ATTACHMENT C

RESPONDENT'S ARGUMENT

RESPONDENT'S ARGUMENT
IN RESPONSE TO APPEAL OF REINSTATEMENT FROM DISABILITY RETIREMNT

To: Board Service Unit Coordinator
From: Edgardo Silva
Date: May 24, 2026
Re: Appeal of reinstatement from disability retirement (Ref. No. 2025-1011)

I am respectfully submitting this argument in response to the appeal concerning reinstatement from disability decision issued in a letter received on May 12, 2026. The original appeal I made was on November 22, 2024. After reevaluation of Doctor Nasser Heyrani whose specialty is foot and ankle and resulting, according to him in reinstated to my previous position as Electrician II.

As stated in the appeal letter, his evaluation lasted less than 10 minutes and only based on observation of my lower back and made me move up and down my right shoulder. My condition is not only my right shoulder but both shoulders, but my lower back, foot, knee, neck, hands, arms and especially constant pain all over my body been the lower back is the most critical area as the pain radiates all the way down to the feet. My condition has not improved to the point of being no longer substantially incapacitated from performance of my duties as electrician II with Department Of Transportation District 07, as he states in his report. Considering that Dr. Nasser Heyrani is not a shoulder, spine specialist nor pain management doctor, and his medical report was just to fill out the paperwork as he told me. I did appeal and go through all this process not to get advantage of the system but because the pain that my condition causes me has truly limited me in my daily life. For this reason, I sought to insure continued medical care following the conclusion of my workers' compensation claim.

Since I started in Caltrans as an Electrician, I have worked pulling wire from a distance of 100 feet or more. This wire, when its pull weight 10 to 15 pounds each pull each pull. The weight increases each pull, while arms get tired as well in this task hands, arms, back and knee is involved, This type of work I had to do it constantan for about three to four days a week per about 10 year combine with installing traffic signal heads, pole, lights, traffic signal cabinet all these components can weight from 10 to 100 pounds all this component I had to move or dragging them sometimes without help.

Traffic signal work consists not only in cleaning and checking the timing program, but also in replacing all components like a service cabinet that can weigh close to 200 pounds. Although we use a crane to lift, we must push and pull to set up on the

base. Changing a traffic light consists of going on the bucket lift and working overhead to install them. This kind of work I have been doing for about 10 years, 3 to four days a week, combined with replacing halogen street-lights with LED street-lights (Highway lights)

Halogen street-lights can weigh between 40 and 80 pounds depending on the model. I had to replace these old lights with the new LED lights many times by myself without help. I had to load the truck and drive to different places on the freeway, remove old lights and install new ones. This is this kind of work. I have done it for almost two years, all the time, working overhead until I got to the point that I can't hold these lights for much longer these lights, I had to rest several times to install one of the lights.

Installing security boxes (anti-wire theft) These metal boxes can weigh from 70 to close to 200 or more. I was doing this kind of 4 to 5 days a week. This task consists of loading the truck with several cement bags that weigh 94 pounds each without help. Once on the place of work, unload and carrying them on uneven terrain, prepare the cement and pour it into a hole that we had to dig to install the security box. Also, I must unload the security boxes several times without help and drag them were going to be installed.

The job description that is given for this job classification, as electrician, it does not always reflect the reality of the work performance that I was doing at that time when I started at Caltrans. As described above, many times I must do the work by myself. In recent years, they started to enforce the safety that we must have to do the work on these dangerous freeways, highways and streets, but many times I had to install many freeway lights, traffic heads and lights by myself without backing up just a few cones per request of my supervisor.

CONCLUSION

I object that the decision is solely based on the evaluation made by Doctor Nasser Heyrani, whose specialty is foot and ankle, not shoulder, spine specialist or pain management doctor, and his medical report was just to fill out the paperwork as he told me. I have been evaluated by many specialists for my condition, and as stated in their reports, my condition wasn’t temporary, it is permanent and not improving. For all this time, I have been struggling with severe pain that incapacitated me from performing my usual job duties, even my daily activities, causing me pain not discomfort. It is chronic ongoing lumbar, feet, knees, back, shoulders, hands, arms,

neck (all over my body). It has progress. It has not gotten any better. It is a condition of pain, stiffness, and mobility which restricts my ability to perform even in daily life activities like walking, sitting and standing for short periods of time. It has been so much that I had to seek medical attention again. I will attach the medical report with the restrictions imposed by the doctor that I am seeing.

Respectfully submitted,

Edgardo Silva Valdovinos
[redacted]

Spectrum Medical Group

Work Status

Patient Name: Edgardo Silva
DOB: [redacted]
Exam Date: 05/01/2026
Follow Up: 06/05/2026

Work Status		
☐	Deferred to Primary Treating Physician	
☐	TTD (Total Temporary Disability)	☐ 30 days ☐ 45 days ☐ next visit
■	**Return to work with modified Duty on: 05/01/2026**	**No lifting more than 10lbs. No pushing/pulling more than 10lbs Avoid repetitive/prolonged: bending/stooping, twisting, kneeling/squatting, gripping/grasping Avoid above the shoulder activity Alternate between sitting and standing as needed TTD if modified duties not available**
☐	Return to Full Duty on	

☐ Per AME Dated:	☐ Per PQME Dated:	☐ Per P&S Dated:

Work Restrictions	
☐ No / ☐ Limited use of: _____	_____ ☐ min / ☐ hrs / ☐ day(s) / ☐ continuous
☐ No / ☐ Limited kneeling and/or squatting:	_____ ☐ min / ☐ hrs / ☐ day(s) / ☐ continuous
☐ No / ☐ Limited stooping and/or bending:	_____ ☐ min / ☐ hrs / ☐ day(s) / ☐ continuous
☐ No / ☐ Limited standing or walking:	_____ ☐ min / ☐ hrs / ☐ day(s) / ☐ continuous
☐ No / ☐ Limited overhead work:	_____ ☐ min / ☐ hrs / ☐ day(s) / ☐ continuous
☐ No / ☐ Limited climbing: (stair/Ladder)	_____ ☐ min / ☐ hrs / ☐ day(s) / ☐ continuous
☐ No / ☐ Limited sitting:	_____ ☐ min / ☐ hrs / ☐ day(s) / ☐ continuous
☐ No / ☐ limited: ☐ lifting ☐ Pushing ☐ Pulling	☐ 5 lbs ☐ 10 lbs ☐15 lbs ☐ 20 lbs ☐ 25 lbs ☐ 35 lbs ☐ 45 lbs ☐ OTHERS: _____
☐ Semi-Sedentary Work	☐ Sedentary Work
☐ Must Wear ☐ May Wear:	☐ Splint ☐ Immobilizer ☐ Back Support ☐ _____ Brace ☐ OTHER _____
☐ Must be able to stand and sit at will	☐ Keep Wound/Bandage clean and dry
☐ No forceful ☐ No Repetitive	☐ grasping ☐ gripping ☐ torqueing ☐ RUE ☐ LUE
☐ No forceful ☐ No Repetitive	☐ Pushing ☐ Pulling / ☐ RUE ☐ LUE
☐ No Repetitive	☐ Bending ☐ Stooping ☐ turning ☐ Cervical Spine ☐ Lumbar spine
☐ No Prolonged positioning of cervical spine (Fixated Head positioning)	
☐ Must have a ____ minute break every _____ ☐ min / ☐ hrs/	

Physicians Signature: Nicole, Record Date: 05/01/2026

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Lic: DC21989

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June 19, 2021

WORKERS' COMPENSATION APPEALS BOARD
Disability Evaluation Unit
320 W. 4th Street, 9th Floor
Los Angeles, California 90013

EMPLOYEE	:	**EDGARDO SILVA**
EMPLOYER	:	Cal Trans
D/INJURY	:	CT: May 4, 2009 – April 30, 2018 August 3, 2017
CLAIM NO.	:	06304052; 06363436
WCAB NO.	:	ADJ11095415; ADJ11300786
EXAM DATE	:	June 19, 2021

ORTHOPEDIC PANEL QUALIFIED MEDICAL RE-EVALUATION REPORT:

Gentlepersons:

This is an **ORTHOPEDIC PANEL QUALIFIED MEDICAL RE-EVALUATION** performed in the County of Los Angeles at 2760 E. Florence Avenue, Huntington Park, California 90255, on June 19, 2021.

ML201-95 is billed, noting 20 minutes face to face time. In addition, I declare under penalty of perjury that I have received and personally reviewed 1211 pages of medical records which included a declaration and attestation.

CURRENT COMPLAINTS:

NOSE: The examinee complains of recurrent nasal congestion and dryness in his nose. He notes recurrent blood in his mucus. His symptoms are aggravated with the change of weather. He notes no specific treatment that alleviates his symptoms.

Since his last evaluation, his nose issues have remained the same.

NECK: The examinee complains of recurrent dull and pins and needles pain in the neck, with pain radiating to his shoulders and upper back. He has recurrent headaches with associated nausea, blurred vision, and vomiting. He has continuous numbness and tingling in both upper extremities. Weakness is noted in both upper extremities. He notes popping and stiffness in his neck. His symptoms are aggravated with turning his head from side-to-side, looking up and down, tilting his

head to the sides, keeping his head in a fixed position for prolonged periods of time, reaching, pushing, pulling, lifting, carrying, and cold weather. The symptoms are alleviated with medication, hot showers, and topical cream.

Since the time of his last evaluation, his symptoms have remained the same.

SHOULDERS: The examinee complains of continuous sharp, burning, and pins and needles pain in his shoulders, right greater than left without pain radiation. He has no popping, instability, or grinding. He has recurrent locking and stiffness in his shoulders. Weakness is noted in both upper extremities. His symptoms are aggravated with reaching, pushing, pulling, lifting, carrying, lying on his sides, and cold weather. He notes no specific treatment that alleviates his pain.

Since the time of his last evaluation, his symptoms have gradually worsened.

ELBOWS: The examinee complains of recurrent pain in his elbows, equally without pain radiation. He has no swelling or popping. He has continuous numbness and tingling in both upper extremities. Weakness is noted in both upper extremities as well. His symptoms are aggravated with gripping, grasping, torquing, pushing, pulling, bending and extending the elbow, leaning his elbow on a hard surface, lifting, carrying, and cold weather. The symptoms are alleviated with medication, hot showers, and topical cream.

Since the time of his last evaluation, his symptoms have remained the same.

HANDS: The examinee complains of continuous sharp and pins and needles pain in the hands equally without pain radiation. He has recurrent swelling in his hands. He has continuous numbness and tingling in both upper extremities. Weakness is noted in both upper extremities as well. He recurrently wears wrist/hand supports. His symptoms are aggravated with gripping, grasping, torquing, repetitive movements of his fingers, pushing, pulling, lifting, carrying, and cold weather. He notes no specific treatment that alleviates his pain.

Since the time of his last evaluation, his symptoms have remained the same.

FINGERS: The examinee complains of continuous sharp and pins and needles pain in all fingers. He has locking all his fingers, bilaterally. He has continuous numbness and tingling in his upper extremities. Weakness is noted in his upper extremities as well. His symptoms are aggravated with gripping, grasping, repetitive movements of his fingers, pushing, pulling, lifting, and carrying. He notes no specific treatment that alleviates his pain.

Since the time of his last evaluation, his symptoms have remained the same.

LOWER BACK: The examinee complains of continuous burning, pins and needles, and sharp pain in his lower back, with pain radiating down both lower extremities to his feet. He has recurrent numbness and tingling in his lower extremities. Weakness is noted in both lower extremities as well. His symptoms are aggravated with bending, twisting, turning, pushing, pulling, reaching,

stooping, squatting, lifting, carrying, ascending and descending stairs, standing up from a seated position, and prolonged sitting, standing, and walking. He has no difficulties controlling his bladder or bowel. He notes no specific treatment that alleviates his symptoms.

Since the time of his last evaluation, his symptoms have gradually worsened.

HIPS: The examinee complains of continuous sharp and pins and needles pain in his hips, equally without pain radiation. He has no popping, instability, locking, or grinding. Weakness is noted in both lower extremities. The symptoms are aggravated with bending, twisting, turning, stooping, squatting, ascending and descending stairs, and prolonged sitting, standing, and walking. He notes no specific treatment that alleviates his symptoms.

Since the time of his last evaluation, his symptoms have remained the same.

KNEES: The examinee complains of continuous sharp, dull, and pins and needles pain in the knees, equally. He has recurrent instability and locking in knees. He has no swelling, popping, or grinding. He recurrently walks with an uneven gait and wears bilateral knee supports. His symptoms are aggravated with stooping, squatting, kneeling, ascending and descending stairs, walking on uneven surfaces, standing up from a seated position, prolonged standing and walking, and cold weather. He notes no specific treatment that alleviates his pain.

Since the time of his last evaluation, his symptoms have remained the same.

ANKLES: The examinee complains of continuous burning and sharp pain in the ankles, equally. He has no swelling, popping, or instability in the ankles. He recurrently walks with an uneven gait. His symptoms are aggravated with stooping, squatting, kneeling, walking barefooted, getting on his tiptoes, ascending and descending stairs, walking on uneven surfaces, standing up from a seated position, prolonged standing and walking, and cold weather. He notes no specific activity that aggravates his symptoms.

Since the time of his last evaluation, his symptoms have remained the same.

FEET: The examinee complains of continuous burning, pins and needles, dull, and sharp pain in his feet, equally. He has no swelling. He notes recurrent numbness and tingling in both lower extremities. He has recurrent cramping in all his toes, bilaterally. His symptoms are aggravated with stooping, squatting, walking barefooted, getting on his tiptoes, ascending and descending stairs, walking on uneven surfaces, prolonged standing and walking, and cold weather. He notes no specific activity that alleviates his symptoms.

Since the time of his last evaluation, his symptoms have worsened.

INTERNAL: The examinee complains of recurrent chest pain, heart palpitation, and shortness of breath. His symptoms are aggravated with exertion. His symptoms are alleviated with rest.

Since the time of his last evaluation, his symptoms have remained unchanged.

ACTIVITIES OF DAILY LIVING: The examinee has difficulty with his activities of daily living of showering and washing his back and legs, combing his hair, putting on dress shirts, t-shirts, pants, socks and shoes, cooking, cleaning, mopping, sweeping, vacuuming, washing dishes, doing laundry, folding and hanging clothes, grocery shopping, wiping himself after using the restroom, writing, using a computer, turning facets on and off, entering and exiting a vehicle, driving for extended periods of time, taking out the trash, and feeling the things he touches.

INTERVAL HISTORY:

Mr. Silva was last evaluated on June 15, 2018.

In the last report issued on Mr. Silva, I diagnosed him with the following:

1. Lumbar and bilateral knee strain from August 3, 2017 when slipping and twisting his torso and knees while employed by the Department of Transportation as an electrician.
2. Subsequent cumulative trauma claim from May 4, 2009 through April 30, 2018 essentially including his entire body.
3. Left knee pain with MRI showing grade II chondromalacia of the medial joint and patella on October 21, 2017 study as per Dr. Pelton on May 9, 2018 record with a subsequent MRI of the left knee showing softening of the cartilage of the patella only on October 3, 2018.
4. Clinical evidence of plica syndrome of the left knee.
5. Plica syndrome of the right knee with an otherwise benign physical examination and with normal x-ray of the right knee from September 4, 2014.
6. Chronic neck pain documented starting on August 29, 2017 with a normal MRI of the cervical spine on September 8, 2017 and subsequent MRI showing disc degeneration and 1-2 mm bulge at C5-6, C6-7 and C7-T1 on May 8, 2019 MRI.
7. Chronic low back pain with multiple MRIs of the lumbar spine showing normal findings with the latest MRI showing partial sacralization at the L5, L4-5 moderate to severe right sided neural foraminal stenosis with disc degeneration as per May 8, 2019 MRI.
8. Bilateral upper extremity pain and numbness with hypersensitivity to routine sensory examination with a completely normal bilateral upper extremity EMG/nerve conduction studies of May 14, 2019.
9. History of industrial injury 2001 with lower back and leg pain and documentation of constant moderate low back pain with leg pain for seven years on July 18, 2008 clinical note by Dr. Espinoza.
10. October 13, 2014 MRI of the lumbar spine positive for moderate facet arthropathy bilaterally at L3-4 and minimal disc bulge at L4-5.
11. Fibromyalgia diagnosed through Kaiser.
12. Right shoulder MRI finding minimal effusion and AC joint arthritis as per January 29, 2019 MRI.
13. Left shoulder MRI showing slight acromion, mild AC joint arthritis and mild bursitis and tendonosis on January 10, 2019 MRI.

14. Status post declaration of permanent and stationary by Dr. Kevin Pelton with regards to August 3, 2017 date of injury with date of permanent and stationary on November 18, 2019 with rating of 13% for the lumbar spine, 2% for each knee and 3% for chronic pain syndrome.

Since the last evaluation Mr. Silva underwent the following treatment:

Physical Therapy: Received about two months of physical therapy for about two months (dates not recalled) and noted no relief.
Chiropractic: Received about eight to nine sessions (dates not recalled) and noted no relief.
Acupuncture: Received 12 sessions (dates not recalled) and noted no relief.
Diagnostic Studies: MRI of the neck, lower back, hands, elbows, shoulders, and knees (dates not recalled).
Injection: Right shoulder (date not recalled) and developed increased pain.
Surgeries: None.

WORK STATUS:

Since the last evaluation Mr. Silva, he has not worked. He last worked in 2017.

SUBSEQUENT INJURIES:

Work Related: None.
Non-Work Related: None.

CURRENT TREATMENT:

He is not presently under the care of a physician. He is presently taking meloxicam (dose not recalled) one tablet two times per day and over the counter Excedrin two tablets three to four times per week.

PHYSICAL EXAMINATION:

General: The examinee is a 43-year-old, right hand dominant Hispanic male.

Vital Signs:

Height	:	5'8"
Weight	:	178 lbs.
Blood Pressure	:	114/82
Pulse	:	79
Temperature	:	97.5

Skin: No gross lesions, no rashes and no lesions other than specified in the extremity examination.

Cardiovascular: Pulses were intact. No pedal edema was noted. Fingers with good capillary refill.

CERVICAL SPINE:

Range of Motion	Applicant / Normal
Flexion	40 degrees / 50 degrees
Extension	30 degrees / 60 degrees
Lateral bending – right	30 degrees / 45 degrees
Lateral bending – left	30 degrees / 45 degrees
Rotation – right	80 degrees / 80 degrees
Rotation – left	80 degrees / 80 degrees

Tenderness	Right worse than left mid cervical spine with palpable spasm on the right.
Compression	Negative.

Reflexes	Applicant / Normal
Biceps	2+ / 2+
Triceps	2+ / 2+
Brachioradialis	2+ / 2+

UPPER EXTREMITIES:

Major Extremity: RIGHT

Range of Motion	Right / Left
Shoulder	
Abduction	170 degrees / 170 degrees
Adduction	40 degrees / 40 degrees
Flexion	180 degrees / 180 degrees
Internal rotation	80 degrees / 80 degrees
External rotation	60 degrees / 60 degrees
Extension	50 degrees / 50 degrees

Elbow	Right / Left
Extension	0 degrees / 0 degrees
Flexion	140 degrees / 140 degrees
Pronation	70 degrees / 70 degrees
Supination	80 degrees / 80 degrees

Wrist	Right / Left
Dorsiflexion	60 degrees / 60 degrees
Palmar flexion	60 degrees / 60 degrees
Radial deviation	20 degrees / 20 degrees

Ulnar deviation	30 degrees / 30 degrees

Motor Strength	Right / Left
Deltoid	4+/5+ / 5/5
Biceps	5/5 / 5/5
Triceps	5/5 / 5/5
Brachioradialis	5/5 / 5/5
Wrist extensors	5/5 / 5/5
Wrist flexors	5/5 / 5/5
Intrinsics	5/5 / 5/5

On the right shoulder forward flexion strength was 4+/5+ being unable to resist two finger downward pressure.

