DR. X MEDICAL GROUP

11111 BROOKSHIRE AVENUE, SUITE 111
DOWNEY, CALIFORNIA 90241
(562) 904-7345 FAX: (562) 904.7345

December 6, 2011

Ally McBeal, Esquire
10000 Hollywood Blvd, Suite 100
Hollywood, California 91601.

Forever insurance
Post Office Box 100000
Oklahoma City, OK 72000

REGARDING:	**CRUZ, John**
DATE OF INJURY:	**September 13, 2010**
EMPLOYER:	**Metropolis Construction**
INSURANCE CARRIER:	**Forever Insurance**
CLAIM NUMBER:	**WCXXXXXXXX**
WCAB NUMBER:	**ADJ XXXXXXX**
DATE OF INITIAL EVAL:	**March 29, 2011**
DATE OF RE-EVAL	**September 8, 2011**
DATE OF CURRENT REPORT:	**December 6, 2011**

PANEL QUALIFIED MEDICAL EVALUATOR'S PERMANENTAND STATIONARY REPORT AND REVIEW OF MEDICAL RECORDS

Dear Gentlepersons:

This Permanent and Stationary Report is being billed as an ML 106-95 and represents a total of 4 hours in reviewing Mr. Cruz's medical records for the period September 29, 2010 through August 19, 2011, a review of my prior medical reporting, addressing his subjective factors, objective findings, work restrictions, my assessment of impairment, the need for both vocational rehabilitation and future medical care, addressing causation and apportionment and preparation of this report. My comments and medical opinion are as follows:

Since last being seen on April 1, 2011 I have been provided with additional medical records for my further review and comment.

REVIEW OF ADDITIONAL MEDICAL RECORDS

09/29/10 JOHN CARTER, M.D.
Progress Report — Pain is 10/10 still. DIAGNOSIS: Acute lumbar radiculopathy. PLAN:

Tylenol with Codeine, Naprosyn, Morphine sulfate IM, off work. DC to ortho, Dr. Owens.

01/19/11 GREGORY HOUSE, M.D.

OPERATION: 1. Lumbar transforaminal epidural steroid injection at L4, L5, and S1 right side. 2. Epidurography (nondural puncture myelogram). 3. Fluoroscopic interpretation of nondural puncture myelogram. 4. Fluoroscopic guidance. PRE/POSTOPERATIVE DIAGNOSIS: 1. Lumbosacral disc disease at L3-4 and L4-5 with a 4mm disc protrusion with moderate narrowing at the right L3-4 and right L5-S1. 2. Lumbar radiculopathy more on the right at L5 and SI dermatomes with some L4 contribution. 3. Lumbar facet arthropathy at L4-5 and L5-S1 bilaterally more on the right.

02/23/11 GREGORY HOUSE, M.D.

OPERATION: 1. Lumbar transforaminal epidural steroid injection at L4, L5, and SI on the right side. 2. Epidurography (nondural puncture myelogram). 3. Fluoroscopic interpretation of nondural puncture myelogram. 4. Fluoroscopic guidance. PRE/POSTOPERATIVE DIAGNOSIS: 1. Lumbar radiculopathy more on the right at L5 and S1 dermatomes with some L4 contribution. 2. Lumbar disc disease, L3-4 and L4-5 with a 4mm focal disc protrusion with right neural foraminal narrowing. 3. Lumbar facet arthropathy. L4-5 and L5-S1, more on the right.

03/03/11 DEREK SHEPARD, M.D.

Progress report — Persistent back and leg complaints. DIAGNOSIS: Right-sided 15-SI foraminal disc herniation with tight lower extremity radiculopathy. PLAN: Candidate for lumbar epidural injection. He may ultimately require surgery. Hydrocodone/APAP RX. TTD.

05/05/11 DEREK SHEPARD, M.D.

Progress Report — Persistent back and leg pain. Needs lumbar surgery. MRI scan not yet available for review. DIAGNOSIS: Right-sided L5-S1 foraminal disc herniation with tight lower extremity radiculopathy. PLAN: Final decisions to be made once MRI scan is reviewed. Hydrocodone/APAP and Tramadol/APAP RX. Return in 4 weeks. TTD.

