Representing injured workers since 1956

FARRELL FRAULOB & BROWN
A Professional Law Corporation

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April 14, 1997

RECEIVED
APR 17 1997
DIVISION OF
WORKERS COMPENSATION
STOCKTON OFFICE

WORKERS' COMPENSATION APPEALS BOARD
31 E. Channel Street, Room 344
Stockton, CA 95202

RE: Thomas Beard vs. San Joaquin Mesquito and Vector Control
W.C.A.B. No: STK 0124216/0124214

Greetings Judge:

Your attention is directed to the enclosed documents:

[] Please file the Application(s) for Adjudication of Claim.

[x] It is requested that this matter be set for hearing in accordance with the attached Declaration of Readiness to Proceed.

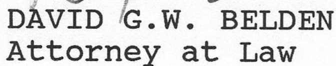
[ ] Please file the medical reports of:

[ ] Please note the new address of the applicant:

[ ] Other:

Very truly yours,

FARRELL, FRAULOB & BROWN
A Professional Law Corporation



DAVID G.W. BELDEN
Attorney at Law

cc: See attached Proof of Service

PLEASE DO NOT STAPLE IN THIS AREA

Keenan & Associates
392-D Connors Court
Chico, CA 95926
CONTACT: Elaina Piazzisi
CLAIM NUM: 6938950005

Served: 1/14/97
cc: Client

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / CHAMPUS (Sponsor's SSN) / CHAMPVA (VA File #) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): **SSN: 558-76-6159**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): **BEARD, TOM**

3. PATIENT'S BIRTH DATE MM DD YY: **9.24.49** SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): **San Joaquin Mosquito & Becton Control**

5. PATIENT'S ADDRESS (No., Street): **2937 Toyon Drive**

CITY: **Stockton** STATE: **CA**

ZIP CODE: **95203** TELEPHONE (Include Area Code): **209-941-0617**

6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse [ ] / Child [ ] / Other [ ]

7. INSURED'S ADDRESS (No., Street): **7759 So. Airport Way**

CITY: **Stockton** STATE: **CA**

ZIP CODE: **95206** TELEPHONE (Include Area Code): ( )

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M [ ] F [ ]

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10. IS PATIENT'S CONDITION RELATED TO: **Applicant**

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

c. OTHER ACCIDENT? [ ] YES [ ] NO

10d. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER: **STK0124216**

a. INSURED'S DATE OF BIRTH MM | DD | YY SEX M [ ] F [ ]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO If yes, return to and complete item 9 a-d.

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READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED________ DATE________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED________

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY: **see #17 for date(s)**

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM | DD | YY: **N/A**

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: **INJURY DATE(S): 6.22.95,ct-1.18.96**

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZED DATES RELATED TO CURRENT SERVICES FROM MM | DD | YY TO MM | DD | YY

19. RESERVED FOR LOCAL USE: **Orthopedics**

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____. _ 3. ____. _
2. ____. _ 4. ____. _

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24.	A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	12.2.96	12.2.96	11		ML102		500.00					
2												
3												
4												
5												
6												

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25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: **94-2819401**

26. PATIENT'S ACCOUNT NO.: **8009284 /51526**

27. ACCEPT ASSIGNMENT? (For gvt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE: **$ 500.00**

29. AMOUNT PAID

30. BALANCE DUE: **500.00**

31. I DECLARE UNDER PENALTY OF PERJURY THAT THIS BILL FOR MY SERVICES IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. SIGNED AT: Sacramento County, California

Bart A. Kornblatt, M.D. **12.31.96**

SIGNED Bart A. Kornblatt DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

ADELBERG ASSOCIATES MEDICAL GROUP
9856 Business Park Drive, Suite E
Sacramento, CA 95827

33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

ADELBERG ASSOCIATES MEDICAL GROUP
9856 Business Park Drive, Suite E
Sacramento, CA 95827
(916) 362-5112

PIN# GRP#

Department of Industrial Relations, Industrial Medical Council, PO Box 8888, San Francisco, CA 94128 - Tel (415) 737-2767

State of California

Qualified or Agreed Medical Evaluator's Findings Summary

Patient

1. Patient Name (First, Middle Last): TOM BEARD
2. Social Sec No.: 558-76-6159
3. Date of Injury: Mo/Dy/Yr 6.22.95,ct-1.18.96
4. Address No. and Street: 2937 Toyon Drive — City: Stockton, CA — Zip: 95203
5. Telephone: 209-941-0617

Employer

6. Name: San Joaquin Mosquito & Becton Control
7. Address No. and Street: 7759 So. Airport Way — City: Stockton, CA — Zip: 95206
8. Telephone:

Exam Referral Schedule

9. Date of Appointment Call: 8.28.96
10. Date of Initial Examination: 12.2.96
11. Date of Referral for Medical Testing/Consultation:
12. Date QME's Medical Legal-Report Served on all Parties

Disputed Medical Issues And Conclusion

13. The follwing medical issues will be used to determine the patient's eligibility for workers' compensation. Check the appropriate box and reference the correspnding pages(s) or section of the med-legal report for details.

