February 22, 2014

Apple Insurance Company
P.O. Box 123456
Beverly Hills, NY 12345

RE:	**SMITH, PEPE**
DATE OF BIRTH	1/2/34
EMPLOYER	Orange Juice Company
OCCUPATION	Mechanic
DATE OF INJURY	CT 1/1/01 to 1/1/02
CLAIM #	
WCAB #	
DATE OF EVALUATION	February 22, 2014
DATE OF REPORT:	February 22, 2014

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT

Mr. Smith returns to my Beverly Hills office today on February 22, 2014 for orthopaedic follow-up referencing the above date of injury. The examination was conducted with the assistance of a certified interpreter.

This permanent impairment evaluation was performed in accordance with the American Medical Association *Guides to the Evaluation of Permanent Impairment,* 5th edition.

REVIEW OF HISTORY AND TREATMENT:

I initially saw Mr. Smith on January 14, 2013, regarding a work-related continuous trauma injury from January 1, 2001 to January 1, 2002, when he developed pain in his low back and later in his neck as well as internal and psychological symptoms as a result of his repetitive job duties. He began experiencing low back pain in late 1999 or early 2000. He saw a personal doctor for a regular checkup, thinking his pain was temporary. He was examined, given a local lumbar spine injection for pain with temporary relief, and was prescribed pain medication. There were no braces or physical therapy given. He was not placed on modified duty, but he was advised to limit his work activities. He was not advised to be treated as a worker's compensation case. He reported the low back pain to his leader, Mr. Xyz, around late 2000 or early 2001 but there was no paperwork filled out. The patient was not advised regarding any treatment, but he was given a day off after a local injection. He then continued working under these conditions and continued experiencing pain in his low back up until about November 2001, when he was laid off because the company was closing. He continued feeling the pain in his low back, was losing his medical insurance, and was still on medications for his treatment so he decided to seek legal counsel in early 2002.

He did not report the injury again to his employer prior to being laid off.

In early 2002, he was referred by his attorney to Jack Jill, M.D. The patient was examined, had x-rays taken, was prescribed medication, and referred for physical therapy and chiropractic treatment for various months during 2002 with temporary relief. He recalls receiving two epidural injections in his low back, which provided temporary relief.

Sometime in early 2003, he was transferred to Joe Abc, M.D., who then made a referral to Dr. Jekyll Hyde, who performed another set of injections. The patient reports that again he felt no relief from these injections. He continued following up with Dr. Hyde, who continued prescribing medication and referring the patient to physical therapy but none of that treatment provided relief.

In early 2004 he was referred to Dr. John Def, an orthopaedist, as the primary treating physician for an EMG/NCV study of the legs and an MRI scan of the low back. After reviewing the results of the studies, the patient was referred to Dr. Peter Ghi, a spine surgeon in Orange, for an orthopaedic consultation. The patient eventually underwent surgery, which was performed at a surgery center in Orange. During the non-invasive surgery, his spinal cord was accidentally punctured, which resulted in being rushed to Saint Hospital, where the patient underwent treatment to help with the leaking of the spinal fluid, but he cannot recall the specifics because he was heavily sedated. However, he does recall being there for 4-5 days. He denies having spinal headaches. He developed psychological problems such as anxiety and depression after this failed surgery due to the increased pain and because he felt as if he would not get any better.

After this surgery, he was referred to He Man, M.D., for a psychiatric consultation. He referred the patient to a psychologist and also for biofeedback therapy. The patient was also prescribed medication.

After this procedure, he continued with Dr. Def, who eventually made a referral to physical therapy. The therapy did not help at all, and the patient was heavily dependent on pain medication. He also began experiencing an aggravation of pain in his neck around this time. He continued with his treatment but felt little to no relief from it and continued seeing Dr. Ghi occasionally.

In late 2006, Dr. Ghi performed a discogram in the low back. After reviewing the results, Dr. Ghi determined that the patient was a candidate for a second surgery to his low back.

In October 2006, he underwent a second anterior-posterior low back fusion, which was performed by Dr. Ghi at Saint Medical Center. The patient was kept for about 4-5 days for observation. He continued experiencing pain in his low back after the surgery but felt some relief from the pain which was radiating down his left leg.

He continued with Dr. Def as the primary treating physician after this procedure and continued receiving pain medications such as Tylenol #3. However, this began causing severe heartburn, gas, and dry mouth so the patient sought medical attention from his family doctor. While under the care of Dr. M, the patient was referred to aquatic therapy for approximately six months which caused some relief in his back pain and made it easier for him to walk. He continued with Dr. Ghi until around October 2007 when the patient was made permanent and stationary.

He has not seen any other doctors for this particular injury other than his family doctor, Peter Mno, M.D., who gives the patient pain medication when his back pain flares up. He also has not seen any other doctor for this worker's compensation injury other than his psychiatrist, Mark Pqr, M.D., in Santa Ana. The patient began treating with Dr. Pqr sometime in 2007 and was prescribed many psychotropic medications. The patient has not seen Dr. Pqr for about a year due to insurance issues.

In approximately 2008, the patient was re-evaluated by Dr. Stu to whom the patient was referred by the insurance carrier. After the evaluation he was then returned to the care of Dr. Pqr, with whom the patient follows up regularly and Cymbalta 60 mg has been prescribed for the last two years or so. He denies any other treatment other than this and remains symptomatic.

He is currently not working. He has continued pain and psychological problems.

During the course of treatment, the patient was seen for Orthopaedic Qualified Medical Evaluations on January 31, 2006 and October 15, 2007 with supplemental reports dated January 28, 2008, August 21, 2008 and December 18, 2008, by David Goliath, M.D. These have been previously reviewed.

After interviewing and examining the patient on January 14, 2013, I diagnosed status post multilevel laminectomy with discectomy at L5-S1, 9/16/14; status post lumbar anterior partial vertebrectomy at L5-S1; anterior interbody fusion at L5-S1 and L5-S1 cage, anterior instrumentation and decompression from L4 to sacrum per Dr. Ghi, 10/19/06; and exacerbation of pain and left sciatica. I requested the operative reports done on September 16, 2004 and October 19, 2006. I prescribed Norco 5 b.i.d. p.r.n. #60, omeprazole 20 mg b.i.d. #60 and Axid b.i.d. #60. I advised him to discontinue taking gabapentin. He declined physical therapy and acupuncture.

He continued primary follow-up evaluations every four to six weeks and while under my care he received the following treatment:

Mr. Smith underwent diagnostic studies during the course of treatment, as noted below in review of diagnostic studies. These included x-rays of the chest and lumbar spine, and CT myelogram of the lumbosacral spine.