Sensation Right hand sensation was decreased to the thumb. The rest of the fingers are hypersensitive.

Left hand sensation is somewhat diffuse hypersensitivity.

Mildly positive carpal tunnel Tinel's on the right and negative on the left.

Circumference Meas. (cm)	Right	Left
Biceps	37.0	36.0
Elbows	29.0	30.0
Forearms	30.0	30.0
Wrists	18.0	18.0
Hands	24.0	23.0

Jamar Grip Strength (kg)	Right	Left
	4/4/4	10/2/5

Comments

On the right shoulder, he has subacromial tenderness. He has positive impingement sign.

On the left shoulder, he has no tenderness. Impingement is negative.

THORACOLUMBAR SPINE:

Range of Motion	Applicant / Normal
Flexion	60 degrees / 90 degrees

Extension	15 degrees / 25 degrees
Lateral bending – right	20 degrees / 25 degrees
Lateral bending – left	20 degrees / 25 degrees
Rotation – right	30 degrees / 30 degrees
Rotation – left	30 degrees / 30 degrees

Extension of the thoracolumbar spine is 15 with pain.

Pelvic tilt	None
Scoliosis/kyphosis	None
Muscle spasm	Palpable left L4-L5
Tenderness	Bilateral L4-L5 and L5-S1
Guarding	Positive

Straight leg raising	Right / Left
Sitting	Negative / Negative
Supine	Negative / Negative

Lasègue	Negative / Negative
Patrick	Negative / Negative
FABER	Negative / Negative

LOWER EXTREMITIES:

Gait: The applicant has a complete and normal gait with normal cadence and velocity. The examinee has a normal heel-toe gait. There is no appreciable limp.

Range of motion (degrees of active motion)

Hip	Right / Left
Flexion	110 degrees / 110 degrees
Extension	0 degrees / 0 degrees
Abduction	30 degrees / 30 degrees
Adduction	20 degrees / 20 degrees
Internal rotation	30 degrees / 30 degrees
External rotation	40 degrees / 40 degrees

Knee	Right / Left
Flexion	110 degrees / 110 degrees
Extension	0 degrees / 0 degrees

Ankle	Right / Left
Dorsiflexion	20 degrees / 20 degrees

Plantar Flexion	30 degrees / 30 degrees
Inversion	30 degrees / 30 degrees
Eversion	20 degrees / 20 degrees

Great Toes	Proximal	Distal
Extension	40 / 40	0 / 0
Flexion	25 / 25	50 / 50

Muscle Strength	Right / Left
Iliopsoas	5/5 / 5/5
Quadriceps	5/5 / 5/5
Hamstrings	5/5 / 5/5
Tibialis anterior	5/5 / 5/5
Extensor hallucis longus	5/5 / 5/5
Peroneal	5/5 / 5/5
Gastrocsoleus	5/5 / 5/5

Sensation: Intact, all dermatomes

Deep Tendon Reflexes	Right / Left
Patellae	2+ / 2+
Achilles	2+ / 2+

Pulses	Right / Left
Posterior tibial	2+ / 2+
Dorsalis pedis	2+ / 2+

Tenderness: None

Comments

On both knees, he has tender anterior plicas bilaterally with positive snap sign. There is no effusion. McMurray's are negative.

Circumference Meas. (cm)	Right	Left
Thighs	44.0	44.0
Knees	41.0	41.0
Calves	38.0	38.0
Ankles	25.0	25.0
Feet	26.0	26.0

REVIEW OF MEDICAL RECORDS:

Medical records were reviewed, please see attached.

ASSESSMENT:

1. Mechanical fall twisting his torso and landing on his knees employed by the Department of Transportation as an electrician on August 3, 2017.

2. Lower back and bilateral knee pain from August 3, 2017 injury.

3. Lumbar MRI showing partial sacralization of L5, L4-L5 moderate to severe right sided neuroforaminal stenosis with disc degeneration, moderate facet arthropathy at L3-L4 with 2-3 mm bulge as per May 18, 2019 MRI.

4. Normal lower extremity EMG/nerve conduction studies, February 25, 2020.

5. Chronic bilateral knee pain with clinical evidence of plica syndrome on both knees.

6. Left knee MRI showing grade II chondromalacia of the medial joint and patella from a October 21, 2017 study as per Dr. Pelton's record of May 9, 2018 with subsequent MRI showing softening of the cartilage of the patella only, October 3, 2018.

7. CT claim alleging total body pain.

8. Chronic neck pain with cervical spine MRI showing degeneration and 1-2 mm bulge at C5-C6, C6-C7 and C7-T1 as per May 8, 2019 MRI.

9. Chronic right shoulder pain with clinical evidence of impingement syndrome with alleged increased pain following cortisone injection subsequent to my initial QME with MRI showing minimal effusion and AC joint arthritis as per January 29, 2019 MRI.

10. Improved left shoulder pain with benign physical findings to the left shoulder.

11. Prior declaration of permanent and stationary with Dr. Pelton with regards to August 3, 2017 date of injury with 13% whole person impairment for lumbar spine, 2% for each knee and 3% chronic pain syndrome on November 18, 2019.

12. Bilateral upper extremity pain and numbness with normal EMG/nerve conduction of the bilateral upper extremities, May 14, 2019, with subsequent EMG/nerve conduction positive for right carpal tunnel syndrome with clinical correlation, mild ulnar nerve compression at the wrist bilateral without clinical correlation as per February 21, 2020 study.

13. History of prior industrial injury in 2001 with lower back and leg pain with MRI of

October 13, 2014 showing moderate facet arthropathy at L3-L4 and minimal disc bulge at L4-L5.

14. Diagnosis of fibromyalgia through Kaiser.

DISCUSSION:

This is the first re-evaluation subsequent to June 15, 2018 Initial QME. Therefore, it has been three years since his Initial QME.

The examinee has undergone subsequent EMG/nerve conduction studies to the upper extremities which was positive for mild right carpal tunnel syndrome which may explain his sensory deficit in the right hand. He had mild ulnar nerve compression at the wrist electrodiagnostically without clinical correlation.

The EMG/nerve conduction to the lower extremities was normal from February 25, 2020. The examinee states he had a cortisone injection to the right shoulder which caused increased pain. Therefore, he declined an injection to the left shoulder. Subsequently, the left shoulder pain has improved. He has residual pain in the right shoulder with the applicant showing clinical evidence of impingement to the right shoulder.

For his knees, he still has clinical evidence of plica syndrome. For the lumbar spine, the examinee was provided a cortisone injection apparently with no significant benefits.

At this point, the examinee's condition is chronic, nearly four years old. He is not expected to improve. Therefore, the examinee is considered to have reached MMI status.

MMI:

The examinee is now declared MMI.

CAUSATION:

Causation for the lumbar spine and bilateral knees is from the specific injury of August 3, 2017.

The examinee's impairment to the right shoulder, right carpal tunnel syndrome and cervical spine is industrial based on cumulative trauma with apportionment.

APPORTIONMENT:

For the lumbar spine, the examinee had a prior lower back injury in 2001, and therefore, he had pre-existing lower back pain. Seventy-five percent (75%) will be apportioned to the August 3, 2017 specific injury, and 25% to prior injury of the lumbar spine.

For the cervical spine, 75% will be considered industrial cumulative trauma, and 25% will be due to causes other than cumulative trauma exposure to the cervical spine.

Apportionment for the right carpal tunnel syndrome is entirely 100% due to cumulative trauma exposure.

For the right shoulder impairment, it is entirely due to cumulative trauma exposure.

For the bilateral knees, it is entirely from the specific injury of August 3, 2017.

PERMANENT IMPAIRMENT RATING PER FIFTH EDITION AMA GUIDELINES:

Cervical Spine

For the cervical spine, he is rated under DRE Category II for 8% whole person impairment.

Lumbar Spine

For the lumbar spine, he has non-verifiable radicular symptoms with normal EMG/nerve conduction studies. There are no significant objective findings to indicate the presence of lumbosacral radiculopathy, and therefore the examinee clearly falls under DRE Category II and is provided 8% whole person impairment.

Right Shoulder

For the right shoulder, he has loss of flexion strength which is rated at 6% upper extremity. Loss of abduction strength is 3% upper extremity. Combined 9% upper extremity converts to 5% whole person impairment for the right shoulder.

Right Wrist and Hand

For the right carpal tunnel syndrome out of maximum 39% impairment will be modified by 20% in mild severity, which results in 8% upper extremity which converts to 5% whole person impairment.

Left Shoulder

For the left shoulder, there is no ratable impairment. The examinee does not have clinical evidence of ulnar nerve compression across the wrist.

Right Knee

For the right knee, the examinee has anterior knee pain from chronic plica syndrome which is similar to someone with chronic patellofemoral chondromalacia pain. Therefore, using Almaraz/Guzman, the examinee will be assigned 2% whole person impairment using Almaraz/Guzman to someone with chronic patella crepitation and pain for 2% whole person impairment.

Left Knee

For the left knee, using the same principle, is provided 2% whole person impairment.

WORK RESTRICTIONS:

The examinee is restricted from pushing, pulling and lifting greater than 20 pounds, and no repetitive forceful squeezing with the right hand and no repetitive overhead work with the right, and no repetitive turning and twisting of his head and neck.

VOCATIONAL REHABILITATION:

The examinee is a Qualified Injured Worker for vocational rehabilitation.

FUTURE MEDICAL CARE:

The examinee may be a candidate for right shoulder surgery with possible arthroscopic decompression.

Since the cortisone injection made his pain worse allegedly, no further injections are recommended.

For the right carpal tunnel syndrome, he can be treated with a cockup splint, possible cortisone injection and ultimately right carpal tunnel release.

For the bilateral knees, he may consider arthroscopic excision of plica if conservative treatments are not helpful.

For the lumbar spine and cervical spine, he can be treated through physical therapy and/or chiropractic treatments up to 12 sessions per year.

My medical opinion expressed in this report is based upon all forms of medical evidence presented to me and represents what is considered to fall within the envelope of reasonable medical probability.

Thank you for referring this examinee for my evaluation, and if there are any further questions, please do not hesitate to contact this office.

SOURCE OF ALL FACTS AND DISCLOSURE:

The source of all facts was the history given by the examinee and review of the previous examiner's medical reports. I personally interviewed the examinee, performed the physical examination, reviewed the history with the examinee, reviewed the medical records provided, dictated this report and it reflects my professional observations, conclusions and recommendations. Face-to-face time conformed with DWC guidelines. I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to the information that I have indicated and received from others. As to this information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true. Labor Code 139.3 was not violated. Assistance with preparation of this report was provided by Dianna Johnson, Historian; Rapid Care/RA, Record Summarizer; and Mechelle Newberry, Assistant, all of whom were trained by Arrowhead Evaluation Services, Inc.

I have received an attestation and declaration from the adjuster attesting 1211 pages for review and comment.

Date of Report: June 19, 2021. Signed this 14th day of July, 2021 at San Bernardino County, California.

Sincerely,

DONALD D. KIM, M.D.
Orthopedic Surgeon

DDK:rrp

cc: Joe Southard & Yeah, LLP
11620 Wilshire Boulevard, Suite 900
Los Angeles, California 90025
Attention: Debbie Joe, Esquire

State Compensation Insurance Fund
P.O. Box 65005
Fresno, California 93650-5005
Attention: Ludy R. Yee Chut, Claims Representative
Attention: Cindy Kim, Esquire

Attached: Review of medical records

Recv'd Date: 20210716 Bill ID: 101694119
SCIF RECD DATE :07/16/2021

REVIEW of MEDICAL RECORDS
Silva, Edgardo
DOB: [redacted]

Pages Reviewed: 1211

Attestation: Declared total page count of the documents provided to the physician: 328

Attestation: Declared total page count of the documents provided to the physician: 883 (Distorted image).

05/03/18-06/14/18 (12 visits) - PT Daily Notes at Absolute PT & Rehab Center. Pt underwent 12 sessions of PT to B/L knee and L/S. Pt reported same level of pain in low back and knees. Level of pain was 8/10.

06/05/18 - PR-2 by Kevin Pelton, MD/Natalie Hammond, PA-C. Pt presents today for f/u regarding the L/S and B/L knees. L/S pain is constant rated at 8/10 and is about the same since the last visit, pain radiates into the BLE. R knee pain is at 7/10, constant and has slightly worsened since the last visit. L knee pain at 7/10, constant and has slightly worsened since the last visit. Pt is currently doing PT for the lower back. He has completed 10/12 sessions with only minimal pain relief. Pt has failed conservative tx of 22 PT sessions. Pt is taking Tylenol #3, which helps decrease his pain from a 9/10 down to a 4/10. Repetitive activities and changes in weather makes his symptoms worse. Pain is made better with rest and med. PE: L/S with decreased ROM in all planes. Moderate symmetric motion loss. SLR is positive B/L. R greater than L with radiation into the B/L posterior LE to the plantar feet. Neurologically, there is a mild abnormal sensation of the B/L posterior thigh, calf and plantar feet. B/L Knees-TTP over the medial joint line B/L. Decreased ROM in all planes. Positive McMurray on the L. Dx: 1) No meniscus tear. Chronic sprain of the ACL, no high-grade ligament tear. Grade II chondromalacia medial compartment and patella, per MRI of 10/21/17. 2) Chronic lumbar strain with stenosis and acute injury. 3) L knee pain. Plan: Re-request MRI of L/S to r/o disc herniation. Continue the remaining 2 PT to the L/S and B/L knees and continue home exercise and meds. TTD until 06/26/18.

06/26/18 - PTP's PR-2 by Kevin Pelton, MD/Natalie Hammond, PA-C. DOI: 08/03/17. L/S and B/L knee injury. L/S pain was frequent at 8/10, and same since the last visit. Pain radiating into the BLE with N/T. B/L knee pain was frequent at 7/10 and same since last visit. Knees continue to lock and give out at times. Completed 12 sessions of PT to L/S with minimal improvement. Tylenol No. 3, helped to decrease his pain from at 8/10, down to a 4/10. PE: Decreased ROM of L/S in all planes. Moderate asymmetric motion loss.SLR positive B/L, R>L with radiation into the B/L posterior lower extremities to the plantar feet. Mild abnormal sensation of the B/L posterior thigh, calf and plantar feet. B/L TTP over the medial joint line bilaterally. Decreased ROM in all planes. Positive McMurray on L. Dx: 1) No meniscus tear. Chronic sprain of the ACL, no high-grade ligament tear. Grade II chondromalacia medial compartment and patella, per MRI of 10/21/17. 2) Chronic lumbar strain with stenosis and acute injury. 3) L knee sprain. Plan: Requested for MRI of L/S and acupuncture. TTD.

07/25/18 – PTP's PR-2 by Kevin Pelton, MD/Nora Nazarian, PA-C. Overall pain constant 8/10 and same as the last visit L/S pain radiating down to B/L thigh with N/T. Dx remains unchanged. Plan: Recommended MRI of L knee. Re-requested MRI of L/S and acupuncture. Continue meds. TTD.

08/14/18 - UR Determination by EK Health. The requested acupuncture for L/S 2x5 has been modified to 2x3. The requested MRI of L/S (No UR) addressed by claims administrator.

08/22/18 – Progress Note by Kevin Pelton, MD/Nora Nazarian, PA-C. L/S pain 9/10, constant and worse since last visit. B/L knee pain was 8/10, constant and slightly worse since last visit. Dx remains unchanged. Plan: Re-request made for MRI of L knee, B/L custom orthotics and acupuncture. MRI of L/S was denied. Advised to continue meds. Recommended pain management eval for LESI. TTD.

09/17/18 - UR Determination at EK Health. UR has delayed the medical necessity determination for the entire RFA for acupuncture, MRI of L/S and B/L custom orthotics due to insufficient information.

09/19/18 - Urine Drug Screen by US Lab. Result: Negative.

09/21/18 – Progress Note by Kevin Pelton, MD/Nora Nazarian, PA-C. Pain in L/S was 7/10, constant, and slightly worsened since last visit, radiating to BLE. Pain in B/L knee were 7/10, constant, and both have slightly worsened since last visit; pain radiating into B/L foot. Dx remains unchanged. Plan: Re-requesting authorization of MRI of L knee and acupuncture. Continue meds. TTD.

09/24/18 - UR Determination at EK Health. The requested acupuncture to L/S denied due to lack of medical necessity. The requested B/L custom orthotics denied for lack of information.

10/03/18 - MRI of L knee w/o contrast by Mauricio De La Lama, MD at Renaissance Imaging Ctr. Findings: Patellofemoral Joint: Mild chondral softening was seen at the lateral patellar facet. Other Findings: Physiologic amount of joint fluid. Impression: impression: 1) No acute meniscal, ligament or osseous injury. 2) Mild chondral softening at the lateral patellar facet without high-grade chondral defects.

10/19/18 - PTP's PR-2 by Kevin Pelton, MD/Nora Nazarian, PA-C. L/S pain was frequent at 8/10 and same since last visit. B/L knee pain was frequent 7/10, and same since last visit. Knees continued to lock and give out. Dx: L knee - no acute meniscal, ligament or osseous injury. Mild chondral softening at the lateral patellar facet without high-grade chondral defects, per MRI 10/03/18. Rx: Ibuprofen and Tylenol. Orthotics and acupuncture had been denied. Plan: Recommended pain management consultation. TTD.

10/22/18 - Urine Drug Screen from US Lab. Result: Nortriptyline: Positive, inconsistent.

11/16/18 – PTP's PR-2 by Kevin Pelton, MD/Nora Nazarian, PA-C. L/S pain was frequent 7/10, and same since last visit. B/L knee pain was frequent 8/10, and since last visit. Authorized for pain management consultation. Dx remains unchanged. Rx: Gabapentin. TTD.

11/28/18 - PTP's PR-2 by Archie Mays, MD. Complaints and dx remains unchanged. Plan: Re-order MRI. Continue chiro and meds. Ordered UDS. Instructed HEP for B/L hands. Off work until 30-45 days.

11/28/18 - Urine Drug Screen from US Lab. Result: Negative.

12/04/18 - History and Physical by Reed Levine, MD at Pasadena Rehabilitation Institute. On 08/03/17, he was walking at work down a hill outside and slipped and caught himself before falling twisting his ankle and knees. He was sent to a clinic by work and was told to return to work. He received no treatment at that time, but 3-4 months later had x-rays of R knee and sent to a doctor who then referred him to Dr. Pelton, who sent him to PT. C/o of LBP and knee pain. Back pain was a burning, stabbing, and sharp type radiating down both legs, at 8/10. B/L knee pain was 7/10. Received PT and pain meds. PT was not effective, but meds were partially effective. PE: SLR was positive B/L. Dx: 1) Disc disorder of lumbar region. 2) Spinal stenosis of lumbar region. 3) Depression. 4) Chondromalacia, knee. 5) Lumbar strain. 6) Knee sprain. 7) Chronic instability of knee. Rx: Cymbalta. Plan: Requested MRI of L/S. Discussed common and serious potential side effects and risks of meds. Advised to call for any worsening or persistent symptoms. Off work since 03/2018 per Dr. Pelton.

