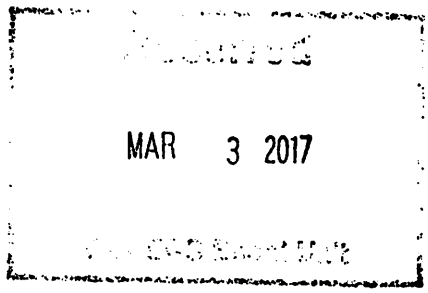
ATTACHMENT C

RESPONDENT'S ARGUMENT

March 02,2017

Rosa Maria Ponce



Attention: Cheree Swedensky, Assistant to the board

Dear Cheree Swedensky,

I am very disappointed with Dr. Brooks decision but not surprised because he is an orthopedic surgeon he has only seen three patients regarding medical legal work such as conducting IME's for Calpers as he mentioned on November 16, 2016 at the administration hearing in Sacramento also disappointed that you didn't take under consideration the report from Dr. Matthew D Johnson DO who is a specialist in this field also Dr. Andrew Bert and Dr. Ethelinda Tolentino. On July 8, 2014 I saw Dr. Angela Tanglo my second appointment was on 09/09/14 and was canceled because she became very ill. I was informed that she might not be coming back and had to find another neurologist that's they never sent you the medical report.

I believe that Dr. Brooke focus only on the accident at 8/17/12 during the years I work for the school district I had other accident and was never treated for them.

On 04/06/2016 while making deliveries my right leg slipped from the ramp that is about 2 feet high and I hurt my back and hurt my leg and twisted my ankle.

2008 I fell on the floor hit my buttocks and back of head I called the nurse and she said it was not necessary to see a doctor and lost to report till this day it was never found.

09/10/2010 my coworker spilled hot oil on the floor when I went to turn on the oven off the oven I slipped and did the splits and was unable to get back up by myself, Shelly came to help me get up.

08/17/2012 while transferring milk from one color to another milk cooler I was injured again and I hurt my neck and back.

11/02/2012 while opening the filling draw I hurt my lower back again even Dr. Kitchen said it was the same injury I don't agree with him because I got worse after that.

Even though I kept on working with the pain I would take pills before work and after work it got worse after the accident on 09/10/2010 my legs and hands would go numb but even though I was still working. After the accident on 08/17/2012 and 11/02/2012 made it made it worse. Every accident left a sequence on my body. Now I suffer from upper middle and lower back pain with numbness in feet and hand severe headaches and vision problems also carpotunnel and neuropathy of the hands and feet and depression.

Dr. Brooks mention that I had back problems in the past and headaches yes but it was a different pain and was taken care of before I started working in the school district you are talking about medical history from 1989 which has nothing to do a present medical. I was in good health when I started working and now I'm not. All these accidents has taken a great toll on me physically mentally and emotionally.

Enclosed you will find a copy of medical records from Dr. Matthew D Johnson OD if you need any information please call me at

Thank you for taking the time to look into this matter.

Sincerely,

Rosa Maria Ponce

CAUSATION: Ms. Ponce has suffered from work-related injuries which reportedly occurred in April 5, 2006, an injury on an unknown date in 2008, September 30, 2010, August 17, 2012 and on November 2, 2012 during the course of her employment as a cafeteria assistant for Fairfield-Suisun Unified School District.

I have considered causation in each of these cases:

- In regards to the 2006 reported injury there is no documentation in the medical records that have been provided that support the patient's claims. It is simply not possible to consider causation for an industrial injury 8 years after the reported incident without any supporting evidence. There is mention in JANUARY 2006 by Dr. Saavedra of waking up with left leg pain and bruising. No mention is made of right ankle pain or an industrial injury that I can see in the 2006 records. With only the patient's subjective report I do not think it is reasonable to consider industrial injury from this reported injury. If there is any other evidence of a specific industrial injury I would need to review this or if there is a question of factuality I would defer to a trier of fact

- In regards to the 2008 reported injury where the patient states she fell on the floor in the kitchen and hit her buttocks and head resulting in chronic buttock pain I did not see any supporting medical records discussing the reported injury. Again, without any supporting documentation or records it is not possible for me to consider industrial causation for this reported injury

- In regards to the 9/30/2010 injury where the patient states she slipped on oil and fell to the ground resulting in back pain, again, there are no medical records to evaluate or supporting evidence to consider an industrial injury in this circumstance. If other records exist this would need to be reconsidered