06/02/11 DEREK SHEPARD, M.D.

Progress Report and Request for Authorization — COMPLAINTS: He had LESI's helping his leg pain significantly. Did not help his back pain to the same degree. MRI scan reviewed done on 05/04/11 personally, noting disc desiccation at L3-4 and L5-S1. At L5-S1, there is a right-sided disc herniation which is causing central and lateral recess stenosis. There is neuroforaminal stenosis as well as stenosis on the right side. DIAGNOSES: 1. Right-sided L5-S1 foraminal disc herniation with right lower extremity radiculopathy 2 disc desiccation with right-sided neuroforaminal stenosis. 3. Right-sided 15-SI disc herniation with disc desiccation. 4. Right lower extremity radiculopathy. PLAN: A fusion is likely necessary if he is to improve. He needs to have a discography done first at L3-4, L45 and L5-S1 levels to determine this. MRI scan of the lumbar spine to be used to control a level. Medrox ointment,

tizanidine, Tramadol/APAP, Zolpidem and Omeprazole RX. Return in 4 weeks. WORK STATUS: TTD.

08/19/11 HANNIBAL LECTER, M.D.

Initial Psychological Comprehensive ML Evaluation — COMPLAINTS: Symptoms have progressed causing more stress and inability to function fully, both at home and at work. Severe pain in back and right leg. Emotional and psychological, symptoms. Often has tension. Trouble sleeping and feels tired and fatigued. Worries about his future, health and career. Pre-occupations with happenings at work. Thoughts of exhaustion. Self-doubt due to his physical injuries. Persistent physical pain. He was asymptomatic prior to the work related injury and now has psychiatric consequences from the physical injuries while working for Metropolis Construction. HISTORY: 41 year Old male, cement foreman for Metropolis Construction. Industrial injury in 09/10 to his back and right leg. He is off work on temporary medical leave. Feels troubled by pain. Wants to get better and return to work. IMPRESSION: Axis I: Adjustment disorder with depressed mood, Axis II: Diagnosis deferred. Axis III: Physical disorders and conditions: as diagnosed by appropriate examining specialists. Axis IV: Severity of psychosocial stressors: medical problems, pain and physical limitations, financial problems. Axis V: GAF: current 63 and prior year is unknown. WPI: 11%. RECOMMENDATIONS: He is to get stress treatment using biofeedback. Referral to a sleep clinic for sleep disturbance recommended. Deep muscle relaxation exercises and/or biofeedback exercises recommenced. He is to adhere to strict sleep Induction routine, daily exercise, low stimulation prior to sleep, relaxation training, and bland diet to help with sleep problems. Weekly stress and pain management therapy would be useful.

DISCUSSION

As you will recall, I did have the pleasure of evaluating Mr. Cruz in my capacity as Panel Qualified Medical Evaluator on several occasions. He was initially seen on March 29, 2011 and was re-evaluated September 8, 2011 for his ongoing low back complaints as it relates to the specific injury of September 13, 2010. I have authored several reports with regard to his orthopedic condition, with my most recent reporting September 12, 2011 following my September 8, 2011 re-evaluation.

I have since that time, been provided with additional medical records which are summarized above.

As the parties will recall, in my previous reporting, I did note that Mr. Cruz had ongoing significant lower back complaints with radiation into the right lower extremity. He did have clinical findings consistent with a lumbar radiculopathy. I also had the opportunity to review an updated MRI study of the lumbar spine, which was performed at my request which revealed evidence, for multiple level lumbar disc protrusions, as well as multilevel lumbar stenosis. The most significant finding was at L4-5 where there was a broad-based 5mm disc protrusion present causing bilateral neural foraminal stenosis.

At that time, it was noted that he had undergone some lumbar epidural steroid injections, which did provide him with some relief but since the relief was not permanent, he did not wish to proceed with any additional epidurals.

