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Occupational Medicine

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February 28, 2005

Patient:  
Employer:  
D/I:  
Claim No:  
WCAB:

XXXX  
XXXXXXXXXX  
XXXXXXXXXX  
Oakland, CA 94604-2927

Dear XXXX:

On January 29, 2005, I had the opportunity to interview and evaluate XXXX in connection with the above referenced Workers Compensation Claim.

The applicant arrived to my Albany office on time, alone, and was interviewed and examined alone. She was advised that a doctor-patient relationship was not established today, and that a copy of my report would be sent to XXXX, senior claims examiner.

**COMPLEXITY FACTORS AND FEE JUSTIFICATION**

The revised medical-legal fee schedule indicates that ML104 may be billed if four complexity factors exist. The four complexity factors here are:

1. Two or more hours of face-to-face time by the physician with the patient;
2. Two or more hours of record review;
3. A bona fide issue of medical causation discovered in the evaluation and in any event a written request by the requesting party for discussion of the issue of medical causation;
4. A bona fide issue of apportionment discovered in the evaluation;

I verify under penalty of perjury that I spent 3.0 hours in face-to-face interview time with XXXX. I further verify that I spent 6.0 hours reviewing the medical records and 0 hours in research. Finally, I spent 3.0 hours preparing this report for a total of 12.0 hours.

This report is being billed at ML104. This was clearly an extraordinarily complex medical-legal evaluation, involving review of 25 years worth of medical records, and evaluating a number of different work injuries.

In your cover letter, you state that the applicant's attorney has filed a DWC-1 Form, alleging cumulative work injuries to the spine, upper extremities and feet. You state that the cause, nature and extent of the applicant's injuries, disability and need for medical treatment are in question.

I would note that I consider the applicant to be sincere and credible, although she is not a good historian. In particular, she believes that she has been working with permanent restrictions for the past several years, but she cannot tell me what these restrictions may be. She does describe multiple injuries, pains and problems which she feels are caused by work and, of course, these are discussed in detail below.

### **GENERAL BACKGROUND**

In general, it would appear that this 61-year-old housekeeper, who has been employed at XXX for 27 years, experiences pain throughout her body, which is worse at the end of the day, and she feels like she is ready to retire. She says that her supervisor at work has suggested that she should retire. However, the applicant realizes that she cannot afford to retire, since she will then have no income. It appears that this is the dilemma. I asked that applicant why she retained an attorney and what she expects the attorney might help her to accomplish, and she really appears to be unable to articulate any answer to this question. Apparently she just generally feels frustrated and does not know what to do.

In general, the applicant describes moderately heavy work activities over the past 27 years at XXX, at first involving unloading trucks, stacking merchandise and ordering it and delivering it. In addition, she handled linen and laundry. In addition, and particularly more recently, her housekeeping duties include cleaning and buffing floors and a variety of miscellaneous activities. She is right-handed.

The work injuries that she describes to me include a fracture of the left ankle in the early 1980s, a "pinched sciatic nerve" in the 1990s, back pain and back spasms throughout her back for the past 15-20 years, painful feet due to "fallen arches" for the past 20 years, neck and right shoulder pain for the past 10 years, tennis elbow of the left elbow for the past 10 years or so, better now, "carpal tunnel syndrome" due to excessive vacuuming for the past two to three years, a torn meniscus in the right knee as a complication of the right shoulder injury, since it occurred while she was getting physical therapy for the right shoulder, and bilateral hand pain for the past several years.

The applicant states that she went to a lawyer "because I am hurting all the time." She begins crying at this point in this discussion. She says she does not want to retire and to be in pain. She says she

is unable to retire because social security does not provide much money. On the other hand, the applicant states that “I know what’s wrong with me and I work around it.” She says that she does not want to bother the doctors with her problems, although her stack of medical records would suggest a considerable rate of utilization at XXX over the past 25 years. The applicant tells me that she does not want to be like some workers who want to be off work due to their injuries, although the records indicate various periods of temporary total disability due to her various work injuries.

The applicant is not sure whether she is still treating with physicians at XXX for her various injuries or when her next appointment might be. She believes that she last saw XXXX about eight months ago for her hand problems.

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### **JOB DESCRIPTION**

I do not see a formal job analysis in the information you have provided to me. The applicant states that when she started at XXXX about 27 years ago, there were multiple functions including unloading trucks, stacking and organizing supplies, and delivering them to the various departments. In addition, she dealt with linen and laundry and, in particular, she prepared the clean, white coats for the doctors and handled the garments on hangers and carried them around. She believes that this is how she developed the left elbow epicondylitis. In addition, she refers to having to vacuum, mop and buff floors and she believes that this has contributed to her bilateral hand problems and also, is the cause of her chronic right shoulder problem. Furthermore, her work obviously includes a great deal of walking, and she attributes her foot pain over the past 20 years to “fallen arches” which she says is due to walking on hard floors.

The work activities described by the applicant include a moderate amount of lifting, and occasionally lifting up to 50 pounds in the past, although she believes that over the recent years she has not been lifting more than 10 pounds due to doctors’ advice. I do not find any such advice in the medical records.

Therefore to summarize, the applicant’s occupation probably represents a medium level of physical exertion, but would be characterized by a moderate amount of walking and lifting and repetitive arm and hand movements.

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### **HISTORY OF INJURY**

This is complicated and uncertain, but the applicant makes the apt statement that “lots of things have happened to me in 25 years and it’s catching up with me.”

With regard to the right shoulder problem, apparently this began around the middle of 1996, and she claims that she complained to her supervisor that vacuuming was causing her shoulder to hurt, and she was then given an even bigger and heavier vacuum cleaner to use. Finally after complaining for

many months, she had an MRI scan of her shoulder which revealed rotator cuff tear. Finally in May of 1997, she underwent surgery for repair of a supraspinatus tear and resection of the lateral clavicle and acromioplasty. Thereafter she was off work for a long period of time, and her progress with rehabilitation was very slow. She finally returned to work in January of 1997. It appears she never fully regained the range of motion of the right shoulder.

She underwent a second surgical procedure due to a “frozen shoulder”, namely manipulation under anesthesia. In spite of this, she has continued to have rather significant problems with her right shoulder to the present day. There is a record of a “Stipulated Award” for the date of injury 5/10/96 and the award was granted on 8/13/99 with provision for future medical care. There is reference to “multiple upper extremity injuries.”

At the present time, the applicant continues to report rather severe pain, stiffness and dysfunction involving the right shoulder, and she describes right-sided neck pain and pain radiating down to the right elbow, which she also attributes to the basic underlying shoulder problem.

Regarding the right knee injury, the history is that on 8/06/97, the applicant felt pain in the right shoulder after being examined and sat up suddenly and grabbed the right shoulder with the left hand, simultaneously arising to a standing position apparently, and thereby injured her right knee. Since then, she has had chronic pain in the right knee. Eventually, an MRI scan was performed which showed degenerative changes in both medial and lateral menisci, with possible tears in both menisci. Apparently arthroscopic surgery was recommended for this, but it has never been carried out.

Currently, the right knee pain does limit her activities. She is able to walk well on a level surface but has difficulty walking up a hill or down a hill, up or down stairs, or to make any sudden twisting or pivoting movement. Therefore, given the history, it would appear to me that the right knee injury should be considered a complication of the right shoulder injury and should have been addressed at the time that the disability award was made.