12/21/18 - PTP's PR-2 by Kevin Pelton, MD/Nora Nazarian, PA-C. Overall pain 7/10. L/S pain radiating down BLE with N/T in B/L knee continued to lock and give out. Dx: 1) R knee - No meniscus tear. Chronic sprain of ACL, no high-grade ligament tear. Grade II chondromalacia medial compartment and patella, per MRI 10/21/17. 2) Chronic lumbar strain with stenosis and acute injury. 3) L knee sprain. 4) L knee – no acute meniscal ligament or osseous injury. Mild chondral softening at the lateral patellar facet without high-grade chondral defects, per MRI 10/03/18. Plan: Requested PRP injection to R knee. Continue meds. Obtain records from Dr. Levine. TTD.

01/09/19 - Urine Drug Screen from US Lab. Result: Nortriptyline and Gabapentin: Positive inconsistent.

01/15/19 - UR Determination by EK Health. The requested PRP injection to R knee was denied due to lack of medical necessity.

01/15/19 - Progress Note by Reed Levin, MD. Back pain at 8/10, knee pain at 7/10. Meds were partially effective. Dx remains unchanged. Plan: Consider FRP eval after review of scheduled MRI of L/S. Requested UTOX. Off work per Dr. Pelton.

01/15/19 – UDS Rpt from Aegis Sciences Corporation. Result: Ethyl Glucuronide, Ethyl Sulfate, and Gabapentin: Positive.

01/15/19 - UDS Rpt at Synovation Med Grp. Result: Negative.

01/18/19 - PTP's PR2 by Kevin Pelton, MD/Mark Lee, PA-C. B/L knee pain 8/10. L/S radiating to BLE with N/T. Dx remains unchanged. Plan: Pt would like to hold PRP injection and try conservative measures. Requested acupuncture therapy for L/S and B/L knee. TTD.

02/18/19 - MRI of L/S w/o IV contrast by Zee Daniel, MD at San Gabriel Valley Med Ctr. Positive Findings: Bones: Small hemangioma identified in the L4 vertebral body. L3-L4: Mild disc bulge with mild bilateral foraminal stenosis. L4-L5: Mild disc bulge and facet arthropathy with mild bilateral foraminal stenosis and moderate bilateral subarticular recess stenosis.
Impression: Mild degenerative disease at L3-4 and L4-5.

02/22/19 - PTP's PR-2 by Kevin Pelton, MD/Mark Lee, PA-C. Overall pain 8/10 and was constant. Additionally, c/o pain in C/S and T/S at 7/10 radiating into BUE. PRP injection on R knee was denied. Dx remains unchanged. Plan: Re-requested acupuncture therapy. TTD.

02/27/19 - Progress Note by Reed Levin, MD. Back pain, 8/10. Knee pain 7/10. Dx: Neuroforaminal stenosis of L/S. Plan: Requested TFESI at B/L L4-5. Off work per Dr. Pelton.

03/15/19 - PTP's PR-2 by Kevin Pelton, MD/Mark Lee, PA-C. Overall pain in low back, B/L knee, C/S, L/S remains at 7/10. Dx remains unchanged. TTD.

04/08/19 - Procedure Rpt by Reed Levine, MD at Pasadena Surgery Ctr Inc.
Pre/Post-procedure Dx: 1) Low back pain. 2) Lumbar radiculitis/radiculopathy.3) Lumbar DDD.
Procedure Performed: Lumbar transforaminal epidural steroid Injection at L4-L5 bilaterally, with fluoroscopy guidance and epidurography.

04/08/19 - Anesthesia Record.

04/10/19 – Progress Note by Reed Levine, MD. Back pain, 9/10. Knee pain, 7/10. S/p TFESI had worsened pain. Dx remains unchanged. Plan: Consider trial of Lyrica. Off work per Dr. Pelton.

04/12/19 - PTP's PR-2 by Kevin Pelton, MD/Mark Lee, PA-C. Complaints and Dx remains unchanged. He did not feel much difference from steroid injection. Acupuncture therapy was denied.

05/08/19 - MRI of C/S w/o contrast by Mitchell Berner, MD at Orange Advanced Imaging.
Positive Findings: There was loss of central vertebral body height seen at the C3, C6 and C7 levels with 20%, 30%, and 25% loss of vertebral body height, respectively. The marrow signal was minimally heterogeneous with scattered levels of trace endplate degenerative change.

Degenerative changes were seen with scattered levels of disc desiccation and disc space narrowing most significantly at the C4-5 and the C5-6 levels of a minimal degree. At C2-3, minimal bilateral facet degenerative changes noted. At C3-4, minimal bilateral uncovertebral and facet hypertrophic degenerative changes seen. At C4-5, posterior osteophytic ridging was identified with minimal bilateral uncovertebral and mild-to-moderate bilateral facet degenerative change. Partial effacement of the ventral thecal sac was seen without significant spinal canal stenosis. At C5-6, trace posterior disc osteophyte complex was seen extending 1 to 2 mm posterior with mild bilateral uncovertebral and mild-to-moderate bilateral facet degenerative change. Partial effacement of ventral thecal sac was seen without significant central canal narrowing. At C6-7, a trace posterior disc osteophyte complex was seen extending 1 to 2 mm posterior with mild L and minimal R uncovertebral hypertrophic degenerative change. Mild bilateral facet degenerative changes seen with redundancy of ligamentum flavum. Indentation of the thecal sac was seen without significant spinal canal stenosis. At C7-T1, a trace posterior disc osteophyte complex was seen extending 1 to 2 mm posterior with trace bilateral uncovertebral minimal bilateral facet degenerative change. There was slight epidural lipomatosis redundancy of ligamentum flavum without significant spinal canal stenosis.

Impression: 1) Scattered minimal degenerative changes were seen without levels of significant central canal or neuroforaminal narrowing. 2) There were levels of chronic loss of central vertebral body height including at the C3, C6, and C7 levels with approximately 20%, 30%, and 25% loss of vertebral body height. No acute osseous injury was identified.

05/08/19 - MRI of L/S w/o contrast by Mitchell Berner, MD at Orange Advanced Imaging.
Positive Findings: Transitional lumbar anatomy was identified with partial sacralization of the L5 vertebral body particularly along the left aspect. The marrow signal was minimally heterogeneous with a rounded focus of hyperintense T1/T2 signal in the L4 vertebral body measuring 7 mm (image 10, series 4 and 5). This was consistent with an intraosseous hemangioma. There was a Schmorl's node seen in the inferior endplate of the T11 vertebral body. Degenerative changes seen with disc desiccation most significantly at the L4-5 level, but also to a lesser extent at the L3-4 level. Scattered levels of trace ventral endplate osteophyte formation were seen most significantly at the L3-4 level. At L1-2, minimal bilateral facet degenerative changes seen. At L2-3, mild B/L facet degenerative changes seen with trace L facet effusion. There was prominence of ligamentum flavum and epidural fat. At L3-4, a diffuse disc bulge was seen with predominant foraminal component measuring 2 to 3 mm. Moderate bilateral facet degenerative changes seen with prominence of ligamentum flavum. Trace L lateral recess narrowing was identified. Moderate R and mild-to-moderate L neuroforaminal narrowing was seen with the foraminal components of the disc abutting the bilateral exiting L3 nerve roots causing slight compression on the right. At L4-5, a diffuse disc bulge was seen extending 1 to 2 mm posteriorly with moderate bilateral facet degenerative change. There was prominence of ligamentum flavum and epidural fat. Indentation of the ventral thecal sac was seen without significant spinal canal stenosis. Moderate-to-severe R and mild-to-moderate L neuroforaminal narrowing was seen with the foraminal components of the disc abutting the bilateral exiting L4 nerve roots causing compression on the right. At L5-S1, transitional lumbar anatomy was identified with partial sacralization the L5 vertebral body.

Impression: 1) Transitional lumbar anatomy was identified with partial sacralization of the L5 vertebral body. 2) Degenerative changes were seen, as detailed above. At the L4-5 level there was moderate-to-severe R and mild-to-moderate L neuroforaminal narrowing with the foraminal component of the disc abutting the B/L exiting L4 nerve roots, causing compression on the R. 3) At the L3-4 level there was moderate R and mild-to-moderate L neuroforaminal narrowing with the foraminal components of the disc abutting the B/L exiting L3 nerve roots causing slight compression on the R. Please refer to above for level by level details.

05/13/19 – Progress Note by Reed Levine, MD. Back pain and knee pain, 7/10. Dx remains unchanged. Rx: Lyrica. Off work per Dr. Pelton.

05/14/19 - EMG/NCV of BUE and cervical paraspinous muscles by Ronald Levine, MD. Impression: Normal EMG of both upper extremities and cervical paraspinous muscles. Normal NCS, motor and sensory, both ulnar nerves, above elbow to wrist and below elbow to wrist (no evidence of tardy ulnar palsy). Normal NCS, motor and sensory, both median nerves (no evidence of CTS). Normal NCS, B/L superficial radial nerves.

05/17/19 - PTP's PR-2 by Kevin Pelton, MD/Mark Lee, PA-C. Overall pain at 4/10. Dx remains unchanged. TTD.

06/14/19 - PR-2 by Kevin Pelton, MD/Mark Lee, PA-C. Pain in lower back is at 7/10, constant and has slightly worsened since the last visit. Pain radiates into BLE with associated N/T. Pain in B/L knees are at an 8/10, constant and are about the same since the last visit. Additionally c/o pain in the neck, which he rates at a 5/10 and radiates into B/L upper extremities with associated N/T. Pain is made worse with activities and changes in weather. Dx: remains unchanged. Plan: Referral to spine specialist. TTD until 06/28/19.

06/24/19 – Progress Note by Reed Levine, MD. Complaints and Dx remain unchanged. Had been on Lyrica for 1 week and no benefit thus far. Plan: Continue Lyrica. Off work per Dr. Pelton.

06/28/19 - PR-2 by Kevin Pelton, MD/Mark Lee, PA-C. Pt rates his L/S pain at a frequent 7/10. B/L knee pain at a frequent 8/10 and slightly worse since last visit. B/L knees continue to lock and give out. Dx remains unchanged. Plan: TTD until 07/26/19.

07/26/19 - PR-2 by Kevin Pelton, MD/Mark Lee, PA-C. Pt's L/S pain of frequent 7/10, on a pain scale with radiating pain down B/L lower extremities with persistent N/T sensation. B/L knee pain is in a frequent 8/10 in both knees continues to lock and give out. Pt will follow-up with pain management on 08/05/19 and is also scheduled to see Spine surgeon, Dr. Yuri Falkinstein on 08/09/19. Medications help control his pain. Dx: 1) R knee - No meniscus tear. Chronic pain of ACL, no high-grade ligament tear. Grade II chondromalacia medial compartment and patella, per MRI 10/21/17. 2) Chronic lumbar strain with stenosis and acute injury. 3) L knee sprain. 4) L knee - no acute meniscal, ligament or osseous injury. Mild chondral softening at the lateral patellar facet

without high-grade chondral defects, per MRI 10/03/18. Plan: Continue f/u with Pain medicine specialist as directed.

08/05/19 – Progress Note by Reed Levine, MD. Back pain at 1-2/10 if not active and 5-7/10 if he did too much activity. Knee pain, 7/10. Pt's pain was reduced overall with Lyrica and sleeps better at night and was able to do more activities than before. Dx remains unchanged. Plan: Continue Lyrica. Scheduled appointment with Dr. Falkenstein, Spine surgeon as per Dr. Pelton's plan but, pt was hesitant to proceed with spine surgery. Off work per Dr. Pelton.

08/06/19 (1 visit) - Acupuncture Therapy Note at Tri-County Med Grp. Pt completed 1 session of acupuncture therapy for B/L shoulder and B/L feet. Pain level 7/10. C/o constant pain with N/T.

08/09/19 - PR-2 by Archie Mays, MD. Pt c/o constant moderate 7/10 R shoulder pain and stiffness, constant severe 8/10 L shoulder pain and stiffness, constant severe 8/10 throbbing B/L foot pain and stiffness R worse than L. Loss of sleep due to pain. C/o depression and anxiety. On 03/20/19, pt injected his R shoulder with Lidocaine and Depo-Medrol. Reports mild relief for about 2 weeks. States acupuncture is helping. Dx remains unchanged. Plan: Continue acupuncture. Ordered UDS. Referral to podiatrist. Referral to hand surgeon. Pt wants to hold off the B/L foot injections at the moment. Referral to ortho surgery consult. TTD.

08/09/19 – UDS Rpt at US Lab. Results: Positive and inconsistent for Pregabalin.

08/09/19- STP's Initial Consult Rpt by Yuri Falkinstein, MD. DOI: 08/03/17. Pt sustained an injury to the neck and low back. Pt slipped and twisted his knees. C/o pain in the neck as 8/10 on pain scale. C/o LBP with stiffness, spasm, tingling, weakness and locking, rated as 8/10 on pain scale. In physiological pain drawing, pt marks in pain in the neck, low back, B/L shoulders, B/L elbows, B/L hands, B/L knees, B/L thighs and B/L feet. PE: ROM of C/S and L/S demonstrates asymmetric motion loss. There is diffuse cervical paraspinal tenderness of C/S and L/S. MRI of the cervical and L/S reveals acceptable alignment and very minimal disc disease with no obvious significant nerve compression or stenosis and no obvious significant structural abnormalities. Dx: H/o neck and back pain with cervical and lumbar strain and mild disc disease with no significant neurologic deficits or compromise. Plan: Recommended conservative management, anti-inflammatories, self-directed therapy and exercise program. Causation: Work-related injury.

08/13/19-09/09/19 (5 visits) - Acupuncture Therapy Notes at Tri-County Med Grp. Pt completed 5 sessions of acupuncture therapy for B/L shoulders and B/L foot. Pain level 6/10. C/o constant N/T.

08/30/19 - PR-2 by Kevin Pelton, MD/Mark Lee, PA-C. Pt rates his overall pain out of frequent 7/10 and about the same since last visit. Dx remains unchanged. Plan: TTD.

09/09/19 - PR-2 by Archie Mays, MD. Pt c/o constant moderate 6/10 R shoulder pain and stiffness, constant severe 6/10 L shoulder pain and stiffness, constant severe 8/10 throbbing B/L foot pain

and stiffness, R worse than L. Dx remains unchanged. Plan: Ordered UDS. Requested EMG/NCV of LE to r/o tarsal tunnel syndrome. TTD.

09/09/19 - UDS Rpt at US Lab. Results: Positive and inconsistent for Pregabalin.

09/01/19 - Secondary Dr's 1st Rpt by Scott Rosenzweig, MD. CT: 05/04/09-04/30/18. Pt c/o B/L shoulder pain 7/10. PE: Tender B/L shoulder. Contusion abnormal margin. Decreased pain on ROM. B.L shoulder weakness. Dx: 1) B/L shoulder s/s, bursitis. 2) B/L shoulder joint effusion, tendinosis. 3) R bicipital tenosynovitis. Plan: Continue acupuncture, meds and HEP. Possible shoulder arthroscopy. TTD.

09/12/19 (1 visit) - Acupuncture Therapy Note at Tri-County Med Grp. Pt completed 1 session of acupuncture for B/L shoulders and B/L feet. Pain level 6/10. Pain constant with N/T.

09/19/19 – Supplemental PQME Rpt by Gerald Markovitz, MD. Discussion: Reviewed submitted records. Pt has been under the care of an orthopedist and pain specialist. He received at least one epidural and has been tried on various medications. In addition to these paper records, this examiner was sent a CD with a password, which must be corrupted because the contents could not be opened. Please send another CD that is not corrupted. Once, the missing medical records are made available, this examiner would issue a supplemental report. Otherwise, there are no changes in his opinions as previously stated.

09/23/19-09/24/19 (2 visits) - Acupuncture Therapy Notes at Tri-County Med Grp. Pt completed 2 sessions of acupuncture therapy for B/L shoulders and B/L foot. Pain level 6/10. Constant pain with N/T.

09/28/19 - Secondary Dr's 1st Rpt by John Katzen, MD. DOI: CT 05/04/09-04/30/18. Pt sustained CT to his neck, B/L shoulders, B/L hands, fingers, nose, upper back, mid back, B/L hips, B/L legs, B/L ankles, B/L feet and toes and he also developed circulatory, respiratory and digestive problems. Pt worked under severe stress and pressure. His symptoms began sometime in 2014. Reported his symptoms to a supervisor but was not offered medical care. He self-treated with OTC med. He continued working regular duty until 04/30/18. On 04/30/18, pt was placed on TTD due to a specific injury he sustained in 08/2017 also while working for California Transportation Burbank. Currently, pt c/o constant B/L wrist and elbow pain at 7/10 with N/T, pain is worst at night. PE: L Hand and Wrist: Positive Phalen's test and Tinel's sign. Compression over the median nerve in the carpal tunnel with numbness of the thumb, index and middle finger at approximately three seconds. Positive axial grind test, anatomic snuffbox pain, pain on ulnar deviation at the wrist, Pain on radial deviation at the wrist, pain on wrist flexion and extension, pain over the lateral epicondyle. R Hand and Wrist: Positive Phalen's test, Tinel's signs, compression over the median nerve in the carpal tunnel with numbness of the thumb, index and middle finger at approximately three seconds. thenar atrophy, abductor pollicis brevis weakness, axial grind test, anatomic snuffbox pain, pain on ulnar and radial deviation at the wrist, pain on wrist flexion and extension, pain over the lateral epicondyle. Dx: 1) RUE overuse syndrome, r/o CTS, r/o ulnar nerve

compression. 2) LUE overuse syndrome, r/o CTS, r/o ulnar nerve compression. 3) R wrist s/s and TFCC tear per MRI. 4) L wrist s/s, r/o internal derangement. 5) R elbow s/s. 6) R elbow MRI shows effusion and OA. 7) L elbow s/s. 8) L elbow MRI shows effusion and OA. Plan: Recommended EMG/NCV of BUE and L wrist MRI. Requested formal PT. Instructed on home exercise tx. Consider anti-inflammatories, topical analgesics, oral med. Ordered B/L volar wrist braces and B/L elbow straps to wear all the time. Consider injection to R and L carpal tunnel if symptoms worsen after EMG is completed. Pt is deferred to Dr. Leynes for OA.

10/02/19 - Progress Note by Reed Levine, MD. On 08/03/17, pt was walking at work down a hill outside and slipped and caught himself before falling but twisted his ankle and knees in process. He was sent by work to a clinic in Burbank and was told to return to work. He said he received no Tx or studies but then 3-4 months later they did x-rays of R knee. He was sent to another doctor that sent him to Dr. Pelton, Ortho. Dr. Pelton sent him to PT. Currently, pt's back pain is 2-3/10 at rest and with house chores or walking far 6+/10. Pain has been present for years. Radiates down both legs. C/o B/L knee pain. Has been previously treated with PT and pain medication. PT was ineffective. Pain medication was partially effective. Pt reports of depression due to his health issues. U-Tox done 01/15/19; shows positive for alcohol and metabolites and Gabapentin. Dx: 1) Disc disorder of lumbar region. 2) Spinal stenosis, lumbar region. 3) Depression. 4) Chondromalacia, knee. 5) Lumbar strain. 6) Knee sprain. 7) Chronic instability of knee. 8) Neural foraminal stenosis of L/S. Plan: Request note from Dr. Pelton. Referral to FRP evaluation. Continue Lyrica.

10/08/19 (1 visit) - Acupuncture Therapy Note at Tri-County Med Grp. Pt completed 1 session of acupuncture therapy for B/L shoulders and B/L feet. Pain level 7/10. C/o constant pain with N/T.

