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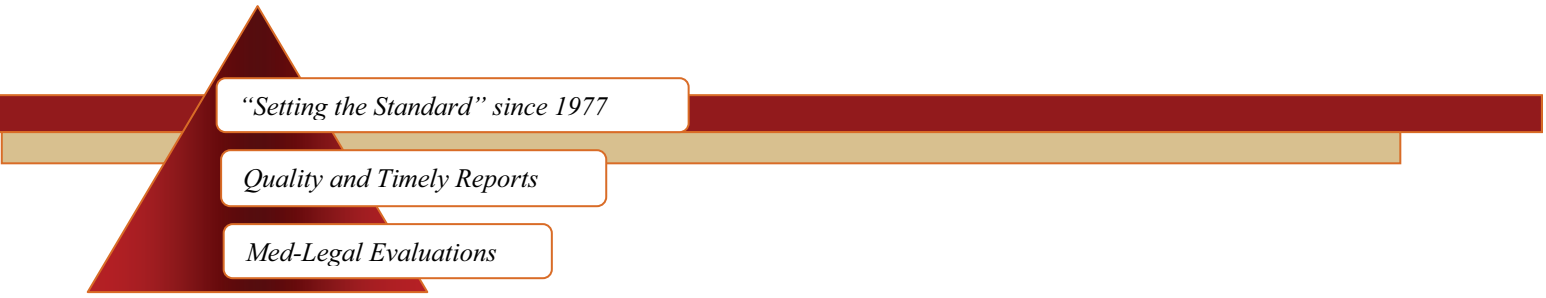

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AME SAMPLE REPORT
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RE: Ms. WORLD COUNTRIES
EMP: COMPANY J
WCAB NO: OAK 000000; OAK 000001
CLAIM NO: 000000000; 00000001
DOI: 10/1/05; CT through 7/18/06

Dear Attorney X and Attorney Y:

At your request, I conducted a neurologic evaluation of Ms. WORLD COUNTRIES on 12/16/08 in my Oakland office. I have received a letter dated 11/19/08 from Attorney X. I am advised that the applicant is evaluated for two claims, 10/1/05, for neck, shoulders and upper extremities, and a cumulative trauma claim through 7/18/06, involving the neck, right shoulder, upper extremities, right hip and back. Left shoulder is denied, per Dr. UNITED STATES's report. I am asked to evaluate the patient with regard to headaches. Dr. UNITED STATES evaluated the patient as a panel QME on orthopedic injuries with regard to the 10/1/05 injury and Attorney X states that there was no evaluation on a cumulative trauma claim. At this point, it is not known whether there is any agreement that I should evaluate the neck, shoulders, upper extremities, back and right hip. I have also received a letter dated 12/1/08 from Attorney Y. I am advised that my evaluation is limited to headaches only.

This report is submitted pursuant to 8 Cal. Code Regs. Section 9795(b)&(c) as an ML104-94, Comprehensive Agreed Medical-Legal Evaluation Involving Extraordinary Circumstances and meets the requirement of ***four complexity factors***. These factors include:

(4) 4+ hours spent on any combination of two of the complexity factors (1)-(3), which shall count as **two complexity factors**;
(6) addressing the issue of medical causation, which shall count as **one complexity factor**;
(7) addressing the issue of apportionment, which shall count as **one complexity factor**.

Time spent in face-to-face contact with the patient was 50 minutes. Time spent reviewing records was two hours and 35 minutes. Time spent in medical research was two hours and 15 minutes. Time spent preparing the report was two hours and 15 minutes. Total time spent on this case was seven hours and 20 minutes. Complexity is further reflected by the involvement of three or more employers. Legal documents were reviewed.

HISTORY FROM THE PATIENT:

Ms. WORLD COUNTRIES is 50 years old and right-handed. I am evaluating her today to address the issue of her headaches as they relate to a specific injury of 10/1/05 (to her

neck, shoulder and upper extremities) and a cumulative trauma claim through 7/18/06 (neck, back hips shoulders and upper extremities).

Ms. WORLD COUNTRIES began working at COMPANY J in 1998 as a unit service worker. She worked predominantly in the nursery but did float other places in the hospital. She was employed basically doing housekeeping type of duties where she would have to clean the rooms after a patient's discharge. She would also have to bring in equipment.

Her job involved walking and climbing stairs about a third of the day. A third of the day she would have to lift up to 50 pounds but not beyond that. There was a lot of repetitive standing, walking, forceful gripping, reaching, overhead reaching, twisting, stooping, bending, pushing and pulling. The job also involved some crawling and kneeling, as well as mostly squatting.

She worked through July of 2007.

Prior employment was at the medical pavilion where she worked somewhat more than a year doing basically the same job. She had no injuries while there. Before that, she worked as a homemaker but, in her younger days, also ran a daycare.