The patient underwent lumbar spine surgeries with Peter Ghi, M.D. on October 19, 2006, as noted below:

Operative Report, Multilevel Laminectomy with Discectomy, St. J Hospital, by Peter Ghi, M.D., 10/19/06: Pre and Postoperative Diagnoses: 1. Lumbar degenerative disk disease L4-5, L5-S1. 2. Remote lumbar laminectomy L4-5, L5-S1. 3. Facet arthropathy L4-5, L5-S1. Procedures Performed: 1. Lumbar laminectomy L4-5, L5-S1 (revision). 2. Posterior lumbar interbody fusion L4-5. 3. Insertion of biomechanical cage L4-5 (Alphatec). 4. Posterolateral fusion L4-5, L5-S1. 5. Segmental instrumentation L4-5, L5-S1 (Alphatec). 6. Insertion of bone morphogenic protein, trademark infuse – corticocancellous allograft local bone graft. 7. Somatosensory evoked potentials upper and lower extremities. Continuous electrical monitor for lower extremities. Complications: None. The patient was transferred to the recovery room in stable condition.

Operative Report, Lumbar Anterior Partial Vertebrectomy, St. J Hospital, by Peter Ghi, M.D., 10/19/06: Pre and Postoperative Diagnoses: 1. L5-S1 lumbar degenerative disk disease. 2. L5-S1 internal disk disruption, annular tear. 3. L5-S1 post laminectomy syndrome. Procedures Performed: 1. Anterior partial vertebrectomy, L5-S1. 2. Anterior interbody fusion, L5-S1. 3. Insertion of biomechanical cage application, L5-S1 (Alphatec). 4. Anterior instrumentation L5-S1. 5. Insertion of bone morphogenic protein, trademark InFuse. 6. Somatosensory evoked potentials, upper and lower extremities. Continuous electromyography, lower extremities. Complications: None. The patient was transferred to the recovery room in stable condition.

Operative Report, Retroperitoneal Exploration and Mobilization of the Intra-abdominal Great Vessels, St. J Hospital, by Peter Ghi, M.D., 10/19/06: Pre and Postoperative Diagnosis: Lumbar disk disease. Procedure Performed: Retroperitoneal exploration and mobilization of the intra-abdominal great vessels. Complications: None. The patient tolerated the procedure well.

When seen for a primary follow-up evaluation on June 20, 2013, I had a long discussion with the patient about the next step of treatment. He stated that he prefers not to have surgery now but wants to have the option if necessary. He was advised to continue Vicodin 5 b.i.d. p.r.n, Prilosec 20 mg b.i.d., Axid b.i.d., Flexeril h.s., urine drug test and topical ointment tramadol 20% 30 gm. He will be seen for possible permanent and stationary evaluation on his next visit.

On July 9, 2013, he underwent a final functional capacity evaluation by Mark Vwx, D.C. The results of the tests were reliable and valid. He could lift 8 pounds from waist level, and carry up to 3 pounds occasionally up to 30% of the work day. Floor lifting, shoulder and overhead lifting, pushing and pulling are self-limited due to increased pain. He could sit and stand for 30 minutes, and walk for 20 minutes or 0.5 mile continuously. His walking tolerance does not meet the DOT Demand Minimum Functional Capacity requirement of walking for one mile continuously (@ 2mph). He was able to climb at least one flight of stairs, and reach for objects in all directions with each arm. Crouching and stooping is self-limited due to increased pain.

On August 1, 2013, I saw the patient for a permanent and stationary evaluation. Through my office, he has been taking Norco 5 mg b.i.d., Prilosec and Axid which controls his gastritis, and Flexeril h.s. He has been using topical creams which provided modest relief. He uses a cane part-time. His lumbar support is old and broken (three years old) so he was given a new one. He is using interferential unit. He was seen by Dr. Doo, family doctor for diabetes mellitus, cholesterol, high blood pressure and constipation. He was advised to take narcotics from only one doctor. He denies having chiropractic treatment. He had physical therapy and aquatherapy in the past which helped. He had acupuncture with no benefit.

In June 2013 he saw Dr. Opq for Qualified Medical Evaluation in Orthopaedics, but the report is not yet available for review.

CURRENT COMPLAINTS:

Lumbar spine: The patient reports constant pain in the left more than right lumbar spine rated 7 to 8 on a scale of 1-10, ten being most severe. The pain constantly radiates to the left lower extremity to the lateral

aspect of the left thigh, leg and little toe. He denies pain in the right lower extremity. The pain increases with fast walking, pushing, pulling, bending, prolonged sitting, standing, and walking. He wakes up 2-3 times at night and he sleeps approximately four hours per night. He reports numbness and tingling on the same area as the pain. He reports weakness of the left more than right lower extremity. He reports giving way which worsen and has fallen 3-4 times. His last fall was in April 2013. He reports occasional perineal numbness and urinary incontinence. He denies sphincter problems. He has problems maintaining an erection.

ACTIVITIES OF DAILY LIVING:

The patient states that he manages most of his personal self-care with some help. He can only lift, push and pull very lightweight objects, uses a cane to ambulate, and perform light activity for at least two minutes. Climbing one flight of stairs is performed with a lot of difficulty. He can only sit, stand and walk for less than 15 minutes at a time. He has a lot of difficulty reaching and grasping something off a shelf at chest level, and with forceful activities with his arms and hands. He has some difficulty with gripping, grasping, holding and manipulating objects with his hands, and with repetitive motions such as typing on a computer. He cannot kneel, bend or squat. His sleep is greatly disturbed and there has been a major change in his sexual function because of his injury. He states that his pain is currently moderate, but that it is fairly severe most of the time. He cannot travel, or engage in social or recreational activities. Most of the time pain interferes with his concentration and thinking. He has severe depression and anxiety. He reports a mild change in his seeing, hearing and speaking ability, and a moderate change in his writing ability. His pain level averages 6-8/10 and is 8/10 at its worst.

RELEVANT PAST HISTORY:

The patient reports no other history of injury to the lumbar spine.

He reports no history of traffic accidents, falls, sports injuries, fractures, other orthopaedic conditions, or other industrial or non-industrial injuries.

OCCUPATIONAL HISTORY AND JOB DESCRIPTION:

The patient worked for ABCD as a mechanic from about 1996 until January 2002, but he last worked in November 2001. His job duties included carrying moldings weighing between 20-50 pounds and setting up machines for prolonged periods for operators to create cables used for many different applications. He had to stand and walk for prolonged periods, sit, bend, stoop, squat, lift and carry up to 50 pounds, grip, grasp, twist, push, pull, reach at all levels, and repetitively use his hands. He worked 8-12 hours per day, five days per week. A pre-employment physical examination was not required.

He states that this was his first job when he arrived in the U.S.A.