10/09/19 - STP's PR-2 by Scott Rosenzweig, MD/Rafael Begluyan, NP. Pt c/o constant B/L shoulder pain at 7/10 with reaching up and out, lifting and going through an arc of ROM. Dx: 1) B/L shoulder pain. 2) B/L shoulder impingement. 3) B/L shoulder bursitis. 4) B/L shoulder rotator cuff tendinosis. 5) R shoulder partial thickness rotator cuff tear. Plan: Will see how pt responds to shoulder injection received three weeks ago. Offered injection for L shoulder which pt has declined today. Continue acupuncture, meds and home exercises. If he fails conservative management, consider shoulder arthroscopy. Currently, pt not interested in surgery or injection.

10/11/19 – PR-2 by Kevin Pelton, MD/Mark Lee, PA-C. Pt c/o B/L knee and back pain at 8/10. His condition remains same. Dx remains unchanged. Plan: Note recommended for any surgery at this time. TTD until 11/18/19.
10/15/19 (1 visit) - Acupuncture Therapy Note at Tri-County Med Grp. Pt completed 1 session of acupuncture for B/L shoulders and B/L feet. Pain level 7/10. C/o constant pain with N/T.

10/16/19 - PR-2 by Archie Mays, MD. Pt c/o 7/10 B/L shoulder pain and 8/10 B/L feet pain. Dx remains unchanged. Plan: Continue acupuncture. Ordered UDS. TTD.

10/16/19 - UDS Rpt at US Lab. Results: Positive and inconsistent for Pregabalin.

10/25/19 - STP's PR-2 by John Katzen, MD/Rafael Begluyan, NP. Pt c/o constant B/L wrist and elbow pain at 7/10 with N/T and pain worse at night. Dx remains unchanged. Plan: Continue acupuncture, kinetic activities and home exercises. Re-ordered EMG/NCV of BUE, B/L volar wrist braces and B/L elbow straps. Continue pain meds. Consider injection to B/L carpal tunnel if symptoms worsen after EMG is completed. 2nd request for referral to Dr. Leynes for OA.

10/29/19-11/14/19 (2 visits) - Acupuncture Therapy Notes at Tri-County Med Grp. Pt completed 2 sessions of acupuncture therapy for B/L shoulders and B/L feet. Pain level 7/10. C/o constant pain with N/T.

11/11/19 - Initial FRP Request and Multidisciplinary Evaluation by Mauro Zappaterra, MD. Pt has hx of LBP as well as B/L knee pain. Had been complaining of his low back pain prior to the injury in August 2017, however the injury in August 2017 significantly exacerbated his LBP. He was walking down the hill, and slipped, and twisted his ankle and knees in the process. Did not have any immediate care. Now he has LBP at 7/10 radiating into BLE into his feet. Also has B/L knee pain at 7/10. Has tried PT, acupuncture, chiropractic, massage, as well as an ESI without significant benefit. He states that he was evaluated by an orthopedic surgeon and was deemed to not be a surgical candidate. He wishes to avoid any surgery if possible. He also describes having fatigue, insomnia, and symptoms of mild depression. The Cymbalta medication did not help. He was an electrician, and has difficulty performing his job, as he has difficulty standing on his feet, and bending over, and crawling. He is very motivated to improve, and to return to work. Difficulty performing his ADLs. PE: L/S: TTP over paraspinal musculature, + muscle spasms. Spine ROM limited by 75% in all planes. Positive muscle spasm. Positive B/L seated SLR, + pelvic obliquity. Dx: 1) Disc disorder of lumbar region. 2) Spinal stenosis, lumbar region. 3) Depression. 4) Chondromalacia, knee. 5) Lumbar strain. 6) Knee sprain. 7) Chronic instability of knee. 8) Neural foraminal stenosis of lumbar. 9) Lumbar paraspinal muscle spasm. 10) Pelvic obliquity. 11) LBP. 12) Insomnia. Plan: Pt is a candidate for FRP.

11/14/19 - Progress note by Reed Levine, MD. Back pain of 6/10. Also has B/L knee pain. Dx remain unchanged. Plan: Continue Lyrica.

11/15/19 - PR-2 by Archie Mays, MD. Pt c/o 7/10 B/L shoulders and 8/10 B/L feet. Dx remains unchanged. Plan: Ordered UDS. TTD.

11/15/19 - UDS Rpt at US Lab. Results: Positive and inconsistent for Pregabalin.
11/18/19 – PTP's P&S Rpt by Kevin Pelton, MD. DOI: 08/03/17. Currently, pt c/o constant sharp and dull pain in low back at 9/10 with weakness and numbness. Also, c/o constant sharp and dull pain and stiffness in the bilateral knees at 7/10 with weakness and numbness. Pt had reached MMI as of the date of this exam. Pt marks pain in neck, B/L shoulders, B/L elbows, B/L wrists and hands, low back, B/L thighs, B/L knees, B/L calves and B/L feet. ADLs are done with much difficulty. PE: L/S: TTP over lumbar paraspinal muscles, L/S and hypertonicity bilaterally. SLR positive bilaterally. Sensation was decreased in S1 dermatome on R. Knees: TTP over medial joint

line B/L. Patellofemoral Grind test is positive bilaterally. Limited ROM of L/S and knees. Dx: 1) Chronic lumbar strain with stenosis and acute injury. 2) R knee - No meniscus tear. Chronic sprain of the ACL, no high-grade ligament tear. Grade II chondromalacia medial compartment and patella, per MRI 10/21/17. 3) L knee sprain. 4) L knee - no acute meniscal, ligament or osseous injury. Mild chondral softening at the lateral patellar facet without high-grade chondral defects, per MRI 10/3/2018. MMI: Reached MMI and is P&S. Positive factors of disability are asymmetric loss of ROM, palpable tenderness, and muscle guarding, positive orthopedic tests, and decreased sensation in S1 dermatome on the right. In regard to B/L knees, pt has loss of ROM, palpable tenderness, positive orthopedic tests and positive diagnostic Imaging. AMA Impairment Rating: L/S 13%, R knee 2%, L knee 2%, and 3% for pain. Apportionment: 0% of the current level of impairment to the presence of prior industrial or nonindustrial factors and 100% of the current level of impairment to industrial injury on 08/03/17, arising out. Work Restrictions: Lifting limited to 25 lbs. No ending/twisting/squatting. Should restrictions not be accommodated by employer, pt would be an excellent candidate for a Supplemental Job Displacement voucher. Future Medical Care: Concerning L/S, pt should be provided access to orthopedic PTP for monitoring of appropriate medications, short courses of chiropractic and PT for flare-ups above his P&S level. In the event that his symptoms worsen, he should be allowed epidural steroid injections and surgery. Concerning B/L knees, pt should be provided access to an orthopedic PTP for monitoring of appropriate medications, short courses of physical therapy for flare-ups above his permanent and stationary level. In the event that his symptoms worsen, he should be allowed PRP injections and viscosupplementation injections.

11/19/19 - Comprehensive Behavioural Medicine Eval by Denniz Hernandez, Psy.D. DOI: 08/03/17. Pt reported lower back and knee pain due to a work-related injury in 2017. He was walking down a hill while working and he slipped twisting both knees. Reported dealing with pain for about 20-years. Pain has worsened over the past 3-4 years, and that his injury only aggravated his condition. Pt was referred to a doctor. MRI and x-ray findings revealed 4-5 herniated discs. C/o LBP, knee pain, shoulder and hand pain, N/T in his legs and needle sensations on his feet. Has undergone PT and has been treated with epidural injections and medications, all without significant long-term benefits. Difficult to engage in ADLs. Pt reported feeling depressed, anxious, frustrated, apathetic, and anhedonic. However, pt continues to experience severe pain which is significantly impacting the quality of his life. Dx: Psychological Factors Affecting Physical Condition. Plan: Pt is a good candidate for integrated interdisciplinary functional restoration program.

11/20/19 – PT Evaluation Pasadena Rehab Institute. Pt c/o LBP and B/L knee and ankle pain. Would benefit from PT as a part of FRP program.

11/22/19 - STP's PR-2 by John Katzen, MD/Rafael Begluyan, NP. Pt c/o constant B/L wrist and elbow pain rated at 8/10 with N/T and pain worst at night. C/o weakness to B/L wrist and hands. Dx remains unchanged. Plan: Requested R wrist MRA due to TFCC sprain on MRI and involuntarily dropping of objects. Ordered Naproxen. 3rd request made for referral to Dr. Leynes.

11/25/19-12/03/19 (2 visits) - Acupuncture Therapy Notes at Tri-County Med Grp. Pt completed 2 sessions of acupuncture therapy for B/L shoulders and B/L feet. Pain level 5/10. C/o constant pain with N/T.

12/10/19 - Utilization Review by Shahriar Pirouz, MD. Requested FRP daily no-show rate has been denied.

12/20/19 - PR-2 by Archie Mays, MD. Pt c/o 8/10 B/L shoulder and B/L feet pain. Dx remains unchanged. Plan: Ordered UDS. TTD.

12/20/19 - UDS Rpt at US Lab. Results: Positive and inconsistent for Pregabalin.

01/06/20 – 01/07/20 (2 visits). Psychotherapy Note by Denniz Hernandez, PsyD. Pt has attended 2 sessions of group psychotherapy.

01/06/20 - Progress note by Mauro Zappaterra, MD. Pt visited for FRP day #1. LBP and B/L knee pain at 7/10. Also describes having fatigue, insomnia, and symptoms of mild depression. Dx: 1) Lumbar paraspinal muscle spasm. 2) LBP. 3) Insomnia. Plan: Continue FRP.

01/07/20 – PT Note at Pasadena Rehab Institute. Pt underwent PT for L/S and B/L knee and ankle. Had improvement with motion. Continue PT.

01/08/20 - Progress note by Mauro Zappaterra, MD. Pt participated in the FRP lecture. Mood and affect were appropriate. Assessment: Chronic pain syndrome.

01/08/20 - FRP Team Conference Rpt. Pt has completed 3 days of FRP. Feeling hopeful. Continue with FRP. (partial report)

01/09/20-01/14/20 (2 visits) - Acupuncture Therapy Notes at Tri-County Med Grp. Pt completed 2 sessions of acupuncture therapy for B/L shoulders and B/L feet. Pain level 7/10. C/o constant pain with N/T.

01/09/20 – PT Note at Pasadena Rehab Institute. Pt presents with increased lumbar lordosis. Underwent PT for L/S and B/L knee and ankle. Fair retention noted. Continue PT.

01/09/20 - Progress Note by Reed Levine, MD. LBP at 5-7/10. Also reports of B/L knee pain. Dx remains unchanged. Plan: Continue Lyrica.

01/10/20 – 01/13/20 (2 visits). PT Note at Pasadena Rehab Institute. Pt presents feeling well without any signs of pain or discomfort. Completed 2 sessions of PT for L/S and B/L knee. Continue PT.

01/13/20 - Psychotherapy Note by Denniz Hernandez, PsyD. Pt has attended group psychotherapy session.

01/13/20 - Progress Note by Mauro Zappaterra, MD. Pt has used breathing techniques to decreased stress. Dx remains unchanged. Continue FRP.

01/14/20 - PT Note at Pasadena Rehab Institute. Pt presents feeling well without any signs of pain or discomfort. Completed one session of PT for L/S and B/L knee. Continue PT.

01/14/20 - Psychotherapy Note by Denniz Hernandez, PsyD. Pt has attended a group psychotherapy session.

01/15/20 - FRP Team Conference Rpt, week #2. Pt has not missed any days of program. Done initial mindfulness and meditation techniques. Feeling hopeful. Active throughout the house and household chores. Continue with FRP. (partial report)

01/15/20 - Progress Note by Mauro Zappaterra, MD. Pt attended FRP lecture titled medications. Mood and affect were appropriate. Assessment: Chronic pain syndrome.

01/16/20 - Quick Note on Functional Restoration Program by Mauro Zappaterra, MD. Today discussed mindfulness of emotions, the practice of localizing emotions in the body mindfully and breathing into the bodily location that the emotion is felt to create a breathing space for the emotion. Practiced with mild rated negative emotions and positive emotions. Participated in localizing emotions mindfully exercises. Dx: Chronic pain. Plan: Continue with FRP.

01/16/20 (1 visit) - Physical Therapy Note at Pasadena Rehab Institute. Pt completed 1 session of PT for BUE and BLE. Pt presents feeling well w/o any signs of pain or discomfort. Pt demonstrated good tolerance with BUE and BLE strengthening exercises with min cues for pacing and postural correction.

01/16/20 (1 visit) - Psychotherapy Note by Denniz Hernandez, Psy.D. Pt attended 1 session of group psychotherapy.

01/17/20 - STP's PR-2 by John Katzen, MD/Rafael Begluyan, NP. Pt c/o constant B/L wrist and elbow pain at 7/10 with N/T and pain worse at night, c/o weakness to B/L wrist and hands. Dx remains unchanged. Plan: Re-ordered R wrist MRA, EMG/NCV.
01/17/20 - PT Note at Pasadena Rehab Institute. Pt states decreased tolerance with ambulation and activities at home due to B/L feet pain. Completed one session of PT for L/S and B/L knee. Continue PT.

01/20/20 - Goal Log. Week #2. Pt perceived disability is 66% indicating severe disability.

01/20/20 – 01/21/20 (2 visits) Psychotherapy Note by Denniz Hernandez, PsyD. Pt has attended 2 sessions of group psychotherapy.

01/20/20 - Progress Note by Mauro Zappaterra, MD. Discussed at length opioid medications, side effects, and warning strategies as well as risks of concomitant opioids and benzodiazepines. In addition, discussed non-pharmacological sleep hygiene techniques at length. Dx remains unchanged. Continue FRP.

01/20/20-01/21/20 (2 visits) - PT Note at Pasadena Rehab Institute. Pt presents with improved affect. Good participation with PT session. Completed 2 sessions of PT for L/S and B/L knee. Continue PT.

01/20/20-01/30/20 (5 visits) - PT Note at Pasadena Rehab Institute. Pt is cooperative with good participation in PT session. Completed 5 sessions of PT for L/S and B/L knee. Encouraged to follow HEP. Continue PT.

01/22/20 - FRP Team Conference by Mauro Zappaterra, MD/Apurva Zawar, PT/Harold Gottliedb, Ph.D/Denniz Hernandez, Psy.D/Nicole Mena, FRP Clinical coordinator. Week #3. Pt is here for eval for the FRP. He is very motivated to improve and to return to work. He is participating very well in the program. He is doing more at home, being more active, using more non-pharmacological tools to help with decreasing pain flares. States would have a difficult time working more than 2 consecutive days. He may benefit from a graded RTW plan working 2-3 days per week and slowly increasing. Pt actually thinks he could work at this time as an electrician, he would just need a day off to recover. Plan: Continue PT, a work conditioning program and CBT. An FCE may be appropriate as well. Continue with FRP.

01/22/20 - Progress Note by Mauro Zappaterra, MD. Pt attended FRP lecture titled Anti-Inflammatory Lifestyle. Mood and affect were appropriate. Assessment: Chronic pain syndrome.

01/23/20-01/27/20 (2 visits) - Acupuncture Therapy Note at Tri-County Med Grp. Pt completed 2 sessions of acupuncture therapy for B/L shoulders and B/L feet. Pain rated 5/10. C/o constant pain with N/T.

01/23/20 – 01/31/20 (4 visits). Psychotherapy Note by Denniz Hernandez, PsyD. Pt has attended 4 sessions of group psychotherapy.

01/27/20 - PR-2 by Archie Mays, MD. Pt c/o 7/10 B/L shoulder pain and 8/10 B/L feet pain. Completed acupuncture therapy. Dx remains unchanged. Plan: Ordered UDS. Re-ordered EMG/NCV. Off work until 30-45 days.

01/27/20 - Goal Log. Pt completed 3rd week of psychotherapy. Pt's perceived disability is 60% severe disability.

01/29/20 - Quick Note by Mauro Zappaterra, MD. Dx: Chronic pain syndrome.

01/30/20 - Quick Note by Mauro Zappaterra, MD. Today discussed gratitude and benefits of gratitude. Participated in gratitude exercise.
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02/12/20 - MR Arthrogram of the R Wrist Interpreted by Alan Turner, MD at F & M Radiology Med Ctr Inc. Positive Findings: A small cyst is seen in the lunate and capitate measuring 1 mm in diameter. The triangular fibrocartilage complex appears of a normal low signal intensity with no tears. Fluid is seen in the radiocarpal, ulnocarpal and carpal joints. The surrounding soft tissues reveal normal intermediate signal intensity. The flexor and extensor tendons demonstrates normal low signal intensity without tear. Impression: 1) Cyst in the lunate and capitate. 2) Joint effusion.

02/20/20 - Progress Note by Reed Levine, MD. Pt's back pain severity is 2-7/10. Also reports B/L knee pain. Completed FRP with some benefit but still has significant discomfort at times. Has been undergoing acupuncture and completed in early February 2020 without much benefit. Dx remains unchanged. Plan: Taper off Lyrica.

02/21/20 - EMG/NCV of BUE Interpreted by Jeff Altman, MD at California Diagnostic Specialists, Inc.
Impression: 1) Mild R carpal tunnel (median demyelinating neuropathy across the wrist) affecting sensory fibers. 2) Mild B/L ulnar sensory demyelinating neuropathies at the wrist. 3) No findings of any plexopathies or cervical radiculopathies on the current study.

02/25/20 – EMG/NCS of LS and BLE Interpreted by Javier Torres, MD.
Impression: 1) Normal EMG studies of LE with no acute or chronic denervation potentials. 2) Normal NCV studies of the LE did not reveal any electrophysiological evidence of peripheral nerve entrapment.

02/28/20 - PR-2 by Archie Mays, MD. Pt c/o 8/10 B/L R shoulder and B/L feet pain. Dx remains unchanged. Plan: Off work until 30-45 days.

03/19/20 - STP's PR-2 by John Katzen, MD. Pt c/o constant B/L wrist and elbow pain at 7/10 with N/T and pain worse at night. C/o weakness to B/L wrist and hands. Pt completed all therapies. Dx remains unchanged. Plan: 4th request made for referral to Dr. Leynes.

03/25/20 – Supplemental PQME Rpt by Gerald Markovitz, MD. DOI: 04/30/18. Additional records were reviewed especially of ortho and pain specialist. Examiner mentioned that pt has been receiving care and meds at Kaiser as well. At initial visit, pt told he had been a Kaiser pt for about 10-12 years. Pt was prescribed narcotic analgesics, which would be expected to cause constipation, anti-inflammatory med, which could cause heartburn and chronic severe pain med would affect the quality of his sleep. His sleep and GI problems may be industrial. For instance, the pain records stated that pt denies any GI symptoms and the HPI contains no information about his internal medicine complaints. Need additional medical records in order to arrive at final conclusions.

03/27/20 - PR-2 by Archie Mays, MD. Pt c/o 8/10 B/L shoulder and B/L feet pain. Dx remains unchanged. Plan: Ordered Lidocaine ointment. TTD.

04/02/20 - Progress Note by Reed Levine, MD. Pt's back pain severity is 4-6/10. Also reports B/L knee pain. Dx remains unchanged. Plan: Pt wants to hold off Vertiflex and SCS.

04/29/20 - PR-2 by Archie Mays, MD. Pt c/o 7/10 R shoulder pain, 6/10 L shoulder pain and 8/10 B/L feet pain. Dx remains unchanged. Plan: TTD.