She has had preinjury difficulty with headaches. She is not sure when they started. She thinks it was less than ten years ago. She thinks they occurred about once every 2-3 weeks and would last a matter of hours. Usually, they responded to over-the-counter medications but there were a few headaches where she had to see her doctor for additional medications. What she describes is bitemporal throbbing, sometimes associated with nausea when they were severe. There was no associated photophobia, phonophobia or visual changes. When she would have one of these headaches, she would take medication and then lie down for about a half hour and then would be able to resume her activities. She has had prior difficulties with her low back, not in association with an injury. She saw Dr. FRANCE for that and had chiropractic.

The injury of October 2005 occurred when she was pulling a big Isolette unit. It would not budge. She tried to prevent it from hitting the wall. She pulled very hard and experienced an electric shock like sensation from her fingers up to her neck posteriorly. That lasted for about 20 minutes and then her arm was a little numb.

Initially, she did not receive any treatment. She thought the symptoms would resolve on their own. After a few months, her symptoms worsened and she saw Dr. ITALY and was sent for a cervical MRI.

She notes that about a month after the injury, her headaches changed in distribution and frequency. They started to occur about twice a week and last all day and involved the occipital region where there was burning and pressure. The headaches tended to be worse when her neck pain was worse. These headaches, when very severe, would cause her to vomit and were associated with noise and light sensitivity. Typically, she would have to lie down. For some reason, she felt it helped to tie a sock around her head. She would be out

for about 2-3 hours to rest and would take Tylenol or Aleve. These would help maybe a little bit if she was lucky.

She also developed difficulty with her right shoulder which was treated. She underwent imaging study and electrodiagnostic workup. She ultimately came under the care of Dr. CUBA. She underwent a C4 through C6 anterior cervical corpectomy and fusion in April of 2007. This helped her neck for a while, as well as her upper extremity symptoms. Before the surgery, the headaches had escalated to either daily or every other day and would last maybe 2-3 days. After the surgery, she recalls having no headaches for about six months.

After she took off her cervical brace and started moving more, the headaches came back but, fortunately, not as bad as they were before the surgery.

Since the surgery, she has had a pretty persistent burning sensation in her neck. The headaches are now occurring almost daily, but they are milder than they were preoperatively (down from a 10/10 to a 7-8/10). She notes that, with repetitive neck and head motions, her headaches tend to increase. She indicates she can deal with the pain. She typically takes hydrocodone twice a day and, if she gets a headache and takes the hydrocodone, the headache will go away. If she does not take it, the headache may last for hours. The headache pain is still throbbing and burning in the back of the head. She no longer gets the nausea and vomiting. When the headaches are pretty strong, she still gets some light and noise sensitivity. When the headaches are very severe, about three times a month, she will have to lie down almost all day. When she has a headache, she cannot really function and just sitting up or moving around makes her a lot worse.

She is not sure about what role her cumulative trauma claim played in her symptoms. She thinks that the lifting and bending on the job may have impacted her low back.

She does not believe that the day to day activities impact her headaches. In her mind, it is clear that the headaches began after her injury in October of 2005.

She has not had specific treatment for her headaches. She does have hydrocodone but that is not specifically for headache pain.

Other medications include Metformin, Lotrel for high blood pressure, meloxicam, Duetact, carvedilol, furosemide. She is also on Topamax, Tricor, Coreg, Temazepam, Pristiq for depression and hydrocodone.

She is not sure why she has been prescribed the Topamax. Her understanding was that it was not prescribed for headaches. She notes that she is no longer taking the Lotrel and carvedilol.

She has not noticed any change in her headaches since starting Topamax. She cannot recall when she started taking this.

CURRENT SYMPTOMS:

Her headaches are as described above.

They do tend to correlate with increases of her neck pain but not all the time. She continues to have posterior cervical and upper trapezial pain, as well as right shoulder girdle pain and pain down the right upper extremity into the radial aspect of the forearm. In addition, she has low back pain, right hip pain and posterior thigh pain.

She also has difficulty with lightheadedness. Usually this is orthostatic, when she gets out of a chair quickly. This will be associated with some degree of dizziness, vertigo and balance problem. She has a feeling that she may faint, but she has not fainted.

She notes that she has fallen three times. She feels like her feet are clumsy and she feels unsteady when she walks.

She also has urinary urgency.

She endorses problems with depression, frequent crying, irritability and moodiness. She has trouble relaxing. She also has difficulty with memory, forgetfulness, thinking clearly, and concentrating. She has trouble sleeping. She frequently awakens at night with pain in her hip or neck, or she will awaken with a headache. Four to five times a month, she will awaken from sleep due to a headache.

Headaches interfere with ADLs, typically 3/5.

During the day, she does not have difficulty staying awake.

Currently, she can lift about 20 pounds if she takes her medications. She can walk on a flat surface for two hours, hills not at all. She can stand 1-2 hours, but this is painful. She can sit and drive about an hour with pain, grocery shop an hour with pain, do housework 1-3 hours with pain. She is no longer able to play baseball or basketball.

PAST HISTORY:

Injuries: None.

Surgery: C-section, cholecystectomy and hysterectomy.

