying of weights midway between heavy and light and with any more than occasional squatting, kneeling, climbing, crouching and crawling, prolonged standing or walking, and work on even terrain or at unprotected heights. [redacted] has the following objective factors: There is restricted volitional motion of the right knee with respect to extension and flexion of the knee, there is increased ligamentous laxity particularly to valgus and anterior drawer and Lachman testing, there is moderate patellofemoral and femoral tibial crepitus in the right knee with pain to patellar compression on the right, and pain to McMurray and Pivot shift testing on the right although these specific tests are negative, there is 1/2-inch of right thigh atrophy. [redacted] has painful restriction of his volitional ability to squat with complaints of pain in the right, and he has a slight limp on ambulation favoring the right lower extremity, which is also present on heel and toe-walking.

[redacted], with regard to the right knee, is able to work with the prophylactic restriction of no substantial lifting and carrying and no more than occasional squatting, kneeling, climbing, crouching and crawling contemplating on a prophylactic basis 75% loss of pre-injury capacity for those tasks. Further,

[redacted] has a prophylactic restriction of no prolonged standing and walking contemplating on a prophylactic basis that [redacted] should not have to stand or walk for more than 15 minutes without a 15-minute period off his feet. Additionally, [redacted] has a prophylactic work restriction precluding work on even terrain or at unprotected heights.

With respect to the cervical spine, it is my opinion that [redacted] would have subjective factors that would not exceed a point midway between constant and slight and constant and moderate with very heavy lifting were [redacted] to perform this task. [redacted] is noted to have crepitus to range of motion testing of the cervical spine, there is slight restriction of volitional motion of the cervical spine. The results of diagnostic testing are noted.

[redacted], with regard to the cervical spine, has ratable subjective factors, but no actual work restrictions.

4. With respect to apportionment, [redacted] is noted to have had prior work-related injuries to his low back; however, if [redacted]'s characterization of his work duties is accurate, that is he was required to lift weights of 100+ pounds by himself, namely an air conditioner, then [redacted] would appear to have self-rehabilitated and he had no actual work restrictions whilst employed by Brymarc Management. This is in the absence of a for Job Analysis for [redacted]'s employment with Brymarc Management. Causation and apportionment in the above scenario would relate 100% to the specific injury of January 6, 1998 with respect to [redacted]'s neck, low back and right knee.

5, 6. [redacted] requires provision for future medical care. [redacted] needs access to over-the-counter medication. Provision should be made for [redacted] to be seen by preferably a Board-certified orthopedic surgeon for prescription medication, short courses of formal physical therapy, and local injections of medication. [redacted], in my opinion, has had centralization of his pain as part of his chronic pain syndrome, and because of this, it is my opinion that he is unlikely to perceive that he will obtain any significant long-term benefit from additional invasive management.

I do not recommend that [redacted] have further surgery to his low back or surgery to his neck unless a true orthopedic emergency arises, that is the presence of a progressive neurological deficit or the onset of bowel and bladder incontinence such as in a cauda equina syndrome.

With respect to the right knee, provision should be made for [redacted] to have surgery to his right knee; however, I believe that prior to surgery, [redacted] be seen and assessed by a reputable Board-certified pain management specialist who is

preferably part of a multi-disciplinary group with respect to the appropriateness of surgery.

7. Based on [redacted]'s characterization of his work duties, it would appear probable that [redacted] is a qualified injured worker and vocational rehabilitation is appropriate.

Yours Sincerely,

Andrew L. Sew Hoy, M.D.
Orthopedic Surgeon

ALSH:gsk

Disclaimer: The patient was informed that the purpose of the examination was to address specific injuries or conditions as outlined by the requesting party, and that this examination was for evaluation purposes only and not meant to constitute a general medical examination, nor was said examination a substitute for said patient's personal physician or health care. The patient was informed prior to the examination not to engage in any physical maneuvers beyond what could possibly be tolerated or which was beyond their limits or could cause any physical harm or injury.

In compliance with AB3660 and Labor Code Section 4628 (j), 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 the information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided me and, except as noted therein, that I believe it to be true.

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 patient or the preparation of this report.

Certification Section 10606: This history was recorded from preliminary forms completed by [redacted] and [redacted], the professional interpreter, and from interviews with a medical historian, [redacted], and myself. The physical examination and dictation of the report are the product of my own effort.

The time spent face-to-face with [redacted] was in compliance with the IMC regulations pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

Executed this 23rd day of April, 2004,
Los Angeles, Los Angeles County, California.