04/30/20 - Progress Note by Reed Levine, MD. Pt c/o back pain at 6-7/10 with radiation to BLE down to feet. Dx remains unchanged. Plan: Pt wants to hold off on other treatments and would wait until Covid 19 crisis is a bit better.

05/15/20 - STP's PR-2 by John Katzen, MD/Rafael Begluyan, NP. Pt c/o constant B/L wrist and elbow pain at 7/10 with N/T and pain is worse at night with weakness to B/L wrists and hands. Dx remains unchanged. Plan: 5th request made for referral to Dr. Leynes.

06/12/20 - STP's PR-2 by John Katzen, MD. Pt c/o constant B/L wrists and elbow pain at 7-8/10 with N/T and pain is worse at night. C/o weakness to B/L wrists and hands. Dx remains unchanged.

06/18/20 - Progress Note by Andrew Seltzer, MD. Pt c/o back pain at 6-7/10 with radiation to BLE down to feet. Only taking Codeine sparingly for LBP flare-ups. Dx remains unchanged. Rx: Meloxicam. Plan: Trial of Mobic and pt is willing to try this. Not interested in proceeding with any other invasive procedures now.

06/19/20 - PR-2 by Archie Mays, MD. Pt c/o 5/10 B/L shoulder pain and 8/10 B/L feet pain. Dx remains unchanged. Plan: TTD.

07/13/20 – Supplemental PQME Rpt by Gerald Markovitz, MD. Additional records were reviewed. The records reflect that pt has had ortho problems for many years. He has been prescribed multiple anti-inflammatories muscle relaxers and narcotic analgesics. He has required sleeping pills. He was also seen for HAs severe enough to be associated with nausea and sometimes vomiting as well. The records show that pt has been prescribed Prilosec. The records did not mention constipation. Examiner last saw the pt two years ago. Examiner will need to reevaluate pt to issue a final report.

07/17/20 - STP's PR-2 by John Katzen, MD/Rafael Begluyan, NP. Pt c/o frequent B/L wrists and elbow pain at 7-8/10 with N/T and weakness in hands, pain worse at night. Dx remains unchanged.

07/24/20 - PR-2 by Archie Mays, MD. Pt c//o 8/10 B.L shoulder pain and 7/10 B/L feet pain. Completed PT< chiro and acupuncture therapy, helps temporarily. Dx remains unchanged. Rx: Zanaflex and Pepcid. Plan: Recommended FCE. TTD until 6 weeks.

07/30/20 - Progress Note by Reed Levine, MD. Back pain at 7/10 with radiation to BLE. Dx remains unchanged. Plan: Continue with Mobic.

08/14/20 - Functional Capacity Eval by Aaron Basco, DC at Tri-County Med Grp, Inc. Recommendations: Pt is not able to return to work. Work capacity is within the sedentary PDL, f/u with PTP. Limit bending, squatting and exposure to material handling. Provide frequent breaks. Continue current rehab program. A re-eval of the pt can determine if their condition is exacerbated and whether or not performance is significantly changed. This will aid the evaluator and in the injured worker's physician in the effort to make appropriate work preclusions and possible tx recommendations. Pt should be allowed to continue tx with the goal of gaining significant improvement in reduced pain, increased ROM and increased strength.

08/24/20 - PR-2 by Archie Mays, MD. Pt c/o 6/10 B/L shoulder pain and 7/10 B/L feet pain. Dx remains unchanged. Plan: TTD until 6 weeks.

08/28/20 - STP's Initial Internal Medicine Eval by Maria Leynes, MD. DOI: CT 05/04/09-04/30/18. Pt sustained CT from 05/2009 to 04/30/18 to his B/L hands and fingers, wrists, elbows, and shoulders, neck, lower back, knees and feet. His pain started in his hands and shoulders sometime in 2017 or 2018, which he attributes to constantly reaching overhead while installing street/city lights. He also had a lot of pain in the knees and feet because of prolonged periods of walking and kneeling. Sometime in 2017-2018, he reported his pain to his immediate supervisor. He was not taken seriously and was never referred for medical attention. In the same year, he slipped on a wet slope and twisted his knees. His knee pain was aggravated, and after the incident, his pain increased. This time he was referred to company doctor, but only for his knee. After his initial visit, he was sent back to work. He returned to work normal duties and continued f/u care with the company doctor. No other forms of tx were provided. Pt does not recall if he was prescribed meds for pain. He continued working his normal duties while in pain. Eventually, the supervisor assigned him lighter duties. After three months of limited medical tx, pt stopped seeing the company doctor and sought legal advice. His attorney referred him to Dr. Archie Mays 1-1/2 years ago for his shoulders, hands and wrists. He is seeing Dr. Pelton from White Memorial Hospital for Tx for his lower back and knees. He has two separate claims. For his L/S, he was referred to White Memorial Hospital, where he was treated with PT and pain management. He has had MRIs and indicated surgery in the L/S. Pt is reluctant of the prospect of lumbar surgery but his surgeon informed him that because of the pandemic, surgery may not be possible unless it is an emergency. Pt states that his lumbar pain is severe, but he can still walk and move around. He does not use any support devices to ambulate, although he states that he could use a cane. He can still walk for approximately 10 minutes before he has to rest to relieve his lumbar pain. Pt is no longer attending PT because it was of not much help. Also, he was declared P&S, date not recalled. He continues to attend pain management tx at the same hospital. For his wrists, hands and shoulders, he was referred to Dr. Archie Mays. He has completed multiple courses of PT, also not helpful long term. He also had MRIs and nerve conduction tests. He was examined by Dr. Scott Rosenzweig. Surgical procedures were indicated, but he is reluctant about any type of surgeries.

He states that for now he wants to wait until he can no longer live with his pain. Pt has multiple areas of pain. His PCP from Kaiser referred him to a specialist, who diagnosed OA about three years ago. He was still working for Cal Trans Burbank at that time, but he denies a prior h/o arthritis before his Dx. He has a family h/o arthritis; his maternal grandmother had a lot of joint arthritis. Pt is managing his arthritic pain with meds prescribed by his treating physicians. He is taking Trezix, Tizanidine; Meloxicam and Omeprazole. Pt has gastritis, constipation and burning pain in the stomach, which he attributes to the many meds for pain he is currently taking. His pain meds do not help his pain much, but he continues to take them indicated. PMH: He was in good health when he began his employment with Cal Trans Burbank. He gradually began to develop multiple areas of pain starting with his shoulders and hands and then his lower back and knees. He has not gotten good control of his pain. He was also previously diagnosed with OA. Family Hx: Has family hx of chronic HAs and OA. Social Hx: Denies smoking, drinks beer or wine once in a while. PE: Pt is overweight. Extremities-TTP of the MCP joints B/L. Wrists revealed tenderness in the lateral areas or the ulnar side of both wrists without swelling. X-rays of B/L hands and wrists were normal. X-rays of R shoulder normal. X-ray of L shoulder showed degenerative changes. Dx: 1) Multiple joint pain. 2) Orthopedic dx. Plan: Ordered RA, ANA, ESR, CRP, uric acid and CCP antibody for lab work.

09/10/20 - Progress Note by Reed Levine, MD. Back pain at 6-7/10 with radiation to BLE. When taking Meloxicam, pain improves 30-40%. Dx remains unchanged. Plan: Continue with Mobic.

09/30/20 - PR-2 by Archie Mays, MD. Pt c/o 6/10 B/L shoulder pain and 7/10 B/L feet pain. Dx remains unchanged. Plan: TTD until 6 weeks.

10/16/20 - STP's PR-2 (Telemedicine) by Maria Leynes, MD. Hands and joint pains unchanged. No activities panel done. Pt had no new complaints. Dx remains unchanged. Plan: Ordered labs.

10/28/20 - PR-2 by Archie Mays, MD. Pt c/o 6/10 B/L shoulder pain and 7/10 B/L foot pain. Meds help reduce pain to 5/10. Dx remains unchanged. Plan: TTD until 6 weeks.

11/06/20 – Internal Medicine PQME Rpt by Gerald Markovitz, MD. DOI: 04/30/18. Pt continues to receive his general medical care at Kaiser. He told that he no longer sees Dr. Pelton. He has another orthopedist, Dr. Mays. He continues to have chronic ortho problems. He was observed to have a very stiff gait. He told hat Dr. Pelton has recommended low back surgery but pt is apprehensive. Pt told Dr. Mays has recommended R shoulder surgery and possibly foot surgery on at least maybe the R foot. Pt was not quite sure about all of the details. Pt continues taking Tylenol #3 for pain. Meds upset his stomach, so he limits its use to about two or three times per week. Med causes him to experience nausea and heartburn. For that reason then, he will take what he thinks is a prescription antacid from Dr. Mays. He cannot recall the name of that med. Pt continues to have problems with constipation. He will eat prunes and fiber about every two to three days, when he has constipation.

When he takes Tylenol With Codeine, he will skip for two days. For the last two years or so, he has had problems with what sounds like anal irritation with bleeding if he strains. This might occur about once a month. He does not use any Tx. Pt continues to have problems with his sleep. His sleep latency is about one hour due to his shoulder and back complaints, as well as N/T of his hands. He tosses and turns, which wakes him up every night. In total, he estimates he obtains only about four hours of broken sleep per night. He has tried taking Melatonin without much help. He has not taken any other prescription sleeping meds for the last two years. He has also tried some natural teas to help with his sleep. If he has a bad sleep one night, the next day he tends to have HA for which he will take Excedrin. He still has severe HAs. In the last two years, he has been to the ER about two or three times at Kaiser Downey when he has a severe HA with nausea. In order to avoid these severe HAs, he takes the Excedrin. Pt experiences needle-like pain in the bottom of both feet as well as back pain and knee pain after walking about a block. His hand problems cause him to be unable to lift weights. He c/o of pain and depression from all of these problems.

Dx: 1) Heartburn. 2) Constipation. 3) Insomnia. Causation: With regard to stomach, constipation and insomnia it is industrial basis. Apportionment: With regard to stomach, constipation and insomnia it is industrial basis. Impairment Rating: With regard to stomach 3% WPI. With regard to constipation 5% WPI. With regard to insomnia 15 % WPI. Future Medical Care: With regard to stomach, constipation and insomnia needs future medical care on an industrial basis. For his stomach, he should be provided with antacids or anti-nausea meds as needed. For his constipation, he should be provided with stool softeners and other bowel preparations as needed. For his sleep, he should be provided with non-habit forming sleeping meds used on an as needed basis. Discussion: Pt has two orthopedic injuries. He has an accepted claim for injury of 08/03/18 to both knees and low back. He has an accepted CT injury from 05/04/08 to 05/30/18 for neck, fingers of both hands, both hands, back, both shoulders, and both elbows. In terms of apportionment for his internal medicine problems as discussed above, if he takes the pain meds for pain related to both injuries, then examiner would not be able to apportionment between the two injuries. If he has taken the narcotic analgesics for pain related to both injuries, then examiner would not be able to apportion between the two injuries.

If he has difficulty with his sleep due to pain from both injuries, then examiner would not be able to apportion between the two injuries. On an internal medicine basis, these two injuries would be-inextricable intertwined. On the other hand, if the orthopedist is able to clearly tell that the pt has only taken pain meds and has pain from one or the other injury, then apportionment would be assigned to that one or the other injury.

11/06/20 - ECG Rpt

11/06/20- Oximetry Record.

11/10/20 - Progress Note by Reed Levine, MD. Pt has seen QME on 11/06/20. Report pending. When taking Meloxicam, pain is improved by 30-40%. Dx remains unchanged. Plan: Continue with Mobic.

12/09/20 - PR-2 by Archie Mays, MD. Pt continues to be symptomatic. C/o 6/10 B/L shoulder pain and 7/10 B/L feet pain. His depression and anxiety have not gotten better. Meds help to reduce pain to 5/10. Dx remains unchanged. Plan: Continue home exercises. TTD until 6 weeks.

01/07/21 - Progress Note by Reed Levine, MD. Pt c/o ongoing increased LBP with radiation to BLE down to feet in last couple of days. Feels this may be due to cold weather. Pain will improve only when he takes Meloxicam, not found it as helpful with his current flare-up. Rx: Lorzone. Continue with Mobic.

01/11/21 - PR-2 by Archie Mays, MD. Pt continues to be symptomatic. C/o 7/10 B/L shoulder pain and 8/10 B/L feet pain. Dx remains unchanged. Plan: TTD until 45 days.

02/08/21 - PR-2 by Archie Mays, MD. Pt c/o 7/10 B/L shoulder and 8/10 B/L feet. Dx remains unchanged. Plan: TTD until 45 days.

03/03/21 - Progress Note by Reed Levine, MD. Pt c/o ongoing unchanged LBP radiating to BLE down to feet. Meloxicam improves the pain to 30-40%. Has completed the FRP program and thinks there was some benefit but still has significant discomfort at times. Finished acupuncture without much benefit. Dx remains unchanged. Plan: Restarted Lorzone. Continue Meloxicam. Pt still not interested in any further injections. He is hesitant to proceed with spine surgery. Pt wants to hold off on Vertiflex and SCS and see how he feels in the coming months. He said he might want to try SCS trial and then depending on outcome to either proceed with SCS implant or Vertiflex. He is anxious about doing anything invasive right now. Continue with Mobic. He still uses Trezix for severe pain. UDS done on 01/15/19 shows positive for alcohol and metabolites and Gabapentin. Currently not working. Pt is on permanent disability.

03/17/21- PR-2 by Archie Mays, MD. Pt c/o 7/10 B/L shoulder and 8/10 B/L feet pain. Meds help to reduce pain to 5/10. Dx remains unchanged. Plan: TTD until 45 days.

04/28/21 - PR-2 by Archie Mays, MD. Pt c/o 7/10 B/L shoulder pain and 8/10 B/L feet pain. Meds helps to reduce pain to 5/.10. Dx remains unchanged. Plan: Completed all tx, helped temporarily. Continues med. Pending podiatrist consult. Pt wants to hold off B/L foot injections. Per Dr. Rosenzweig, no surgery for both shoulders. F/u prn for corticosteroid injection. Pt has reached MMI today w/FMC and permanent restrictions per FCE.

05/03/21 - Progress Note by Reed Levine, MD. Pt continues to c/o ongoing unchanged LBP radiating to BLE down to feet. Pain level 6/10. Dx remains unchanged. Plan: Continue Meloxicam. He wants to continue to hold off on Vertiflex and SCS. He is not currently working and is on permanent disability as per Dr. Pelton.

11/06/21 - Epworth Sleepiness Scale by Gerald Markovitz, MD. Total score 16 indicating abnormal range.

Recv'd Date: 20210716 Bill ID: 101694119
SCIF RECD DATE :07/16/2021

Physician's Return-to-Work & Voucher Report

FOR INJURIES OCCURRING ON OR AFTER 1/1/13

☒ The Employee is P&S from all conditions and the injury has caused permanent partial disability

Employee Last Name	Employee First Name	MI	Date of Injury
SILVA	EDGARDO		07/14/2021

Claims Administrator	Claims Representative
State Compensation Insurance Fund	Ludy R. Yee Chut

Employer Name	Employer Street Address
Cal Trans	

Employer City	State	Zip Code	Claim No.
	CA		06304052

☐ The Employee can return to regular work

☒ The Employee can work with the following restrictions:

	hours: 1-2	2-4	4-6	6-8	None
Standing	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Forward Bending	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Crawling	☐	☐	☐	☐	☐
Twisting	☐	☐	☐	☐	☐
Keyboarding	☐	☐	☐	☐	☐
R/L/Bilat Hand(s) (circle): *Grasping*	☐	☐	☐	☐	☐
R/L/Bilat Hand(s) (circle): *Pushing/ Pulling*	☐	☐	☐	☐	☐
Other: _____ (See below)	☐	☐	☐	☐	☐

Lift/Carry Restrictions: May not lift/carry at a height of _____ more than _____ lbs. for more than _____ hours per day.

Describe in what ways the impaired activities are limited:

The examinee is restricted from pushing, pulling and lifting greater than 20 pounds, and no repetitive forceful squeezing with the right hand and no repetitive overhead work with the right, and no repetitive turning and twisting of his head and neck.

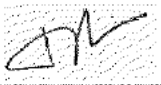
If a Job Description has been provided, please complete: ☐ *Regular* ☐ *Modified* ☐ *Alternative Work*

Job Title: _____ *Work Location*: _____

Are the work capacities and activity restrictions compatible with the *physical requirements* set forth in the provided job description? ☐ *Yes* ☐ *No, explain below*

Physician's Name: Donald Kim, M.D.

Role of Doctor (PTP, QME, AME): QME

Physician's Signature: 

Date: 07/14/2021

State of California
Division of Workers' Compensation

Physician's Return-to-Work & Voucher Report Instructions
FOR INJURIES OCCURRING ON OR AFTER 1/1/13
DWC - AD 10133.36

Who is responsible for filling out this form? The first physician (primary treating physician, Agreed Medical Evaluator, or Qualified Medical Evaluator) who finds that the disability from all conditions for which compensation is claimed has become permanent and stationary (or has reached maximum medical improvement) and finds that the injury has caused permanent partial disability.

What is the purpose of this form? The purpose of the form is to fully inform the employer of the work capacities and activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work. The information contained on the form is for voucher purposes and is not considered in any permanent impairment rating or any permanent disability indemnity.

Is this a mandatory form? This is a mandatory attachment to the first medical report finding that the disability from all conditions for which compensation is claimed has become permanent and stationary and that the injury has caused permanent partial disability. This form should be attached to a comprehensive medical-legal evaluation and does not replace such comprehensive medical-legal evaluations.

When does the form need to be completed? This form does not need to be completed until all conditions for which compensation is claimed have become permanent and stationary.

If the employer or claims administrator has provided the physician with a job description providing physical requirements of the employee's regular work, proposed modified work, or proposed alternative work, the physician will evaluate and describe in the form whether the work capacities and activity restrictions are compatible with the physical requirements set forth in that job description. The bottom portion of the form does not need to be completed if the physician has not been provided with a job description.

Completing the employee's work restrictions: The physician should indicate work restrictions in terms of how many hours a particular activity is restricted during an 8-hour work day. For hand restrictions, the physician should indicate whether the restrictions are for the right hand, left hand, or both.

Other restrictions can include psychiatric restrictions, chemical exposure, use of equipment, or any other restrictions.

How does the employer receive the form? The claims administrator will forward the form to the employer.

PRINT CLEAR

State of California
DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT

AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

Case Name: EDGARDO SILVA *(employee name)* v Cal Trans *(claims administrator name, or if none employer)*

Claim No.: 06304052 **EAMS or WCAB Case No. (*if any*):** ADJ11095415

I, RAYLENE TENORIO *(Print Name)*, declare:

1. I am over the age of 18 and not a party to this action.
2. My business address is: 1680 PLUM LANE, REDLANDS CA 92374
3. On the date shown below, I served the attached original, or a true and correct copy of the original, comprehensive medical-legal report on each person or firm named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A	depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: *(For each addressee, enter A – E as appropriate)*	Date Served:	Addressee and Address Shown on Envelope:
A	07/15/21	State Compensation Insurance Fund - SENT ELECTRONICALLY
A	07/15/21	Joe Southard & Yeah, LLP 11620 Wilshire Boulevard, Suite 900 Los Angeles, California 90025
A	07/15/21	State Compensation Insurance Fund P.O. Box 65085 Fresno, California 93650-5085

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: 07/15/2021

Raylene Tenorio *(signature of declarant)*

RAYLENE TENORIO *(print name)*

Archie R. Mays, MD
338 N. Western Ave.
Los Angeles, CA 90004
Tel: (213) 250-5106 Fax: (213) 250-8861

MEDICAL FACSIMILE COVER SHEET

IF YOU RECEIVE THIS FAX IN ERROR, PLEASE CONTACT THE SENDER IMMEDIATELY, AND THEN DESTROY THE FAXED MATERIALS.