It was noted at that time that his low back complaints became so severe that he did have to present to the emergency room at St. Francis Medical Center and was provided an injection of morphine.

At that time, he did tell me that Dr. Shepard, his primary treating physician was requesting surgical intervention and, although I did indicate that he may be a candidate for a lumbar spinal surgery, I requested a review of Dr. Shepard's reporting before making that determination.

At this point, additional medical records have been provided. He did see Dr. Carter in September of 2010 and at that time had severe low back pain. He is diagnosed as having acute lumbar radiculopathy and was given an Injection of morphine, as well as Tylenol with Codeine and Naprosyn.

There are some medical records from Dr. House which outline the epidural procedures that were performed in January and February of 2011.

When he returned to Dr. Shepard in June of 2011, it was noted that the lumbar epidural steroid injections did help his leg pain significantly, but did not help his back pain to the same degree. This would certainly seem accurate as epidural injections focus on radiculopathy rather than the tow back complaints.

Dr. Shepard at that time indicated that a fusion surgery was likely necessary and recommended discography at the levels of L3-4, L4-5, and L5-SI.

Of particular interest, I noted an August 19, 2011 psychological evaluation with Dr. Lecter. He diagnosed Mr. Cruz as having an adjustment disorder with depressed mood.

This is certainly troubling as numerous studies have shown that discography is unreliable in the face of depression and therefore, considering his psychologic condition, it is my opinion that a discogram would be inappropriate.

As to the need for surgery, the fact that he now has been diagnosed with depression. I am extremely reluctant to recommend anything surgically as patients with depression make remarkably poor surgical candidates.

I think at this point in time, until he can be cleared psychologically, it would be best to make him permanent and stationary and maximum medical improvement as of my Panel Qualified Medical Evaluation of September 8, 2011.

He should be rated for the following factors of permanent disability:

SUBJECTIVE FACTORS

Lumbar Spine

Constant slight but less than moderate pain, becoming frequently moderate and occasionally moderate to severe.

OBJECTIVE FINDINGS

Lumbar Spine

1. Limitation of lumbar spine range of motion.
2. Tenderness to palpation.
3. Positive Kemp's test.
4. Positive right straight leg raise test.
5. Positive Braggard's test, right.
6. Diminished sensation lateral aspect of right lower leg.
7. MRI findings showing multiple level lumbar disc protrusions.

WORK RESTRICTIONS

Work restrictions for the lumbar spine preclude heavy work.

IMPAIRMENT DETERMINATION ACCORDING TO AMA GUIDES TO PERMANENT IMPAIRMENT FIFTH EDITION

It is my opinion that Mr. Cruz has reached a point of maximum medical improvement, which, according to Chapter 1, Page 2, means that this patient's condition "is well stabilized and unlikely to change substantially in the next year with or without medical treatment."

I am aware that as of January 1, 2005, residual permanent impairment was to be determined utilizing the ***AMA Guides to the Evaluation of Permanent Impairment.*** *5TH Edition*. I will therefore now provide my calculations and determination regarding the permanent impairment in compliance with these guidelines.

Mr. Cruz has evidence for multiple level lumbar disc protrusions with multilevel lumbar central canal and neural foraminal stenosis. Once again, there is a 3mm disc protrusion, at the level of L3-4, and bilateral neural foraminal stenosis, and mild to moderate spinal canal stenosis. At L4-5, a 2-3mm disc protrusion is present causing mild central canal stenosis. At L4-5, there Is a broad-based 5mm disc protrusion present causing moderate right mild to moderate left neural foraminal stenosis. Considering the three level involvement$_1$ I would provide a 9% whole person impairment according to Table 15-7, I have reviewed all of the criteria contained in the AMA Guides and correlated this criteria with the patients history and findings. I feel that this patient qualifies to be rated utilizing the *range of motion method* according to Chapter 15,

section 15.2, pages 379-381.