The applicant reports bilateral leg problems. Her account of this is rather confusing. She tells me that she had a “pinched sciatic nerve” in her left leg due to walking and that this is still symptomatic, although only on an occasional basis. However, the medical records refer to an industrial accident which occurred in August of 1989, when she stumbled and hurt her back and then developed pain going down the RIGHT leg. This was diagnosed as right sciatic pinch or sciatic bursitis and was treated for several months, including an injection. She was then returned to regular work for this problem on 10/23/89. Therefore, there was total temporary disability for about two months at that time.

The records indicate that in August of 1991, the applicant developed left leg pain while walking. She was treated by her personal physician at XXXX for trochanteric bursitis and received an injection, and was off work for a period of time. Apparently she recovered from this problem.

With regard to back problems, the applicant tells me that some time in the late 1980s, while in bed,

she developed severe back pain, which she says was due to “muscle spasm”. She did receive medical attention and eventually had an MRI scan of her lower back without any significant findings. At the present time she says she still experiences spasms throughout her back at times, and she cannot lie on her back. She does use some kind of back support at work, although it is uncomfortable at times. As reviewed below under “Medical Record Review”, the applicant has, in fact, been treated for various pains in the upper, middle and lower back, but it is hard to ascribe her back pains to any specific industrial injury. Of course, her statement that lots of things have happened in 25 years that are catching up with her, could be interpreted as an allegation that her repetitive activities at work have caused chronic back pain. On the other hand, the applicant tells me that her back problems began while she was in bed one night. She did eventually have a rheumatological evaluation at XXXX performed a couple of years ago, with negative results.

With regard to the bilateral foot problem, the applicant says she has had “fallen arches” for about 20 years and, in fact, the medical records do substantiate that she complained of foot pain and that this was interpreted as being due to “falling arches”. I would note that this is not a medical term but rather a lay term. In fact, the applicant did consult with podiatrists who made the diagnosis of metatarsalgia and plantar fasciitis on various occasions. It is interesting that there are actually numerous doctor’s first reports on record in reference to the chronic foot pain, whereas it seems the instigation for these reports were simply that the applicant wanted to get new orthotics for her shoes, since she was told they would wear out every two years or so and would need to be replaced. Apparently there was some vague allegation that her foot problems were due to work many years ago, and therefore this situation has been persisting indefinitely. In the records, there is no narrative report or any explanation of how her foot problems would be due to work. Certainly any individual who walks at work can allege that their foot pain is caused by work, but this is not a medical opinion. Such opinion is to be found in the medical records.

At the present time, the applicant continues to experience some pain in the bottoms of her heels, primarily towards the medial aspects. This is greatly relieved by the orthotics that she has been using.

Regarding the foot situation, there is recorded a fracture of the left fibula in 1981, and the records indicate that a cast was used for a period of time. There was slow improvement but gradual recovery. At the present time, there is only very slight discomfort felt in the lateral aspect of the left ankle. Therefore, the ankle fracture is not significantly contributing to her ongoing foot problems.

In the middle of 1984, the applicant developed pain in the left elbow, attributed to manipulating coats on hangers. She received conservative treatment and this finally improved. Currently there is no significant pain in the left elbow or any disability there.

The applicant does describe neck discomfort, but she basically feels that the complex of pain involving the right side of the neck, the right shoulder and the right upper arm are really due to the shoulder injury. In the records there is some reference to upper back and neck discomfort at times, and records of diagnostic studies of the neck being made, but there is no specific report of any

industrial neck injury. Currently, the applicant reports discomfort on the right side of the neck when she elevates the right shoulder. I am not aware of any specific or cumulative neck injury that anyone has suggested as contributing to her current disability.

Finally, there is the issue of bilateral hand pain, which the applicant refers to as “carpal tunnel syndrome”, although she had a nerve conduction test several years ago which was negative for carpal tunnel syndrome. She does have diffuse hand pain and swelling which is ongoing. She attributes this to excessive vacuuming at work. There were various diagnoses in the XXXX records including wrist tendinitis, hand tendinitis, De Quervain’s tendinitis, and “possible carpal tunnel syndrome,” as well as arthritis of the metacarpal- phalangeal joint of the left thumb. A rheumatologist suggested that the problem might be due to carpal tunnel syndrome. Treating doctor suggested the possibility of repeating the nerve conduction tests, which the applicant did not want to do. The diagnosis of the bilateral hand pain and its relation to work, are not clear.

Having summarized the situation, I will now address the problems more specifically in the remainder of this report.

### **OCCUPATIONAL HISTORY**

After high school, the applicant first worked at a clothing manufacturing company where she was involved in production and pressing for about two years. She then worked for XXXX, involved in the manufacture of XXX, for about three and a half years. She then worked as a short order cook and counter person at a burger restaurant for about two years. There was a period of several years when she primarily functioned as a homemaker and mother, and then went back to work at XXXX doing retail sales for one or two years, at which time she was also beginning to work at XXXX.

In 1978, she began work at the XXXX facility, first as a housekeeping aide and rising through the ranks to head housekeeper at the present time, where she says she does have some supervisory responsibilities for about 12 other employees, although this may be rather minimal in that they are pretty much self-directed. She notes that around 1997, administrative changes resulted in the housekeeping department being separated from linen and laundry and likewise from that of materials.

Regarding any chemical exposures, the applicant tells me that she is exposed to certain chemicals such as cleaning solutions and bleach. Several years ago, she did have an asthma attack when she was exposed to a deodorizing spray in a restroom while at work. This seems to have cleared up without any sequelae. Therefore I see no issue of disability due to toxic exposure or need for future monitoring of same.

### **CONFLICTS OR HARASSMENT AT WORK**

None.

### **JOB PERFORMANCE EVALUATIONS**

Denies.

### **CURRENT WORK STATUS**

Currently the applicant continues to work an 8-hour day. She says she does limit her activities, and in particular does not wash walls anymore due to her left shoulder problem. However, it is not clear to me whether any physician has imposed permanent restrictions on her work activities or whether this is just an informal arrangement at work.

### **PERIODS OF TEMPORARY DISABILITY**

Regarding the right shoulder injury, the records indicate a period of temporary total disability from 2/28/97 through 1/19/98, and temporary partial disability from 1/19/98 through 11/02/99. There is no comment in the records on disability subsequent to that date, but I would assume that XXXX intended to maintain the applicant on partial temporary disability indefinitely, since it was his pattern to extend the disability at each visit.

Regarding the bilateral hand pain, the records indicate a period of partial temporary disability from July of 2000 through 9/22/00, and again from 1/08/01 through 1/31/01. The treating physician did not recommend any permanent disability regarding the bilateral hand pain.

Regarding the fifth metacarpal fracture, there was a period of partial disability from 6/17/03 through 8/22/03. There was no permanent disability noted.

Regarding the bilateral foot pain, there is no record of any partial or total disability regarding that situation, whether temporary or permanent.

### **PREVIOUS WORKERS' COMPENSATION INJURIES**

Multiple injuries at XXXX, as detailed elsewhere in this report.

### **CURRENT COMPLAINTS**

Pain in the right shoulder area (including upper arm and right trapezius and base of the neck), which is slight and intermittent, increasing to moderate on a less than occasional basis with precipitating activities such as lifting the arm overhead. The pain seems to radiate from the anterior shoulder to the base of the neck on the right side and down to the anterior right elbow. Difficulty lifting overhead. Difficulty with handling heavy vacuum. Difficulty with washing walls.

Left hip discomfort which radiates down the posterior leg to the calf at times. This is minimal in intensity, occurring on a less than occasional basis.