Confidentiality Notice

The information contained in this fax is privileged and confidential information intended for the use of the individuals or entities described below. Health Care Information is personal and sensitive and should only be read by authorized individuals. Failure to maintain confidentiality is subject to penalties under State and Federal Law.

The following fax contains information pertaining to:

Patient Name:	Edgardo Silva
Employer:	Cal Trans Burbank
Insurance:	SCIF
Claim Number:	06363436
Facsimile:	(707) 646-6592
Applicant Attorney:	Joe Southard & Yoeh Los Angeles
Facsimile:	(424) 264-2311

Date Sent:	May 5, 2021	Number of Pages:	5
Description:	Progress Report (PR-2) and RFA dated 4/28/2021		

Sent By: Wendy Garcia

In the event that any of the above information is incorrect, please contact the front office personnel or office manager to provide correct information.

State of California
Division of Workers' Compensation

Additional pages attached ☐

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 or PR-4.

☒ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☒ Released from care
☐ Change-in work status ☒ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☒ Request for authorization
☐ Other: MMI TODAY, 4/28/2021, W/ FMC, NEEDS DICATATION

Patient:

Silva	Edgardo		MI
Patient last name:	Patient first name:		Male
[redacted]			
Patient's street address/PO Box	Patient City	State / Zip Code	Sex
Electrician	[redacted]	Date of Birth	[redacted]
Occupation	Phone Number		
	Claims Administrator	Date of Injury	CT:5/4/09-4/30/18
SCIF	06363436		
Claims Administrator Name	Claim Number		
P.O. BOX 3171	Suisun City	CA	94585
Claims Administrator Street Address	Claims Administrator City	State	Zip Code
(800) 684-3639	(707) 646-6592	Cal Trans Burbank	
Phone Number	Fax Number	Employer Name	Phone Number

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective Complaints:
NO INTERPRETER PER PATIENT
Mr. Silva complains of constant moderate 7/10 bilateral shoulder pain and stiffness.
Mr. Silva complains of constant severe 8/10 throbbing bilateral foot pain and stiffness. Right=Left.
There is complaint of loss of sleep due to pain. Mr. Silva states his depression and anxiety have not gotten better.
S/P cortisone injection to right shoulder on 3/20/2019. Pt. had no major improvement
Medication helps reduce his pain to 5/10.

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)
BP: 115/80 P: 80 WT: 181 pounds HT: 5'8, BMI: 27.5

Right Shoulder: The right shoulder ranges of motion are decreased and painful, he has tenderness to the AC joint (Flexion 165/180, Extension 35/50, Abduction 165/180, Adduction 30/40, Internal Rotation 60/80, External Rotation 70/90).
Left Shoulder: The left shoulder ranges of motion are decreased and painful, mild to moderate tenderness to AC joint (Flexion 150/180, Extension 40/50, Abduction 150/180, Adduction 30/40, Internal Rotation 65/80, External Rotation 75/90).
Bilateral Feet: This man has tenderness to medial aspects of both feet at the tarsal tunnels. He has tenderness at the plantar regions as well.

11/06/2020 – PQME, INTERNAL MEDICINE, DR. GERALD MARKOVITZ, MD- DX: HEARTBURN, CONSTIPATION, AND INSOMNIA. THE PATIENT IS AT MMI PENDING FINAL REPORT FROM ORTHOPEDIST PQME, WPI; 15 %. INDUSTRIAL CAUSATION. NEEDS ONGOING FUTURE MEDICAL CARE.

8/14/2020- FCE – AARON BOSCO, D.C – RECOMMENDATIONS: NOT ABLE TO RETURN TO USUAL WORK. WORK CAPACITY IS WITHIN SEDENTARY PDL.

9/28/19- DR. KATZEN, HAND SURGEON, RECOMMENDS: MRI OF BOTH ELBOWS, EMG UPPERS, WRIST BRACES AND SLEVES, MRA WRIST JOINTS.

MRI OF RIGHT FOOT 01/30/2019
IMPRESSION:
Small 5 x 5mm subarticular cyst / geode noted in navicular.
Minimal meta-tarso-phalangeal joint effusion of first and fourth toe.

MRI OF LEFT FOOT 02/01/2019
IMPRESSION:
Minimal effusion noted in inter-tarsal and meta-tarso-phalangeal joints.
Minimal ankle joint effusion.

MRI OF RIGHT HAND 01/29/2019
IMPRESSION:
Minimal effusion noted at metacarpophalangeal joints.
Mild soft tissue edema noted over palmar aspect of base of thumb

Silva Edgardo Date of Exam: 4/28/2021

MRI OF LEFT HAND 02/02/2019
IMPRESSION:
Minimal effusion noted at metacarpophalangeal joints.
Small 5 x 4mm subarticular cyst / geode noted in distal end of third metacarpal.

MRI OF RIGHT WRIST 01/30/2019
Impression:
1. Small effusion.
2. Edematous and indistinct ulnar attachment of the TFC , consistent with sprain or partial tear.
3. Radiocarpal joint effusion.

02/01/19 MRI OF LEFT WRIST IMPRESSIONS:
Tenosynovitis of the extensor carpi radialis brevis and longus.
Degenerative changes are seen in the 1st metacarpophalangeal joint.
Subcortical cystic changes seen in the head of the 3rd metacarpal and capitate.
Strip of fluid in the pisotriquetral, midcarpal and 1st metacarpophalangeal joint.

MRI OF RIGHT ELBOW 02/02/19:
Impression:
1. Interval finding of radiohumeral effusion. Associated joint space narrowing noted. Marginal osteophyte off the articulating margins of the radiohumeral joint. Radiohumeral joint osteoarthrosis.
2. Interval finding of ulnohumeral effusion. Thinned ulnohumeral joint cartilage. Associated joint space narrowing noted. Marginal osteophyte off the articulating margins of the ulnohumeral joint. Ulnohumeral joint osteoarthrosis.

MRI OF LEFT ELBOW 01/18/19
Impression:
1. Interval finding of radiohumeral effusion. Associated joint space narrowing noted. Marginal osteophyte off the articulating margins of the radiohumeral joint. Radiohumeral joint osteoarthrosis.
2. Interval finding of ulnohumeral effusion. Thinned ulnohumeral joint cartilage. Associated joint space narrowing noted. Marginal osteophyte off the articulating margins of the ulnohumeral joint. Ulnohumeral joint osteoarthrosis.

MRI OF RIGHT SHOULDER 01/29/2019
IMPRESSION:
1. Minimal shoulder joint effusion.
2. Minimal collection in subacromiodeltoid bursa suggestive of bursitis.
3. Supraspinatus tendinosis.
4. Bicipital tenosynovitis.
5. Acromioclavicular joint arthropathy.

MRI OF LEFT SHOULDER 01/18/19
Impression:
1. Flat laterally downsloping acromion.
2. Mild acromioclavicular joint separation. Mild acromioclavicular joint osteoarthritis.
3. Mild supraspinatus tendinosis.
4. Small glenohumeral joint effusion.
5. Small subacromial/subdeltoid bursitis. Small subcoracoid bursitis.

ELECTRODIAGNOSTIC MEDICINE IMPRESSION 2/25/20:
1. NORMAL EMG studies of lower extremities with no acute or chronic denervation potentials.
2. NORMAL NCV studies of the lower extremities did not reveal any electrophysiological evidence of Peripheral Nerve Entrapment.

Diagnosis:

1.	OVERUSE SYNDROME	ICD-10	M70.90] WITH
2.	BILATERAL SHOULDER SPRAIN/STRAINS, RIGHT SHOULDER SUPRASPINATUS TENDINOSIS, LEFT SHOULDER AC OA AND MILD SUPRASPINATUS TENDINOSIS, PER MRI	ICD-10	S43.402A, S46.912A, S43.401A, S46.911A, M24.811, M24.812]
3.	RULE OUT COMPRESSIVE NEUROPATHY, BILATERAL UPPER EXTREMITIES, RIGHT ELBOW ULNAHUMERAL EFFUSION, PER MRI.	ICD-10	G56.91, G56.92]
4.	BILATERAL FOOT PAIN, RULE OUT TARSAL TUNNEL SYNDROME	ICD-10	M79.671, M79.672, G57.51, G57.52]
5.	RULE OUT PLANTAR FASCIITIS	ICD-10	M72.2]
6.	MODERATE TO SEVERE ANXIETY, DEPRESSION AND INSOMNIA	ICD-10	F41.1, F33.0, G47.00]

Silva Edgardo Date of Exam: 4/28/2021

Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s)

1. Completed all Treatment, helped temporarily.
2. Continue: Zanaflex 4mg #60, Naproxen 500mg #60, Nexium 20mg #30, and Lidocaine ointment 5% 50gm 2x a day- 1 tube
3. Pending Podiatrist for Consult for bilateral foot pain, right foot cyst.
4. Patient wants to hold off on bilateral foot injections at the moment
5. Orthopedic surgeon, Dr. Rosenzweig, for both shoulders, no surgery per Dr. Rosenzweig, Follow up PRN for corticosteroid injections.
6. Completed FCE, ADL's and ROM
7. Previously Reviewed PQME report from 11/06/2020, Internist, Dr. Markovitz.
8. Obtain Orthopedic PQME report from Dr. Kim. Initial and final reports pending.
9. RTC PRN OR upon receipt of PQME reports from Dr. KIm.
10. MMI TODAY, NEEDS DICATATION

Chronic condition that have or could exacerbate or complicate today's acute symptoms have been reviewed and addressed. Patient advised to F/u with PCP for the treatment and management of other chronic condition/symptoms.

Work Status: This patient has been instructed to: **[MMI TODAY W/ FMC AND PERMANENT RESTRICTIONS PER FCE]**

☐ Remain off-work until _____

☐ Return to *modified* work on _____ with following limitations or restrictions
(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

☐ Return to full duty on with no limitations or restrictions.

Primary Treating Physician: (original signature, do not stamp) Date of exam: 4/28/2021

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Physician Signature:		Cal. Lic. #	A46453
Executed at:	Los Angeles, CA.	Date (*mm/dd/yyyy*)	4/28/2021
Physician Name:	Archie R. Mays, MD	Specialty:	Orthopedic
Physician Address:	338 N. Western Ave, Los Angeles CA. 90004	Phone:	(213) 250-5106

PRIVACY NOTICE: A statement of current date collection and use policies and certain privacy rights of injured workers may be found at the following website: http://www.dir.ca.gov/od_pub/privacy.html

State of California, Division of Worker's Compensation
REQUEST FOR AUTORIZATION
DCW Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DCW Form PR-2, or equivalent narrative report substantiating the requested treatment.

Requesting Physician Information

x New Request ☐ Resubmission - Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health.
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information

Name: Silva, Edgardo
Date of Injury: CT:5/04/2009-4/30/2018 | Date of Birth: [redacted]
Claim Number: 06363436 | Employer: Cal Trans Burbank

Name: Dr. Archie Mays, MD
Practice Name: Tri-County Medical Corp. | Contact Name:
Address: 338 N. Western Ave | City: Los Angeles | State: CA
Zip Code: 90004 | Phone: (213) 250-5106 | Fax Number: (213) 250-8861
Specialty: Orthopedic consultant | NPI Number: 1568414886
E-mail Address:

Claims Administrator Information

Company Name: SCIF | Contact Name:
Address: PO Box 3171 | City: Suisun City | State: CA.
Zip Code: 94585 | Phone: (800) 684-3639 | Fax Number: (707) 646-6592
E-mail Address:

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Overuse Syndrome	M70.90			
Bilateral shoulder sprain/strain R/O I.D	S43.402A,S46.912A S43.401A,S46.911A M24.9	RTC		PRN
R/O Compressive Neuropathy, BUE Right Elbow Ulnahumeral Effusion	G56.91, G56..92			
Bilateral foot pain R/O Tarsal Tunnel Syndrome	M79.671, M79.672, G57.51, G57.52			
R/O Plantar Fasciitis	M72.2			
Anxiety, Depression, Insomnia	F41.1, F33.0, G47.00			

Requesting Physician Signature: [signature] Date 4-28-21

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (If assigned): | Date:
Authorized Agent Name: | Signature:
Phone: | Fax Number: | E-mail Address:
Comments:

KEVIN J. PELTON, M.D., FAAOS
FELLOW, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

NOVEMBER 18, 2019

SCIF
[redacted]

RE : **SILVA, EDGARDO**
DOI : 08/03/2017
DOB : [redacted]
INS/ADM : SCIF
ADJUSTER : MICHAEL A
EMPLOYER : CAL TRANS BURBANK
OCC : ELECTRICIAN
CLAIM# : 06304052
WCAB# : ADJ11095415
DOE : 11/18/2019

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT

To Whom It May Concern:

I had the opportunity of examining and treating Mr. Silva for industrial injuries he sustained during the course of his occupation as an Electrician while working for Caltrans Burbank.

The following report will address the patient's current status, factors of disability, if any, need for continued care relative to the industrial injury which occurred on the above referenced date.

My history, x-ray studies, review of medical records, physical, orthopedic and neurological findings were as follows.

CURRENT COMPLAINT:

16530 Ventura Blvd. Suite 100
Encino, CA 91436

1700 E. Cesar Chavez Ave. Suite 2200
East Los Angeles, CA 90033

23502 Lyons Ave. Suite 202A
Santa Clarita, CA 91321

Mailing Address: P.O. Box 260980, Encino, CA 91436

Phone: (818) 788-0101 • Fax: (818) 788-4158

On the final date of examination, the patient complained of the following:

LOW BACK:

The patient complains of constant sharp and dull pain in the low back with weakness and numbness. The pain is described as a 9 on a 1-10 scale. The pain is made worse with sitting, standing, walking, bending, twisting, lifting, pushing and pulling. The pain is improved with rest.

BILATERAL KNEES:

The patient complains of constant sharp and dull pain and stiffness in the bilateral knees with weakness and numbness. The pain is described as a 7 on a 1-10 scale. The pain is made worse with sitting, standing, walking, lifting, squatting, climbing, kneeling, crawling and stairs. The pain is improved with rest.

HISTORY OF INJURY:

The original history of injury is well detailed in my initial report dated January 29, 2018.

At the time of the initial examination in this facility, the patient presented with complaints of pain in the low back and bilateral knees. Following my examination, I diagnosed him with right knee chronic ACL sprain and partial tear, left knee sprain and chronic lumbar strain with stenosis and acute injury. I recommended an MRI of the lumbar spine and left knee as well as physical therapy for the lumbar spine and bilateral knees. A written prescription was given for Tylenol 3.

The patient underwent physical therapy for the lumbar spine and bilateral knees with minimal benefit.

The patient was recommended acupuncture and orthotics, but these were denied.

On October 3, 2018, an MRI was performed of the left knee revealing mild chondral softening at the lateral patellar facet without high-grade chondral defects.

On December 6, 2018, the patient underwent a pain management evaluation with Dr. Levine for the lumbar spine. The patient was referred for an MRI of the lumbar spine.

On April 8, 2019, the patient was administered a lumbar spine epidural steroid injection without significant benefit.

On August 9, 2019, the patient underwent a spine surgery consultation with Dr. Falkinstein and was not currently recommended surgical intervention.

The patient presented today for reevaluation with a complaint of pain in the low back and bilateral knees.

It was determined that the patient had reached a point of maximum medical improvement as of the date of this exam and did present for final permanent and stationary examination.

PHYSIOLOGICAL PAIN DRAWING:

The patient marks pain in neck, bilateral shoulders, bilateral elbows, bilateral wrists and hands, low back, bilateral thighs, bilateral knees, bilateral calves and bilateral feet.

COMMONLY MEASURED ACTIVITIES OF DAILY LIVING (ADL)

	Without difficulty	With some difficulty	With much difficulty	Unable to do
Self-Care, Personal Hygiene: (Example – Urinating, Defecating, Brushing Teeth, Combing Hair, Bathing, Dressing Oneself, Eating)				
Dress yourself including shoes			X	
Comb your hair			X	
Wash and dry yourself			X	
Take a bath			X	
Get on and off the toilet			X	
Brush your teeth			X	
Cut your food		X		
Lift a full cup/glass to your mouth		X		
Open a new milk carton			X	
Make a meal			X	
Communication: (Example – Writing, Typing, Seeing, Hearing, Speaking)				
Write a note			X	
Type a message on a computer			X	
See a television screen		X		
Use a telephone		X		
Speak clearly	X			

Physical Activity: (Example – Standing, Sitting, Reclining, Walking, Climbing Stairs				
Work outdoors on flat ground			X	
Climb up 1 flight of 10 steps			X	
Stand			X	
Sit			X	
Recline			X	
Rise from a chair			X	
Run errands			X	
Light housework			X	
Sensory Function: (Example – Hearing, Seeing, Tactile Feeling, Tasting, Smelling)				
Feel what you touch		X		
Smell the food you eat	X			
Taste the food you eat	X			
Nonspecialized Hand Activities: (Example – Grasping, Lifting, Tactile Discrimination)				
Open car doors		X		
Open previously opened jars		X		
Turn faucets on and off		X		
Travel: (Example – Riding, Driving, Flying)				
Shop			X	
Get in and out of the car			X	
Drive a car			X	
Take a flight			X	
Sleep/Sexual Function: (Example – Restful, Nocturnal Sleep Pattern, Orgasm, Ejaculation, Lubrication, Erection)				
Sleep			X	
Engage in sexual activity			X	

PHYSICAL EXAMINATION:

EXAMINATION OF THE LUMBAR SPINE:

Inspection revealed no evidence of edema, bruises, atrophy, discoloration, rashes, abrasion or laceration.

Range of Motion per AMA Guides 5th Edition, pages 407 & 409:

Motions	Measured	Normal
Flexion	45, 50, 45	60
Extension	15, 15, 15	25
Right Lateral Bending	20, 20, 15	25
Left Lateral Bending	15, 15, 15	25

Palpation of the lumbar paraspinal muscles revealed tenderness and hypertonicity bilaterally. Palpation of the lumbar spine revealed tenderness. Straight leg raising test was positive bilaterally. Clonus was absent, bilaterally. Muscle strength was 5/5 in the L4, L5 and S1 musde groups, bilaterally. Deep tendon reflexes were +2/+2 at L4 bilaterally. Sensation was decreased in the S1 dermatome on the right.

EXAMINATION OF THE KNEES:

Inspection is considered normal with no evidence of edema, bruises, atrophy, discoloration, rashes, scars, abrasions or lacerations.

Range of Motion: Goniometric evaluation AMA *Guides* 5th edition, pg 540.

Motions	Right	Left	Normal
Flexion	130	130	150
Extension	0	0	0

There is palpable tenderness over the medial joint line bilaterally. Patellofemoral Grind test is positive bilaterally. Valgus and Varus Stress, McMurray's, Anterior and Posterior Drawer, Lachman's and Pivot Shift tests are negative bilaterally. Muscle strength is 5/5 in flexion and extension bilaterally.

