Hyperlinked
Chronology & Summary
Date:

Patient Name:
Insurance Claim No.:
Social Security No.:
Date of Birth:
Date of Injury:

Medical records provided for review came from the following sources:

Page number references in the summary below refer to a scanned PDF file made from the medical records sent for my review. The records were reviewed, summarized, and put into chronological order as below.

Medical records provided for review span a timeframe from 01/12/2012 through 09/26/2014.

Source List

Facility 1
- Provider 1, M.D.
- Provider 2, M.D.

Facility 2
- Provider 3, M.D.
- Provider 4, M.D.

Facility 3
- Provider 5, M.D.

Brief Summary/Flow of Events

On 01/12/2012, patient was evaluated by Provider 1, M.D. at Facility 1. On 01/12/2012, patient was making the bed and felt cold chills and lower back pain that started to hurt associated with cold sweats and cold chills. She was diagnosed with lumbago, lumbosacral neuritis and lumbar region sprain, and recommended physical therapy. She was placed on modified duty with limited stooping and bending for 2 hours per day, limited pull and push to 20 lbs, and must wear back support.

Upon follow-up evaluation on 01/19/2012, patient reported worsening lower back pain radiating down right leg associated with tingling and numbness in the right leg. She also noted some constipation from the Naprosyn. She was advised to decrease Naprosyn once a day, prescribed Norflex, advised to begin home exercises and Dispensed Back massager.

MRI of the lumbar spine performed on 02/15/2012 revealed grade 2 anterolisthesis of L5 on S1 secondary to bilateral pars interarticularis defects. There is resultant severe bilateral neural foraminal narrowing. The spinal canal and neural foramina are otherwise adequate.

Patient underwent Agreed Medical Examination on 11/16/2012 by Provider 4, M.D., for CT 04/03/2011 – 01/19/2012; 04/03/2011. Patient reported an injury to the right hand while taking out trash and sustained a twisting injury to the right hand and had a little bit of pain which increased with passage of time. Her right wrist pain was aggravated when cooking and cold weather. She was not working and now sees Dr. *ABC* who had requested permission for more therapy. She also receives medications. She experienced a lot of pain in the right gluteal area that may radiate to the bottom of the right foot associated with numbness in the anterior aspect of the right thigh and the medial right calf. She was provided impressions of straining injury to the lumbar spine, 04/03/2011, superimposed upon pre-existing grade I/II anterior listhesis L5-S1, right wrist sprain, 08/01/2011, resolved, prior history of right wrist sprain, complaints of right shoulder pain, MRI of the lumbosacral spine from 02/15/2012 showing grade II anterolisthesis at L5-S1 with bilateral pars intra-articularis defects and severe neuroforaminal stenosis bilaterally, and ongoing complaints of right radicular pain. Patient was Permanent and Stationary from all injuries while working. Relative to the right wrist date of injury, 08/01/2011, patient has no work limits and/or restrictions and guards the right wrist. She requires no further care and/or treatment to the right wrist. In regards to the right shoulder girdle, there was no evidence of any industrial injury and/or trauma. In regards to the lumbosacral spine, patient has limitations in lifting and carrying to 20 lbs with a 75% loss of her pre-injury ability for activities such as bending, stooping, lifting, pushing, and/or pulling. Future care to the lumbosacral spine would include a series of epidural steroid injections, and lumbar spinal fusion at L5-S1. She did not appear to be a candidate for further physical therapy. Causation of her disability and limitations would be apportioned 50% to the pre-existing grade II spondylolisthesis at L5-S1 which is non-industrial and which at this time would have produced 50% of her disability and limitations with reasonable medical probability. The remaining 50% of her disability and limitations would be apportioned to and caused by the specific injury of 04/03/2011. There was no evidence that there has been a period of continuing trauma to the lumbar spine. The disability and limitations are related to the pre-existing grade I spondylolisthesis at L5-S1 with pre-existing neuroforaminal stenosis with the specific date of injury 04/03/2011. Patient falls into DRE lumbar Category III, resulting in 13% Whole Person Impairment.

On 09/26/2014, patient was seen by provider 5, M.D at Facility 3, Patient noted continued low back and leg pain bilaterally after surgery, with pain radiating down posterior legs to the feet. She was advised to continue to use pain meds as needed and continue home PT exercises, and placed on Temporary Total Disability.

DOS	Provider Service	Category	Summary	Links
01/12/2012		DWC-1 Form	Date of injury: 04/03/2011. Body parts affected: Feeling cold, chills and lower back pain. Injury description: Making the bed and feeling cold chills and lower back pain starting hurting, cold sweats and cold chills. Employer: *ABC*.	File NameInitial EvalMeds-7-10-17 544.pdf_Page 35
03/20/2012		Application of Adjudication of Claim	Employer: *XYZ*. Date of injury: 08/01/2011. Body parts injured: Nervous system. Mechanism of Injury: Twisted wrist while taking out the trash. Occupation at time of injury: Housekeeper	File Name-Initial Eval Meds-7-10-17 544.pdf_Pages 23-27
01/12/2012	Provider 1, M.D. Facility 1	Doctor's First Report of Occupational Illness or Injury	**Date of injury:** 01/12/2012 **Hx of injury:** Patient was making the bed and felt cold chills and lower back pain that started to hurt associated with cold sweats and cold chills. **Diagnosis:** Lumbago, Lumbosacral neuritis. Lumbar region sprain. **Work Status:** Patient is not able to perform usual work.	File Name-InitialEval Meds-7-10-17 544.pdf_Pages 194-199
01/12/2012	Provider 2, M.D. Facility 1	Work Status Report	**Diagnoses:** Back pain, lumbar sprain/strain, lumbar radiculopathy. **Plan:** Physical therapy to the lumbar spine 3 times a week for 2 weeks. **Work Status:** Modified duty with limited stooping and bending for 2 hours per day, limited pull and push to 20 lbs. Must wear back support. Follow-up on 01/19/2012.	File Name-Initial Eval Meds-7-10-17 544.pdf_Pages 190-191
01/19/2012	Provider 1, M.D. Facility 1	Primary Treating Physician's Progress	Patient presents for follow up and reports worsening lower back pain radiating down right leg associated with tingling and numbness in the right leg. She also notes	File Name-Initial Eval Meds-7-10-17

		Report PR-2	some constipation from the Naprosyn. Patient is on modified duty and reports following the treatment plan as directed. **Diagnosis:** Lumbar radiculopathy. Lumbar sprain/strain. Back pain. **Plan:** Decrease Naprosyn once a d ay due to constipation. Norflex to be used at bedtime. Advised to begin home exercises. Orphenadrine 100 mg. Polar Frost 150 ml 5oz gel tube. Tramadol 37.5/325 mg. DME supplies: Back massager. **Work Status:** Modified duty with limited stooping and bending for 2 hours per day, limited pull and push to 20 lbs, and must wear back support.	544.pdf_Pages 178-187
02/15/2012	Provider 3, MD Facility 2	MRI of the lumbar spine	**Impression:** Grade 2 anterolisthesis of L5 on S1 secondary to bilateral pars interarticularis defects. There is resultant severe bilateral neural foraminal narrowing. The spinal canal and neural foramina are otherwise adequate.	File NameInitial EvalMeds-7-10-17 544.pdf_Pages 153-154
12/21/2012	Provider 4, M.D.	Agreed Medical Examination on 11/16/2012	Date of injury: CT 04/03/2011 – 01/19/2012; 04/03/2011 **History:** Patient reports an injury to the right hand while taking out trash and sustained a twisting injury to the right hand and had a little bit of pain which increased with passage of time. Her right wrist pain is aggravated when cooking and cold weather. She is not working and now sees Dr. ABC who has requested permission for more therapy. She also receives medications. She reports that she was making beds and felt a lot of pain developing in her right lower back radiating to the right hip. She experiences a lot of pain in the right gluteal area that may radiate to the bottom of the right foot associated with numbness in the	File NameInitial EvalMeds-7-10-17 544.pdf_Page 455-464