Diffuse back pain characterized as “spasms”, in the thoracic and lumbar areas, which is slight and occasional, increasing to moderate on a less than occasional basis. This does not consistently cause any reduction of activities.

Bilateral foot pain in the heels and in the MTP area. This is occasional and slight. It increases to moderate on a less than occasional basis with activities such as prolonged walking.

The left elbow problem has resolved and is essentially asymptomatic.

Right knee pain which is occasional and slight, increasing to moderate on a less than occasional basis, with precipitating activities such as prolonged walking, climbing or twisting or pivoting. The applicant has to avoid sudden movements, and finds it difficult to walk up a hill or upstairs due to the right knee pain. She has some difficulty with prolonged kneeling or squatting. No clicking, locking or giving way.

Bilateral hand pain, left worse than right. Slight numbness of all five fingers of both hands, which occurs on a less than occasional basis. Slight weakness of the left hand with activities such as removing a lid from a jar. Bilateral hand pain increases to moderate on a less than occasional basis with precipitating activities such as repetitive motions or heavy grasping such as with using a large vacuum or mop. Symptoms occur at night as well as during the day. Applicant uses bilateral wrist splints for her comfort, as well as ibuprofen.

Left ankle pain which is slight and occurs on a less than occasional basis. No current swelling or instability of left ankle.

In general, the applicant feels like she hurts all over, particularly after a work day, and wants to retire.

#### **HISTORY OF PRE-EXISTING DISEASE THAT WAS EXACERBATED BY EMPLOYMENT**

None documented in records.

## RECREATIONAL TOXIC EXPOSURES

None.

## CURRENT MEDICATIONS

Ibuprofen 800 mg, one or two daily, for pain in hands and right shoulder.

Also occasional Excedrin or aspirin for same purpose.

Until recently, she was using Vicodin for this purpose, but her doctor recommended discontinuing it.

Actifed for seasonal rhinitis symptoms.

Occasional bronchodilator inhaler for symptoms of asthma.

Multivitamins.

Drug Allergies: Erythromycin, sulfa.

Certain substances may precipitate asthma, such as room deodorizer.

## PAST MEDICAL HISTORY

**Surgery:** Hysterectomy, remote, due to bleeding fibroids. Excision of benign parotid adenoma, right side of neck, 5/97. Right shoulder rotator cuff repair and acromioplasty 1997. Right shoulder manipulation under anesthesia 1997. Sequelae of chronic right shoulder pain and stiffness.

Patient had a left ankle fracture, as referred to elsewhere in this report, for which she had a cast and recovered without significant sequelae. She had a right fifth metacarpal bone fracture which was treated with a cast and recovered without incident in 2003.

**Medical:** The applicant has had asthma for many years, which appears relatively mild and well-controlled with bronchodilators, although there are a few episodes of emergency treatment and occasional brief periods of disability due to asthma. She has allergic rhinitis, for which she uses Actifed at times. There have been episodes of chest pain or cardiac arrhythmias or palpitations, but cardiac workup, including treadmill test, EKGs and Holter monitor did not reveal any serious coronary artery disease or cardiac arrhythmia.

The applicant was treated on many occasions for skin problems and rashes. She received multiple evaluations for symptoms of allergies and asthma. She had many

visits for gynecological problems and had a hysterectomy many years ago. There were many episodes of upper respiratory infections, sinusitis, and occasional bronchitis or pneumonia without any definite sequelae. There was a visit or two with complaints of fatigue, and the doctors felt that they were psychosomatic issues. There was recent evaluation in terms of hair loss, but thyroid examination did not show any thyroid disease. There was a rheumatological evaluation due to the various areas of pain, but there was no finding of systemic disease such as rheumatoid arthritis or lupus. Recent laboratory tests showed elevated sedimentation rate, but negative rheumatoid factor.

Psych: The applicant denies any prior psychological or psychiatric evaluation and treatment, although the records indicate that she was, in fact, referred for “behavioral medicine” intervention around five years ago. Apparently this treatment was brief.

Emotional stress:

Work: None.

Home: None.

### **FAMILY HISTORY**

Mother - Deceased, age 85, due to bowel infarction.  
Father - Deceased, age 75, due to aneurysm.  
Siblings - One sister and two brothers are living and well.  
Children - Two children are living and well, ages 40 and 37.

### **SOCIAL ACTIVITIES**

Walking, activities with friends and family.

### **SOCIAL HISTORY**

School: Completed high school.  
Marital: Divorced in 1980, two children. Currently is single.  
Smoking: Quit about 18 years ago. Prior to that a 20- to 30-pack year history.  
Alcohol: One drink per year.

Caffeine: Denies.

Stress: No bankruptcy, felony convictions, IV or other drug abuse.

### **REVIEW OF SYSTEMS**

HEENT: Denies significant changes in hearing or vision, difficulty swallowing, frequent sore throats or neck masses or discomfort.

LUNGS: Occasional wheezing due to asthma, otherwise no chronic cough, no difficulty breathing or chest pain.

HEART: Denies heart pain, palpitations or edema, except of the hands.

GI: Denies indigestion, blood in the stools, melena. Denies abdominal pain.

GU: Denies difficulty urinating or blood in the urine.

Menstrual: Post menopausal.

PSYCH: Denies.

Musculo-Skeletal: Chronic neck pain felt to be due to shoulder injury. Back spasms as detailed elsewhere in this report. Shoulder, hand, elbow, foot and ankle pain as described elsewhere. Otherwise she denies significant joint problems.

Neurologic: Vague numbness of all five fingers of both hands at times, otherwise denies significant numbness or weakness. No significant memory changes.

Skin: Occasional rash on face, otherwise no easy bruising or changes in the skin.

### **MEDICAL RECORD REVIEW**

The medical records provided include four packets, totaling 1,230 pages. This is divided into four parts. In addition, there are about 20 unnumbered pages at the beginning of the first packet. In addition, there is another small packet, totaling about 15 numbered pages, consisting of some podiatrist reports. The first four packets of records consist of the applicant's XXX records.

I have reviewed in detail this 6-inch stack of medical records dating back approximately 30 years. The majority consists of records of episodic medical care by multiple providers at XXXX, referring

to treatment for various medical problems such as uterine fibroids, upper respiratory infections, skin rashes, gynecological problems, episodes of minor trauma, etc. The following is a review of the records which I feel are relevant to the issues at hand, namely any occupational injuries and any disability associated therewith.

### Part One

7/26/76 XXX. Medical Clinic. Low back pain for five days. Strain. Robaxin, Valium, aspirin.

8/24/76 Muscle pain left scapula, rhomboid.

8/14/79 Left ankle sprain.

9/07/79 Cast removed from left ankle.

12/26/80 Painful left foot, diagnosed as strain. Recommend arch support.

1/12/81 XXX. "Posterior tibial tendinitis."

4/30/81 Doctor's first report. Left ankle sprain or fracture. Fracture left fibula, cast for six weeks. Return to regular work 7/06/81.

6/11/81 Left ankle x-ray. Fracture lateral malleolus.

9/01/81 XXXX. Doctor's first report. Right shoulder pain due to vacuuming. Diagnosis: "Muscle pain". Apply heat, aspirin with codeine. Return to modified duty. "No heavy lifting" four to five days.

12/08/81 Right shoulder steroid injection. Regular work.

11/15/82 XXXX. Ankle contusion.