PHYSICAL EXAMINATION:

General:

The patient is a 52-year-old right-handed male who is 5'4" tall and weighs 175 pounds. He appears uncomfortable and frequently shifts position. He presents with antalgic gait on the left. He uses a cane with the right hand. Blood pressure is 142/78. Pulse is 96.

Lumbar Spine and Lower Extremities:

The patient stands with the right shoulder higher than the left. Head and neck are straight. There is no thoracic shift. Arches and toes are normal. Lumbar lordosis is normal, and there is no evidence of scoliosis or increased thoracic kyphosis. Hips and pelvis are higher on the left. There is tenderness to palpation about the left lumbar paravertebral muscles, and bilateral sacroiliac joints. There is no pain in the sciatic notch.

Gait is antalgic on the left. Walking on tiptoes and heels produces pain in the lumbar spine. He cannot perform a complete squat due to pain in the lumbar spine and left knee.

Lumbar Spine Range of Motion	Normal	Measured
Flexion	60°	8°
Extension	25°	3°
Left lateral bend	25°	15°
Right lateral bend	25°	21°

Neurologic:

Deep Tendon Reflexes	Right	Left
Ankle jerks	2+	2+
Knee jerks	2+	2+

Sensation to pinprick and light touch is normal bilaterally. Motor power is normal and symmetrical in all major muscle groups of the lower extremities.

Straight leg raising is positive on the left bilaterally in the sitting and supine positions. Sitting and supine Lasegue's are positive to 60° on the right and 40° on the left.

Circumferential Measurements	Right	Left
Thighs, 10 cm above patella	48 cm	47 cm
Mid-patella	35.5 cm	35.5 cm
Maximal calf	36 cm	35 cm

Hips:

There is no tenderness to palpation of the trochanters bilaterally. There is no pain to rolling of the hips. Fabere and reverse Fabere are bilaterally negative.

Knees:

The knees appear normal to visual inspection. Alignment is normal. There is no swelling, effusion or synovitis. There is no patellofemoral pain, but there is crepitation on range of motion bilaterally. There is no medial joint line tenderness bilaterally. There is mild lateral joint line tenderness on the left. There is no increased temperature. There is no Baker's cyst bilaterally. McMurray and Apley tests are negative bilaterally. Anterior and posterior drawer and Lachman's are negative bilaterally. Patellar grinding is 1+ bilaterally. Medial and lateral collateral ligaments are bilaterally intact to varus and valgus stress.

Ankles and Feet:

There is no visible swelling, ecchymosis or hematoma. There is no pain to palpation of the joint lines bilaterally. Sub-talar motion is free and normal. There is tenderness to palpation about plantar fascia and left forefoot.

REVIEW OF X-RAYS:

X-ray of the Lumbar Spine, XYZ Medical Group, Approved by ABC, M.D. Ph.D., 1/14/13: Radiographic examination of the lumbar spine reveals a posterior L3 to L5 instrumented fusion with osseous disc implants. Also seen is an anterior screw at L5. Alignment is intact. L2/3 osteophytes are evident and there is partial non-segmentation of L5/S1. Bone density is normal. The visualized joint spaces are well maintained. There is no evidence of acute fracture or dislocation. The soft tissues are unremarkable. The impression is of: a posterior L3 to L5 instrumented fusion with osseous disc implants; an anterior screw at L5; spondylosis, L2/3; a partial non-segmentation, L5/S1; and, no other abnormalities noted.

Review of Films: On January 25, 2013, I reviewed the films of this study. AP view revealed five lumbar vertebrae. The spine was straight. There was no rotation. There was partial lumbarization of S1 on the left side. There was evidence of a posterior and anterior fusion. The posterior fusion involved L4-5 and L5-S1 with pedicular screws. There was no crosslink bar. There was evidence of a midline anteroposterior screw at L5-S1. On the oblique views, there was evidence that all the pedicular screws are in the pedicle. Lateral view revealed sacrolumbar angle of 58 degrees and lumbar lordosis of 39.4 degrees. There was evidence of fusion at L5-S1. However, at L4-5, there is a radiolucent line surrounded by a sclerotic line between the vertebral body of L4 and the graft. There were mild degenerative changes at L3-4, above the fusion with a tiny anterosuperior osteophyte on the vertebral body of L4. There was also, in neutral, retrolisthesis of L3 on L4 measuring 3.3 mm on the lateral view. In flexion, the L3-4 listhesis measured 2.65 mm and 2.11 mm in extension. There was no evidence of failure of the hardware or radiolucency around L4 pedicular screws. In flexion, the radiolucent line between L4 and the graft measured approximately 2 mm. In extension, the

radiolucent line was not visible and only the sclerosis was present. C**omment:** The x-ray findings suggest a possible non-union of the fusion between the distal vertebral plate of L4 and the graft.

X-Rays of the Lumbar Spine, XXX Hospital, Approved by ABC, M.D., 10/19/06: Impression: Status post interbody fusion at L4-5.

X-Rays of the Lumbar Spine, XXX Hospital, Approved by ABC, M.D., 10/19/06: Impression: Probe centered anterior at L3-4.

X-Rays of the Lumbar Spine, XXX Hospital, Approved by ABC, M.D., 10/19/06: Impression: Interval pedicle screw guide placement at L3 and L4.

X-Rays of the Chest, XXX Hospital, Approved by ABC, M.D., 10/09/06: Impression: Stable 6 mm nodule left lung base, unchanged over the two year interval confirming benign etiology.

REVIEW OF DIAGNOSTIC STUDIES:

CT Myelogram of the Lumbosacral Spine, XXX Medical Imaging of Torrance, Approved by ABC, M.D., 6/3/13: Impression: 1. CT myelogram revealed mild spinal stenosis at the level of L2-3 above the fused segment which appeared to be mostly compressing from posterior aspect of the facet joints area. 2. Osteoporosis of the vertebral bodies with evidence of mild partial compression deformity in the right side of L3 and L4. 3. Multi-level degenerative facet arthropathy at L2-3, L3-4, L4-5 and L5-S1. 4. Bilateral sacralization of L5 with pseudoarthrosis formation more in right side. This is mostly a transitional vertebra of L5.

Anatomical Impairment Measurements, Plain Films of the Lumbar Spine, 1/14/13, ABC, M.D., 8/8/13: DRE assessment revealed that more than one level of loss of translational motion integrity exists at L1-2 with 1.7 mm in flexion and -3.63 mm in extension for a difference of 5.33 mm, and at L2-3 with 2.95 mm in flexion and -5.59 mm in extension for a difference of 8.5 mm; and that there is more than one level of fusion exists at L3-4 and L4-5. ROM assessment revealed that this patient undergone surgical fusion (with or without decompression surgery) at L3-4 and L4-5.