			anterior aspect of the right thigh and the medial right calf. **Current complaints:** Tenderness involving the entire distal right forearm and intermittent lower back pain and right leg becoming slight constant pain in the lower back and right lower extremity, progressing to moderate intermittent pain in the low back and lower extremity with activities of repetitive bending, stooping and lifting. **Physical Exam:** On examination, supine straight leg raise is positive on the right at 80 degrees. X-rays of the lumbar spine were obtained that revealed a first degree spondylolisthesis at L5-S1 with evidence of bilateral pars intra-articularis defects. **Impression:** 1. Straining injury to the lumbar spine, 04/03/2011, superimposed upon pre-existing grade I/II anterior listhesis L5-S1. 2. Right wrist sprain, 08/01/2011, resolved. 3. Prior history of right wrist sprain. 4. Complaints of right shoulder pain. 5. MRI of the lumbosacral spine from 02/15/2012 showing grade II anterolisthesis at L5-S1 with bilateral pars intra-articularis defects and severe neuroforaminal stenosis bilaterally. 6. Ongoing complaints of right radicular pain. **Discussion:** Patient is permanent and stationary from all injuries while working. Relative to the right wrist date of injury, 08/01/2011, patient has no work limits and/or restrictions and guards the right wrist. She requires no further care and/or treatment to the right wrist. In regards to the right shoulder girdle, *provider 4* found no evidence of any industrial injury and/or trauma. In regards to the lumbosacral spine, patient has limitations in lifting and carrying to 20 lbs with a 75% loss of her pre-injury ability for activities such as	

			bending, stooping, lifting, pushing, and/or pulling. Future care to the lumbosacral spine would include a series of epidural steroid injections, and lumbar spinal fusion at L5-S1. She did not appear to be a candidate for further physical therapy. Causation of her disability and limitations would be apportioned 50% to the preexisting grade II spondylolisthesis at L5-S1 which is non-industrial and which at this time would have produced 50% of her disability and limitations with reasonable medical probability. The remaining 50% of her disability and limitations would be apportioned to and caused by the specific injury of 04/03/2011. Dr. *Provider 4* did not find evidence that there has been a period of continuing trauma to the lumbar spine. The disability and limitations are related to the pre-existing grade I spondylolisthesis at L5-S1 with pre-existing neuroforaminal stenosis with the specific date of injury 04/03/2011. Per Table 15-3, page 384 of the American Medical Association's Guides to the Evaluation of Permanent Impairment, Fifth Edition, the patient falls into DRE lumbar Category III, resulting in 13% Whole Person Impairment.	
09/26/2014	Provider 5, M.D. Facility 3	Progress Report	Patient notes continued low back and leg pain bilaterally after surgery, with pain radiating down posterior legs to the feet. Plan: Continue to use pain meds as needed and continue home PT exercises. **Disability Status:** Total Temporary Disability. Follow-up in 6 weeks or as needed.	File NameInitial EvalMeds-7-10-17 544.pdf_Pages266-267

Incident Report # 338116

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Empleado: Complete la sección "Empleado" y entregue la forma a su empleador. Quédese con la copia designada "Recibo Temporal del Empleado" hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al (800) 736-7401 para oir información gravada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

[redacted]

[redacted]

Employee—complete this section and see note above. *Empleado—complete esta sección y note la notación arriba.*

1. Name. *Nombre.* [redacted] Today's Date. *Fecha de Hoy.* Jan/12/12
2. Home Address. *Dirección Residencial.* 459 W California Ave #A
3. City. *Ciudad.* Vista State. *Estado.* C.A. Zip. *Código Postal.* 92083
4. Date of Injury. *Fecha de la lesión (accidente).* 4/3/2011 Time of Injury. *Hora en que ocurrió.* 11 a.m. ☐ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* [redacted]
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* Making the bed and feeling Cold chills and lower back pain starting hurting. Cold sweats and Cold chills
7. Social Security Number. *Número de Seguro Social del Empleado.* [redacted]
8. Signature of employee. *Firma del empleado.* [redacted]

Employer—complete this section and see note below. *Empleador—complete esta sección y note la notación abajo.*

9. Name of employer. *N* [redacted]
10. Address. *Dirección.* [redacted]
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* 12-28-2011
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* 1-12-12
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* 1-12-12
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.*
15. Insurance Policy Number. *El número de la póliza de Seguro.*
16. Signature of employer representative. *Firma del representante del empleador.* [redacted]
17. Title. *Título.* Assistant General Mgr. 18. Telephone. *Teléfon* [redacted]

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within one working day of receipt of the form from the employee.

Empleador: Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de un día hábil desde el momento de haber sido recibida la forma del empleado.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/*Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

01/17/2012

[redacted]

23

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
APPLICATION FOR ADJUDICATION OF CLAIM

☐ Amended Application

Case No

[redacted]
SSN (Numbers Only)

Venue choice is based upon (Completion of this section is required)

☑ County of residence of employee (Labor Code section 5501.5(a)(1) or (d))

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d))

☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d))

SDO
Select 3 - Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Injured Worker (Completion of this section is required)

[redacted]
First Name MI

[redacted]
Last Name

[redacted]
Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

International Address (Please leave blank spaces between numbers, names or words)

OCEANSIDE CA 92057
City State Zip Code

Applicant (If other than Injured Worker)

☐ Insurance Carrier ☐ Employer ☐ Lien Claimant

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

Street Address2/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

WCAB1

[redacted]

24

Employer Information (Completion of this section is required)

☑ Insured ☐ Self-Insured ☐ Legally Uninsured ☐ Uninsured

[redacted]

Employer Name (Please leave blank spaces between numbers, names or words)

[redacted]

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words)

OCEANSIDE | CA | 92056

City | State | Zip Code

Insurance Carrier Information (If known and if applicable - include even if carrier is adjusted by claims administrator)

[redacted]

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

PO BOX 29210

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

HOT SPRINGS | AR | 71903

City | State | Zip Code

Claims Administrator Information (If known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City | State | Zip Code

IT IS CLAIMED THAT (Complete all relevant information):

1 The injured worker, born [redacted] (DATE OF BIRTH MM/DD/YYYY), while employed as a(n) [redacted] (OCCUPATION AT THE TIME OF INJURY)

(Choose only one)

☑ specific injury 08/01/2011 (Date of Injury MM/DD/YYYY)

suffered a

☐ cumulative injury which began on (Start Date MM/DD/YYYY) and ended on (End Date MM/DD/YYYY)

The injury occurred at [redacted]

Street Address/PO Box - Please leave blank spaces between numbers, names or words

OCEANSIDE | CA | 92056

City | State | Zip Code

[redacted]

25

(State which parts of the body were injured)

ERVOUS

. . . . injury occurred as follows.

(EXPLAIN WHAT THE WORKER WAS DOING AT THE TIME OF INJURY AND HOW THE INJURY OCCURED)

TWISTED WRIST WHILE TAKING OUT THE TRASH

3. Actual earnings at the time of injury:

Rate of Pay $ 9.18 ☐ Monthly ☐ Weekly ☑ Hourly

State value of tips, meals, lodging, or other advantages, regularly received $ ____ ☐ Monthly ☐ Weekly ☐ Hourly

Number of hours worked per week 32

4. The injury caused disability as follows:

Last day off work due to injury ____ MM/DD/YYYY

First Period of Disability Start Date ____ MM/DD/YYYY End Date ____ MM/DD/YYYY

Second Period of Disability Start Date ____ MM/DD/YYYY End Date ____ MM/DD/YYYY

5. Compensation:

Compensation was paid ☐ Yes ☑ No

Total paid ____

Weekly rate(s) ____

Date of last payment ____ MM/DD/YYYY

6. Has the worker received any unemployment insurance benefits and/or any unemployment compensation disability benefits (state disability) since the date of injury? ☐ Yes ☑ No

03/26/2012

[redacted]

26

7. Medical treatment:
Medical treatment was received ☑ Yes ☐ No

All treatment was furnished by the Employer or Insurance Carrier ☑ Yes ☐ No

Date of last treatment _____ MM/DD/YYYY

Other treatment was provided/paid by CONTINUING
(NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Did Medi-Cal pay for any health care related to this claim? ☐ Yes ☑ No

Names and addresses of doctor(s)/hospital(s)/clinic(s) that treated or examined for this injury, but that were not provided or paid for by the employer or insurance carrier.

Name of Doctor/Hospital/Clinic 1 (Please leave blank spaces between numbers, names or words)

Name of Doctor/Hospital/Clinic 2 (Please leave blank spaces between numbers, names or words)

8. Other cases have been filed for industrial injuries by this worker as follows:

Case Number 1 _____ Case Number 3 _____

Case Number 2 _____ Case Number 4 _____

9. This application is filed because of a disagreement regarding liability for:

- ☑ Temporary disability indemnity
- ☑ Reimbursement for medical expense
- ☑ Medical treatment
- ☑ Compensation at proper rate
- ☑ Permanent disability indemnity
- ☑ Rehabilitation
- ☑ Supplemental Job Displacement/Return to Work
- ☑ Other (Specify) LABOR CODE

01/26/2012

Is the Applicant Represented? [✓] Yes [ ] No If "No", applicant is to sign and date below

If "Yes", applicant's representative is to complete the following and is to sign and date below.