DIAGNOSES:

1.	Chronic lumbar strain with stenosis and acute injury	ICD-10:	S39.012D; M48.07
2.	Right knee - No meniscus tear. Chronic sprain of the ACL, no high-grade ligament tear. Grade II chondromalacia medial compartment and patella, per MRI 10/21/17	ICD-10:	S83.511D; M22.40
3.	Left knee sprain	ICD-10:	S83.92XD
4.	Left knee - no acute meniscal, ligament or osseous injury. Mild chondral softening at the lateral patellar facet without high-grade chondral defects, per MRI 10/3/2018	ICD-10:	M22.40

MAXIMUM MEDICAL IMPROVEMENT: AMA *Guides* 5th Edition; pg 601

It is my opinion that the patient has reached maximum medical improvement as of today's date and has reached permanent and stationary status for rating purposes.

OBJECTIVE FACTORS OF DISABILITY:

In regard to the LUMBAR SPINE, the patient's objective factors of disability are as follows:

1. Asymmetric loss of range of motion.
2. Palpable tenderness and muscle guarding.
3. Positive orthopedic tests.
4. Decreased sensation in the S1 dermatome on the right.

In regard to the RIGHT KNEE, the patient's objective factors of disability are as follows:

1. Loss of range of motion.
2. Palpable tenderness.
3. Positive orthopedic tests.
4. Positive diagnostic imaging.

In regard to the LEFT KNEE, the patient's objective factors of disability are as follows:

1. Loss of range of motion.
2. Palpable tenderness.
3. Positive orthopedic tests.
4. Positive diagnostic imaging.

AMA IMPAIRMENT RATING AND RATIONALE: AMA *Guides*, 5th Edition; pgs.

Whole person impairment values were calculated utilizing criteria outlined in the "AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT" 5th edition and were calculated as follows:

Body Impairment	WPI%	Table #(s)	Page #(s)
LUMBAR SPINE (DRE Method)	**13%**	15-3	384

Utilizing **Table 15-3**, page 384, the patient would qualify for DRE Category III based on the following observations: the clinical history and examination findings are compatible with a specific injury; tenderness and muscle guarding to palpation of the bilateral lumbar paraspinals; asymmetric loss of range of motion; verified radiculopathy along the right S1 dermatome; no alteration of structural integrity.

Body Impairment	WPI%	Table #(s)	Page #(s)
RIGHT KNEE Patellofemoral Pain	2%	17-31	544

The patient has a history of direct trauma to the knee with a complaint of patellofemoral pain. Per table 17-31, the patient is provided 2% whole person impairment.

Body Impairment	WPI%	Table #(s)	Page #(s)
LEFT KNEE Patellofemoral Pain	2%	17-31	544

The patient has a history of direct trauma to the knee with a complaint of patellofemoral pain. Per table 17-31, the patient is provided 2% whole person impairment.

ALMARAZ – GUZMAN II ANALYSIS

To briefly summarize the decision of the courts in the recent Almaraz-Guzman II En Banc decision, a permanent impairment rating that is established by the strict application of the AMA Guides, 5th Edition, is rebuttable in the event it is felt by the medical examiner that the AMA Guides does not accurately depict the patient's true level of impairment when considering both the limitations with non-work activities of daily living and work activities of daily living. One method of rebutting the impairment rating is to challenge one of the component elements of that rating. Though it is not permissible to go outside the four corners of the AMA Guides, a physician may utilize any chapter, table or method in the AMA Guides that most accurately reflects the patient's true level of impairment.

In February 2009, according to the recent Almaraz-Guzman II En Banc decision, in order to provide an accurate impairment the physician must take into consideration the following criteria: 1. His own clinical judgment based on his experience, training and skill. 2. Generally accepted medical literature or criteria. 3. How an injured worker's injury has impaired his or her ability to perform ADL (including complex tasks such as work). 4. An assessment while using appropriate chapters of the AMA Guides.

Recently, further decision relative to Almaraz-Guzman, known as "AG III" has been decided by the 6th District Court. It reads in part, "*The Guides itself recognizes that it cannot anticipate and describe every impairment that may be*

experienced by injured employees. To accommodate those complex or extraordinary cases, it calls for the physician's exercise of clinical judgment to evaluate the impairment most accurately, even if that is possible only by resorting to comparable conditions described in the Guides."

There is no indication for Almaraz-Guzman II application at this time as the conventional use of the AMA Guides, 5th Edition has adequately reflected the patient's actual level of impairment.

PAIN ASSESSMENT (Limitations of non-work activities of daily living)
The burden of this worker'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. **There will be an additional 3% whole-person impairment rating attributable to such pain.**

APPORTIONMENT: California Labor Code §4663 (a), (b), (c) and §4664

Regarding the lumbar spine, I am currently unable to provide an opinion on apportionment absent medical records. The patient indicated that he sustained a previous industrial injury to the lumbar spine in approximately 2002 and received a settlement and monetary award. I have not been provided medical records regarding the patient's previous injury. As the patient did receive a settlement, apportionment for the lumbar spine is indicated. I request that medical records be provided including any medical legal evaluations or final reports as well as the Stipulations with Request for Award.

Regarding the bilateral knees, based on the history given to me by the patient and available medical records, there is no indication of prior history of industrial or non-industrial factors, occurring either before or subsequent to the industrial injury that contributed to this patient's current impairment. Mr. Silva did not experience any limitations/impairments of Activities of Daily Living or work related impairments prior to the industrial injury he sustained on August 3, 2017.

In compliance with Labor Code Section 4663 and 4664 I have analyzed causal factors of permanent impairment for purposes of apportionment. With a reasonable degree of medical probability, **I am apportioning 0% of the current level of impairment to the presence of prior industrial or non-industrial factors and 100% of the current level of impairment to the direct result of Mr. Silva's industrial injury on August 3, 2017**, arising out of and occurring in the course of his employment.

If additional medical records become available for my review, I will be glad to re-evaluate my present conclusions.

WORK RESTRICTIONS:

The patient may return to work with restrictions as follows:

The patient is precluded from bending, twisting, squatting and lifting greater than 25 pounds.

RETURN TO WORK:

Should the restrictions not be accommodated by the employer, the patient would be an excellent candidate for a Supplemental Job Displacement voucher.

FUTURE MEDICAL CARE:

Concerning the **LUMBAR SPINE**, the patient should be provided access to an orthopedic primary treating physician for monitoring of appropriate medications, short courses of chiropractic and physical therapy with utilization per the MTUS Guidelines for flare-ups above his permanent and stationary level. In the event that his symptoms worsen, he should be allowed epidural steroid injections and surgery.

Concerning the **BILATERAL KNEES**, the patient should be provided access to an orthopedic primary treating physician for monitoring of appropriate medications, short courses of physical therapy with utilization per the MTUS Guidelines for flare-ups above his permanent and stationary level. In the event that his symptoms worsen, he should be allowed PRP injections and viscosupplementation injections.

I reserve the right to modify my opinions based on any additionally provided medical evidence. Should further medical records be made available, I would be happy to review them and provide a supplemental report if necessary.

If you need any additional information, please do not hesitate to contact my office.

Disclosure:

The above evaluation was performed on November 18, 2019 at 1700 E. Cesar E. Chavez Avenue, Suite 2200, East Los Angeles, CA 90033.

The time spent performing this evaluation was in compliance with the guidelines established by the industrial Medical Council or the Administrative Director pursuant to paragraph (5) of subdivision (j) of Section 139.2.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true. I further declare under penalty of perjury that I personally performed the evaluation of the patient, and that except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to all applicable provisions of Section 139.2 and/or Section 5307.6 of the California Labor Code. I further declare under penalty of perjury that I have not violated any of the provisions of California Labor Code Sections 139.3 nor 139.32 with regard to the evaluation of this patient or the preparation of this report.

I further declare under penalty of perjury that there has been no violation of California Labor Code Section 139.32(d)(2), in that I have not offered, delivered, received or accepted any rebate, refunds, 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.

Kevin Pelton, M.D.
Primary Treating Physician:
Board Certified Orthopedic Surgeon
Orthopedic Surgery, Trauma
Sports Medicine QME, IME

Los Angeles County, California

KP: gs

cc: LAW OFFICES OF HALEH SHEKARCHAIN
9440 SANTA MONICA BLVD., SUITE 707
BEVERLY HILLS, CA 90210

DEPARTMENT OF TRANSPORTATION
DIVISION OF HUMAN RESOURCES
1727 30th STREET
P. O. BOX 168037, MS-88
SACRAMENTO, CA 95816-8037
PHONE (916) 227-7512

Making Conservation a California Way of Life.

CERTIFIED MAIL, RETURN RECEIPT REQUESTED AND REGULAR MAIL

May 11, 2020

Edgardo Silva-Valdovinos
[redacted]

Dear Mr. Silva-Valdovinos:

I am a Return to Work Coordinator with the California Department of Transportation (Caltrans) and have received your Primary Treating Physician Dr. Pelton's 11/18/19 report that indicates you have the following permanent restrictions:

- **Lifting limited to 25 pounds**
- **No bending, twisting or squatting**
-

Caltrans cannot permanently accommodate your work restrictions in your usual & customary job as a CT Electrician II. At this time, Caltrans invites you to engage in the interactive process to discuss your physician's findings, begin the transition of returning you to work, and/or to develop a plan should you decide to explore other options. To facilitate this discussion, I am providing the following information to let you know of the various options which may be available to you. I look forward to discussing with you any option you may be interested in, however please be advised some options may not be available to you in light of the particular facts of your situation.

Enclosed for your review is a list of options that may be available to you, either now or in the future, and a Discussion Option Checklist. The Description of Options provides you with a brief narrative of these various options. The Discussion Option Checklist is for you to select as many options as you would like to discuss or obtain additional information.

These options may not include all available legal options. If you have any other options that you would like to discuss, please let me know. If you do not respond to this letter or we are unable to reach a resolution, we may pursue one of the following options:

1. **Medical Transfer/Demotion:** If you are able to work in an alternate classification, we may medically transfer or demote you to a currently vacant position for which you meet the minimum qualifications.
We will make an effort to place you in the highest paying vacant position for which you are qualified, which is not promotional and which meets your medical restrictions.

2. **Disability Retirement:** If you have not pursued disability retirement but are eligible to apply, we may file on your behalf. While the application is pending, you may utilize your existing leave credits until exhausted. If you exhaust all of your leave credits prior to CalPERS determination, you will be paid by the Department a temporary disability allowance (TDA) equal to the estimated amount of your disability retirement benefit. Should CalPERS grant the disability retirement application, you would then receive the disability retirement allotment directly from CalPERS. If the disability retirement application is denied, you have a right to return to work, with back pay, less any TDA received.

3. **Medical Termination:** If you are not entitled to disability retirement or you waive your right to file for disability retirement, we may medically terminate you pursuant to Government Code section 19253.5.

You must remain in contact with your supervisor in regard to any absence from work. Failure to report may result in the Department invoking the Absence without Leave (AWOL) provisions of Government Code Section 19996.2. Absence without Leave, whether voluntary or involuntary, for five consecutive working days is an automatic resignation from state service, as of the last date on which the employee worked.

Please return the completed documents by ***Tuesday, May 26, 2020.*** If we do not receive the completed documents from you by ***Tuesday, May 26, 2020***, it may be necessary for Caltrans to proceed with choosing an option for you. If you have any questions, please call me at **(916) 227-7512**.

Sincerely,

Monica Morse

Monica Morse
Return to Work Coordinator

Enclosures: Description of Options
Option Checklist
Location Preference for Placement Assistance
Employment Application STD. 678
DD-48-R3 Reasonable Accommodation
DD-61-R2 Return to Work

CC: RA Coordinator
WC File

Description of Options

1. Return to Work

a. **Full Duty:** You may be able to return to work as a [insert job title] performing full duty with no restrictions, if you provide a full medical release, in writing, from your treating physician. This medical release must be provided prior to your return to work.

b. **Reasonable Accommodation:** If you believe that you are disabled and that a reasonable accommodation would enable you to perform the essential functions of your current position/classification, you may request a reasonable accommodation. Each request will be considered separately, taking into account how your disability limits you in performing your essential functions. There is no one particular accommodation for a specific limitation; rather, a wide range of options may be considered as possible accommodations.

c. **Temporary/Modified/Alternative Work:** Temporary/Modified/Alternative Work (TMAW) is a type of reasonable accommodation that may be provided to employees with temporary medical restrictions who cannot perform the essential function(s) of their job. The Hiring Authority or designee shall, on a case-by-case basis, have the final decision in granting TMAWs. The employee's supervisor will be responsible for monitoring the duration of the TMAW. The Hiring Authority, at its discretion, may terminate a TMAW that is no longer necessary, or negatively impacts local operations, upon written notice to the employee.

d. **Medical Transfer/Demotion:** If you are unable to perform the work of your current position but are qualified for and able to perform the work of another position in the Department, you may be able to medically transfer or medically demote to such a position. If you would like to pursue reassignment to another classification, a list of current job vacancies will be provided to you; if more than one vacancy is available you may be asked to indicate your level of preference for each. Please note: medical transfers and demotions are subject to State Personnel Board (SPB) Rules 425, 430-435, and 444, which permit transfers from one classification to another if the duties, level of responsibility, and salary of the two classes are substantially the same (as determined by Caltrans), are not in the same class series, and do not constitute a promotion. Also, per SPB Rule 250, it is still necessary to meet the education and experience requirements (as defined in the Minimum Qualifications of the State Personnel Board Job Specifications for the classification), as well as possessing any required license, certificate, credential, etc. If at a later date you are no longer incapacitated for duty in your original position, under most circumstances, you would have a mandatory right to reinstatement to that classification or an equivalent classification. This option is available through the provisions of

Government Code section 19253.5.**Temporary Assignment for Injured Employees:** Temporary Assignments for Injured Employees, as outlined in SPB Rule 443, are job assignments identified and approved by two hiring authorities facilitated by the Caltrans Division of Human Resources. A temporary assignment or loan of employee within an agency or between agencies cannot exceed two years and may be available to facilitate your return to work. You would have a mandatory right of return to your former position when the temporary assignment ends.

e. **Civil Service Appointment**: You may elect to apply for and secure state service employment (Caltrans or another State Department) without the assistance from your supervisor. An individual's job-related qualifications for any position will be based on knowledge, skills, abilities, experience, education, training, and in some instances physical and mental fitness, and any other personal characteristics related to the job requirements as determined by a candidate's performance in the examination and selection process. This includes a position of a promotional nature.

2. **Temporary Disability**

a. **Family Medical Leave Act (FMLA) / California Family Rights Act (CFRA):** If you qualify, you may request a leave of absence under either of these statutes. Both allow qualified employees to take up to 12 weeks of unpaid leave each year when they, or a qualified family member, have a serious health condition. You may be able to utilize existing leave credits. These statutes require that the employer maintain an employee's health, dental and vision coverage during such leave.

b. **Pregnancy Disability Leave:** If you are unable to perform all the essential functions in your current position due to a disability related to pregnancy, you may be entitled to unpaid leave. Accrued leave credits may be available to supplement leave.

c. **Medical Leave of Absence**: At the discretion of the Hiring Authority, you may request an unpaid medical leave of absence for up to one year. Under this option, the employer is not required to maintain an employee's health, dental and vision coverage. You may choose to pay for these benefits yourself. Additionally, you will not accrue state service or leave credit time.

d. **Leave Balances:** You may be able to utilize existing leave balances, including a request for catastrophic leave.

e. **Non-Industrial Disability Insurance (NDI):** If you are on authorized leave and have a non-industrial health condition, or a denied Workers' Compensation claim, which prevents you from working, you may be entitled to NDI benefits. Your doctor must provide medical substantiation of your health condition in

order for EDD to determine your eligibility for NDI benefits. While on NDI, health, dental and vision benefits are covered. While on NDI, you will still be required to comply with all sick leave policies applicable to you.

The Employment Development Department (EDD) administers the NDI benefit. You may contact the EDD statewide toll-free number for California State Government Employees, 1-866-352-7675, for more information. Note: Employees in State Employees International Union (SEIU) bargaining units are not eligible for NDI, they are eligible for SDI instead.

f. **State Disability Insurance Program (SDI):** SDI pays part of an employee's wages if they have to stop working because of a non-work-related illness or injury. SDI also covers an employee if they take time off due to pregnancy or childbirth, or to bond with a minor child within one year of its birth, adoption, or foster care placement. SDI also covers time off to care for a seriously ill child, spouse, parent, or domestic partner.

You may be eligible to receive SDI benefits while waiting for an approval for your worker's compensation claim. If your claim is approved, any SDI benefits received may be required to be repaid.

SDI is an employee paid benefit and payments are administered by Employment Development Department (EDD). While on SDI, health, dental, and vision benefits are covered for up to 26 weeks; however, you will not accrue state service credit(s). While on SDI you are also still required to comply with all sick leave polices applicable to you.

The Employment Development Department (EDD) administers the NDI benefit. You may contact the EDD statewide toll-free number for California State Government Employees, 1-866-352-7675, for more information.

g. **Industrial Disability Leave/ Temporary Total Disability:** If you are industrially injured, you may be entitled to Industrial Disability Leave or Temporary Total Disability benefits for a maximum not to exceed 104 weeks, when medically certified by your primary treating physician, Qualified or Agreed Medical Examiner. For injuries on or after January 1, 2004 you may be entitled to supplemental job displacement benefits. To determine your eligibility, please contact your State Compensation Insurance Fund Claims Adjuster or your workers' compensation attorney. While out utilizing this benefit you may accrue state service credit(s).

3. **Separation from State Service**

a. **Disability Retirement (DR) or Industrial Disability Retirement (IDR):** If you are unable to return to work due to your permanent functional limitations, you may apply for DR or IDR with the California Public Employees' Retirement

System (CalPERS). DR and IDR are considered a temporary separation from state service. Health benefits are available through CalPERS while you are on retirement status. If, after you are approved for DR or IDR and, at a later date, it is determined you are able to return to work, you will have a mandatory right of reinstatement to your current classification.

While you await the determination of your disability retirement application from CalPERS, you may use your existing leave credits, request FMLA/CFRA leave, or request a medical leave of absence. If you are eligible you may also apply for service retirement pending approval of your DR or IDR. This process may take on average 180-270 days (6-9 months).

b. **Service Retirement:** If you are eligible, you may apply for service retirement with CalPERS. A service retirement is a permanent separation from state service. Health benefits are available through CalPERS while you are on retirement. You would retain permissive reinstatement rights to state service. This process may take on average 30-90 days (1-3 months).

c. **Voluntary Resignation:** You may choose to voluntarily resign from state service. You will retain permissive reinstatement rights. You may be able to purchase health, dental and vision benefits.

Option Checklist

From the list below, select as many options as you would like to discuss or obtain additional information:

Return to Work

___ Full Duty

___ Reasonable Accommodation

___ Temporary Modified/Alternative Work

___ Medical Transfer/Demotion

___ Temporary Assignments for Injured Employees (per SPB Rule 443)

___Civil Service Appointment

Temporary Disability

___ Family Medical Leave Act (FMLA) / California Family Rights Act (CFRA)

___ Pregnancy Disability Leave

___ Medical Leave of Absence

___ Use existing leave balance

___ Non-Industrial Disability Insurance (NDI)

___ State Disability Insurance (SDI)

___ Industrial Disability Leave/Temporary Total Disability

Separation from State Service

___ Disability Retirement

___ Service Retirement

___ Voluntary Resignation

Signature _____ Date _____ Phone ( ) _____

PLEASE RETURN THIS CHECKLIST BY: **DATE: TUESDAY, MAY 26, 2020**

Return to: Monica Morse
Division of Human Resources
PO Box 168037, MS-88
Sacramento, CA 95816

LOCATION PREFERENCE FOR PLACEMENT ASSISTANCE

COMPLETE AND RETURN THIS FORM ONLY IF YOU ARE INTERESTED IN PLACEMENT TO ANOTHER POSITION.