DIAGNOSES:

1) STATUS POST MULTILEVEL LAMINECTOMY WITH DISCECTOMY AT L5-S1 9/16/04.

2) STATUS POST LUMBAR ANTERIOR PARTIAL VERTEBRECTOMY AT L5-S1; ANTERIOR INTERBODY FUSION AT L5-S1; L5-S1 CAGE, ANTERIOR INSTRUMENTATION AND DECOMPRESSION FROM L4 TO SACRUM, DR. --- 10/19/06.

3) EXACERBATION OF LUMBAR SPINE PAIN AND LEFT SCIATICA; STATUS POST ANTEROPOSTERIOR FUSION AT L4-5, L5-S1 WITH FIXATION SCREWS, POSSIBLE NON UNION BETWEEN L4 BODY AND GRAFT; RETROLISTHESIS OF L3 ON L4, MEASURING 3.23 MM IN NEUTRAL, 2.65 MM IN FLEXION, 2.11 MM IN EXTENSION ON X-RAY 1/14/13.

4) MILD SPINAL STENOSIS AT LEVEL L2-3 ABOVE FUSED SEGMENT WHICH APPEARED O BE MOSTLY COMPRESSING FROM THE POSTERIOR ASPECT OF THE FACET JOINTS AREA; OSTEOPOROSIS OF THE VERTEBRAL BODIES WITH EVIDENCE OF MILD PARTIAL COMPRESSION DEFORMITY IN THE RIGHT SIDE OF L3 AND L4; MULTILEVEL DEGENERATIVE FACET ARTHROPATHY AT L2-3, L3-4, L4-5 AND L5-S1; BILATERAL SACRALIZATION OF L5 WITH PSEUDOARTHROSIS FORMATION MORE ON THE RIGHT SIDE; MOSTLY TRANSITIONAL VERTEBRA OF L5 ON CT MYELOGRAM OF THE LUMBAR SPINE 6/3/13. BY MY READING, PATIENT HAS TRANSITIONAL VERTEBRA; L4-5 AND L5-S1 ANTEROPOSTERIOR FUSION, FUSED WITH DEGENERATIVE CHANGES AT L3-4; 1.65 MM RETROLISTHESIS OF L3 ON L4 AND CENTRAL CANAL NARROWING MEASURING 8.33 MM WITH BILATERAL FORAMINAL STENOSIS.

5) GASTRITIS DUE TO MEDICATIONS.

CAUSATION:

The history is consistent with the mechanism of injury and the patient's complaints and findings on physical examination and diagnostic studies. There is no evidence of other factors before the continuous trauma injury from January 1, 2001 to January 1, 2002. The industrial injury on that date appears to be the cause of the patient's current symptoms and need for treatment.

DISCUSSION:

Mr. Smith is a 52-year-old mechanic whom I have followed for work related injuries. The patient has been treated conservatively, has had appropriate diagnostic studies, and has been evaluated by specialists as indicated. The findings and recommendations of all consultants are hereby incorporated by reference into this report.

It is my professional opinion that this patient's orthopaedic injuries have stabilized. No further significant improvement can be expected with additional conservative care. The patient has reached maximal medical improvement and can be considered permanent and stationary for purposes of rating. Impairment rating is performed in accordance with the AMA *Guides to the Evaluation of Permanent Impairment*, 5th edition.

The patient has required and continues to require transportation to medical and physical therapy appointments. This requirement is in effect until further notice.

Objective Factors of Disability:

Per physical examination and diagnostic studies summarized above.

Impairment Rating and Rationale:

TOTAL COMBINED WHOLE PERSON IMPAIRMENT: *%

Return to Work:

According to the functional capacity evaluation performed on July 9, 2013, this patient was capable of lifting 8 pounds from waist level, and carrying up to 3 pounds occasionally up to 30% of the work day. Floor lifting, shoulder and overhead lifting, pushing and pulling are self-limited due to increased pain. He could sit and stand for 30 minutes, and walk for 20 minutes or 0.5 mile continuously. His walking tolerance does not meet the DOT Demand Minimum Functional Capacity requirement of walking for one mile continuously (at 2mph). He was able to climb at least one flight of stairs, and reach for objects in all directions with each arm. Crouching and stooping is self-limited due to increased pain.

Future Medical Care:

The patient should have access to future medical care for exacerbation of symptoms in the lumbar spine which should include spine surgical consult and physical therapy, and return consultation with a pain management specialist for future epidurals or facet injections. He may require updated advanced diagnostic studies including CT myelogram if necessary, and a repeat EMG/NCV of the lower extremities if necessary. If his pain increases he should have access to prescription analgesic and anti-gastric medications.

Apportionment:

I have reviewed apportionment in light of the *Escobedo* decision. It is my opinion that, to a reasonable medical probability, 100% of the permanent impairment is a direct result of the industrial injury "arising and occurring in the course of employment" on a continuous trauma injury from January 1, 2001 to January 1, 2002, and none was caused by other factors, either before or after that date. There is no medical evidence of any symptoms, disability, or impairment prior to that date.

Thank you for the opportunity of evaluating and treating this patient. If there are any questions, please do not hesitate to contact me.

LABOR CODE §§4663, 4664:

I have discussed apportionment in the body of this report. If I have assigned impairment to factors other than the industrial injury, that percentage constitutes the apportionment. The ratio of non-industrial impairment, if any, to total impairment represents my best medical judgment of the approximate percentage of impairment or disability caused by the industrial injury and that caused by other factors, as defined in *Labor Code §§4663 and 4664*.

DISCLOSURE:

Transcription of this report was provided by eDATA Services, Inc.

I reserve the right to change my opinion based on additional medical evidence.

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 for information that I received from others. As for that information, I declare under penalty of perjury that the report accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Pursuant to Sections LC 5703 and 5307 (a) (1), I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise as compensation or inducement for any referred examination or evaluation.

Signed on _____, in the County of Los Angeles, California.

Sincerely yours,

_____
Christopher Lee, M.D., F.A.A.O.S., Q.M.E.
Diplomate, American Board of Orthopaedic Surgery.

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February 22, 2014 **SAMPLE**

Apple Insurance Company
P.O. Box 123456
Beverly Hills, NY 12345

RE:	**SMITH, PEPE**
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OCCUPATION	Mechanic
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early 2001 but there was no paperwork filled out. The patient was not advised regarding any treatment, but he was given a day off after a local injection. He then continued working under these conditions and continued experiencing pain in his low back up until about November 2001, when he was laid off because the company was closing. He continued feeling the pain in his low back, was losing his medical insurance, and was still on medications for his treatment so he decided to seek legal counsel in early 2002.

He did not report the injury again to his employer prior to being laid off.