6/25/83 "Upper back spasm". Treatment: Heat, massage, physical therapy, Robaxin, Valium.

6/30/83 Pain in mid back for eight months, "no incident". Diagnosis: Thoracic back sprain. Treatment: Stretching and icing. Physical therapy visits - 7/01, 7/05, 7/13, 8/01 with improvement.

7/25/84 Left ankle x-ray. No fracture.

7/29/96 X-ray right shoulder showing mild degenerative changes, AC joint, calcific tendinitis.

8/05/96 X-ray cervical spine showing moderate degenerative changes.

2/1/97 MRI scan right shoulder. Positive for supraspinatus tear and acromioclavicular joint degenerative changes.

2/05/97 X-ray, "supraspinatus outlet view". Decreased size.

4/12/97 Chest x-ray normal.

10/09/97 MRI scan, right knee, showing meniscal degenerative changes, possible lateral meniscus and medial meniscus tears.

5/05/98 Right shoulder MRI. Supraspinatus tendon abnormality, deltoid atrophy. Post surgical changes.

5/11/98 Chest x-ray negative.

10/29/99 Right shoulder x-ray, one view, negative.

7/27/04 XXXX. Chest x-ray negative.

## Part Two

5/04/84 Doctor's first report. XXXX. Date of injury: 6/23/83, upper back pain. Objective findings of spasms of scapular and lumbar area, diffuse. Diagnosis: "Back strain/spasm." Plan: Heat, massage, PT. PT visits - 6/30, 7/01, 7/05, 7/13/83. Regular work 5/04/84.

6/13/84 XXXX. Aching left elbow. Diagnosis: Epicondylitis. Plan: Rest, heat, Motrin.

8/14/84 Orthopaedic Clinic. XXXX. Epicondylitis. Plan: Motrin and splint.

8/24/84 Doctor's first report. Illegible, but stating return to regular work.

8/25/84 Left ankle sprain.

10/30/84 Left gastrocnemius strain.

2/04/85 "Muscle spasm, back." Robaxin.

3/01/85 XXXX. "Chronic muscle strain neck and mid low back." Objective: Tender trapezia. Assessment: Neck muscle strain overuse. Plan: Regular work, PT, cervical collar.

3/07/85 Right hand x-ray normal.

3/22/85 Doctor's first report. XXXX. Fracture right fourth metacarpal phalangeal joint. Modified work for 10 days.

4/02/85 Supplemental report. XXXX. History of "back strain." Objective: Tender trapezia. Assessment: Chronic neck muscle strain secondary to overuse. Plan: Regular work, collar, PT, Robaxin.

7/85 Physical therapy notes regarding treatment for right-sided neck pain.

11/14/85 Refer to doctor of podiatric medicine for "falling arches." Needs support. Refer to podiatrist.

12/02/85 XXXX. Diagnosis: Metatarsalgia and plantar fasciitis. Plan: Tape, orthotics, Advil.

12/12/85 XXXX. Doctor's first report. Subjective: Pain in legs and feet due to walking. Objective: Fallen arches. Assessment: Fallen arches. Plan: Refer to podiatrist.

5/16/86 "Tired", discussed psychosomatic symptoms.

4/20/87 XXXX. Orthopaedics. Right shoulder pain for four years. Assessment: Acromioclavicular arthritis and bicipital tendinitis. Plan: Nonsteroidal medication.

3/88 Physical therapy. "Dysfunction of back."

3/19/88 Podiatrist. Pain both feet. Treatment with taping.

3/24/88 PT referral for lumbosacral strain. History of low back pain two days. "No trauma."

11/22/88 Orthopaedic evaluation noting pes planus, recommending heel pads.

11/24/88 Doctor's first report. XXXX. Right ankle sprain.

11/24/88 Right ankle x-ray. Soft tissue swelling, sprain.

11/29/88 Supplemental report. Right ankle sprain. Brace. Return to regular work. Possible orthopaedic referral.

11/29/88 Orthopaedic referral for right ankle sprain.

2/6/89 Chest x-ray negative.

2/28/89 PT referral for mechanical low back pain, right shoulder and bilateral leg pain.

3/13/89 XXXX. Fell 11/25/88. Right ankle sprain, left sacral pain radiating down left leg. Range of motion. Tender left buttock. Assessment: Muscle pain, not radiculopathy.

3/13/89 Orthopaedics. Discomfort left buttock with sitting.

8/29/89 "Industrial work sheet." History of stumble. Hurt back, pain in back down right leg.

8/29/89 XXXX. Diagnosis: Acute sciatic pinch. Recommend PT and Naprosyn.

9/05/89 XXXX. Industrial visit. Off work 8/29/89 through 9/18/89.

9/10/89 PT notes regarding right-sided sciatica.

9/18/89 XXXX. Followup right sciatic neuritis with some improvement.

9/18/89 Industrial visit. Off work 9/18/89 through 10/09/89.

9/18/89 Lumbosacral x-ray. Degenerative changes L5-S1. Diagnosis: Right sciatica.

10/06/89 Return to work 10/03/89.

10/23/89 XXXX. Doctor's first report. Right sciatic bursitis and pinch. Recommend physical therapy. Regular work on 10/23/89.

10/24/89 XXXX. Return to work 11/20/89.

11/14/89 XXXX. Supplemental report.

8/15/91 XXXX. Industrial progress report. Pain proximal right thigh. Objective: Tender greater trochanter. Assessment: Trochanteric bursitis. Plan: Injection. Off work 8/15/91 through 8/18/91.

8/23/91 Industrial visit note. Date of injury: 8/14/91. "Left leg pain while walking."

5/05/92 XXXX. Off work 5/05/92 through 5/11/92.

5/12/92 XXXX. Off work 5/11/92 through 5/12/92, and off work 5/15/92 through 5/19/92 due to upper respiratory infection.

No date Page 480. Lumbosacral pain. CT scan showing bulging discs L3-4, L4-5, L5-S1. Impression: Not radiculopathy. Assessment: Strain, myofasciitis. Plan: Physical

therapy, back class, Motrin. Regular work.

Part Three

- 8/09/93 PT referral for cervical strain due to auto accident six weeks ago.
- 1/11/94 XXXX. Doctor's first report. Date of injury: 11/01/85. Fallen arches. Needs orthotics.
- 4/27/94 Note to XXXX. Industrial nurse requests prescription for something which has been approved by Workers' Comp.
- 8/31/94 Orthopaedics. Left lateral shoulder pain. No heavy lifting. Impression: Sprain left deltoid.
- 1/09/96 "Stopped by and requested prescription for arch supports."
- 11/22/96 Refill Vicodin for right shoulder.
- 5/10/96 Industrial report for "right shoulder girdle and neck pain secondary to repetitive lifting."
- 5/10/96 Industrial Visit Questionnaire. Date of injury: 5/08/96. History: Using "huge" vacuum sweeper, pain in whole right side of my top body, ribs, chest, shoulder, neck and head."
- 5/10/96 XXXX. Doctor's first report. Cumulative injury. History as given immediately above. Objective: Neck, back, increase in symptoms with ROM. Diagnosis: Right shoulder girdle neck pain secondary to repetitive movement and lifting. Treatment: Ibuprofen, heat. Followup prn. (No advice on work status).
- 7/29/96 XXXX, orthopaedics. Bicipital tendinitis. Modified work through 8/15/96.
- 7/30/96 XXXX. Right shoulder pain. Objective: Tender bicipital tendon. Treatment: Ibuprofen. Modified work 7/29/96 through 8/14/96. Return to regular work 8/15/96.
- 8/02/96 Bicipital tendinitis. PT. Modified work through 8/29/96.
- 8/19/96 XXXX. Bicipital tendinitis. Return to regular work 8/25/96.
- 8/29/96 XXXX.. Orthopaedics. Objective: Right shoulder pain on abduction. Diagnosis: Calcific tendinitis. Plan: Injection with Lidocaine and Kenalog, Vicodin. Off work 8/28/96 through 9/12/96.