[✓] Law Firm/Attorney [ ] Non-Attorney Representative

[redacted]

Law Firm or Company Name (If Applicable)

[redacted]

Law Firm Number (If Applicable)

[redacted]

Attorney/Representative First Name MI

[redacted]

Attorney/Representative Last Name

[redacted]

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

SAN DIEGO CA 92108

City State Zip Code

[redacted]

Applicant Attorney/Representative Signature

Signature on file

Applicant Signature

Dated at SAN DIEGO, California

City

Date 03/20/2012

MM/DD/YYYY

03/28/2012

HealthWorks MEDICAL GROUP

PATIENT INFORMATION / HEALTH HISTORY

PATIENT DETAILS

Employer (Patrón) [redacted] Date (Fecha) Jan/12/12 SSN [redacted]

First Name (Nombre): [redacted] Middle Initial (Inicial) ____ Last Name (Apellido) [redacted]

Address (Domicilio): [redacted]

Telephone # (Teléfo[redacted]

Best number to reach you (Mejor número para localizarle): [redacted] reo Electrónico): ____

Date of Birth (Nacimiento [redacted]

INJURY DETAILS

Date of Injury (Fecha de lesión): 1/n/n Time (Hora): 11am Date last worked (Último día que trabajó): Jan/12/12

Occupation (Ocupación) Room Attendant Employer Telephone (Teléfono del Patrón): [redacted]

Address where injury occurred (Domicilio donde ocurrió la lesión) Address (Domicilio): [redacted]

City (Ciudad): Oceanside State (Estado): C.A. Zip (C. Postal): [redacted]

Was your problem caused by something that happened at work? (¿Fue su problema causado por algo sucedido en su trabajo)? ☒ Yes (Sí) ☐ No

Injury was reported to (Lesion fue reportada a): Noa Tellez Date (Fecha): 1/n/n Time (Hora): 11am

Have you been treated at U S HealthWorks before? (Alguna vez ha sido tratado en U.S. HealthWorks?): ☒ Yes (Sí) ☐ No When? (Cuando?):

In case of emergency contact (En caso de emergencia llamar a) [redacted]

Please describe below how your present injury/illness occurred. (Por favor, describa a continuación cómo ocurrió su actual lesión ó enfermedad.)

I was making the bed and feeling cold chills and lower back pain starting hurting - cold sweats and cold chills

PLEASE COMPLETE THE FOLLOWING DIAGRAM (Por favor complete el diagrama a continuación)
If you feel any of the symptoms below, mark the areas of the body where you feel them on the figure below and indicate the type of symptom.
Si siente alguno de los síntomas listados a continuación, marque la zona del cuerpo en donde los siente, en la figura a debajo e indique el tipo de síntoma.

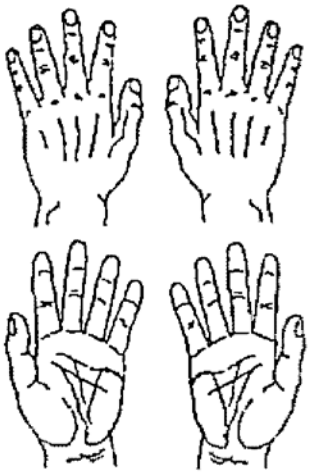
Symptoms (Síntomas)
1. Pain (Dolor)
2. Numbness (Adormecimiento)
3. Burning (Quemazón)
4. Pins/Needles (Punzadas)

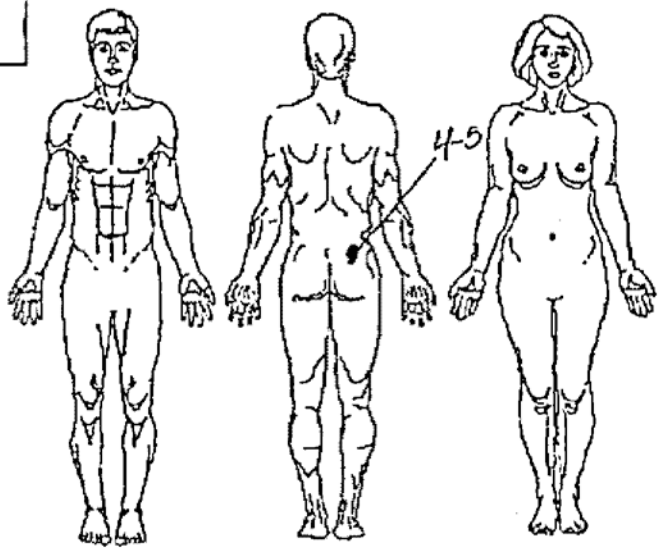
Exercise (Ejercicio)

Rate the intensity of your pain. Indique la intensidad de su dolor.

NO PAIN SIN DOLOR — MOST PAIN DOLOR INTENSO

0 1 2 3 4 5 6 7 8 9 10





04/17/2012

[redacted]

[redacted]

DOCTOR'S FIRST REPORT OF OCCUPATIONAL ILLNESS OR INJURY

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P O Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours

2 EMPLOYER [redacted]	1 INSURER [redacted]	PLEASE DO NOT USE THIS COLUMN
3 Street Address City, State, Zip 4 Business Type	Street Address City, State, Zip Claim #	Case No
5 PATIENT NAME (First, Middle, Last) [redacted]	6 Sex [redacted] / 7 Date of Birth [redacted]	Industry
8 Address No and Street City [redacted] Zip	9 Telephone Number [redacted]	County
10 Occupation (Specific Job Title) Room Attendant	11 Social Security Number [redacted]	Age
12 Injured at City	County	Hazard
13 Date and hour of injury or onset of illness 1/12/12 11:00 AM	14 Date last worked Mo Day Yr 1/12/12	Disease
15 Date and hour of first examination or treatment 1/12/12 6 00 PM	16 Have you (or your office) previously treated patient? ☐ Yes ☒ No	Hospitalization
17 PATIENT, PLEASE DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Be specific)		Occupation
		Return Date Code

18/19/20 SUBJECTIVE COMPAINTS/OBJECTIVE FINDINGS/DIAGNOSIS Chemical or toxic compounds involved? ☐ Yes ☒ No

04/17/2012

Diagnosis 724 2 LUMBAGO
724 4 LUMBOSACRAL NEURITIS NOS
847 2 SPRAIN LUMBAR REGION
X-ray and laboratory results (state if none or pending)

21 Findings consistent with patient's statement?	22 Other condition that will impede recovery	Explain
☐ Yes ☒ No	☐ Yes ☒ No	

23 TREATMENT RENDERED

24 If further treatment required, specify treatment
25 If hospitalized as inpatient, give hospital name and location
Estimated Days
Date Admitted Estimated stay

26 WORK STATUS Is patient able to perform usual work? ☐ Yes ☒ No If no, extended return date to
Regular Work Mod Work Specify Restrictions

Doctor's Signature [redacted]
Name and Degree
Address
CA License [redacted]
IRS Number
Phone Numb

ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY FALSE OR FRAUDULENT MATERIAL STATEMENT OR MATERIAL REPRESENTATION FOR THE PURPOSE OF OBTAINING OR DENYING WORKERS COMPENSATION BENEFITS OR PAYMENTS IS GUILTY OF A FELONY

<< Back to Review [redacted]

Jan. 16 2012 10:30AM No 0903 P 2/3

U.S. HealthWorks MEDICAL GROUP
The Right Care, Right Away

#338166

AUTHORIZATION / SPECIALTY EVALUATION

Date of Request 01/12/12 Clinic: U[redacted]

PATIENT INFORMATION

Patient Name [redacted] Soc. Security # [redacted]

Date of Birth [redacted] of Injury 0[redacted]

Address [redacted] City Vista [redacted]

INSURANCE INFORMATION

[redacted]

EMPLOYER INFORMATION

Email

[redacted]

REQUEST INFORMATION

** Diagnosis 1 724 2 / LUMBAGO
2 847.2 / SPRAIN LUMBAR REGION
3. 724.4 / LUMBOSACRAL NEURITIS NOS

Reasons for Request. See attached medical notes

Request for. Evaluation: ☐ Consult ☐ Referral ☐ AOE/COE Evaluation ☐ Other.