In early 2002, he was referred by his attorney to Jack Jill, M.D. The patient was examined, had x-rays taken, was prescribed medication, and referred for physical therapy and chiropractic treatment for various months during 2002 with temporary relief. He recalls receiving two epidural injections in his low back, which provided temporary relief.

Sometime in early 2003, he was transferred to Joe Abc, M.D., who then made a referral to Dr. Jekyll Hyde, who performed another set of injections. The patient reports that again he felt no relief from these injections. He continued following up with Dr. Hyde, who continued prescribing medication and referring the patient to physical therapy but none of that treatment provided relief.

In early 2004 he was referred to Dr. John Def, an orthopaedist, as the primary treating physician for an EMG/NCV study of the legs and an MRI scan of the low back. After reviewing the results of the studies, the patient was referred to Dr. Peter Ghi, a spine surgeon in Orange, for an orthopaedic consultation. The patient eventually underwent surgery, which was performed at a surgery center in Orange. During the non-invasive surgery, his spinal cord was accidentally punctured, which resulted in being rushed to Saint Hospital, where the patient underwent treatment to help with the leaking of the spinal fluid, but he cannot recall the specifics because he was heavily sedated. However, he does recall being there for 4-5 days. He denies having spinal headaches. He developed psychological problems such as anxiety and depression after this failed surgery due to the increased pain and because he felt as if he would not get any better.

After this surgery, he was referred to He Man, M.D., for a psychiatric consultation. He referred the patient to a psychologist and also for biofeedback therapy. The patient was also prescribed medication.

After this procedure, he continued with Dr. Def, who eventually made a referral to physical therapy. The therapy did not help at all, and the patient was heavily dependent on pain medication. He also began experiencing an aggravation of pain in his neck around this time. He continued with his treatment but felt little to no relief from it and continued seeing Dr. Ghi occasionally.

In late 2006, Dr. Ghi performed a discogram in the low back. After reviewing the results, Dr. Ghi determined that the patient was a candidate for a second surgery to his low back.

In October 2006, he underwent a second anterior-posterior low back fusion, which was performed by Dr. Ghi at Saint Medical Center. The patient was kept for about 4-5 days for observation. He continued experiencing pain in his low back after the surgery but felt some relief from the pain which was radiating down his left leg.

He continued with Dr. Def as the primary treating physician after this procedure and continued receiving pain medications such as Tylenol #3. However, this began causing severe heartburn, gas, and dry mouth so the patient sought medical attention from his family doctor. While under the care of Dr. M, the patient was referred to aquatic therapy for approximately six months which caused some relief in his back pain and made it easier for him to walk. He continued with Dr. Ghi until around October 2007 when the patient was made permanent and stationary.

He has not seen any other doctors for this particular injury other than his family doctor, Peter Mno, M.D., who gives the patient pain medication when his back pain flares up. He also has not seen any other doctor for this worker's compensation injury other than his psychiatrist, Mark Pqr, M.D., in Santa Ana. The patient began treating with Dr. Pqr sometime in 2007 and was prescribed many psychotropic medications. The patient has not seen Dr. Pqr for about a year due to insurance issues.

In approximately 2008, the patient was re-evaluated by Dr. Stu to whom the patient was referred by the insurance carrier. After the evaluation he was then returned to the care of Dr. Pqr, with whom the patient follows up regularly and Cymbalta 60 mg has been prescribed for the last two years or so. He denies any other treatment other than this and remains symptomatic.

He is currently not working. He has continued pain and psychological problems.

During the course of treatment, the patient was seen for Orthopaedic Qualified Medical Evaluations on January 31, 2006 and October 15, 2007 with supplemental reports dated January 28, 2008, August 21, 2008 and December 18, 2008, by David Goliath, M.D. These have been previously reviewed.

After interviewing and examining the patient on January 14, 2013, I diagnosed status post multilevel laminectomy with discectomy at L5-S1, 9/16/14; status post lumbar anterior partial vertebrectomy at L5-S1; anterior interbody fusion at L5-S1 and L5-S1 cage, anterior instrumentation and decompression from L4 to sacrum per Dr. Ghi, 10/19/06; and exacerbation of pain and left sciatica. I requested the operative reports done on September 16, 2004 and October 19, 2006. I prescribed Norco 5 b.i.d. p.r.n. #60, omeprazole 20 mg b.i.d. #60 and Axid b.i.d. #60. I advised him to discontinue taking gabapentin. He declined physical therapy and acupuncture.

He continued primary follow-up evaluations every four to six weeks and while under my care he received the following treatment:

Mr. Smith underwent diagnostic studies during the course of treatment, as noted below in review of diagnostic studies. These included x-rays of the chest and lumbar spine, and CT myelogram of the lumbosacral spine.

The patient underwent lumbar spine surgeries with Peter Ghi, M.D. on October 19, 2006, as noted below:

Operative Report, Multilevel Laminectomy with Discectomy, St. J Hospital, by Peter Ghi, M.D., 10/19/06: Pre and Postoperative Diagnoses: 1. Lumbar degenerative disk disease L4-5, L5-S1. 2. Remote lumbar laminectomy L4-5, L5-S1. 3. Facet arthropathy L4-5, L5-S1. Procedures Performed: 1. Lumbar laminectomy L4-5, L5-S1 (revision). 2. Posterior lumbar interbody fusion L4-5. 3. Insertion of biomechanical cage L4-5 (Alphatec). 4. Posterolateral fusion L4-5, L5-S1. 5. Segmental instrumentation L4-5, L5-S1 (Alphatec). 6. Insertion of bone morphogenic protein, trademark infuse – corticocancellous allograft local bone graft. 7. Somatosensory evoked potentials upper and lower extremities. Continuous electrical monitor for lower extremities. Complications: None. The patient was transferred to the recovery room in stable condition.

Operative Report, Lumbar Anterior Partial Vertebrectomy, St. J Hospital, by Peter Ghi, M.D., 10/19/06: Pre and Postoperative Diagnoses: 1. L5-S1 lumbar degenerative disk disease. 2. L5-S1 internal disk disruption, annular tear. 3. L5-S1 post laminectomy syndrome. Procedures Performed: 1. Anterior partial vertebrectomy, L5-S1. 2. Anterior interbody fusion, L5-S1. 3. Insertion of biomechanical cage application, L5-S1 (Alphatec). 4. Anterior instrumentation L5-S1. 5. Insertion of bone morphogenic protein, trademark InFuse. 6. Somatosensory evoked potentials, upper and lower extremities. Continuous electromyography, lower extremities. Complications: None. The patient was transferred to the recovery room in stable condition.