Medical Illnesses: High blood pressure, diabetes and depression. She notes that her blood sugar control has been good lately.

Allergies to Medications: None.

Current Medications: See above.

Habits: Tobacco and alcohol, none.

Family History: Diabetes and high blood pressure.

Socioeconomic History: Married, with four children, one of whom remains a dependent.

Education: Eleven years of schooling.

Military Service: None.

PHYSICAL EXAMINATION:

Height and weight: 5 feet and 190 lbs. She is right-handed.
She is a well-developed, well-nourished, pleasant, friendly, cooperative woman in no acute distress.

Gait: Gait is normal based. The patient can toe, heel and tandem walk. Romberg is absent. Squat is full.

Reflexes: Right biceps and brachioradialis reflexes are trace, on the left they are 1+ to 2-. Triceps are symmetrically 1+. Patellar and Achilles reflexes are symmetric at 1+. Hoffman is negative. Plantar reflexes are downgoing bilaterally.

Coordination: No disorganization or ataxia of upper or lower extremity movements is noted. It is hard for her to do heel to knee to shin on the right because of hip pain.

Motor: There is no pronator drift or arm roll fixation. She has pain inhibition giveway weakness about the right shoulder girdle but more distal strength is intact in the upper extremities bilaterally and in both lower extremities.

Sensory: There is intact light touch, pinprick, and vibration throughout.

Cranial Nerves: The discs are flat bilaterally. The pupils are round and briskly reactive to light and near. Extraocular movements are full, conjugate and without nystagmus. There is no ptosis. Sensation to pinprick and light touch is intact over the face. The face is symmetric with full strength in eye closure and jaw opening. Hearing is intact to 512 Hertz tones and there is no lateralization of the Weber. The palate is in the midline and elevates symmetrically with phonation. The tongue protrudes in the midline and is without fasciculations or atrophy. Shoulder shrug is intact and equal bilaterally.

Inspection of her head reveals a well healed cervical scar. Her head is in the midline without abnormal curvature or tilt. There is no spasm.

She is nontender over the posterior cervical and trapezial muscles and over the occiput.

Cervical Spine Range of Motion, using the inclinometer method:

Flexion/50	20 degrees
Extension/60	40
Right Rotation/80	50
Left Rotation/80	60
Right Tilt/45	30
Left Tilt/45	20

There is negative seated straight leg raising.

CHART REVIEW:

I have received a medical reports file of approximately one inch. There is a deposition of Ms. WORLD COUNTRIES dated 10/10/08, 50 pages. There are the following subpoenaed files; COMPANY J, approximately 1/4 inch; Chiropractic Center, approximately 1/4 inch; ITALY, M.D., 1/4 inch; CANADA, D.O., 1/4 inch; and Muir Ortho Specialists, 55 pages. These records include, but are not limited to, the following.

6/28/00 - ER visit. Patient has headache, nausea and sleepiness. Blood sugar is noted to be 235. Liver functions, AST are elevated. The physician's note indicates complaints of fatigue, malaise and elevated blood sugar. She was feeling improved and discontinued her Glucophage several months ago and then gradually developed fatigue and malaise. Today, she awakened and had trouble keeping herself asleep. She has no severe headaches or visual disturbance. No neck pain or stiffness. Her symptoms are attributed to elevated blood sugar. She is given IV insulin with good results. Her blood sugar showed glucose at 235.

1/24/01 - FRANCE, M.D. Patient had no specific injury. She has aching low back. She remembers falling about 1-1/2 weeks ago before the pain started. It goes into the left leg to the knee.

1/25/01 - Lumbar MRI interpreted by a medical doctor that is normal.

2/2/01 - Dr. FRANCE. He states lumbar MRI is normal. She still has back pain and considerable lumbar radiculopathy. His impression is that she has primarily musculoligamentous and inflammatory symptoms, which will be treated symptomatically.

2/15/01 - Dr. FRANCE. Patient is reevaluated for a lumbar strain. She is marginally better. She has very minimal leg pain. She has had six physical therapy sessions. Lumbar strain is diagnosed. Continued therapy if not improved chiropractic is recommended. She is on Valium, Vioxx, Vicodin and Soma. It is noted she has constant low back pain and left leg pain.

2/28/01 - Dr. PANAMA. Patient is evaluated regarding her low back. She describes severe back pain beginning 1/10/01, 7/10. On an intake form, she endorses low back pain and

pain in the upper leg or hip, side not specified. She also endorses headache. Handwritten notes indicate pain radiating to both thighs.

2/28/01 through 6/27/01 - Chiropractic records. Symptoms involve low back, mid back. No neck symptoms or headaches are endorsed.

4/2/01 - Dr. PANAMA. Patient is taken off work.

5/31/01 - Dr. PANAMA. Patient is taken off work.

6/13/01 - JAPAN, D.C. Review of lumbar MRI showing L5-S1 disc bulge, anterior osteophytes, T11-12, facet hypertrophy, L5-S1, lumbar spine films are felt to show L5-S1 facet arthrosis, spondylosis T11-12 and left convex curve.