8/29/96 XXXX. Discontinue physical therapy for shoulder.

9/04/96 XXXX. Calcific tendinitis. Refer to XXXX for injection. Recheck two weeks.

9/04/96 XXXX. Injection.

9/10/96 XXXX. "Doctor's Certificate." Treated from 7/26/96 through 8/28/96 for right shoulder bicipital tendinitis. Recommend off work, rest, medication. Return to regular work on 8/29/96.

9/11/96 XXXX. Calcific tendinitis, right subdeltoid, resolved. Return to regular work 9/13/96.

9/18/96 XXXX. Off work 7/29/06 through 9/13/06.

10/08/96 XXXX. Subjective: Right neck and shoulder pain felt to be radicular by therapist. Objective: Cervical spine x-ray shows degenerative joint disease and narrowing at C5-6. Plan: Physical therapy. Followup with XXXX.

1/06/97 XXXX. Subjective: Shoulder pain. Assessment: Subacromial bursitis or rotator cuff tear. Plan: MRI. Off work until 1/10/97.

1/7/97 XXXX. MRI positive for rotator cuff tear. Plan: Consult with orthopaedist. Modified work 1/7/97 through 3/27/97.

2/08/97 XXXX. Right shoulder pain, injected.

2/20/97 XXXX. Noted injection. Discussed surgery with XXXX. Off work 2/28/97 through 3/27/97.

2/27/97 XXXX. ?surgery.

3/07/97 XXXX. Needs surgery. Schedule as soon as possible.

3/24/97 XXXX. Orthopaedics. Pain right shoulder, awaiting clearance for surgery.

3/25/97 XXXX. Pain lateral shoulder. Surgery to be scheduled. Off work 3/24/97 through 5/24/97.

3/25/97 Return to regular work 5/24/97.

4/25/97 XXXX. Office visit.

5/22/97 XXXX. Right shoulder rotator cuff tear. Partial operative note.

6/19/97 XXXX. Off work 5/22/97 through 7/15/97.

7/08/97 XXXX. Objective: Atrophy right deltoid. Limited range of motion. Improving with physical therapy. Plan: Return to clinic in one month.

7/10/97 XXXX. Off work 7/07/97 through 8/07/97.

8/06/97 XXXX. Status post right rotator cuff repair and acromioplasty. Adhesive capsulitis. Plan: Manipulation. Off work 8/06/97 through 9/06/97.

8/06/97 Workers' Comp Claim. From table in physical therapy, twisted to right to grab right shoulder and injured right knee.

8/13/97 "Preop exam." Right shoulder surgery 8/18/97 for adhesive capsulitis.

9/10/97 Doctor's first report. Right knee. Date of injury: 8/06/97. ?meniscal tear. Plan: MRI scan.

9/10/97 XXXX. Off work 9/06/97 through 9/30/97.

9/17/97 XXXX. Continue physical therapy.

9/23/97 XXXX. Followup manipulation. Good range of motion and weak. Plan: Off work until October. Physical therapy.

10/07/97 MRI scan right knee showing degenerative menisci with lateral and medial tears.

10/08/97 XXXX. Off work 10/01/97 through 11/01/97.

10/22/97 XXXX. Right shoulder improving.

10/29/97 XXXX. Disability report. Unable to give opinion.

11/24/97 XXXX. Right knee complex tear both menisci. Consider surgery.

11/25/97 XXXX. Great deal of problems with right knee. Scheduled for surgery.

11/25/97 XXXX. "Great deal of problem with right shoulder." Objective: Pain acromioclavicular ligament. Plan: One to one and a half years of recovery.

12/03/97 XXXX. Continued right shoulder pain due to bicipital tendinitis. Right knee

meniscus tear. Plan: Return to work as desired. Regular work.

- 12/04/97 Telephone call to XXXX to cancel knee surgery.
- 1/09/98 XXXX. Pain acromial ligament. Recommend excision. Right knee, ?surgery. Return to work 1/19/97 (sic).
- 1/09/98 XXXX. Modified work 1/19/98 through 5/01/98.
- 1/15/98 XXXX. Attending physician report. Diagnosis: Meniscal tear right knee with positive MRI. Plan: Physical therapy, medications. Return to work on 1/19/97 (sic), and consider surgery in April or June if needed.
- 1/17/98 XXXX. Right shoulder improving. Weakness may take one year to get better. Also right knee pain.
- 3/12/98 XXXX. Plan to return to regular work 1/19/97 (sic).
- 4/01/98 XXXX. Right shoulder continues to improve range of motion and strength in physical therapy. Modify activity. Assessment: Deconditioned. Slow recovery. Needs MRI.
- 4/29/98 XXXX. Modified work 5/01/98 through 6/01/98.
- 6/01/98 XXXX. Modified work 6/01/98 through 8/01/98.
- 7/10/98 XXXX. Pain continues in right shoulder.
- 8/28/98 XXXX. Modified work 9/02/98 through 11/02/98.
- 8/28/98 XXXX. Continues pain, anterior right shoulder injected, coracoacromial ligament.
- 8/31/98 Telephone call. Right shoulder pain to elbow no better.
- 10/30/98 XXXX. Modified work 11/02/98 through 11/02/99.
- Undated Various chest x-rays, mammograms and laboratory tests which are non contributory to the issues under discussion.

#### Part Four

- 3/12/99 Illegible signature. Right shoulder, right knee. QME 10/98. Modified work since 1/98, 3/08/99 housekeeping. "Unable to do full job." Objective: Right shoulder

decreased range of motion. Assessment: Chronic right shoulder pain. Plan: Continue physical therapy. ?interscalene block. Diagnosis: Rotator tear. Regular work 3/12/99.

- 8/13/99 XXXX Workers' Compensation. Stipulated Award on XXX with future medical regarding date of injury XXX. "Multiple upper extremity." No details.
- 8/26/99 XXXX. Refill Vicodin #100.
- 10/12/99 XXXX. Modified work 11/02/99 through 11/02/00. Right shoulder decreased range of motion, recurrent rotator cuff tear. Right knee meniscal tear.
- 3/08/00 XXXX. Right shoulder no change. Right knee, arthroscopic. Modified work lifting up to 100 pounds, 25% of the time.
- 7/19/00 XXXX. Subjective: Pain in both hands. Objective: Positive Phalen's test, left wrist. Assessment: Tendinitis, improved, rule out carpal tunnel syndrome. Plan: Splints at night, nerve conduction study, physical therapy and self care. Modified work 7/19/00. Occasional repetitive motion.
- 7/25/00 XXXX. Tendinitis. Rule out cubital tunnel syndrome. Work status: Modified work with no repetitive motions.
- 7/28/00 Not legible.
- 7/30/00 XXXX. Bilateral wrist tendinitis and left De Quervain's. Modified work.
- 8/01/00 XXXX. Multiple joint and muscle symptoms. Abnormal labs. ?rheumatoid disease. ESR 34. ANA 2+ 1:80. RA negative.
- 8/01/00 XXXX. Modified work 8/01/00. No repetitive movements.
- 8/09/00 Tendinitis, improving. Modified work. No repetitive motions.
- 8/16/00 Improving. Occasional repetitive motions.
- 8/24/00 XXXX. Improving. Regular work on 9/01/00.
- 8/30/00 Behavioral Medicine. "Work stress." Recommends yoga, Tai-Chi and EAP.
- 9/08/00 XXXX. Regular work 9/08/00.
- 9/23/00 XXXX. Bilateral tendinitis. Regular work 9/22/00.