In regards to the 8/17/2012 injury: the patient has filed a claim for the neck, shoulders, back, eyes and head which has been accepted as low back injury only. In this claim the patient was moving crates of mild to the refrigerator. A case of milk was going to fall. She twisted and had sudden sharp pain of the neck, mid-back, low back by report

In March of 2012 there is a note from Dr. Ayeung documenting low back pain and abdominal pain. Xray at this time revealed spondylolisthesis. In April of 2012 the patient was diagnosed with low back pain and sacroiliac joint strain. She had continued working at that time. April 6,2012 not document progressively worsening back pain which did not resolve. She had pelvic pain and dyspareunia. Xray in May of 2012 documented degenerative changes of the right foot. The patient had evaluation from Dr. Kitchens August of 2012 following the 8/17 injury with a diaganosis of Sacroiliac pain. The initial note does not prominently mention neck pain or thoracic pain, however, subsequent notes discuss neck pain from this injury (Aug 22, 2012, Jan 10, 20130). In the records it appears the treatment was directed primarily at the low back

It is my medical opinion that the patient's history, medical records and clinical presentation are consistent with an industrial injury to her Cervical, Thoracic, Lumbar spine which occurred 8/17/2012 as a result of the lifting incident.

The patient had well documented vision issues prior to 2012 and to a degree of medical probability I cannot see any reason to consider industrial injury to her eyes.

The patient had well documented history of migraine headaches, dizziness prior to the specific incident of 2012. In my medical opinion there is no evidence to consider industrial causation to these body parts.

In Regards to the 11/2/2012 injury which was reported while on modified duty for the previous injury. She reported this injury to the low back while moving files which by report resulted in worsened back pain. According to the record from Gary Hollinger from November 8th, 2012 the patient's symptoms remained largely unchanged in terms of location and quality as well as radiation. The patient was still in treatment for the 8/7/2012 injury. It is my opinion, to a degree of medical probability that the reported 11/2/2012 injury was a flareup of the 8/17/12 injury and would be considered a part of that injury rather than a new specific injury. The treatment plan did not appear to change dramatically, nor did the physical symptoms or examination.

APPORTIONMENT: Apportionment is carried out with considerations for Senate Bill 899, the California State Worker's Compensation Labor Code, Sections 4663 and 4664, and the Escobedo vs. Marshalls case. I understand that I am to consider and may apportion to any pre-existing or subsequent issues, prior awards, non-industrial issues.

A review of the records reveals the patient had chronic pain at the extremities, neck, head in 2007 and had been evaluated for inflammatory arthritis in the past. In a note from Dr. Saavedra from March 29, 2007 it is noted the patient had mid back pain, neck pain, chest pain, headache, rotator cuff tendonitis. In 2008 she was noted to have left groin pain. The patient has a documented history of osteopenia. She also has previously documented neck pain, low back pain. The patient had low back pain documented prior to her specific injury of 8/7/2012, however, had been able to continue working full duty until the injury on that date and subsequently had more severe pain and increased functional limitations.

As documented in the causation section it is my opinion there is medical evidence to support the presence of an industrial injury occurring 8/7/2012 to the neck, mid, low back only.

Considering the pre-existing non-industrial issues in this circumstance it is apparent that apportionment is necessary. It is my medical opinion, to a degree of medical probability

that 70% of her permanent disability is related to the industrial injury sustained August 17, 2012. The remaining 30% is apportioned to non-industrial pre-existing chronic strain, sacroiliac pain, degenerative joint and disc disease and subsequent injury in motor vehicle accident. In this circumstance I have apportioned the majority of the disability to the industrial injury based on the decline in functional state resulted from the accepted 8/17/12 injury. Prior to this injury the patient had been able to maintain full time, full duty employment without level of treatment required following the specific injury. I considered whether the pre-existing issues would have led to the patient's decreased level of function on their own and it is my medical opinion they would not have and that the industrial injury was the catalyst resulting in the majority of the patient's limtations, impairment and resulting disability.

I reserve the right to alter my opinions in light of any additional submitted medical information that may be presented subsequent to this report.

PERIODS OF TEMPORARY DISABILITY: The patient was temporarily totally disabled from April 17, 2013 until she returned to modified duty on May 15, 2013. She was subsequently taken off of work temporarily totally disabled by her acupuncturist but the dates are unclear. She should be considered administratively temporarily totally disabled for any periods of unaccomodated modifed duty.