Operative Report, Retroperitoneal Exploration and Mobilization of the Intra-abdominal Great Vessels, St. J Hospital, by Peter Ghi, M.D., 10/19/06: Pre and Postoperative Diagnosis: Lumbar disk disease. Procedure Performed: Retroperitoneal exploration and mobilization of the intra-abdominal great vessels. Complications: None. The patient tolerated the procedure well.

When seen for a primary follow-up evaluation on June 20, 2013, I had a long discussion with the patient about the next step of treatment. He stated that he prefers not to have surgery now but wants to have the option if necessary. He was advised to continue Vicodin 5 b.i.d. p.r.n, Prilosec 20 mg b.i.d., Axid b.i.d., Flexeril h.s., urine drug test and topical ointment tramadol 20% 30 gm. He will be seen for possible permanent and stationary evaluation on his next visit.

On July 9, 2013, he underwent a final functional capacity evaluation by Mark Vwx, D.C. The results of the tests were reliable and valid. He could lift 8 pounds from waist level, and carry up to 3 pounds occasionally up to 30% of the work day. Floor lifting, shoulder and overhead lifting, pushing and pulling are self-limited due to increased pain. He could sit and stand for 30 minutes, and walk for 20 minutes or 0.5 mile continuously. His walking tolerance does not meet the DOT Demand Minimum Functional Capacity requirement of walking for one mile continuously (@ 2mph). He was able to climb at least one flight of stairs, and reach for objects in all directions with each arm. Crouching and stooping is self-limited due to increased pain.

On August 1, 2013, I saw the patient for a permanent and stationary evaluation. Through my office, he has been taking Norco 5 mg b.i.d., Prilosec and Axid which controls his gastritis, and Flexeril h.s. He has been using topical creams which provided modest relief. He uses a cane part-time. His lumbar support is old and broken (three years old) so he was given a new one. He is using interferential unit. He was seen by Dr.

Doo, family doctor for diabetes mellitus, cholesterol, high blood pressure and constipation. He was advised to take narcotics from only one doctor. He denies having chiropractic treatment. He had physical therapy and aquatherapy in the past which helped. He had acupuncture with no benefit.

In June 2013 he saw Dr. Opq for Qualified Medical Evaluation in Orthopaedics, but the report is not yet available for review.

CURRENT COMPLAINTS:

Lumbar spine: The patient reports constant pain in the left more than right lumbar spine rated 7 to 8 on a scale of 1-10, ten being most severe. The pain constantly radiates to the left lower extremity to the lateral aspect of the left thigh, leg and little toe. He denies pain in the right lower extremity. The pain increases with fast walking, pushing, pulling, bending, prolonged sitting, standing, and walking. He wakes up 2-3 times at night and he sleeps approximately four hours per night. He reports numbness and tingling on the same area as the pain. He reports weakness of the left more than right lower extremity. He reports giving way which worsen and has fallen 3-4 times. His last fall was in April 2013. He reports occasional perineal numbness and urinary incontinence. He denies sphincter problems. He has problems maintaining an erection.

ACTIVITIES OF DAILY LIVING:

The patient states that he manages most of his personal self-care with some help. He can only lift, push and pull very lightweight objects, uses a cane to ambulate, and perform light activity for at least two minutes. Climbing one flight of stairs is performed with a lot of difficulty. He can only sit, stand and walk for less than 15 minutes at a time. He has a lot of difficulty reaching and grasping something off a shelf at chest level, and with forceful activities with his arms and hands. He has some difficulty with gripping, grasping, holding and manipulating objects with his hands, and with repetitive motions such as typing on a computer. He cannot kneel, bend or squat. His sleep is greatly disturbed and there has been a major change in his sexual function because of his injury. He states that his pain is currently moderate, but that it is fairly severe most of the time. He cannot travel, or engage in social or recreational activities. Most of the time pain interferes with his concentration and thinking. He has severe depression and anxiety. He reports a mild change in his seeing, hearing and speaking ability, and a moderate change in his writing ability. His pain level averages 6-8/10 and is 8/10 at its worst.

RELEVANT PAST HISTORY:

The patient reports no other history of injury to the lumbar spine.

He reports no history of traffic accidents, falls, sports injuries, fractures, other orthopaedic conditions, or other industrial or non-industrial injuries.

OCCUPATIONAL HISTORY AND JOB DESCRIPTION:

The patient worked for ABCD as a mechanic from about 1996 until January 2002, but he last worked in November 2001. His job duties included carrying moldings weighing between 20-50 pounds and setting up machines for prolonged periods for operators to create cables used for many different applications. He had to stand and walk for prolonged periods, sit, bend, stoop, squat, lift and carry up to 50 pounds, grip, grasp, twist, push, pull, reach at all levels, and repetitively use his hands. He worked 8-12 hours per day, five days per week. A pre-employment physical examination was not required.

PHYSICAL EXAMINATION:

General:

The patient is a 52-year-old right-handed male who is 5'4" tall and weighs 175 pounds. He appears uncomfortable and frequently shifts position. He presents with antalgic gait on the left. He uses a cane with the right hand. Blood pressure is 142/78. Pulse is 96.

Lumbar Spine and Lower Extremities:

The patient stands with the right shoulder higher than the left. Head and neck are straight. There is no thoracic shift. Arches and toes are normal. Lumbar lordosis is normal, and there is no evidence of scoliosis or increased thoracic kyphosis. Hips and pelvis are higher on the left. There is tenderness to palpation about the left lumbar paravertebral muscles, and bilateral sacroiliac joints. There is no pain in the sciatic notch.

Gait is antalgic on the left. Walking on tiptoes and heels produces pain in the lumbar spine. He cannot perform a complete squat due to pain in the lumbar spine and left knee.

Lumbar Spine Range of Motion	Normal	Measured
Flexion	60°	8°
Extension	25°	3°
Left lateral bend	25°	15°
Right lateral bend	25°	21°

Neurologic:

Deep Tendon Reflexes	Right	Left
Ankle jerks	2+	2+
Knee jerks	2+	2+

Sensation to pinprick and light touch is normal bilaterally. Motor power is normal and symmetrical in all major muscle groups of the lower extremities.

Straight leg raising is positive on the left bilaterally in the sitting and supine positions. Sitting and supine Lasegue's are positive to 60° on the right and 40° on the left.

Circumferential Measurements	Right	Left
Thighs, 10 cm above patella	48 cm	47 cm
Mid-patella	35.5 cm	35.5 cm
Maximal calf	36 cm	35 cm

Hips:

There is no tenderness to palpation of the trochanters bilaterally. There is no pain to rolling of the hips. Fabere and reverse Fabere are bilaterally negative.