10/20/00 XXXX. Regular work.

11/15/00 Bilateral tendinitis. Regular work.

12/08/00 XXXX. Regular work 12/07/00.

1/05/01 XXXX. Pain comes and goes. Patient declines nerve conduction studies. Advised return to regular work.

1/08/01 XXXX. Supplemental report regarding exam on 8/01/00. Return to modified work. No repetitive movements.

1/12/01 XXXX. Rheumatology consultation. Assessment: Positive ANA but doubtful SLE. High probability of CTS. No arthritis.

1/31/01 XXXX. Return to regular work.

2/15/01 XXXX. Permanent and stationary report. This report refers to a date of injury of XXX. Permanent and stationary as of 1/31/01. History of pain in both hands due to vacuuming and buffing. Some improvement with physical therapy and medications. Continues bilateral hand pain, numbness and tingling. Nerve conduction study on 7/28/00 was normal. Experiences intermittent pain on a daily basis with no specific aggravating activities. Bilateral hand discomfort, occasional swelling. Difficulty opening jars. Symptoms in the palms of both hands. Padded gloves at work. Occasional splints at night. Diagnoses: Right carpal tunnel syndrome and bilateral wrist tendinitis. No work restrictions. No apportionment. Not qualified injured worker. Future medical should be provided with medications, physical therapy, cortisone injection.

4/26/01 XXXX. PR-2 report. Right shoulder pain. Decreased range of motion. Rotator cuff tear, recurrent. Plan: Vicodin. Regular work.

6/07/01 XXXX. Right shoulder pain. Physical therapy.

7/16/01 XXXX. Regular work.

8/13/01 XXXX. Regular work.

3/04/02 XXXX. Bilateral hand tendinitis.

4/21/03 XXXX. Both hands doing well. DJD left thumb MCP joint. Use Vicodin.

6/07/03 Doctor's first report. Right hand contusion. Return to regular work.

6/30/03 Followup on fracture right fifth metacarpal. Return to modified work.

7/18/03 -  
9/03 Reports regarding work injury, consisting of left leg contusion with cellulitis, treated with rest and antibiotics. Return to regular duty. No permanent disability.

8/22/03 Right hand. Return to regular work.

3/26/04 XXXX. Bilateral heel pain since 1985. Orthotics every three years. Plantar fasciitis.

3/26/04 XXXX. Doctor's first report. Subjective: "Fallen arches." Diagnosis: Bilateral plantar fasciitis.

3/04 Emergency Department visit for right leg cramps.

4/01/04 XXXX. Doctor's first report. Right hand contusion.

4/21/04 XXXX. Followup on plantar fasciitis.

6/03/04 XXXX. Followup on plantar fasciitis.

6/29/04 XXXX. Followup on plantar fasciitis treated under future medical provisions.

11/26/04 XXXX. Doctor's first report. Date of injury: 11/26/04, left chest wall strain. Modified work.

12/08/04 XXXX. Rib strain improving. Modified work through 12/07/04.

12/21/04 Rib strain. Return to regular work.

No date Emergency Department visit for swelling of both hands. Followup with occupational medicine.

No date Right hand fracture. Return to regular work.

Part Five

12/02/85 "Biomechanical morphological data chart" indicating pronated feet, and a propulsive toe-off, slightly antalgic, evaluation and treatment.

12/02/85 XXXX. Reason for consultation: "Fallen arches." Has old orthotics and needs new prescription. History of bilateral foot pain for two months. Balls of feet and arches, worse with weightbearing, relieved with non weightbearing. No history of trauma

except for left broken ankle three years ago. Wore rigid orthotics for 13-15 years for preventative reasons. Wore them up to a few days ago. Has been taping arches for the last three weeks. Physical exam: See morphological data sheet. Impression: Metatarsalgia and plantar fasciitis, bilateral. Plan: Low dye taping today. Evaluate and cast for functional foot orthotics.

- 12/16/85 XXXX. Returns for orthotics. Had plantar fascia pain last night. Good orthotic control. Plan: Given instructions.
- 2/10/86 Returns for orthotic check. Orthotics control foot well during gait. Assessment: Satisfactory control of plantar fascia problem with orthosis. Plan: Return prn.
- 2/11/86 XXXX. Doctor's first report. Date of injury: XXX. Date of exam: 12/02/85. History: Due to walking on cement floors, pain in both legs and feet. Objective: No sign of irritation from orthosis. Diagnosis: Metatarsalgia, plantar fasciitis. Treatment: Same as described immediately above. Work status: Return to usual work on 2/11/86.
- 10/21/88 Painful arches. Wears orthotics. Exam: Painful plantar fascia both feet. Plan: Low dye strapping and orthotics.
- 9/26/94 XXXX. Industrial progress record. Subjective: Presents to clinic for casting for orthotics. Wearing for past 10 years. Plantar fascia pain recently. Knee and leg pain on left side. On feet all day long. Objective: Tender plantar fascia. Decreased range of motion of first MPJ. Assessment: Plantar fasciitis. Functional hallux limitus, bilateral. Plan: Casts for orthotics.
- 10/24/94 Returns to clinic for dispensing orthotics.
- 10/24/94 Biomechanical evaluation in Podiatry Clinic.
- 10/24/94 Doctor's Statement. \$40.04 billed for metatarsalgia and plantar fasciitis both feet.

### **PHYSICAL EXAM**

Blood pressure 150/95.  
Pulse 80 and regular.  
Height/Weight 5'1.5"/ 232 pounds.

General Appearance The applicant is a physically deconditioned appearing female, well developed, well nourished, appearing older than her stated age.

HEENT	Pupils are equal and reactive to light and accommodation. Sclera anicteric. Fundoscopic exam normal. Ear canals clear. Tympanic membranes are normal. Nose is patent. Throat shows no enlarged tonsils or inflammation.
Neck	Supple, no masses or thyromegaly. Carotids equal without bruit. No jugular venous distension. Thyroid not palpable. There is a healed surgical scar in the right lower portion of the neck anteriorly.
Heart	Regular rate. No murmur, gallop or rub.
Lung Fields	Lungs are clear to auscultation and percussion. There is no wheezing on forced expiration.
Abdomen	Obese, soft, nontender. No guarding or rebound. No masses. No organomegaly. Bowel sounds are normal.
Extremities	Slight swelling of both hands. The ankles are not swollen. There is no atrophy, deformity of the limbs, cyanosis or clubbing. Peripheral pulses are full.
Lymphatics	No abnormal lymph glands.
Musculoskeletal	<p>Cervical spine shows moderately reduced range of motion with flexion about 60 degrees, extension about 15 degrees, lateral rotation 20 degrees to each side, lateral flexion 20 degrees to each side. Extension appears to be the most uncomfortable maneuver. Spurling's test is negative. Right shoulder shows healed anterior surgical scar. There is diffuse tenderness about the anterior and lateral aspects of the right shoulder. The range of motion is markedly reduced to less than 50% of normal with flexion overhead, abduction and adduction, and with internal and external rotation.</p> <p>Left shoulder shows a full range of motion. Thoracic range of motion is limited to about 30 degrees of rotation to each side. Lumbar spine shows limited range of motion, flexion about 60 degrees, extension 20 degrees, lateral flexion 15 degrees to each side. With palpation, there is minimal diffuse paravertebral soft tissue tenderness throughout the cervical, thoracic and lumbar regions, which is most pronounced in the right cervical region. No muscle spasm is appreciated.</p> <p>Both elbows show full range of motion without subluxation of the ulnar nerves. Tinel's test is negative at both ulnar grooves. There is no appreciable tenderness of the lateral or medial epicondyles of either elbow. Both wrists show reduced range of motion with extension about 30 degrees, flexion about</p>