Specialty: ☐ Orthopedist ☐ General / ☐ Hand / ☐ Spine ☐ PM&R ☐ Ophthalmologist ☐ Neurologist ☐ Psychiatrist

☐ General Surgery ☐ Plastic Surgery ☐ Other

Type: ☐ Routine ☐ Urgent ☐ Emergent

Therapy ☒ PT ☐ OT ☐ Chiropractor ☐ Acupuncturist ☐ Other Frequency: 3 Duration 2

Diagnostics: ☐ MRI ☐ CT Scan ☐ w/contrast ☐ w/o contrast ☐ EMG/NCV (w/consult) ☐ Other

☐ Right ☐ Left Body Part

1-18-12 Request for 4S 3x2=6 Request is thru align. Request sent Lourdes Serrato

AUTHORIZATION INFORMATION

☐ Authorized/ ☐ Denied by Name Date

Carrier Authorization #

If request is denied, document reasons for denial

Appointment. Date Time Transportation Provider

Patient Notified by (Name) on (Date)

Employer Notified by (Name) on (Date)

REQUESTING PROVIDER COMMENTS

REQUESTED BY. [redacted]

01/24/2012

HealthWorks MEDICAL GROUP

WORK STATUS REPORT

[redacted]

DIAGNOSES

Pain - Back (724.2), Sprain/Strain Lumbar (847.2), Lumbar Radiculopathy (724.4)

TREATMENT

Diagnostic Tests: Radiology: Radiology tests were ordered. All radiology studies sent to Radiologist for review and confirmation.

Laboratory: Lab Tests were ordered.

Physical Therapy	(X) Start ( ) Continue ( ) Renew	(3) times / week for	(2) weeks	( ) Cancel ( ) Pending
Chiropractic Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Occupational Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Acupuncture	( ) Start ( ) Continue ( ) Renew	( ) # of visits		( ) Cancel ( ) Pending
Ergonomic Evaluation	( ) Start		Other: ( )	

Medications: Medications were dispensed.

WORK STATUS

Causation is pending determination.

Work Restrictions:

Restrictions for return to modified work as follows: frequent change of position as tolerated.
Limited stooping and bending for 2 hours per day. Limited Lift , Limited Pull and Limited Push up to 20 lbs.
Patient must wear back support.

[redacted]

NEXT APPOINTMENT

Next Appointment with Wells Jane on 01-19-2012 02:45 pm.

Executed at: [redacted]

Check In Ti

[redacted]

01/17/2012

[redacted]

MEDICAL DOCUMENTATION : DO NOT DETACH

HealthWorks MEDICAL GROUP

[redacted]

Date of Service:
Patient Name:
Patient Account Number:
Date Of Injury
Date Of Birth:
Employer Name:
Claim #:
Chart #:

[redacted]

Patient Status:
Since the last exam, this patient's condition has Worsened

History Of Present Illness.
Patient is here for follow up visit for injury sustained on 01-12-2012 11:00
The patient reports that their condition is worsening - Patient reports they followed the treatment plan as directed The patient states that treatment was tolerated Patient is currently on modified duty
Comments Patient feeling worse Increase pain Pain 7/10 Pain radiating down right leg Slight tingling down right leg Noticing some constipation from the Naprosyn Also, has history of constipation before this
Back Complaints / Symptoms
Complaint: Patient's complaint at this time is as follows pain - lumbar Patient describes the symptom(s) as sharp She says it is moderately severe The frequency is intermittent The symptoms are exacerbated by moving The symptoms are lessened by rest
Associated Symptoms: The patient denies dysuria The patient denies polyuria The patients states there is no hematuria The patient denies fever, chills, and sweats The patient complains of parasthesias - right leg The patient states there is radiation of back pain - right leg The patient denies any limitations to motion of the back The patient denies any leg weakness The patient states there is no numbness or tingling of the lower extremities The patient denies any changes in bowel habits The patient denies any bladder or bowel dysfunction

Occupational history Length of employment is reported as 6 months to 2 yrs She works 40 hours per week Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, stooping and climbing, lifting, pushing, or pulling up to 25lbs
She denies any lost work-time as a result of this injury She denies any other source of employment
Surgeries: No Known Surgical History
Medical History: Patient denies history of ulcers or gastritis No history of Diabetes r wrist sprain 8mos ago

Tetanus History:
Last tetanus - more than 5 years

Family History: Non-contributory Family History
Social History: Alcohol or Tobacco use: She does not use tobacco Denies alcohol use

Review Of Systems:
A review of the patient's Family History, Social History, Medical History, Allergy, Current Medication and Surgery and a

03/20/2012

[redacted]

[redacted]

complete review of systems obtained from the health history completed on 01-12-2012 was done and any interval changes are noted
Head: Frequent or severe headaches current - not under treatment
Gastrointestinal: Abdominal pain current - not under treatment
Musculoskeletal: Back injury or pain current - not under treatment
Neurological: Parasthesias in extremities current - not under treatment
Endocrine. Alopecia - current - not under treatment
Blood Disorders Bleeding gums - current - not under treatment
Women Only: Menstrual irregularities current - under treatment

Current Medications at the start of Encounter
Naproxen Sodium 550mg Tabs #30 1 twice daily with food/ 1 dos veces al dia con comida, Dispense 1
Allergies:
No Known Drug Allergies

Physical Examination:
Pulse 81/min BP 120/72 mmHg Temperature 97 8 deg F Respiration 12 per min

On a seventy scale the pain is 7 out of 10
FDLMNP: 12/31/2011

Constitutional: The patient is a well-developed, well-nourished female
Psychiatric: Mood and affect appear appropriate
Respiratory: There are no apparent signs of respiratory distress
Gastrointestinal: Abdominal palpation is normal
Genitourinary Costovertebral angle tenderness for renal involvement is not noted
Skin Examination of the thoracolumbar region reveals no evidence of the following conditions Erythema, ecchymosis, scars, swelling, masses and open wound -
Musculoskeletal: The patient ambulates with a normal gait, full weightbearing on both lower extremities The patient has normal posture There is no weakness of the lower extremities The spine is not kyphotic The patient does not have scoliosis The patient has no loss of lumbosacral lordosis The pelvis is symmetrical There is tenderness of the thoracolumbar spine and paravertebral musculature - L3-4, moderate tenderness, also right side Range of motion of the back is restricted Flexion with the fingertips approximating the ankles Extension 15/30 deg, lateral flexion L 45/45 deg R 45/45 deg, lateral rotation L 30/30 deg R 30/30 deg
Cardiovascular. The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ bilaterally and capillary refill time is normal bilaterally
Neurologic Heel/toe ambulation is performed without difficulty Bilateral patellar and achilles deep tendon reflexes are 2/4 Sensation is decreased to light touch and pinprick left anterior thigh (L1-L3), left lateral leg / medial foot (L5), left lateral leg /dorsal foot (L5) and left lateral ventral foot (S1) The back muscles display no weakness

Diagnoses
Lumbar Radiculopathy (724 4)
Sprain/Strain Lumbar (847 2)
Pain - Back (724 2)

Dispensed Medications:
New. NDC 00115-2011-02 Orphenadrine Citrate ER 100mg Tabs #30 1 at bedtime/ 1 al acostarse, Dispense 1
NDC 67138-0533-15 Polar Frost 150ml 5oz Gel Tube Apply to affected area up to 4 times per day as needed , Dispense 1 Tube, Refills 1
NDC 57664-0537-18 Tramadol HCL Acetaminophen 37 5mg/325mg Tabs #30 1-2 Tablet Every 6 Hours as needed for

[redacted]

03/20/2012

pain. Dispense 1 Container

Medications to be Continued until Next Visit:
Naproxen Sodium 550mg Tabs #30 1 po bid pc

Supplies:

Item Name	Quantity	Hcpc / Cpt
Rehab-Back Theracane Massager	1	A9300

Treatment Comments Decrease Naprosyn once a day due to constipation If still constipated, advised to d/c Use Ultracet and Polar Frost for pain Norflex to be used at bedtime to relax muscles Theracane used to massage area Begin therapy once approved Krames book given Advised to begin home exercises

WORK STATUS.