1/14/02 - Patient questionnaire. Patient endorses frequent or severe headaches.

4/12/04 - CANADA, M.D. Patient questionnaire. Patient has sinus problems with allergies. Muscle aches in the legs. She denies frequent or severe headaches.

8/12/04 - Dr. CANADA. Patient is having cramping back pain, nausea, vomiting and headaches. Blood sugars are fluctuating.

9/10/04 - Dr. CANADA. Patient has been using oral contraceptives for menometrorrhagia.

9/13/04 - Dr. CANADA, hysterectomy.

2/9/06 - ITALY, M.D. Patient has pain in the shoulders, neck, both knees and headaches.

3/1/06 - Cervical MRI shows spondylitic changes of the mid and lower cervical spine. There is a mild degree of spinal stenosis at C4-5, C6-7, secondary to annular bulges and endplate hypertrophic changes. There is mild to moderate spinal stenosis at C5-6 due to right paracentral protrusion and annular disc bulge. Neuroforaminal compromise is most significant on the right at C4-5, moderate. Mild cervical lordosis reversal is noted.

3/16/06 - Dr. ITALY. Patient has terrible headaches for two days. She ran out of medications. Ultram was prescribed.

3/17/06 - COMPANY J ER. Patient presents with weakness and lightheadedness about ten minutes prior to arrival. Blood sugar was 150. She had some nausea.

3/21/06 - Dr. ITALY. Patient still has headaches despite Vicodin. Note is very difficult to read.

3/22/06 - Right shoulder MRI shows prominent impingement.

3/24/06 - Cranial MRI shows mild mucosal thickening of the paranasal sinuses.

6/7/06 - Dr. ITALY. Patient stopped (illegible and appears to be mention of headache).

6/30/06 - FINLAND, M.D. Patient has right shoulder and neck pain.

7/12/06 - Dr. FINLAND. Shoulder pain and limited motion are noted. An injection was given.

7/19/06 - Dr. FINLAND. Patient is one week post injection. Ongoing right shoulder, neck pain and upper extremity symptoms are noted.

7/24/06 - Dr. FINLAND. Neck and right upper extremity, including shoulder, symptoms are noted.

8/14/06 - Dr. FINLAND. Neck and right upper extremity symptoms are noted. It is felt she has a right shoulder impingement syndrome and cervical radiculitis. Ortho consultation is recommended.

8/18/06 - NORWAY, M.D., orthopedist. Patient is evaluated for right shoulder injury, 10/1/05, while pulling a crib. She felt shock like pain in the right arm. It was noted she was treated with therapy without benefit. Her neck symptoms are also noted. She had a right shoulder injection but it did not help. The assessment was right shoulder pain, possibly secondary to cervical disc problem.

8/22/06 - CUBA, M.D. Ever since October of 2005 when she was moving a bed, she developed neck and arm pain with numbness and tingling of the radial three digits and the arm. She has posterior suboccipital headaches. Assessment is cervical spondylitic radiculopathy, right C5-6 and failure of non-operative care. Surgery is discussed.

9/7/06 - Dr. CUBA. Surgery is discussed.

9/11/06 - UNITED STATES, M.D., orthopedist. Review of medical records.

9/13/06 - Dr. UNITED STATES. Diagnoses are cervical sprain with radiculopathy in the right upper extremity and multiple level disc disease, impingement of the right shoulder with bicipital tendinitis. Causation for the neck and right shoulder is cumulative in nature on the job. Patient is not permanent and stationary. He recommends epidurals and facet injections rather than a three level fusion. Subacromial injection and possibly decompression are discussed. The patient reported that, in the winter of 2005, she developed neck and right shoulder pain and then, in April of 2006, there was a mishap with a giraffe bed and she developed shooting pain down the right upper extremity. Medical records apparently cited headaches and knee pain as well. She had a cranial MRI showing sinus inflammation. Other workup is noted. The patient described constant neck pain and stiffness with shooting pain into the right upper extremity radial three digits. Shoulder pain was constant with loss of motion. Hypertension and diabetes are noted. Dr. UNITED STATES noted she had chronic problems preceding October of 2005 with an element of

cumulative trauma aggravating her baseline condition with regard to the neck. He comments about 30% apportionment to non-industrial factors, stating that absent the industrial injury, she would have some limitation of function but there is still industrial liability. He recommends conservative measures at this point initially.

10/2/06 - Dr. FINLAND. Patient is in for a reevaluation. Right shoulder impingement and cervical radiculopathy is diagnosed.

10/5/06 - Dr. CUBA. Patient has failed conservative care. Surgical second opinion is discussed, along with Dr. UNITED STATES's evaluation.

10/16/06 - Dr. UNITED STATES. Review of electrodiagnostic tests noting moderate carpal tunnel syndrome. He discusses carpal tunnel treatment.