70 degrees, tenderness of the dorsa of both wrists, tenderness of the bases of both thumbs, slight reduction in pinching and grasping strength in both hands. Tinel's and Phalen's tests are negative at both wrists. Sensation and circulation are intact in the fingertips of both hands. Finkelstein's test is negative in both thumbs bilaterally. Carpometacarpal grind test is negative in both hands bilaterally.

Right knee shows moderate reduction in range of motion with full extension. Flexion lacks about 20 degrees. Left knee shows full extension. Flexion lacks about 10 degrees. Both knees are stable without effusion. Right knee shows moderate medial joint line tenderness. McMurray's test is positive in the right knee. Both hips show moderately reduced range of motion. Flexion to about 60 degrees, extension about 10 degrees, internal and external rotation are about 50% of expected normal.

Right ankle examination shows full range of motion and a stable joint without effusion or tenderness. Left ankle examination shows slight limitation in range of motion to 80% of normal. There is minimal tenderness around the lateral malleolus of the left ankle. The joint is stable without effusion. Both feet show pes planus. There is no particular tenderness of the plantar fascia or metatarsal phalangeal joints. There is mild hallux rigidus deformity bilaterally. Circulation and sensation to the toes are intact.

Gait is somewhat lumbering in nature, characterized by reduced excursion of the hips and knees, and moderate degree of swaying of the trunk from side to side while walking. However, there is no appearance of pain with walking, either in the neck, back, knees, ankles or feet. It is noted that the applicant is wearing bilateral wrist splints.

#### Neurologic

Cranial nerves II-XII intact. Deep tendon reflexes are symmetric and preserved. Light touch sensation is preserved. Mental status is within normal limits. Coordination is intact with Romberg and finger-to-nose tests.

#### Skin

Unremarkable.

## DIAGNOSES

1. Chronic right shoulder pain, due to rotator cuff tear, acromioclavicular arthritis, coracoacromial ligament inflammation, and bicipital tendinitis. These are sequelae of the industrial injury of XXX.
2. Chronic right knee pain, due to degenerative joint disease and degenerative menisci, with lateral and medial meniscal tears. This is an industrial aggravation of a preexisting condition. The date of injury was given as XXX. Technically, it is a complication of the XXX injury to the right shoulder.
3. Pain in both hands, due to wrist tendinitis and overuse syndrome, date of injury: XXX. This condition is caused by work.
4. Chronic bilateral foot pain, due to plantar fasciitis, metatarsalgia and hallus rigidus. This is not caused by work, but is aggravated by work to a minor degree.
5. Chronic back pain in the cervical, thoracic and lumbar regions, due to degenerative joint disease, degenerative disc disease, multiple sprains, overuse and myofasciitis. This is not caused by work but is aggravated by work to a minor degree.
6. Left elbow lateral epicondylitis, due to work injury approximately 1985, resolved.
7. History of intermittent bilateral leg pain or “sciatica”, due to work injuries of various dates, resolved.
8. Right fifth metacarpal fracture, work injury of XXX, resolved.
9. Left leg contusion and cellulitis, due to work injury of XXX, resolved.
10. Right hand contusion, due to work injury of XXX, resolved.
11. Left chest strain, due to work injury of XXX, resolved.
12. Cervical strain, June 1993, due to automobile accident, resolved.
13. Multiple ankle sprains, due to work injuries at various dates, resolved.

## DISCUSSION

XXXX, a 61-year-old woman, has worked as a housekeeper or “environmental services technician” for approximately 27 years at XXXX. She tells me that her supervisor told her she should retire, due

to various aches and pains, and the applicant appears to be interested in doing so. She has had approximately 15 injuries at work over the past 20 years or so, and although there is no permanent disability on record regarding any of these injuries, apparently the applicant has filed a report indicating “cumulative injuries to the spine, upper extremities and feet.”

Certainly this examiner sympathizes with an individual who has worked hard all of her life and now wants to retire and finds herself financially unable to do so. However, it is necessary to examine each specific injury, and each specific painful body part, to determine what disability may apply to each.

It appears that the majority of injuries have resolved without any sequelae, and certainly the medical records do not indicate any permanent disability having been suggested for any of the injuries. Regarding bilateral “leg pains”, the applicant admits that at the present time she only has occasional pain going down the left leg, which is not particularly troubling. Therefore, there would appear to be no permanent disability attached to any of her leg injuries or leg pains.

With regard to the back pains and “spasms” recorded in the chart over a period of many years, there is no clear indication to this examiner that this is caused by work. She does appear to have a tendency to myofascial pain along the paravertebral muscles, which may well be aggravated by her work activities from time to time. However, I do not feel that this rises to the level of any permanent disability.

The various ankle sprains, and left ankle fracture, and left leg contusion, and episode of cellulitis, seem to have cleared up without any sequelae. Therefore, there is no disability for any of these injuries.

The right fifth metacarpal fracture, the right hand contusion, and the left chest wall strain, which have occurred in recent years, seem to have cleared up without any sequelae, therefore, there is no disability.

With regard to the bilateral chronic foot pain, I do not believe that this is caused by work. Instead, it is due to the congenital anatomy of the feet, wear and tear, aging process, and acceleration of these processes by obesity. Walking around frequently on concrete floors may aggravate her foot pain to a minor degree. This will be considered in the apportionment discussion.

With regard to the bilateral hand pain, although the phrase “carpal tunnel syndrome” has been bandied about, I note that the nerve conduction test was negative and my examination today does not reveal specific signs of carpal tunnel syndrome. The chronic hand pain may be due to some degree of tendinitis, muscle aches, and overuse. I believe it is medically probable that the bilateral hand pain is caused by employment. There is some degree of permanent disability there, which I will describe later.

The chronic right knee pain I would consider to be resulting from an aggravation of preexisting

condition, and is caused by work and indirectly due to the right shoulder injury. The degree of disability will be discussed later.

The major issue appears to me to be the right shoulder pain, which is certainly recorded as being due to an industrial injury, cumulative to XXX, due to repeated use of heavy vacuums. This condition is due to employment and there is disability which I will describe below.

Therefore, I would consider that the main issues at hand are the extent of disability regarding the right shoulder, right knee, and bilateral hands. I do not find any disability related to the back, and I do not find that there has been any injury to the "spine".

If additional information becomes available at a later date, then supplemental reports can be issued as required to assess these factors. Such information may or may not change the opinions rendered in this evaluation. The above analysis is based upon the subjective complaints, the history given by the applicant, the review of medical records and tests provided, the physical findings and review of the appropriate medical literature. It is assumed that the material provided is correct.