MAXIMUM MEDICAL IMPROVEMENT: The patient has not yet reached maximum medical improvement (MMI) as it is my opinion that there is a need for new MRI scans and x-rays of the affected areas as well as a referral to a pain specialist of physiatrist for evaluation. However, as it has been two years since the injury I will provide a tentative impairment rating which will is unlikely to change with new imaging

PERMANENT DISABILITY RATINGS: A tentative rating is presented below as it has been two years since the initial injury. The rating is unlikely to change with further treatment or imaging.

The AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition is used in determining the impairment rating.

For the determination of the cervical spine impairment, the diagnosis-related estimates (DRE) method is used. Referencing Chapter 15, Section 15.6, Table 15-5 on page 392, her cervical spine condition falls under DRE Cervical Category II due to the presence of spasms and tenderness to palpation over the bilateral trapezius muscle areas and restricted range of motion. She is assigned 8% whole person impairment to the cervical spine based on ongoing symptoms and complaints at the cervical spine

For the determination of the lumbar spine impairment DRE method is used. Referencing Chapter 15, Section 15.4, Table 15-3 on page 384, I would assign the patient with 12% WPI based on DRE Lumbar Category III due to the presence of restricted range of mo-

tion and lumbar radiculopathy with decreased sensation to monofilament testing at the lateral aspect of the foot

For the thoracic spine turning to page 389, chapter 15, Table 15-4 the patient would fall under a DRE category II based on the presence of hypertonicity and spasm and would fall at the lower end of the provided range (5-8%) and I feel that a 6% WPI would be most clinically accurate based on the patient's ongoing complaints and symptoms

Pain: The burden of the patient's condition has been increased by pain-related impairment in excess of the pain component already incorporated in the Whole Person Impairment (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 by up to 3%." This conclusion is based on the fact that he continues to have significant pain that affects his performance of activities of daily living. Therefore, I have assigned an additional 3% WPI pain-related impairment for the pain experienced by the patient on her neck, and low back. Ref: Chapter 18, page 574, Figure 18-1, step 3, AMA Guides.

Combining the Cervical, Lumbar, Thoracic ratings and adding 3% for chronic pain results in: 27% WPI

ALMARAZ-GUZMAN DECISION: I have considered Almaraz-Guzman II WCAB decision. In this circumstance it is my opinion that the provided standard AMA guides ratings are clinically accurate and Almaraz-Guzman rating is not necessary

I reserve the right to alter my opinions in light of any additional submitted medical information that may be presented subsequent to this report.

DISPUTED MEDICAL ISSUES: In this circumstance, there are no specific disputed medical issues I am aware of outside of the denied claims.

FUTURE MEDICAL TREATMENT: The patient should have new MRI scans for the cervical and lumbar spine to rule out herniation as well as new x-ray of the cervical spine, lumbar spine. The patient has decreased sensation to monofilament testing at the right foot. She should be referred to psychology/psychiatric evaluation for pain coping skills. NCS/EMG of the bilateral upper and lower extremities to evaluate for radiculopathy is also recommended. A trial with Cymbalta or other SNRI medication should be considered for musculoskeletal and neuropathic pain. ESI versus MBB/RFA should also be considered after review of imaging results. I would recommend a referral to a pain specialist or physiatrist for management of her pain issues for consideration of multidisciplinary treatment of her pain as described above. If the patient chooses not to pursue further treatment or imaging she would be at MMI at that time.

VOCATIONAL REHABILITATION/QUALIFIED INJURED WORKER: Vocational rehabilitation/qualified injured worker determination will be provided once the patient is declared MMI.

WORK PRECLUSIONS: The patient is has restrictions of lifting a maximum of 25 pounds occasionally, 10 pounds frequently and no repetitive flexion, extension, or rotation of her neck.

This report was prepared in compliance with Labor Code 4628. The history was taken directly from the applicant by the examining physician. The examining physician reviewed the submitted medical records and performed the entire physical examination. The examining physician composed this report.

I swear under penalty of perjury that to the best of my information and belief, I have not violated California Labor Code Section 139.3 because 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 indictment for any referred examination or evaluation.

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

This report was executed in Contra Costa County, California, on the date given above at the beginning of the report.

MATTHEW JOHNSON, D.O., Q.M.E
Board Certified Physical Medicine & Rehabilitation
Board Certified Pain Management
License #: 20A10073

MJ: jca/abu/mms