10/29/06 - INDIA, M.D., neurologist. Bilateral upper extremity EMG is negative for cervical radiculopathy and shows moderate bilateral median nerve compression at the wrist. Left distal median motor latency is 4.92, right is 4.38. Right median cross palmar latency is 2.59, right median distal SNAP is 4.25, left is 4.28.

11/6/06 - GREENLAND, M.D. Symptoms include neck pain into the right upper extremity with paresthesias. Dr. Lee believes symptoms arise from disc degeneration, cervical stenosis and herniation on the right. He expresses concerns about exacerbating her symptoms or diabetes with an epidural steroid injection and recommends surgery.

12/7/06 - Dr. UNITED STATES. He does not disagree with proposed cervical surgery but suggests a more conservative approach such as epidurals.

1/30/07 - Dr. CUBA. Major complaint is buttock and leg pain. She has some neck symptoms but these are tolerable and improved. Lumbar MRI is ordered.

2/6/07 - MOROCCO, M.D. Peer review. Non-certification of three level cervical fusion.

2/12/07 - Dr. CUBA. Surgical issues discussed.

2/28/07 - Dr. UNITED STATES. Panel QME. Reevaluation. He is to address issues related to neck, shoulders, upper extremity, back and right hip to her last day of work, 7/18/96 (SIC). He is evaluating her with regard to a cumulative trauma through 7/18/06. His impression is cervical sprain with three-level disc disease with no nerve study findings for radiculopathy. She has a shoulder girdle sprain inflammation and facet inflammation, right shoulder impingement improved, quiescent right carpal tunnel syndrome, hip joint inflammation on the right. No left shoulder upper extremity symptoms noted except for quiescent carpal tunnel, low back sprain with no radiculopathy. Causation for the neck and right shoulder are work related and she has an element of wear and tear and discomfort along her neck, preceding the 10/1/05 specific injury, thus there would be an element of cumulative trauma, as well as the specific incident with regard to the neck, latter in 2005. Her job involved mopping, pushing, pulling, bending, reaching and lifting up to 20 pounds,

representing some element of cumulative trauma with regard to the right wrist, although the latter was quiescent, as well as the right hip. The shoulder condition on the right is related to activity on the job in 2005. The left shoulder is not involved or symptomatic. As for her low back, she did repetitive pushing, pulling, bending and lifting up to 20 pounds, and he feels this represents cumulative trauma to the low back. The patient is not permanent and stationary. The patient is presently off work. For her low back, a few therapy sessions are suggested. For her shoulder, she only needs observation. For her wrist, she needs observation. Splinting at night might help. An x-ray of the right hip is suggested. Surgery is felt to be reasonable. Regarding her symptoms, she describes four months of constant low back pain, shooting into her thighs. She has constant pain and stiffness and weather effects in her neck, and headaches all the time. She has shooting pain in her right arm and occasional numbness and tingling in the radial three digits of the right hand.

3/2/07 - EGYPT, M.D. Peer review. Non-certification for three level cervical fusion.

3/6/07 - Dr. CUBA. Discussion of peer review issues.

4/10/07 - Dr. CUBA. Preop visit.

4/13/07 - Cervical MRI shows reversal of cervical lordosis at C6-7. There is a low signal intensity structure in the right paracentral ventral epidural space of C5-6, extending cephalad to lie dorsal to the C5 vertebral body. Possible right paracentral disc extrusion is considered, contributing to moderate to severe central stenosis at this level. Mild to moderate central stenosis is present, C3-4 through C6-7 due to disc osteophyte complex formation, facet hypertrophy and a congenitally slender central canal.

4/23/07 - Anterior cervical corpectomy and fusion, C4 through C6 with iliac bone graft.

4/23/07 - Z. BAHAMAS, M.D., inpatient consultation for sore throat and shortness of breath secondary to spasm in the neck and shoulders and pain. Patient is noted to have no headache or visual changes. Assessment is postop fusion, diabetes, hypertension. Also noted is probable obstructive sleep apnea, low grade postoperative fever, urinary tract infection, hypokalemia, hypomagnesemia and oral thrush. Another evaluation by Peter Rowe is noted. He comments upon hypertension, type II diabetes, non-insulin dependent and the fact that the patient is moderately overweight.

4/25/07 - CT scan of the cervical spine shows degenerative changes C6-7 with anterior and posterior osteophytes, trace bone fragments at the level of the posterior longitudinal in its right lateral extent. Postoperative changes are also noted.

5/7/07 - Dr. CUBA. Patient is two weeks postop. She has pain at the bone graft site. A postoperative CT scan showed some foraminal narrowing which was residual at the “L4-5" levels (he apparently means C4-5).

6/7/07 - Dr. CUBA. Patient's arm pain has completely resolved following surgery. She has some neck discomfort and pain at the site of the iliac crest graft.

7/10/07 - Dr. CUBA. Patient is ten weeks postop. She still has neck pain but no significant arm pain.

8/21/07 - Dr. CUBA. Patient is postop anterior cervical corpectomy and fusion, C4 through C6. Suboccipital headaches are better. She has some neck discomfort.