Based on available information, our clinical evaluation and assessment, it is our opinion that the patient's claim appears to qualify as work related Return to work with restrictions as of 01-19-2012
Work Restrictions:
Restrictions for return to modified work as follows frequent change of position as tolerated
Limited stooping and bending for 2 hours per day
Limited Lift, Limited Push and Limited Pull
up to 20 lbs
Patient must wear back support

Patient Education:
Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury Patient expressed an understanding of work restrictions and injury prognosis

03/20/2012

[redacted]

Next Appointment with Wells Janet on 01-26-2012 05 00 pm

[redacted]

HealthWorks MEDICAL GROUP

[redacted]

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Patient Name Last Barragan [redacted]

Occupation Room Attendant [redacted]

Employer RESIDENCE INN/OCEANSIDE [redacted]

Claims Administrator [redacted]

REASON FOR SUBMITTING REPORT (Check all that apply If any box aside from "OTHER" applies, this report qualifies as mandatory)

( ) Change in patient's condition ( ) Need for referral or consultation ( ) Information requested by
( ) Change in work status ( ) Need for surgery or hospitalization ( ) Released from care ( ) Request for authorization
( ) Change in treatment plan ( ) Periodic Report (45 days after last report) ( ) Other

PATIENT STATUS Since the last exam, this patient's condition has

( ) improved as expected ( ) improved, but slower than expected ( ) not improved significantly
(X) worsened ( ) reached plateau and no further improvement is expected ( ) been determined to be non-work related

04/17/2012

SUBJECTIVE COMPLAINTS

History Of Present Illness

Patient is here for follow up visit for injury sustained on 01-12-2012 11 00

The patient reports that their condition is worsening - Patient reports they followed the treatment plan as directed The patient states that treatment was tolerated Patient is currently on modified duty

Comments Patient feeling worse Increase pain Pain 7/10 Pain radiating down right leg Slight tingling down right leg Noticing some constipation from the Naprosyn Also, has history of constipation before this

Back Complaints / Symptoms

Complaint Patient's complaint at this time is as follows pain - lumbar Patient describes the symptom(s) as sharp She says it is moderately severe The frequency is intermittent The symptoms are exacerbated by moving The symptoms are lessened by rest

Associated Symptoms The patient denies dysuria The patient denies polyuria The patients states there is no hematuria The patient denies fever, chills, and sweats The patient complains of parasthesias - right leg The patient states there is radiation of back pain - right leg The patient denies any limitations to motion of the back The patient denies any leg weakness The patient states there is no numbness or tingling of the lower extremities The patient denies any changes in bowel habits The patient denies any bladder or bowel dysfunction

Occupational history Length of employment is reported as 6 months to 2 yrs She works 40 hours per week Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, stooping and climbing, lifting, pushing, or pulling up to 25lbs She denies any lost work-time as a result of this injury She denies any other source of employment

OBJECTIVE FINDINGS

Physical Examination

Pulse 8 t/min BP 120/72 mmHg Temperature 97 8 deg F Respiration 12 per min

Severity The severity of the pain was 7/10

FDLMNP 12/31/2011

[redacted]

Constitutional The patient is a well-developed, well-nourished female
Psychiatric Mood and affect appear appropriate
Respiratory There are no apparent signs of respiratory distress
Gastrointestinal Abdominal palpation is normal
Genitourinary Costovertebral angle tenderness for renal involvement is not noted
Skin Examination of the thoracolumbar region reveals no evidence of the following conditions Erythema, ecchymosis, scars, swelling, masses and open wound
-
Musculoskeletal The patient ambulates with a normal gait, full weightbearing on both lower extremities The patient has normal posture There is no weakness of the lower extremities The spine is not kyphotic The patient does not have scoliosis The patient has no loss of lumbosacral lordosis The pelvis is symmetrical There is tenderness of the thoracolumbar spine and paravertebral musculature - L3-4, moderate tenderness, also right side Range of motion of the back is restricted Flexion with the fingertips approximating the ankles Extension 15/30 deg, lateral flexion L 45/45 deg R 45/45 deg, lateral rotation L 30/30 deg R 30/30 deg
Cardiovascular The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ bilaterally and capillary refill time is normal bilaterally
Neurologic Heel/toe ambulation is performed without difficulty Bilateral patellar and achilles deep tendon reflexes are 2/4 Sensation is decreased to light touch and pinprick left anterior thigh (L1-L3), left lateral leg / medial foot (L5), left lateral leg /dorsal foot (L5) and left lateral ventral foot (S1) The back muscles display no weakness

Diagnostic Tests Comments Patient feeling worse Increase pain Pain 7/10 Pain radiating down right leg Slight tingling down right leg Noticing some constipation from the Naprosyn Also, has history of constipation before this

DIAGNOSES (Include ICD-9 code, if possible)

Lumbar Radiculopathy (724.4)
Sprain/Strain Lumbar (847.2)
Pain - Back (724.2)

04/17/2012

TREATMENT PLAN

Office Visit / Injury Treatment

Physical Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Chiropractic Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Occupational Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Acupuncture	( ) Start ( ) Continue ( ) Renew	( ) # of visits		( ) Cancel ( ) Pending
Ergonomic Evaluation	( ) Start		Other ( )	

Medication(s) Dispensed

NDC 00115-2011-02 Orphenadrine Citrate ER 100mg Tabs #30 1 at bedtime/ 1 at acostarse, Dispense 1
NDC 67138-0533-15 Polar Frost 150ml 5oz Gel Tube Apply to affected area up to 4 times per day as needed , Dispense 1 Tube, Refill's 1
NDC 57664-0637-18 Tramadol HCL Acetaminophen 37.5mg/325mg Tabs #30 1-2 Tablet Every 6 Hours as needed for pain, Dispense 1 Container

Supplies Dispensed

Item Name	Quantity	Hcpc / Cpt
Rehab-Back Theracane Massager	1	A9300

Treatment Comments Decrease Naprosyn once a day due to constipation If still constipated, advised to d/c Use Ultracet and Polar Frost for pain Norflex to be used at bedtime to relax muscles Theracane used to massage area Begin therapy once approved Krames book given Advised to begin home exercises

[redacted]

Patient Education

Patient voiced understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis.

WORK STATUS

Based on available information, our clinical evaluation and assessment, it is our opinion that the patient's claim appears to qualify as work related. Return to work with restrictions as of 01-19-2012.

Work Restrictions

Restrictions for return to modified work as follows: frequent change of position as tolerated

Limited stooping and bending for 2 hours per day

Limited Lift, Limited Push and Limited Pull up to 20 lbs

Patient must wear back support

DISCHARGE STATUS

( ) Released from care. Return to full duty on ( ) with no limitations or restrictions.

( ) Patient discharged as permanent and stationary with either impairment, work restrictions, and/or need for future medical care. A PR-4 to follow.

( ) NON-INDUSTRIAL. Patient instructed to see private physician at own expense.

PRIMARY TREATING PHYSICIAN

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.

[redacted]

04/17/2012

[redacted]

[redacted]

[redacted]

WORK STATUS REPORT

[redacted]

Date 01-19-2012 16:12:03

NAME Last Barragan [redacted]
Occupation Room Attendant
Employer RESIDENCE INN OCEANSIDE
Claims Administrator [redacted]

Date of Exam 01-19-2012 Case # [redacted]
DOI: 01-12-2012 11:00 Claim #
Tel (760)722-6800 Fax (760)722-6559
Tel (714)543-6291 Fax

PATIENT STATUS Since the last exam, this patient's condition has

(X) Worsened

DIAGNOSES

Lumbar Radiculopathy (724.4), Sprain/Strain Lumbar (847.2), Pain - Back (724.2)

TREATMENT

Physical Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Chiropractic Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Occupational Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Acupuncture	( ) Start ( ) Continue ( ) Renew	( ) # of visits		( ) Cancel ( ) Pending
Ergonomic Evaluation	( ) Start		Other ( )	

Medications Medications were dispensed

WORK STATUS

Based on available information, our clinical evaluation and assessment it is our opinion that the patient's claim appears to qualify as work related
Return to work with restrictions as of 01-19-2012

Work Restrictions

Restrictions for return to modified work as follows: frequent change of position as tolerated
Limited stooping and bending for 2 hours per day Limited Lift, Limited Push and Limited Pull up to 20 lbs.
Patient must wear back support

In the event that your employee has restrictions and no modified work is made available, employer must keep employee off work unless, and until, such modified work is made available

TREATING PROVIDER

Name [redacted] Dr. # PA12882 Signature (Original)
Specialty [redacted] Date of Exam 01-19-2012 [redacted]

NEXT APPOINTMENT

Next Appointment [redacted]
Executed at [redacted]
Check In Time 01-19-2012 15:19 Check Out Time 06:11 pm

01/31/2012

[redacted]

[redacted]

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Patient Name [redacted] First Erika MI [redacted] Date of Service 01-19-2012 Case [redacted]

Occupation Room Attendant SS# [redacted] Date of Injury 01-12-2012 11:00 Claim #

Employer [redacted] Contact [redacted] Tel [redacted] Fax [redacted]

Claims Administrator [redacted] Tel [redacted] Fax

REASON FOR SUBMITTING REPORT (Check all that apply. If any box aside from "OTHER" applies, the report qualifies as mandatory)