The examiner's opinions are based upon reasonable medical probability and are totally independent of the requesting party. Medicine is both an art and science. There is no guarantee that the applicant will not be re-injured or suffer additional injury or disease. If applicable, the employer should follow the process established in the Americans with Disabilities Act, Title 1. The opinions expressed here do not constitute a recommendation that specific claims or administrative functions be made or enforced.

### **DISABILITY STATUS**

With regard to the bilateral hand pain, XXXX is permanent and stationary and became so on XXX, as reported by the treating physician.

With regard to the right shoulder pain, the condition is permanent and stationary as of XXX, when the attending orthopedist documented a stable condition.

With regard to the back pain, the condition is permanent and stationary as of today.

With regard to the bilateral foot pain, the condition is permanent and stationary as of today.

### **FACTORS OF DISABILITY**

**SUBJECTIVE:** Regarding the right shoulder pain, the subjective factors are slight pain, which is intermittent. It increases to moderate on a less than occasional basis with precipitating activities such as lifting overhead or heavy lifting.

With regard to the bilateral hand pain, subjective factors include slight pain, which is frequent. It increases to moderate on a less than occasional basis with precipitating activities such as repetitive motions or forceful grasping.

With regard to the bilateral foot pain, subjective factors include slight pain, which is occasional in frequency. It increases to moderate on a less than occasional basis with precipitating activities such as prolonged standing or walking or walking up a hill.

With regard to the back pain, subjective factors include moderate pain, which occurs on a less than occasional basis.

**OBJECTIVE:** Regarding the right shoulder, objective factors include a surgical scar, limited range of motion of the right shoulder, and MRI findings of degenerative changes and post surgical changes.

With regard to the bilateral hands, objective factors include slight puffiness of both hands, and reduced range of motion of both wrists to about 75% of normal.

With regard to the bilateral foot pain, objective factors include limited range of motion of the big toe, to about 50% of expected normal.

With regard to the back, objective factors include x-ray and CT scan findings of degenerative joint and disc disease. Also, there is objectively limited range of motion of the cervical and lumbar regions of the spine to about 50-60% of expected normal.

### **WORK RESTRICTIONS**

Regarding the right shoulder, the applicant is precluded from lifting overhead with the right arm, and precluded in lifting more than 30 pounds with both hands from floor to waist, or 20 pounds from waist to shoulder level. She is precluded from lifting more than 10 pounds using the right hand alone. She is precluded from pushing and pulling with the right arm more than 30 pounds of force. The bilateral hand problem would preclude her from repetitive movements more than 45 minutes at a time, or cumulatively more than four hours per day. She is precluded from forceful grasping in excess of 40 pounds. She should wear splints as needed.

With regard to the bilateral foot pain, the applicant would be precluded from standing or walking more than 45 minutes at a time, or cumulatively more than five hours per day. She is precluded from significant climbing activities in excess of two flights of stairs per day.

With regard to the back pain, I do not see any objective basis on which to impose work restrictions. If necessary, a formal functional capacity evaluation might be useful to provide more information.

### **APPORTIONMENT**

I do find issues of apportionment with regard to the various diagnoses.

With regard to the right shoulder problem, I would estimate that 80% of the disability is a direct result of the cumulative work injury, and 20% is the result of other factors such as aging and the degenerative process, and activities of daily living.

With regard to the back pain, I would estimate that 50% is directly caused by the cumulative work injuries and 50% by degenerative processes, wear and tear, and activities of daily living.

With regard to the bilateral hand pain, I would estimate that 50% is directly caused by the cumulative work activities, as well as by the multiple specific injuries to both hands recorded in the records, and 50% to other causes such as degenerative changes, wear and tear, and activities of daily living.

With regard to the bilateral foot pain, I would estimate that 90% is due to nonindustrial causes such as foot anatomy, wear and tear, and activities of daily living, which are accelerated by obesity. I would estimate that 10% of the disability is caused by cumulative work injuries and activities. The reason for this opinion is that plantar fasciitis and metatarsalgia are common painful conditions of the foot which commonly occur in middle-aged individuals who may have an anatomical predisposition and accelerated by obesity. If walking on hard floors was the cause of this problem, then everyone who walks on hard floors would have the problem.

### **VOCATIONAL REHABILITATION**

I cannot give an opinion whether the applicant is able to return to her normal work without reviewing a formal job analysis. It is not clear to me whether the applicant is, in fact, performing her usual and customary work at this time, since she believes that she is on modified duty, but this is not stated in the medical records. Furthermore, it might be advisable to obtain a formal functional capacity evaluation to decide whether the applicant can return to her usual and customary work.

### **FUTURE MEDICAL CARE**

I recommend that future medical care should be provided for the right shoulder problem, which might reasonably consist of nonsteroidal medications or analgesics, and possibly further cortisone injections. It is doubtful to me whether further surgery would be helpful, but perhaps the opinion of an orthopaedic surgeon could be obtained in this regard.

With regard to the bilateral foot pain, I would recommend future medical treatment be provided, which would consist of orthotics and possibly steroid injections.

With regard to the back pain, I do not see that future medical care is indicated. The applicant has already had physical therapy and should be aware of strengthening and stretching exercises at this time. She can use over-the-counter medications if needed. Since it is my opinion that work contributed very little to the back problem, it would be reasonable for the applicant to pursue further medical treatment under her personal health insurance.

Regarding the bilateral hand pain, future medical treatment should be provided and would reasonably consist of evaluation by a hand surgeon, and the possibility of further physical therapy, splinting, or injections.

### **RECOMMENDATIONS**

I believe there is a reference in the medical records to a QME exam having been performed in October of 1998 regarding the right shoulder pain. If this report exists, then I would like to review it.

If permanent and stationary reports exist regarding the shoulder, foot, or back problems, I would like to review them.

If other specific information exists regarding the allegation of cumulative trauma to the various body parts, other than included in the medical records, I would be happy to review that and issue a supplemental report.

I hope that this report is useful to all concerned. If you have any other questions, please feel free to contact me.

Sincerely,

Brian M. Boni, M.D., M.P.H.

BMB/po

**DECLARATION/SIGNATURE PAGE**

I personally took the history from the applicant on the date indicated at the beginning of the report in the medical-legal office located at 1498 Solano Ave, Albany, California, performed the physical examination, reviewed the medical records and prepared this report entirely myself. The medical-legal opinions expressed in this report are solely my own. If medical testing is required, authorization will be requested first and the tests will be performed by an outside hospital or medical entity completely unaffiliated with myself. The results of any medical testing will be addressed by an appropriate supplemental report. For QME reports, additional medical records may be requested and reviewed.

I declare under penalty of perjury that the information obtained 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 that 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 to the best of my knowledge.

The evaluation of this applicant and the time spent performing the evaluation was in compliance with the guidelines established by the Administrative Director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code or any other relevant sections or revisions of the Labor Code.

I further declare under penalty of perjury that I have not knowingly violated the provisions of the California Labor Code Section 139.3 with regards to the evaluation of this applicant or the preparation of this report. I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred exam or evaluation.

In summary, I have not violated Labor Code Section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. All statements on this declaration page are made under penalty of perjury.

**PERSONALLY DICTATED, REVIEWED, EDITED AND MEDICAL LEGAL OPINION  
VERIFIED AS ATTESTED HERETO BY MY ORIGINAL SIGNATURE:**

Signed: \_\_\_/\_\_\_/200\_ in \_\_\_\_\_, California, County of \_\_\_\_\_.

\_\_\_\_\_  
Brian M. Boni, MD, MPH