10/3/07 - Dr. CUBA. Patient has neck pain and feels that her arms and suboccipital headaches are better postoperatively. X-rays show good healing of the fusion.

10/18/07 - Dr. CUBA. Patient's fusion has healed nicely. She is better regarding the neck and arm pain. Over the past 2-1/2 months she has developed progressive low back and right buttock pain, which is activity related. She may not be able to return to work because of this. Further investigation of this is planned. She has L5-S1 spondylosis and Dr. CUBA notes that he does not think workers' comp will cover her low back and buttock discomfort. She is released to light duty.

1/3/08 - Lumbar MRI shows small to moderate broad based disc herniation at L5-S1, probable contact of left S1 nerve root. There is mild facet degenerative changes at L4-5, L5-S1 bilaterally without foraminal stenosis.

1/3/08 - Dr. CUBA. Patient was complaining on her last visit of low back and right buttock pain. An MRI was obtained showing disc desiccation at L5-S1 with some effacement of the right S1 root from a bulge at L5-S1. Epidural steroid injection is recommended. Patient wants to return to work. She can return with a permanent lifting restriction of 30 pounds and no prolonged mopping of the floors after her epidural.

4/9/08 - Dr. FINLAND. Excellent results from the neck surgery without any radicular symptoms. She was released to regular work.

5/22/08 - Physician's Assistant. Fitness for Duty examination. Assessment is cervical discectomy, post fusion, degenerative lumbar disc disease, normal and asymptomatic right shoulder; normal and asymptomatic wrist and hands. Functional capacities evaluation is requested.

5/22/08 - Physician's Assistant. Fit for duty examination addendum. He notes a normal left shoulder exam, apparently without complaints. She has no carpal tunnel complaints or findings bilaterally, noting that this became apparent after an EMG study where Dr. UNITED STATES diagnosed a quiescent carpal tunnel on the right. It was noted that in October of 2007 Dr. CUBA reported a two-month progression of low back discomfort and right buttock pain which was not mentioned prior to this. Mr. Phy Asst was not sure whether the low back was work related. It was felt she has not demonstrated an ability to return to her full and usual work quite yet and a 30-pound lifting restriction and overhead work restriction were given.

6/4/08 - Dr. FINLAND. PTP's P&S report. Patient has no radicular symptoms and occasional stiffness in her neck. There is no numbness or tingling. She can do all the ADLs without difficulty and is returned back to work. Assessment is cervical disc disease with two-level fusion. She is rated 8% whole person impairment.

6/17/08 - Bay Area FCE. She is able to perform in the lower medium levels of work with a 30-pound maximum. No lifting overhead. A pace schedule and microbreaks.

6/20/08 - POLAND, M.D., physiatrist. Electrodiagnostic report. Bilateral carpal tunnel, moderate to severe is reported without cervical radiculopathy. Lower extremity nerve conduction and EMG was normal. Distal right median motor latency was 4.84, left 4.3. Right cross palmar median latency was 2.47, left was 2.41 (this would be considered mild carpal tunnel by most standards).

7/8/08 - Dr. CUBA. Patient has degenerative disc disease at L5-S1 with mechanical low back pain. She had an epidural steroid injection that provided some relief and she would like another injection.

7/15/08 - Right S1 epidural steroid injection.

8/15/08 - Dr. UNITED STATES. Patient was P&S as of 2/16/08 as per Dr. CUBA.

8/20/08 - Dr. CUBA. Patient has degenerative disc disease at L5-S1 with mechanical low back and right leg pain. She has had no relieve with two epidural injections. She points toward the trochanteric bursa where she is exquisitely tender. A trochanteric bursal injection is given.

9/25/08 - Dr. CUBA. Patient is status post ACDF and has lumbar degenerative disc disease with right-sided lumbar radiculopathy. She has pain in the right shoulder with suboccipital headaches. Her back pain has improved after an injection. Assessment is right-sided adhesive capsulitis.

10/10/08 - Deposition of Ms. WORLD COUNTRIES. The 10/1/05 injury while moving a bed is discussed. She developed pain from the neck, into the right arm, shoulder and up the back of her head. There was tingling in the right upper extremity. She did not mention the incident to a supervisor until a few months later. Her neck bothered her ever since 10/1/05. Her current neck symptoms involve limited motion. She has previously seen Dr. PANAMA after the accident at COMPANY J in October of 2005. She first saw Dr. ITALY after her 10/1/05 injury with headaches, neck pain and trouble with her right upper extremity. At that point, she had not attributed the symptoms to her October 2005 injury. She was sent to physical therapy. Treatment with Dr. CUBA is discussed. Neck surgery helped. The patient states she cannot work because she is in too much pain in her neck and her arm. COMPANY J would not give her the old job back. Psychological issues are discussed.

A second cumulative trauma claim is noted. Patient has problems with her right hip, pain with moving her leg. Pain is in the right groin. She reports that this pain came on in early 2006 without any specific injury. She told Dr. ITALY about it. She thinks she might have had physical therapy for her leg, referred by Dr. CUBA. She cannot recall an injury to her back since 10/1/05 or any right hip or leg problems before 10/1/05.