( ) Change in patient's condition ( ) Need for referral or consultation ( ) Information requested by
( ) Change in work status ( ) Need for surgery or hospitalization ( ) Released from care ( ) Request for authorization
( ) Change in treatment plan ( ) Periodic Report (45 days after last report) ( ) Other

PATIENT STATUS Since the last exam, this patient's condition has:

( ) improved as expected ( ) improved, but slower than expected ( ) not improved significantly
(X) worsened ( ) reached plateau and no further improvement is expected ( ) been determined to be non-work related

01/27/2012

SUBJECTIVE COMPLAINTS
History Of Present Illness
Patient is here for follow up visit for injury sustained on 01-12-2012 11:00
The patient reports that their condition is worsening - Patient reports they followed the treatment plan as directed. The patient states that treatment was tolerated. Patient is currently on modified duty.
Comments: Pat ant feeling worse, increase pain. Pain 7/10. Pain radiating down right leg. Slight tingling down right leg. Noting some constipation from the Naproxyn. Also, has history of constipation before this.
Back Complaints / Symptoms
Complaint: Patient's complaint at this time is as follows: pain, lumbar. Patient describes the symptom(s) as sharp. She says it is moderately severe. The frequency is intermittent. The symptoms are exacerbated by moving. The symptoms are lessened by rest.
Associated Symptoms: The patient denies dysuria. The patient denies polyuria. The patient states there is no hematuria. The patient denies fever, chills, and sweats. The patient complains of paresthesias - right leg. The patient states there is radiation of back pain - right leg. The patient denies any limitations to motion of the back. The patient denies any leg weakness. The patient states there is no numbness or tingling of the lower extremities. The patient denies any changes in bowel habits. The patient denies any bladder or bowel dysfunction.

Occupational History: Length of employment is reported as 6 months to 2 yrs. She works 40 hours per week. Main job characteristics include prolonged standing or walking, repetitive use of hands/keyboard/mouse, kneeling or squatting, bending, stooping and climbing, lifting, pushing, or pulling up to 25lbs. She denies any lost work-time as a result of this injury. She denies any other source of employment.

OBJECTIVE FINDINGS
Physical Examination
Pulse 91/min. BP: 120/72 mmHg. Temperature: 97.8 deg F. Respiration: 12 per min.
Severity: The severity of the pain was 7/10.
FDLMNP 12/31/2011

Constitutional: The patient is a well-developed, well-nourished female
Psychiatric: Mood and affect appear appropriate
Respiratory: There are no apparent signs of respiratory distress
Gastrointestinal: Abdominal palpation is normal
Genitourinary: Costovertebral angle tenderness for renal involvement is not noted
Skin: Examination of the thoracolumbar region reveals no evidence of the following conditions: Erythema, ecchymosis, scars, swelling, masses and open wound

Musculoskeletal: The patient ambulates with a normal gait, full weightbearing on both lower extremities. The patient has normal posture. There is no weakness of the lower extremities. The spine is not kyphotic. The patient does not have scoliosis. The patient has no loss of lumbosacral lordosis. The pelvis is symmetrical. There is tenderness of the thoracolumbar spine and paravertebral musculature - L3-4, moderate tenderness, also right side. Range of motion of the back is restricted. Flexion with the fingertips approximating the ankles. Extension 15/30 deg, lateral flexion L 45/45 deg R 45/45 deg, lateral rotation L 30/30 deg R 30/30 deg
Cardiovascular: The popliteal, anterior tibial and posterior tibial pulses are 2+/2+ bilaterally and capillary refill time is normal bilaterally
Neurologic: Heel/toe ambulation is performed without difficulty. Bilateral patellar and achilles deep tendon reflexes are 2/4. Sensation is decreased to light touch and pinprick: left anterior thigh (L1-L3), left lateral leg / medial foot (L5), left lateral leg /dorsal foot (L5) and left lateral ventral foot (S1). The back muscles display no weakness

Diagnostic Tests Comments: Patient feeling worse. Increase pain. Pain 7/10. Pain radiating down right leg. Slight tingling down right leg. Nothing some constipation from the Naprosyn. Also, has history of constipation before this.

DIAGNOSES (Include ICD-9 code, if possible)

Lumbar Radiculopathy (724.4)
Sprain/Strain Lumbar (847.2)
Pain - Back (724.2)

TREATMENT PLAN

Office Visit / Injury Treatment

Physical Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Chiropractic Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Occupational Therapy	( ) Start ( ) Continue ( ) Renew	( ) times / week for	( ) weeks	( ) Cancel ( ) Pending
Acupuncture	( ) Start ( ) Continue ( ) Renew	( ) # of visits		( ) Cancel ( ) Pending
Ergonomic Evaluation	( ) Start		Other: ( )	

Medication(s) Dispensed

NDC:00115-2011-02 Orphenadrine Citrate ER 100mg Tabs #30 1 at bedtime/ 1 at breakfast, Dispense 1
NDC:67136-0533-15 Polar Frost 150ml Box Gel Tube Apply to affected area up to 4 times per day as needed Dispense 1 Tube Refills 1
NDC:57664-0537-16 Tramadol HCL Acetaminophen 37.5mg/325mg Tabs #30 , 1-2 Tablet Every 6 Hours as needed for pain, Dispense 1 Container

Supplies Dispensed

Item Name	Quantity	Hcpc / Cpt
Rehab Back Thermcare Massager	1	A9300

Treatment Comments: Decrease Naprosyn once a day due to constipation. If still constipated, advised to d/c. Use Ultracet and Polar Frost for pain. Norflex to be used at bedtime to relax muscles. Thermcare used to massage area. Begin therapy once approved. Krames book given. Advised to begin home exercises.

01/27/2012

Patient Education

Patient voices understanding of aftercare instructions, including medication use, side effects, and proper use of dispensed supplies (when applicable), work restrictions and expected progress of the injury. Patient expressed an understanding of work restrictions and injury prognosis

WORK STATUS

Based on available information, our clinical evaluation and assessment, it is our opinion that the patient's claim appears to qualify as work related. Return to work with restrictions as of 01-19-2012.

Work Restrictions

Restrictions for return to modified work as follows. Frequent change of position as tolerated

Limited stooping and bending for 2 hours per day

Limited Lift, Limited Push and Limited Pull up to 20 lbs

Patient must wear back support.

DISCHARGE STATUS

( ) Released from care. Return to full duty on ( ) with no limitations or restrictions

( ) Patient discharged as permanent and stationary with either impairment, work restrictions, and/or need for future medical care. A PR-4 to follow

( ) NON-INDUSTRIAL. Patient instructed to see private physician at own expense.

PRIMARY TREATING PHYSICIAN

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

Signature (Original) [redacted]

Signature (Original) [redacted]

[redacted]

[redacted]

01/27/2012

NEXT APPOINTMENT

Next Appointment with Wells Jarrett on 01-26-2012 08:00 am

Executed at: [redacted]

Check In Time: 01-19-2012 1539

Final Report

[redacted]

[redacted]

Patient Name: [redacted]
DOB:
Patient ID:

Study Date: Feb 15,2012 15:18
Reason for Exam: LOW BACK PAIN WITH RADICULOPATHY X 1 YEAR, TRAUMA, NO SURGEY
Modality: MR
Referring Physician: [redacted]
Referring Physician Phone Number:
Referring Physician Fax Number:

Reading Physician: [redacted]
Approved by: [redacted]

Report Date: Feb 15,2012 15:30
Approved On: Feb 15,2012 15:30

02/17/2012

MR lumbar spine

Technique: Sagittal T1, T2 and axial T1 and T2 weighted images were obtained.

Findings: There is 13 mm anterolisthesis of L5 on S1 secondary to bilateral pars interarticularis defects. The vertebral bodies are normal in height. The intervertebral disc space is desiccated at L5-S1. The conus medullaris is unremarkable and its tip is at L1-L2. The paravertebral soft tissues are unremarkable. There is a physiologic right ovarian cyst.

L1-L2: There is no significant disc bulge, spinal stenosis, or neural foraminal narrowing.

L2-L3: There is no significant disc bulge, spinal stenosis, or neural foraminal narrowing.

L3-L4: There is no significant disc bulge, spinal stenosis, or neural foraminal narrowing.

L4-L5: There is no significant disc bulge, spinal stenosis, or neural foraminal narrowing.

L5-S1: There is anterolisthesis of L5 on S1 with minimal symmetric disc bulge. There is no spinal stenosis. There is severe bilateral neural foraminal narrowing.