I have measured this patient's lumbar spine range of motion utilizing the inclinometer technique as outlined in the ***AMA Guides,*** *5th Edition,* Chapter 15, pages 400 to 421 and figures 15-8 and 15-9. This technique has been shown to be the most accurate anti accepted approach to evaluate range of motion. Please refer to page 3 of the attached report of impairment evaluation for the specific findings with regards to this patient's lumbar spine range of motion. According to Chapter 15, pages 398-403, 405-411 and tables 15-B to 15-9, the calculated impairment regarding this patient's lumbar spine range of motion is ***15%*** whole person.

The total combined whole person impairment regarding Mr. Cruz can be determined to be 23% for his lumbar spine,

VOCATIONAL REHABILITATION

Mr. Cruz Cruzs not retain the functional capacity to return to his pre-injury work duties. Therefore, he is a candidate for vocational rehabilitation.

FUTURE MEDICAL CARE

Concerning future medical care, certainly return visits to his primary treating physicians, refills of anti-inflammatory and analgesic medications would be appropriate. Additional lumbar epidural steroid injections would also be appropriate.

Considering surgical intervention, I am extremely reluctant to recommend surgical consultation or intervention in the face of his diagnosis of depression. However, if he is ultimately psychologically cleared, a lumbar surgery may ultimately be required.

As far as physical therapy, short course of physical therapy would also be appropriate as well as use of a lumbar support.

Certainly, repeat MRI and electrodiagnostic studies should also be made available as part of future care.

CAUSATION/APPORTIONMENT

There is no change in my medical opinion with regard to causation, as initially reported on March 29, 2011. I continue to believe that Mr. Cruz did sustain a specific injury on September 13, 2010 at which time he was pulling a hose over his shoulder when he experienced pain in his lower back,

His need for medical care and periods of disability are directly attributable to his specific injury of September 13, 2010.

I have reviewed the criteria's mandated by Labor Code Sections 4663 and 4664, as changed by Senate Bill 899 with regard to apportionment. I have also reviewed the legal decision in the matter of Marlene Escobedo.

In my opinion, there is no basis here for apportionment. I would attribute 100% of his recorded impairment to his specific Injury of September 13, 2010.

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,

_____
DOUGLAS HOWSER, M.D., QME

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February 22, 2014

SAMPLE

REGARDING:	**CRUZ, John**
DATE OF INJURY:	**September 13, 2010**
EMPLOYER:	**Metropolis Construction**
INSURANCE CARRIER:	**Forever Insurance**
CLAIM NUMBER:	**WCXXXXXXXX**
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DATE OF INITIAL EVAL:	**March 29, 2011**
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PERMANENT DISABILITY RATING ANALYSIS

This feedback report concerns industrial injuries claimed by John Cruz on September 16, 2010 while employed as a construction foreman with Metropolis Construction. A copy of a panel qualified medical evaluation report by Dr. Douglas Howser, dated December 6, 2011, has been provided for reference.

The rating string used an occupational group number of "480," which is viewed as reasonable in the context of the applicant's involvement in construction. The applicant is 40 years old on the date of injury.

DISCUSSION

Dr. Howser determined the applicant's lumbar spine permanent disability by using the ROM method secondary to multilevel involvement or pathology noted in the lumbar spine. In interviews with Gunnar Anderson, M.D., the senior orthopedic editor of the *Guides* as well as Robert Haralson, M.D., the chapter chair of the spine chapter, it is made clear that degenerative disc disease is not a basis for a range of motion method rating, but rather it is multilevel radiculopathy. The reviewer considered the indications for using the ROM method per page 398 of the *Guides*. The applicant only presented with findings consistent with right-sided radiculopathy following the L5 nerve root distribution. There was also no indication that the radiculopathy is recurrent. The reviewer opines that the DRE method is the most accurate method of rating in this case.

Per table 15-3 on page 384 of the *Guides*, the applicant's lumbar spine impairment would most accurately fall under DRE Lumbar Category III, which corresponds to 13% whole person impairment. The following permanent disability rating and dollar value are derived.

BODY PARTS	PERMANENT DISABILITY RATING
Lumbar Spine – DRE method	15.03.01.00 13 [5]17 480I 23 23
P.D. DOLLAR VALUE: = $20,815.00	

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