Regarding headaches, she gets headaches due to the injury she had at COMPANY J, 10/1/05. She has had headaches before but now she gets them more often. Right after October, they became more frequent. They go away when she takes her pain medication, and then they are back again. She takes hydrocodone. She was given this for her neck and arm plain by Dr. CUBA. After the neck surgery, the headaches eased. They were not as strong, but lately she has been getting them every day, not as intense as before. She describes a burning sensation at the back of her head and neck, all the way down to both shoulders. It comes on when she has stiffness in the head. She states that, prior to 10/2005, she would get bad migraines. Once in a while, beginning around age 45, she did recall getting a cranial MRI. She did not remember what medications Dr. ITALY gave her for headaches. She discussed headaches with Dr. PANAMA, telling him that she would get headaches. She confirmed that she had frequent or severe headaches as noted in Dr. CANADA's intake form.

DISCUSSION:

Ms. WORLD COUNTRIES is a very pleasant lady who has a history of headaches that predate the 10/1/05 injury involving her cervical spine and right shoulder. The headaches she describes today occurred once every 2-3 weeks, consisting of bitemporal throbbing, sometimes associated with nausea, but without light or noise sensitivity or visual FINLANDges. She apparently saw a doctor for these headaches when they were severe, a few times, and was given medications. Typically, she took over the counter medications and would lie down and rest for 30 minutes.

On 10/1/05, she injured her neck and right shoulder and, within a month, developed a different type of headache consisting of occipital burning and pressure. These were associated with noise and light sensitivity and vomiting when severe. She went on to have a cervical fusion which helped her neck and right upper extremity pain. For approximately six months after the surgery, she did not have headaches but they returned. The current headaches now are occurring on a daily basis but are milder and more tolerable for her. They do last a matter of hours and she will have to lie down for the more severe ones, about three times a month.

She has been prescribed Topamax. She was not aware that this may have been prescribed for her headaches, and apparently it had no benefit. She continues to take hydrocodone twice a day.

On examination, she does not have any tender points in the occiput or cervical musculature. She notes that her headaches are increasing as I put her through cervical range of motion.

In terms of neurologic findings, she does have decreased right biceps and brachioradialis reflexes compatible with residuals of a right upper extremity cervical radiculopathy. There is considerable guarding and limitation of shoulder motion as well, and right hip motion is limited and painful.

In terms of the issue that I am to address, i.e., headaches, I offer the following diagnosis: mixed headache syndrome with cervicogenic and medication overuse headache component.

CAUSATION:

Although this patient had headaches in the past, they were in a different distribution and did not occur with great frequency, despite the fact that they were reported as severe on a few occasions to treating physicians. Subsequent to her October 2005 injury, in association with her neck pain, she developed headaches. They became increasingly severe but, after undergoing an anterior cervical discectomy, corpectomy and fusion, the headaches remitted for several months, only to recur, although to a milder degree. In addition, she continues to take hydrocodone twice a day.

Given the headache history, on a medically more probable than not basis, the injury of October 2005 resulted in cervicogenic headaches which have been further complicated by medication overuse headache. Narcotics and analgesics, in general, if taken more than a few times a week can perpetuate the headaches. I have enclosed a reference list regarding this.

I do not see a role for cumulative trauma in her headaches. The fact pattern strongly supports the relationship to the 10/1/05 injury and not to the cumulative trauma claim.

PERMANENT AND STATIONARY:

Vis-a-vis the 10/1/05 claim and the headaches, her condition is permanent and stationary and likely reached that point at the one year anniversary of her surgery in April of 2008. Beyond that time, further medical intervention does not appear to have altered her condition in terms of the headache and cervical spine. Most subsequent treatment has dealt with her low back.

FUTURE MEDICAL CARE:

My only recommendation for treatment of her headaches would be, if feasible, to withdraw the narcotic medication. If she tolerates Topamax, she may benefit from a higher dose. Failing any response to that, her treating physician could consider use of an older tricyclic such as nortriptyline. I think there is a significant contribution from medication overuse headaches and it is likely the headaches would improve if she were able to be withdrawn from narcotic and analgesic medications. Given her multiple medications for diabetes and hypertension, this would have to be supervised by an internist.

She will likely need five or six physician visits for the first year as her medications are adjusted, tapering off to 3-4 physician visits subsequent to that.

PERMANENT DISABILITY:

The *AMA Guides* is somewhat deficient in rating headaches. One option is to use the 3% pain add on for headaches, as noted in Chapter 18. However, in many patients, this is inadequately assesses the impact of headaches on activities of daily living. Certainly, many individuals with severe headaches will have to retreat from their normal daily activities and rest up to several hours. In Ms. WORLD COUNTRIES' situation, this is the case and, about three times a month now, she will have to lie down for several hours to deal with the headache. Interspersed with these more severe headaches, are daily milder headaches that limit her activities somewhat less but, nonetheless, interfere.