Knees:

The knees appear normal to visual inspection. Alignment is normal. There is no swelling, effusion or synovitis. There is no patellofemoral pain, but there is crepitation on range of motion bilaterally. There is no medial joint line tenderness bilaterally. There is mild lateral joint line tenderness on the left. There is no increased temperature. There is no Baker's cyst bilaterally. McMurray and Apley tests are negative bilaterally. Anterior and posterior drawer and Lachman's are negative bilaterally. Patellar grinding is 1+ bilaterally. Medial and lateral collateral ligaments are bilaterally intact to varus and valgus stress.

Ankles and Feet:

There is no visible swelling, ecchymosis or hematoma. There is no pain to palpation of the joint lines bilaterally. Sub-talar motion is free and normal. There is tenderness to palpation about plantar fascia and left forefoot.

REVIEW OF X-RAYS:

X-ray of the Lumbar Spine, Imaging Medical Group, Approved by Am, M.D. Ph.D., 1/14/13: Radiographic examination of the lumbar spine reveals a posterior L3 to L5 instrumented fusion with osseous disc implants. Also seen is an anterior screw at L5. Alignment is intact. L2/3 osteophytes are evident and there is partial non-segmentation of L5/S1. Bone density is normal. The visualized joint spaces are well maintained. There is no evidence of acute fracture or dislocation. The soft tissues are unremarkable. The impression is of: a posterior L3 to L5 instrumented fusion with osseous disc implants; an anterior screw at L5; spondylosis, L2/3; a partial non-segmentation, L5/S1; and, no other abnormalities noted.

Review of Films: On January 25, 2013, I reviewed the films of this study. AP view revealed five lumbar vertebrae. The spine was straight. There was no rotation. There was partial lumbarization of S1 on the left side. There was evidence of a posterior and anterior fusion. The posterior fusion involved L4-5 and L5-S1

with pedicular screws. There was no crosslink bar. There was evidence of a midline anteroposterior screw at L5-S1. On the oblique views, there was evidence that all the pedicular screws are in the pedicle. Lateral view revealed sacrolumbar angle of 58 degrees and lumbar lordosis of 39.4 degrees. There was evidence of fusion at L5-S1. However, at L4-5, there is a radiolucent line surrounded by a sclerotic line between the vertebral body of L4 and the graft. There were mild degenerative changes at L3-4, above the fusion with a tiny anterosuperior osteophyte on the vertebral body of L4. There was also, in neutral, retrolisthesis of L3 on L4 measuring 3.3 mm on the lateral view. In flexion, the L3-4 listhesis measured 2.65 mm and 2.11 mm in extension. There was no evidence of failure of the hardware or radiolucency around L4 pedicular screws. In flexion, the radiolucent line between L4 and the graft measured approximately 2 mm. In extension, the radiolucent line was not visible and only the sclerosis was present. Comment: The x-ray findings suggest a possible non-union of the fusion between the distal vertebral plate of L4 and the graft.

X-Rays of the Lumbar Spine, XXX Hospital, Approved by ABC, M.D., 10/19/06: Impression: Status post interbody fusion at L4-5.

X-Rays of the Lumbar Spine, XXX Hospital, Approved by ABC, M.D., 10/19/06: Impression: Probe centered anterior at L3-4.

X-Rays of the Lumbar Spine, XXX Hospital, Approved by ABC, M.D., 10/19/06: Impression: Interval pedicle screw guide placement at L3 and L4.

X-Rays of the Chest, XXX Hospital, Approved by ABC, M.D., 10/09/06: Impression: Stable 6 mm nodule left lung base, unchanged over the two year interval confirming benign etiology.

REVIEW OF DIAGNOSTIC STUDIES:

CT Myelogram of the Lumbosacral Spine, Medical Imaging, Approved by ABC , M.D., 6/3/13: Impression: 1. CT myelogram revealed mild spinal stenosis at the level of L2-3 above the fused segment which appeared to be mostly compressing from posterior aspect of the facet joints area. 2. Osteoporosis of the vertebral bodies with evidence of mild partial compression deformity in the right side of L3 and L4. 3. Multi-level degenerative facet arthropathy at L2-3, L3-4, L4-5 and L5-S1. 4. Bilateral sacralization of L5 with pseudoarthrosis formation more in right side. This is mostly a transitional vertebra of L5.

Anatomical Impairment Measurements, Plain Films of the Lumbar Spine, 1/14/13, ABC, M.D., 8/8/13: DRE assessment revealed that more than one level of loss of translational motion integrity exists at L1-2 with 1.7 mm in flexion and -3.63 mm in extension for a difference of 5.33 mm, and at L2-3 with 2.95 mm in flexion and -5.59 mm in extension for a difference of 8.5 mm; and that there is more than one level of fusion exists at L3-4 and L4-5. ROM assessment revealed that this patient undergone surgical fusion (with or without decompression surgery) at L3-4 and L4-5.

DIAGNOSES:

1) STATUS POST MULTILEVEL LAMINECTOMY WITH DISCECTOMY AT L5-S1 9/16/04.

2) STATUS POST LUMBAR ANTERIOR PARTIAL VERTEBRECTOMY AT L5-S1; ANTERIOR INTERBODY FUSION AT L5-S1; L5-S1 CAGE, ANTERIOR INSTRUMENTATION AND DECOMPRESSION FROM L4 TO SACRUM, DR. X 10/19/06.

3) EXACERBATION OF LUMBAR SPINE PAIN AND LEFT SCIATICA; STATUS POST ANTEROPOSTERIOR FUSION AT L4-5, L5-S1 WITH FIXATION SCREWS, POSSIBLE NON UNION BETWEEN L4 BODY AND GRAFT; RETROLISTHESIS OF L3 ON L4, MEASURING 3.23 MM IN NEUTRAL, 2.65 MM IN FLEXION, 2.11 MM IN EXTENSION ON X-RAY 1/14/13.

4) MILD SPINAL STENOSIS AT LEVEL L2-3 ABOVE FUSED SEGMENT WHICH APPEARED O BE MOSTLY COMPRESSING FROM THE POSTERIOR ASPECT OF THE FACET JOINTS AREA; OSTEOPOROSIS OF THE VERTEBRAL BODIES WITH EVIDENCE OF MILD PARTIAL COMPRESSION DEFORMITY IN THE RIGHT SIDE OF L3 AND L4; MULTILEVEL DEGENERATIVE FACET ARTHROPATHY AT L2-3, L3-4, L4-5 AND L5-S1; BILATERAL SACRALIZATION OF L5 WITH PSEUDOARTHROSIS FORMATION MORE ON THE RIGHT SIDE; MOSTLY TRANSITIONAL VERTEBRA OF L5 ON CT MYELOGRAM OF THE LUMBAR SPINE 6/3/13. BY MY READING, PATIENT HAS TRANSITIONAL VERTEBRA; L4-5 AND L5-S1 ANTEROPOSTERIOR FUSION, FUSED WITH DEGENERATIVE CHANGES AT L3-4; 1.65 MM RETROLISTHESIS OF L3 ON L4 AND CENTRAL CANAL NARROWING MEASURING 8.33 MM WITH BILATERAL FORAMINAL STENOSIS.