IMPRESSION

Grade 2 anterolisthesis of L5 on S1 secondary to bilateral pars interarticularis defects. There is resultant severe bilateral neural foraminal narrowing. The spinal canal and neural foramina are otherwise adequate.

Electronically signed

[redacted]

[redacted]

[redacted]

December 21, 2012

Law Offices [redacted]

[redacted]

[redacted]

RE: [redacted]
WCAB: [redacted]
CLAIM: [redacted]
DOL: 4/3/11 - 1/19/12; 4/3/11
YOUR FILE: [redacted]

Dear Sirs:

Per your request [redacted] was seen for an Agreed Medical Examination on 11/16/12. Interpretation was provided by Sandra Reus, certificate #500217. This report is at the ML104-93-94 level with face to face time of 45 minutes, record review time of four hours, report preparation of 1-1/4 hours. There is a total of six hours at the ML104-93-94 level.

HISTORY: Ms. [redacted] is a 24 year old female who reports that she was making beds and felt a lot of pain developing in her right lower back radiating to the right hip.

She also reports an injury to the right hand while taking out trash and she sustained a twisting injury to her right hand. She had a little bit of pain which increased with the passage of time.

Re: [redacted]

December 21, 2012

Her care was initially provided through U S HealthWorks for her back. She was given anti-inflammatory medications. She had an MRI. She has used pain patches.

In regards to the right hand she has had no therapy. She is not working. She now sees [redacted] who has requested permission for more therapy. She also receives medications.

She now experiences a lot of pain in the right gluteal area or the center of her lower back. The pain may radiate to the left side. The pain may go to the bottom of her right foot. Sometimes she gets numbness in the anterior aspect of the right thigh and the medial right calf, but her symptoms are primarily in the right thigh.

Her right wrist hurts with cooking and with activities of daily living and housekeeping. She has right wrist pain in cold weather. She says when it is colder she has more pain.

She denies all prior problems with her back.

She hurt her right wrist previously in another job before the Marriott employment. She was given anti-inflammatories and a home exercise program. She had an x-ray that resolved. She says her pain now is worse in the right wrist, even though she is not working.

PAST MEDICAL HISTORY: She denies allergies.

Her medicines include Naprosyn and others she can't remember.

Illnesses include potentially the beginning of epilepsy.

She denies surgery.

She does not smoke.

REVIEW OF RECORDS:

1. Employment records are reviewed from Residence Marriott Inn:

These records cover the period of time from 3/8/10 to 1/12/12.

She is employed as a housekeeper.

Re: [redacted]
December 21, 2012

2. Records are reviewed from US Healthworks:

These records cover the period of time from 8/9/11 to 2/23/12.

8/9/11 and 8/16/11: Work status reports. She is treated for sprain of the hand.

1/12/12: First Report of Injury. She is diagnosed with lumbago, lumbosacral neuritis, and sprain of the lumbar region.

2/15/12: MRI of the lumbar spine. Impression: Grade II anterolisthesis of L5 on S1 secondary to bilateral pars intraarticularis defects. There is resultant severe bilateral neural foraminal narrowing. The spinal canal and neural foramina are otherwise adequate.

2/23/12: She reports no change in her condition. There is a need for referral or consultation. Diagnoses: Lumbar radiculopathy, sprain/strain lumbar region, and pain in her back. Her injury is work related.

2/29/12: She is returned to modified work. She must wear a back support and must have frequent changes of positions as tolerated.

3. Records are reviewed from [redacted]

These records cover the period of time from 2/28/12 to 4/18/12.

2/28/12: Initial Consultation. 23-year-old female housekeeper reports injury of 4/3/11. She was making a bed and was bending and lifting a corner of the mattress when she felt a pain in the right low back and buttock that subsequently radiated into the posterolateral thigh and calf. She sought treatment in Mexico on several occasions and was given medication. Diagnoses: 1) Preexisting Grade I-II isthmic spondylolisthesis, nonindustrial. 2) Right L5 radiculopathy with neurologic deficit, acute, industrial. She has been working light duty four hours/day.

3/28/12: She has weakness in the right foot as well as numbness and tingling dorsally. Impressions: 1) L5-S1 spondylolisthesis with L5 neural compression, right greater than left, severe neural foraminal stenosis, and disk protrusion pseudo-bulge. 2) Right L5 radiculopathy with neurologic deficit. Causation is attributed to the industrial injury. She can return to work with no lifting over 10 pounds and no bending or twisting.

4/18/12: Surgery is discussed. The patient is afraid of surgery. It is deferred at this time. She remains at modified work.

4. Records are reviewed from [redacted].

3/14/12: She is seen for her work-related lower back injury. Diagnoses: 1) lumbar disk syndrome superimposed over a Grade II spondylolisthesis of L5 on S1. 2) Radiculopathy. She undergoes six chiropractic treatments with no significant benefit. It is this chiropractor's opinion that no additional chiropractic treatment is warranted or will provide any manner of lasting benefit.

5. Records are reviewed from [redacted].

5/1/12: She complains of low back pain radiating into both buttocks and extending down the right leg involving all of the digits of the right foot with associated numbness and tingling. She reports radiating pain in the right wrist up into the right forearm. Impressions: 1) Acute industrial lumbosacral sprain/strain on 4/3/11. 2) Industrial aggravation of L5-S1 spondylolisthesis. 3) Acute industrial right wrist sprain/strain on 8/1/11. 4) Industrial cumulative trauma overuse syndrome secondary to cumulative trauma exposure 4/3/11 to 1/19/12. Regarding the lumbar spine, he recommends a course of physical therapy in order to defer the need for surgical intervention which would more than likely require L5-S1 fusion with instrumentation. She can return to modified duty capacity with no prolonged weightbearing and no lifting greater than 10 pounds. She is precluded from performing repetitive movements of the spine. Causation is attributed to the industrial injury. Apportionment will more than likely be indicated regarding the lumbar spine.

6/12/12: Diagnosis: Lumbar sprain/strain. They are awaiting authorization for physical therapy.

6. Records are reviewed from [redacted].

These records cover the period of time from 8/3/10 to 8/10/12.

8/3/12: First Report of Injury. She reports injury to her right wrist while removing trash weighing approximately 40 pounds. She reports injury to her low back, which she twisted painfully

while making beds. Diagnosis: Rule out lumbosacral IVD syndrome and myalgia.

8/10/12: Request for authorization to treat for the right wrist.

7. Deposition of 9/12/12 is reviewed:

She is alleging injuries of 4/3/11 and 8/1/11.

Her date of birth is 11/8/88.

She is not currently working. She remains employed by [redacted] but they do not have modified duties available for her. She last worked in February, when she was employed as a housekeeper.

She is asked how she injured her right wrist. She states she was making a bed and felt pain in her wrist. She is then asked about the injury of 4/3/11. She was making a bed and felt pain in her low back and right hip. She had intense pain in her right hip. She also had symptoms of fevers with chills and a lot of pain. She reported her injury and tried to finish her shift. She worked an additional two hours and then went home. She returned to work the next day. She completed that shift. She continued with lower back pain and right hip pain as well as fever and chills. She went to Tijuana two or three days later and saw a doctor there. She was afraid she had hurt her kidney. She was prescribed anti-inflammatories. She then underwent chiropractic treatment in Vista. This did not help her. She was referred to [redacted] by US Healthworks. [redacted] offered her the option of acupuncture, surgery, or epidural injections. She has not undergone any of these treatments. She is currently seeing [redacted], who has recommended physical therapy, which she has not yet started. [redacted] has told her that she may be a surgical candidate, but she does not want to have surgery.

Currently, she has pain in her lower back every day. Walking worsens her pain. She has pain radiating into her buttocks and down her right leg and into the sole of her foot.

She is then questioned about the injury of 8/1/11. She was taking out trash and she injured her right wrist. This injury was reported and she was sent to US Healthworks. She was given anti-inflammatories. She then goes on to say that she does not believe the right wrist was work related. Currently, she has

pain in her wrist and into her forearm. She has discussed this with [redacted].

She is then asked what parts of her body she is alleging have been injured as a result of her employment at [redacted]. She states it could be her whole back. It feels tired. She has pain in her neck. She also has pain in her right shoulder. She states the right shoulder is related to her work but she is not sure. She has had neck pain for five or six months. She has not discussed this with Dr. Bernicker. Now, she has difficulty going grocery shopping. She cannot carry heavy items. She can no longer go dancing. Her right shoulder pain began about 1-1/2 months before the Deposition. She has not discussed this with Dr. Bernicker.

According to the Rules of Practice and Procedure of the Workers Compensation Appeals Board, Section 12606, I have reviewed the total medical records and they were summarized by [redacted] R.N., Ph.D.