Given this scenario, it is clear that the impact on ADLs is more significant than would be reflected in the pain chapter. Thus, it is my opinion that it is appropriate to rate this condition by analogy. I would utilize Table 13-3, page 312, Criteria for Rating Impairment Due to Episodic Loss of Consciousness or Awareness. Given the impact on ADLs, and the fact that her functioning is impaired, this is analogous to an episodic alteration of awareness. She would fall into Class I, 0-14% whole person impairment in that she has a paroxysmal disorder with predictable characteristics and unpredictable occurrence that can limit her daily activities. I would place her in the mid range of this at 7% whole person impairment.

VOCATIONAL ISSUES:

Any work restrictions based on headaches would probably be subsumed by restrictions arising from her cervical spine surgery and, hence, I will defer on this to Dr. UNITED STATES.

APPORTIONMENT:

According to recent case law, Escobedo v. Marshall, considerations for apportionment have expanded. The examiner is required to demonstrate an awareness of apportionment concepts in general, and opinions must be expressed on a reasonable degree of medical probability without engaging in speculation or surmise. The examiner must also rely on an accurate patient history and up-to-date medical information when formulating opinions.

In terms of headaches, the major factors to consider for apportionment are her prior headaches. These were somewhat different than the headaches that she is experiencing now but, nonetheless, in the records were a persistent problem. This, in my medical opinion, forms the basis for apportionment. I would apportion 10% of her impairment to preexisting headache conditions.

ADDITIONAL QUESTIONS:

Her period of temporary disability, vis-a-vis the headaches, is through April of 2008.

Please let me know if I can be of further assistance.

I certify that, unless otherwise indicated, I took the complete history from the patient, conducted the physical examination, reviewed all submitted medical records, and composed and drafted the conclusions of this report. 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. In accordance with Labor Code Section 5703(a)(2) there has not been a violation of Labor Code Section 139.3 and the contents of the report are true and correct to the best of my knowledge. This statement is made under penalty of perjury. Pursuant to 8 Cal. Code Regs Sections 49.2-49.9, I have complied with the requirement for face-to-face time with the patient in this evaluation.

I have discussed apportionment in the body of this report. If I have assigned disability caused by factors other than the industrial injury, that level of disability constitutes the apportionment. The ratio of non-industrial disability, if any, to all described disability represents my best medical judgment of the percentage of disability caused by the industrial injury and the percentage of disability caused by other factors, as defined in Labor Code Section §4663 and §4664.

Sincerely yours,

SAMPLE REPORT

Jacquelyn A. Weiss, M.D., Ph.D. Date Alameda County

JAW:bjm

cc: Insurance Company

Medication-Overuse Headache Reference List:

References that support the concept of medication-overuse headache and improvement following cessation of excessive analgesic and other headache medication use include the following:

Zeeberg et al., "Probable Medication-Overuse Headache: The Effect of a Two-Month Drug-Free Period," *Neurology,* 2006.

Zwart et al., "Analgesic Use: A Predictor of Chronic Pain and Medication-Overuse Headache," *Neurology,* 2003.

Zwart et al., "Analgesic Overuse Among Subjects With Headache, Neck, and Low Back Pain," *Neurology,* 2004.

Colas et al., "Chronic Daily Headache With Analgesic Overuse," *Neurology,* 2004.

William Young, "Drug-Induced Headache," *Neurologic Clinics North America,* 2004.

Thomas Ward, "Medication-Overuse Headache," *Primary Care Clinics Office Practice,* 2004.

Katsarava et al., "Rates and Predictors For Relapse in Medication-Overuse Headache: A One-Year Prospective Study," *Neurology,* 2003.

Lipton & Bigal, "Chronic Daily Headache: Is Analgesic Overuse a Cause or Consequence?" *Neurology,* 2003, editorial.

Smith & Stoneman, "Medication-Overuse Headache From Antimigraine Therapy," *Therapy in Practice*, Drugs 2004.

Obermann, et al., "Medication Overuse Headache," *Expert Opinion Drug Safety*, 2007, Vol. 6, pages 97 to 98.

Limmroth, et al., "Features of Medication Overuse Headache Following Overuse of Different Acute Headache Drugs," *Neurology,* 2002, Vol. 59, pages 1011 to 1014.

Diener & Limmroth, "Medication Overuse Headache: A Worldwide Problem," *Lancelet Neurology*, Vol. 3, August 2004, pages 475 to 483.

Eric Eross, "Daily Headaches Due to Medication Overuse," *Neurology Patient*, page 2003.

Silberstein & Welch, "Painkiller Headache," *Neurology*, 2002, Vol. 59, pages 972 to 974.

Lenaerts & Couch, "Medication Overuse Headache," *Minerva Medica*, 2007, Vol. 98, pages 221 to 231.

Bigal & Lipton, "Excessive Acute Migraine Medication Use and Migraine Progression," *Neurology*, 2008, Vol. 71, pages 1821-1828.