1. Please identify the location(s) you would be willing to accept employment.

( ) Eureka Area (District 1)
( ) Redding Area (District 2)
( ) Marysville Area (District 3)
( ) Oakland Area (District 4)
( ) San Luis Obispo Area (District 5)
( ) Fresno Area (District 6)
( ) Los Angeles Area (District 7)
( ) San Bernardino Area (District 8)
( ) Bishop Area (District 9)
( ) Stockton Area (District 10)
( ) San Diego Area (District 11)
( ) Irvine/Orange County Area (District 12)
( ) Sacramento Area

2. Areas of interest or proficiency include:

_____
_____
_____
_____
_____
_____
_____
_____
_____

1. Complete and return this form along with the enclosed application.

2. Vacancies can be viewed on-line at www.jobs.ca.gov

_____

Employee Signature **Date**

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

EXAMINATION / EMPLOYMENT APPLICATION

STD. 678 (REV. 12/2017) Page 1

Applications will be processed ONLY for classifications where an examination is in progress and the published final filing date has not passed, or for vacant positions where a department requests an application.

PRINT OR TYPE--PLEASE SEE INSTRUCTIONS ON BACK PAGE

APPLICANT IDENTIFICATION NUMBER (EASY ID)
FIRST 3 LETTERS OF LAST NAME AT BIRTH | MONTH OF BIRTH | DAY OF BIRTH | Last 4 DIGITS OF SOCIAL SECURITY NUMBER

EASY ID --

APPLICANT'S NAME *(Last)* *(First)* *(M.I.)*

SOCIAL SECURITY NUMBER

MAILING ADDRESS *(Number)* *(Street)*

E-MAIL ADDRESS

WORK TELEPHONE NUMBER

(City) *(County)* *(State)* *(Zip Code)*

HOME/VRS/TTY TELEPHONE NUMBER

EXAMINATION(S) OR JOB TITLE(S) FOR WHICH YOU ARE APPLYING

PERSONNEL USE ONLY

ANSWER THE FOLLOWING QUESTIONS:

1. Enter the county in which you would like to take the examination if different from the county of your residence: _____
2. Do you need reasonable accommodation to take an interview or written test? ☐ Yes ☐ No
3. Do your religious beliefs prevent you from taking an examination on Saturday? ☐ Yes ☐ No
4. Are you now employed by the State of California? (If "YES", fill in the information below.) ☐ Yes ☐ No
   Department: _____ Subdivision: _____
5. Have you ever been fired, dismissed, terminated, or had an employment contract terminated from any position for performance or for disciplinary reasons? If "Yes", give details in the Explanations section below. Refer to the instructions for further information. ☐ Yes ☐ No
6. Have you ever entered into any written agreement with a state agency in which you agreed not to seek or accept subsequent employment with the state or any state agency? ☐ Yes ☐ No
7. Have you ever entered into any written agreement with a state agency involving an adverse action, rejection on probation, or AWOL termination, in which you agreed not to seek or accept subsequent employment with a particular state agency? ☐ Yes ☐ No
8. In addition to English, list any other languages you:
   a. possess verbal fluency in _____
   b. possess written fluency in _____
9. I certify I can type at a speed of _____ words per minute. (For typing applicants only.)

(ANSWER QUESTIONS 10 AND 11 ONLY IF THE EXAMINATION INDICATES THEY ARE REQUIRED.)

10. Do you meet the minimum and/or maximum age requirements? ☐ Yes ☐ No
11. Do you possess a valid California Driver License? (If "YES", fill in the information below.) ☐ Yes ☐ No

License # _____ Class: _____ Restrictions: _____

EXPLANATIONS

CERTIFICATION – IMPORTANT – PLEASE READ BEFORE SIGNING – If not signed, this application may be rejected.

I certify under penalty of perjury that the information I have entered on this application is true and complete to the best of my knowledge. I further understand that any false, incomplete, or incorrect statements may result in my disqualification from the examination process or dismissal from employment with the State of California. I authorize the employers and educational institutions identified on this application to release any information they may have concerning my employment or education to the State of California.

APPLICANT'S SIGNATURE DATE SIGNED

APPLICANTS—DO NOT USE THE SPACE BELOW—FOR PERSONNEL USE ONLY

Classes	01	02	03	04	05	06			
WC for Series/Levels									
RC/Flag for Series/Levels									

Flags _ _ _ _ _ _ _ _

WC _

CODES

FOR PERSONNEL USE ONLY

STATUS ☐ Accepted ☐ REJECTED WC

EXPERIENCE	LICENSE REQUIREMENT
EDUCATION	OTHER
STAFF	DATE PROCESSED

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

EXAMINATION / EMPLOYMENT APPLICATION

STD. 678 (REV. 12/2017) Page 3

APPLICANT'S NAME *(Last)*	*(First)*	*(M.I.)*	EASY ID --

EMPLOYMENT HISTORY *(Continued)*

FROM (M/D/Y)	TO (M/D/Y)	JOB TITLE/CLASSIFICATION (Include Range or Level, if applicable)	SUPERVISOR NAME
HOURS PER WEEK	TOTAL WORKED (Years/Months)	COMPANY/STATE AGENCY NAME	SUPERVISOR PHONE NUMBER
SALARY EARNED No Longer Required	PER No Longer Required	ADDRESS	
DUTIES PERFORMED			
REASON FOR LEAVING			

FROM (M/D/Y)	TO (M/D/Y)	JOB TITLE/CLASSIFICATION (Include Range or Level, if applicable)	SUPERVISOR NAME
HOURS PER WEEK	TOTAL WORKED (Years/Months)	COMPANY/STATE AGENCY NAME	SUPERVISOR PHONE NUMBER
SALARY EARNED No Longer Required	PER No Longer Required	ADDRESS	
DUTIES PERFORMED			
REASON FOR LEAVING			

FROM (M/D/Y)	TO (M/D/Y)	JOB TITLE/CLASSIFICATION (Include Range or Level, if applicable)	SUPERVISOR NAME
HOURS PER WEEK	TOTAL WORKED (Years/Months)	COMPANY/STATE AGENCY NAME	SUPERVISOR PHONE NUMBER
SALARY EARNED No Longer Required	PER No Longer Required	ADDRESS	
DUTIES PERFORMED			
REASON FOR LEAVING			

EQUAL EMPLOYMENT OPPORTUNITY
(For Examination Use Only)

APPLICANT: To assist the State of California in its commitment to Equal Employment Opportunity, applicants are asked to voluntarily provide the following information. This questionnaire will be separated from the application prior to the examination and will not be used in any employment decisions. Government Code Section 19705 authorizes the California Department of Human Resources to retain this information for research and statistical purposes.

SOCIAL SECURITY NUMBER	AGE	GENDER
	☐ Under 21 (1) ☐ 21 - 39 (3) ☐ 40-69 (6) ☐ 70 and Over (7)	☐ Male ☐ Female

PLEASE CHECK ONE OF THE BOXES THAT BEST DESCRIBES YOUR RACE/ETHNICITY HERITAGE:

ASIAN GROUP

- ☐ Asian Indian (M)
- ☐ Cambodian (U)
- ☐ Chinese (J)
- ☐ Filipino (G)
- ☐ Japanese (I)
- ☐ Korean (K)
- ☐ Laotian (V)
- ☐ Vietnamese (L)
- ☐ Other Asian Group (S)

HISPANIC GROUP

- ☐ Cuban (C)
- ☐ Mexican/Mexican American (A)
- ☐ Puerto Rican (B)
- ☐ Other Hispanic/Latino Groups (D)

PACIFIC ISLANDER GROUP

- ☐ Guamanian or Chamorro (R)
- ☐ Hawaiian (P)
- ☐ Samoan (Q)
- ☐ Other Pacific Islander Group (T)

OTHER GROUPS

- ☐ Aleut (O)
- ☐ American Indian/Native American (H)
- ☐ Black/African American (F)
- ☐ Eskimo (N)
- ☐ White (E)
- ☐ Other Racial Group (X)
- ☐ Choose not to Identify (Z)

☐ DISABILITY (Y) —A person with a disability is an individual who: (1) has a physical or mental impairment or medical condition that limits one or more life activities, such as walking, speaking, breathing, performing manual tasks, seeing, hearing, learning, caring for oneself or working; (2) has a record or history of such impairment or medical condition; or (3) is regarded as having such an impairment or medical condition.

☐ MILITARY—A military veteran; a widow or widower of a veteran; or a spouse of a 100% disabled veteran.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

Explanations – Use this section to explain the details of any response that requires additional information. Be thorough, and attach additional sheet(s) if needed.

Applicant's Signature – Your signature and the date signed is required. If the hard copy application is not signed, it may be rejected. Electronic submission of your application through Cal Career Account certifies your application in place of a signature and date signed.

Education – You must include a complete record of your training and educational background. Please read the requirements section of the examination bulletin carefully for any special educational requirements. If more space is needed, you may attach additional documentation.

Licenses – If the examination bulletin requires a specific license, professional certificate, or membership in a professional organization, list the full name of the license, certificate or organization, the license number, and the official expiration date of the document or membership.

Employment History and Experience – You must include a complete list of your paid and/or volunteer work experience **that relates to the qualification requirements specified on examination bulletin.** List all relevant jobs, during the past 10 years, regardless of duration, including part-time and military service. You should also list volunteer experience and jobs held more than ten years ago if they directly relate to the job for which you are applying. **State employees must list the specific departments for which they worked and indicate the specific civil service class title(s) held.**

Equal Employment Opportunity Page – Providing this information is voluntary. This data is only to be used for statistical purposes in evaluating the extent to which the state is complying with state and federal equal employment opportunity and non-discrimination requirements.

Examinations Granting Veterans' Preference – If you have not previously applied and been approved for Veterans' Preference, you must complete and submit the Veterans' Preference Form, CALHR-1093 to the California Department of Human Resources.

NOTE: Your completed application and other examination related information submitted to the department administering this examination becomes confidential information and the property of the State of California as provided by Government Code section 18934. This application and other confidential information **will not be returned;** therefore, it is recommended that you keep a copy of your completed application for your personal records. Your rights to inspect your examination papers are set forth in Section 186-189 of Title 2 of the California Code of Regulations, which can be accessed at Office of Administrative Law web site at: **oal.ca.gov**

PLEASE ENTER YOUR NAME ON PAGES WHERE INDICATED
AND STAPLE ALL PAGES OF THE APPLICATION TOGETHER BEFORE SUBMITTING.

Deputy Directive

Number:	DD-61-R2
Refer to Director's Policy:	DP-03-R1 Safety and Health DP-10 Departmental Commitments DP-11 Caltrans' Workforce DD-48-R3 Reasonable Accommodation
Effective Date:	8/7/2015
Supersedes:	DD-61-R1 (9/28/2008)
Responsible Program:	Administration Human Resources

TITLE Return to Work

POLICY

The California Department of Transportation (Caltrans) makes a good faith effort to return injured or ill employees to work when medically appropriate. If a physician determines that an employee cannot return to his/her usual and customary position, with or without a reasonable accommodation (RA), Caltrans makes a good faith effort to effect permanent placement to a medically appropriate vacant position within the department. A temporary alternate work assignment may address an employee's work restrictions and provide work experience outside of his or her normal classification. If placement to a permanent position cannot be accomplished, non-placement options may be considered including disability and service retirement. Other non-placement options such as medical demotion or termination may be considered after all other options have been exhausted.

BACKGROUND

All employees who incur a work or non-work related injury or illness must be provided with assistance in securing appropriate employment options to attempt to retain them as productive State employees. Caltrans must also ensure compliance with all applicable laws.

RESPONSIBILITIES

Deputy Directors, District Directors, and Division Chiefs

Ensure that managers and supervisors understand their roles and responsibilities in returning injured or ill employees to work, including the obligation to effect mandatory placement when medically appropriate positions are identified.

Managers and Supervisors

- Work closely with the Division of Human Resources Return-to-Work Coordinators, District Safety Officers and/or District Human Resources Liaisons to facilitate the return-to-work or mandatory placement of injured or ill employees when medically appropriate.
- Engage in a meaningful, good faith interactive process with the employee to discuss return-to-work options. These options include the exploration of temporary or permanent regular, modified or alternative work assignments within Caltrans. The interactive process requires the supervisor to:
    - Analyze the purpose and essential functions of the employee's position and how limitations directly affect the employee's ability to perform the essential functions.
    - Engage in a discussion with the employee to identify and assess potential RAs and the options available to mitigate the employee's limitations in performing the essential functions of the position.
    - Confirm information and agreements from discussion in writing to avoid any misunderstandings.
    - Maintain communication with the employee on an ongoing basis to keep them apprised of the status of the RA request.
    - Implement an RA that is reasonable, most appropriate and effective for the employee and the employer.
    - Monitor the RA regularly for effectiveness and appropriateness.
- Complete probationary reports for employees permanently placed into alternate classifications.

Division of Human Resources

- Provides technical assistance and serves as liaison between employees, supervisors, and managers regarding return-to-work issues.
- Notifies an injured or ill employee of permanent placement or non-employment options when return to their usual job is not medically feasible and facilitates implementation of the employee's selected option(s).
- Identifies medically appropriate vacant positions for the permanent placement of injured or ill employees.
- Provides training and guidelines to assist managers and supervisors to fulfill their responsibilities under this policy.

Employees

- Engage in a meaningful, good faith interactive process with their supervisor to discuss return-to-work options. The interactive process requires the employee to:
    - Inform the supervisor of their return-to-work status and any need for RA.

- Provide medical documentation to the supervisor that may assist the employee in returning to work when medically possible.
- Engage in a discussion with the supervisor to identify and assess potential RA and the options available to mitigate any limitations in performing the essential functions of the position.

APPLICABILITY

All Caltrans employees.

Original signed by:

KOME AJISE
Chief Deputy Director

08/07/2015

Date Signed

Deputy Directive

Number: DD-48-R3

Refer to Director's Policy: DP-01 Equal Employment Opportunity

Effective Date: 6/14/2013

Supersedes: DD-48-R2 (11-30-2009)

TITLE Reasonable Accommodation

POLICY

The California Department of Transportation (Caltrans) ensures equal employment opportunities when considering reasonable accommodation requests from employees or applicants. Caltrans makes every effort to provide reasonable accommodation to assist qualified employees and applicants with work-related or non-work-related disabilities, whether or not they are covered by worker's compensation and/or insurance, to participate in applicable Caltrans programs, services, and/or to perform a particular job. Caltrans processes reasonable accommodation requests and engages in timely, good faith interactive processes with individuals who request an accommodation.

Caltrans is not required to provide an accommodation that would cause a direct threat to the health or safety of the employee, applicant, or others. Caltrans is not required to create a position and/or promote an employee who requests a reasonable accommodation. Caltrans is also not required to provide the specific accommodation requested by an employee.

DEFINITION/ BACKGROUND

State and Federal laws require equal employment opportunities for all qualified persons and reasonable accommodation be provided to assist qualified disabled employees and applicants. Applicable laws include the Fair Employment and Housing Act (FEHA) (Government Code sections 12940 et seq.), the Civil Rights Act of 1991, the Americans with Disabilities Act (ADA) of 1990 and Amendments Act of 2008 (ADAA), Section 504 of the Rehabilitation Act of 1973, Section 19230 (c) of the Government Code, Title 2, Section 53.2 of the California Code of Regulations, and the Unruh Civil Rights Act (Civil Code sections 51, et seq.).

Reasonable Accommodation (RA): is a logical adjustment made to a job or work environment that allows a qualified person with a disability that is work-related or non-work related to participate in Caltrans employment process and in applicable work-related functions. To be entitled to an RA, a qualified worker must be impaired in his/her ability to perform the essential functions of the desired or held position because of his/her physical or mental disability or medical condition. RA includes any reasonable adjustment that changes environments, schedules or requirements to adapt to the known physical or mental limitations of an applicant or employee. Such adjustments may include, but are not limited to, modified schedules, leaves of absence, modified duty, provision of assistive devices, reassignments, alternative formats for written materials, equipment or furniture modifications.

RA does not include the purchase of personal use items (i.e., prescription eyeglasses, hearing aids, etc.). A request for a change in supervision does not constitute an RA.

Disability: includes any physical or mental impairment that limits one or more major life activity, a record of having such impairment or regarded as having such an impairment.

Employees: are persons who work for Caltrans and include civil service, temporary, emergency, limited-term, seasonal, exempt, retired annuitant, and special employment workers.

Applicants: are all persons who seek employment with Caltrans.

Essential Functions: are those duties that are fundamental to the job and are designated as such on the Duty Statement. Commuting to or from work is not an essential function and will not be accommodated by Caltrans.

RESPONSIBILITIES

Deputy Director, Administration:

- Ensures the development and dissemination of Caltrans Reasonable Accommodation policy and guidelines.
- Ensures implementation of a reasonable accommodation program that enables employees or applicants the opportunity to participate in Caltrans programs, services and applicable job duties.
- Responds as a second level of appeal for denials of employee's requests for reasonable accommodation.
- Provides oversight to Caltrans RA Program to ensure equal employment opportunities in accordance with Caltrans Equal Employment Opportunity Plan.

- Monitors implementation of the Americans with Disabilities Act Program as established in Caltrans Equal Opportunity Plan.

Deputy Directors, District Directors, Deputy District Directors and Division Chiefs:

- Provide direction to managers and supervisors to engage in the interactive process with their employees.
- Ensure managers and supervisors are trained in reasonable accommodation procedures.
- Respond timely to employees' appeals to denials of request for reasonable accommodation.

Managers and Supervisors:

- Provide the reasonable accommodation policy to employees.
- Provide the reasonable accommodation paperwork when needed (PMS-00 18, 0019 and 0021) to employees with a known disability, including those who have applied for workers' compensation benefits.
- Consult with the Reasonable Accommodation Coordinators, Liaisons and/or the Reasonable Accommodation Branch Chief to obtain assistance in the reasonable accommodation process for a non-work related disability.
- Consult with the Return to Work Coordinators (RTWC), safety officers or Workers' Compensation Branch Chief for assistance in the reasonable accommodation process for work-related disabilities.
- Engage in a meaningful, good faith interactive process with employees requesting reasonable accommodation and consider such requests in accordance with applicable laws.
- Implement approved reasonable accommodation requests.

Reasonable Accommodation Coordinators, Liaisons, Return to Work Coordinators, Safety Officers, and Reasonable Accommodation and Workers' Compensation Branch Chiefs:

- Provide training to managers and supervisors on the reasonable accommodation process.
- Coordinate and monitor reasonable accommodation requests to ensure they are processed in accordance with the law and the policy.
- Provide technical assistance regarding reasonable accommodation to managers, supervisors, and employees.

Employees:

- Notify their supervisor that they have a disability that requires an accommodation to enable them to perform their job's essential functions.
- Submit requests for reasonable accommodation to their immediate supervisor.

- Engage in a meaningful, good faith interactive process with supervisors in considering the request to determine an appropriate accommodation.
- Provide documentation to substantiate requests for reasonable accommodation as required, or as requested by Caltrans.
- Cooperate in obtaining information from their physician to enable the supervisor to fully evaluate the request for reasonable accommodation.

Applicants:

- Identify needs and submit requests for reasonable accommodation as established in the Reasonable Accommodation Guide.

APPLICABILITY

All Caltrans employees and applicants.

Signed by: *6/14/2013*

NORMA ORTEGA
Acting Chief Deputy Director

Date Signed