PHYSICAL EXAMINATION: On examination of the upper extremities she is right hand dominant. Her symptomatology is on the right. She presents with subjective complaints of tenderness involving the entire distal right forearm. There is no evidence of swelling. There is no evidence of guarding.

She presents with a full unrestricted range of motion of the right wrist in flexion and extension, ulnar and radial deviation. Her motion is symmetrical with the left wrist.

Motor examination is normal to the upper extremities including shoulder flexors, abductors, elbow flexors and extensors, wrist flexors and extensors and first dorsal interosseous motor groups.

Her shoulder range of motion is full, unrestricted and unguarded.

Jamar grip right/left is 80-75-82/70-70-68. Forearm circumference right/left is 23.2/22.5 cm.

On examination of the thoracolumbar spine, there is no list, no lumbar and no thoracic spasm. Her movements are not guarded. She walks with a normal gait. She has a normal posture. She has subjective complaints of right low back tenderness.

Re: [redacted]
December 21, 2012

She presents with a full unrestricted range of motion of the thoracolumbar spine with forward flexion of 95 degrees, extension of 35 degrees, side bending of 35 degrees right and left. On full extension she complaints of low back pain.

Hip range of motion is full, unrestricted and unguarded with flexion to 90 degrees bilaterally, internal rotation to 15 degrees bilaterally and external rotation of 35 degrees bilaterally.

Motor examination is normal to the lower extremities with no deficit noted in quadriceps, anterior tibialis, extensor hallucis longus, peroneal and gastrocsoleus motor groups.

She presents with a non anatomic sensory deficit involving the entirety of the right lower extremity.

Knee jerks are symmetrical at 2. Ankle jerks are symmetrical at 2.

Sitting straight leg raise test is negative. Supine straight leg raise test produces complaints of anterior right knee pain on the right at 80 degrees. Supine straight leg raise test is negative on the left.

She can do a normal heel gait and a normal toe gait.

Calf circumference right/left is 33/33 cm.

X-RAYS done in our office of the right wrist are completely normal.

X-rays done of the lumbosacral spine show a first degree spondylolisthesis at L5-S1 with evidence of bilateral pars intra-articularis defects.

IMPRESSION:

1. Straining injury to the lumbar spine 4/3/11 superimposed upon pre-existing grade I/II anterior listhesis L5-S1.
2. Right wrist sprain 8/1/11, resolved.
3. Prior history of right wrist sprain.
4. Complaints of right shoulder pain.
5. MRI of the lumbosacral spine 2/15/12 showing grade II anterolisthesis at L5-S1 with bilateral pars intra-

articularis defects and severe neuroforaminal stenosis bilaterally.
6. Ongoing complaints of right radicular pain.

DISCUSSION: Ms. Barragan is permanent and stationary from all injuries while working for Marriott International.

In regards to the right wrist date of injury 6/1/11, the subjective factors of disability rated by this examiner are nil. The objective factors of disability are nil. The patient has no work limits and/or restrictions and guards the right wrist. Care and treatment of the right wrist has been appropriate. She requires no further care and/or treatment to the right wrist.

In regards to the right shoulder girdle I find no evidence of any industrial injury and/or trauma. The patient's symptomatology in the right shoulder would in fact appear to have started after she ceased employment with Marriot International. The examination of her right shoulder is unremarkable. The subjective factors of disability are graded by this examiner as nil. The objective factors of disability are nil.

In regards to the lumbosacral spine her subjective factors of disability are slight intermittent pain in the lower back and right leg, becoming slight constant pain in the low back and right lower extremity, progressing to moderate intermittent pain in the low back and lower extremity with repetitive bending, stooping and lifting.

Objective factors of disability in regards to the lumbosacral spine include:

1) MRI done on 2/15/12;
2) X-rays done in our office;
3) Positive straight leg raising at 80 degrees on the right;
4) Non anatomic sensory changes about the right lower extremity.

The patient's limitations in regards to the lumbosacral spine would be a limitation in lifting and carrying to 20 pounds with a 75% loss of her preinjury ability for activities such as bending, stooping, lifting, pushing and/or pulling.

Her care to this point has been appropriate.

Re: [redacted]
December 21, 2012

Future care to the lumbosacral spine would include:

1) A series of epidural steroid injections;
2) Lumbar spinal fusion at L5-S1.

She would not appear to be a candidate for further physical therapy, believing that it is improbable that further therapy would resolve her ongoing symptomatology. She has had adequate conservative care for the lumbar spine without full resolution of her symptomatology.

Causation of her disability and limitations would be apportioned 50% to the pre-existing grade II spondylolisthesis at L5-S1 which is non industrial and which at this time would have produced 50% of her disability and limitations with reasonable medical probability. The remaining 50% of her disability and limitations would be apportioned to and caused by the specific injury of 4/3/11 at which time she developed an L5 right-sided radiculopathy. This is with reasonable medical probability.

I find no evidence that there has been a period of continuing trauma to the lumbar spine. The disability and limitations are related to the pre-existing grade II spondylolisthesis at L5-S1 with pre-existing neuroforaminal stenosis with the specific date of injury of 4/3/11.

Using the AMA Guides to the Evaluation of Permanent Impairment, 5th edition, going to page 384 using table 15-3, the patient falls into DRE lumbar category III with a 13% impairment of the whole person with significant signs of radiculopathy with dermatomal pain, a sensory loss, an MRI confirming these subjective complaints.

If I may be of further assistance, please let me know.

DECLARATION: 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 Erika Barragan on November 16, 2012 in my office at [redacted]

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 Paragraph (5) of Subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

I further declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient or the preparation of this report.

I further declare under penalty of perjury that the name and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than clerical preparation, are as follows:

Name	Qualifications
[redacted]	

Signed this 21st day of December 2012, at [redacted]

Yours truly,

[redacted]

RG:bc

CC:

[redacted]

[redacted]

09/26/2014 10:45 AM
Location: [redacted]
Patient #: [redacted]
DOB: [redacted]
Language: Undefined / Race: Undefined / Ethnicity: Undefined
Gender: Female

History of Present Illness

The patient is a 25 year old female who presents for a recheck of chronic low back and leg pain. [redacted] notes continued low back and leg pain bilaterally. These pains wax and wane but have been more severe over the last few days. Pain radiates down the posterior legs to the feet. She is walking much better than prior to surgery. She is using percocet and flexaril for pain mgmt.

Medication History
Percocet (5-325MG Tablet, 1 (one) Oral) Active.
Cyclobenzaprine HCl (10MG Tablet, 1 (one) Oral) Active.

Past Surgical
Spinal Fusion (03/12/2013); anterior/posterior L5-S1 lumbar decompression with interbody instrumented fusion

Diagnostic Studies
Lumbar Spine X-ray (09/26/2014); Lumbar spine x-rays were taken here in the office today. These reveal stable posterior instrumentation and interbody spacer without signs of loosening or failure.

11/04/2014

Physical Exam

Musculoskeletal
Global Assessment
Gait and Station - normal gait and station.
Spine/Ribs/Pelvis
Lumbosacral Spine:
Inspection and Palpation: Alignment - Normal Lumbar Lordosis and without Scoliosis. Surrounding tissue tension/texture is - No spasm noted. Sensation - normal.
Lower Extremity
Hip:
Strength and Tone:
Right: Hamstrings - 5/5. **Hip Flexors** - 5/5.
Left: Hamstrings - 5/5. **Hip Flexors** - 5/5.
Knee/Patella:
Strength and Tone:
Right: Quad - 5/5.
Left: Quad - 5/5.
Tibia/Fibula:
Strength and Tone:
Right: Gastrocnemius - 5/5. **Tibialis Anterior** - 5/5.
Left: Gastrocnemius - 5/5. **Tibialis Anterior** - 5/5.
Ankle/Foot:
Foot:
Strength and Tone:
Right: Extensor hallucis longus - 5/5.
Left: Extensor hallucis longus - 5/5.
Functional Testing - Bilateral - No Straight Leg Raise, Clonus, Foot Drop or Babinski's Reflex.

[redacted]

Assessment & Plan
L5-S1 Spondylolisthesis (756.12)

Lumbar radiculopathy (724.4)

- **DISCUSSION:**
  Erika's low back pain and leg pain have continued after surgery but are more tolerable. The severity of her symptoms wax and wane She was barely able to walk before surgery. She will continue to use pain medications as needed and with her home PT exercises. All of her questions were answered.
- Disability Status: Total Temporary Disability
- Follow up in 6 weeks or as needed

[redacted]

[redacted]

11/04/2014