5) GASTRITIS DUE TO MEDICATIONS.

CAUSATION:

The history is consistent with the mechanism of injury and the patient's complaints and findings on physical examination and diagnostic studies. There is no evidence of other factors before the continuous trauma injury from January 1, 2001 to January 1, 2002. The industrial injury on that date appears to be the cause of the patient's current symptoms and need for treatment.

DISCUSSION:

Mr. Smith is a 52-year-old mechanic whom I have followed for work related injuries. The patient has been treated conservatively, has had appropriate diagnostic studies, and has been evaluated by specialists as indicated. The findings and recommendations of all consultants are hereby incorporated by reference into this report.

It is my professional opinion that this patient's orthopaedic injuries have stabilized. No further significant improvement can be expected with additional conservative care. The patient has reached maximal medical improvement and can be considered permanent and stationary for purposes of rating. Impairment rating is performed in accordance with the AMA *Guides to the Evaluation of Permanent Impairment*, 5th edition.

The patient has required and continues to require transportation to medical and physical therapy appointments. This requirement is in effect until further notice.

Objective Factors of Disability:

Per physical examination and diagnostic studies summarized above.

Impairment Rating and Rationale:

TOTAL COMBINED WHOLE PERSON IMPAIRMENT: 41%

Lumbar Spine: The patient's lumbar spine condition is rated using the diagnosis-related estimates (DRE) method based on significant clinical findings and limitations of his daily activities. Clinical history and examination findings are compatible with injury on a continuous trauma basis. He underwent anterior and posterior lumbar interbody fusion surgery at L4-L5 and L5-S1 performed by Dr. Ghi on October 19, 2006. Examination revealed tenderness over the left lumbar paravertebral muscles, and bilateral sacroiliac joints. There is also decreased and asymmetric loss of range of motion. However, there are no significant signs of lumbar radiculopathy. With these findings, he is placed in DRE Lumbar Category IV with assigned 23% WPI. Ref: Chapter 15, pp. 379-384 (Table 15-3).

Station and Gait Disorders: Impairment in the lumbar spine is also assessed based on station and gait disorders as his spinal injury affected his lower extremities, which consequently limited his activities of daily living and functional capacity. Ref: Chapter 15, Table 15-6, Category C on page 396. As noted, the patient has positive subjective and clinical findings of left lower extremity radiculopathy. He reports weakness of the left more than right lower extremity. He presented with antalgic gait favoring the left. He uses a cane with the right hand. Walking on tiptoes and heels produces pain in the lumbar spine. He cannot perform a complete squat due to pain in the lumbar spine. As described below, he uses a cane for ambulation, and he can only sit, stand and walk for less than 15 minutes at a time. Climbing one flight of stairs is performed with a lot of difficulty. Based on these factors, he is placed in Class 3 with 20% WPI.

Combining the above values for the lumbar spine yields **38%** WPI per Combined Values Chart, p. 8-2, 2005 CA *PDRS*.

Digestive: Deferred to the appropriate specialist.

Pain: The burden of this patient's condition has been increased by pain related impairment in excess of the pain component already incorporated in the WPI rating under Chapters 3-17 of the AMA *Guides*, 5th edition. "If the individual appears to have pain-related impairment that has increased the burden of his or her condition *slightly,* the examiner may increase the percentage [of whole person impairment according to the body or organ rating system] by up to 3%." This conclusion is due to the fact that the patient performs most of his personal self-care activities with some help. He can only lift, push and pull very lightweight objects, uses a cane to ambulate, and perform light activity for at least two minutes. Climbing one flight of stairs is performed with a lot of difficulty. He can only sit, stand and walk for less than 15 minutes at a time. He has

a lot of difficulty reaching and grasping something off a shelf at chest level, and with forceful activities with his arms and hands. He cannot kneel, bend or squat. Most of the time pain interferes with his concentration and thinking. He has severe depression and anxiety. I have assigned an additional pain-related impairment of 3% WPI. Ref: Chapter 18, page 574, Figure 18-1, step 3.

Return to Work:

According to the functional capacity evaluation performed on July 9, 2013, this patient was capable of lifting 8 pounds from waist level, and carrying up to 3 pounds occasionally up to 30% of the work day. Floor lifting, shoulder and overhead lifting, pushing and pulling are self-limited due to increased pain. He could sit and stand for 30 minutes, and walk for 20 minutes or 0.5 mile continuously. His walking tolerance does not meet the DOT Demand Minimum Functional Capacity requirement of walking for one mile continuously (at 2mph). He was able to climb at least one flight of stairs, and reach for objects in all directions with each arm. Crouching and stooping is self-limited due to increased pain.

Future Medical Care:

The patient should have access to future medical care for exacerbation of symptoms in the lumbar spine which should include spine surgical consult and physical therapy, and return consultation with a pain management specialist for future epidurals or facet injections. He may require updated advanced diagnostic studies including CT myelogram if necessary, and a repeat EMG/NCV of the lower extremities if necessary. If his pain increases he should have access to prescription analgesic and anti-gastric medications.

Apportionment:

I have reviewed apportionment in light of the *Escobedo* decision. It is my opinion that, to a reasonable medical probability, 100% of the permanent impairment is a direct result of the industrial injury "arising and occurring in the course of employment" on a continuous trauma injury from January 1, 2001 to January 1, 2002, and none was caused by other factors, either before or after that date. There is no medical evidence of any symptoms, disability, or impairment prior to that date.

Thank you for the opportunity of evaluating and treating this patient. If there are any questions, please do not hesitate to contact me.

LABOR CODE §§4663, 4664:

I have discussed apportionment in the body of this report. If I have assigned impairment to factors other than the industrial injury, that percentage constitutes the apportionment. The ratio of non-industrial impairment, if any, to total impairment represents my best medical judgment of the approximate percentage of impairment or disability caused by the industrial injury and that caused by other factors, as defined in *Labor Code §§4663 and 4664*.

DISCLOSURE:

Transcription of this report was provided by eDATA Services, Inc.

I reserve the right to change my opinion based on additional medical evidence.

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 for information that I received from others. As for that information, I declare under penalty of perjury that the report accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Pursuant to Sections LC 5703 and 5307 (a) (1), I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise as compensation or inducement for any referred examination or evaluation.

Signed on _____, in the County of Los Angeles, California.

Sincerely yours,

_____
Christopher Lee, M.D., F.A.A.O.S., Q.M.E.
Diplomate, American Board of Orthopaedic Surgery

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