	Report pages(s) or section	Yes	No	Pending or Info. Not Sent
a. Did work cause or contribute to the injury or illness?		☒	☐	☐
b. Are there pre-existing or other impairments/disabilities that contribute to permanent disability?		☒	☐	☐
c. Is there a need for current or future medical care?		☒	☐	☐
d. Is the medical condition stable and not likely to improve with active medical or surgical treatment (i.e., is the condition permanent and stationary)?		☒	☐	☐
e. Is there permanent impairment?		☒	☐	☐

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f. Can this patient now return to their usual job? ☒ Yes ☐ No

If yes:

i. Without restrictions ☐ Yes ☐ No If YES, Date:

ii. With restrictions ☐ Yes ☐ No If YES, Date:

If restricted work is recommended, reference page(s)/section in report for details:

Basis for Conclusions

Check box and refer to page(s) or section in report.

	Report pages(s) or section	Yes	No	Pending or Info. Not Sent
14. Are there subjective complaints?		☒	☐	
15. Are there any abnormal physical examination findings?		☒	☐	
16. Are there any relevant diagnostic test results (x-ray/laboratory)?		☒	☐	☐

17. What are the diagnoses? (List)

Page 10

18. Were other physicians consulted? ☐ Yes ☒ No

QME

19. Signature [signature] Date: 12/31/96
20. Name Bart A. Kornblatt, M.D. Specialty Orthopedist Cal. # C40081
21. Address No. and Street: 9856 Business Park Drive, Suite E — City: Sacramento, CA — Zip: 95827 — Telephone: (916) 362-5112

Adelberg Associates

Medical Group

A Professional Corporation

9856 Business Park Drive, Suite E

Sacramento, CA 95827-1704

916-362-5112
800-729-2264
Fax
916-362-6115

Sacramento
Stockton

DATE OF VISIT:	12.2.96
DATE OF REPORT:	DEC 31 1996

David G.W. Belden, Esq.
Farrell, Fraulob & Brown Law Corporation
P.O. Box 160467
Sacramento, CA 95816

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STOCKTON OFFICE

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JAN 06 1997
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A Professional Corporation

RE: Tom BEARD
SSN: 558-76-6159
DOB: 9.24.49
DOI: 6.22.95,ct-1.18.96
WCAB #: STK0124216
EMP: San Joaquin Mosquito & Vector Control
CLM: 6938950005

ORTHOPEDIC EVALUATION - Bart A. Kornblatt, M.D.

Dear Mr. Belden:

Tom Beard is a 47-year-old, right-handed gentleman seen today for evaluation of left knee problems which he relates to his work as a control tech I for the San Joaquin Mosquito and Vector Control Department.

History, as Related by the Applicant: Mr. Beard has worked for the San Joaquin Mosquito and Vector Control Unit as a control tech I since May of 1972. He has had a series of second jobs which included work as a delivery man for 7-Up Bottling Company denying any injuries; he worked as a mechanic for Mike's Detail denying any injuries; he worked as a maintenance person in the Water Department for the City of Stockton denying any injuries; he worked as a pole path operator for the Carnation Company and sustained an injury to his right hand.

He denies any sports injuries relative to his left knee. He denies any left knee injuries related to any motor vehicle accidents. He states that he did have one industrial motor

vehicle accident when his head was hit on a rear glass pane in a pickup truck. He had one non-industrial back and neck injury resulting in his being off work for about two to three weeks total, counting the hours that he was away at medical appointments. He states that he did try to stay active in sports, including jogging, basketball, softball and volleyball, all of which he states that he played until the initial injury to his left knee in 1988.

Mr. Beard describes his job as one that requires him to inspect and treat dairy ponds and drains and open pastures in order to control mosquitoes and vectors. He applies pesticides in several different ways. He uses a truck mounted 50 gallon tank requiring him to pour in 2 to 2-1/2 gallons of concentrate. In order to do this he lifts the 2 to 2-1/2 gallons of concentrate and empties them into a tank. He empties two of them into his tank and has to carry them about 20 feet from a storage area to the truck, noting that he will carry two at a time. He then will fill the tank with water from a hose. He then drives the truck, which he describes as being similar to a pickup truck and then uses a hand control inside the truck to make it spray. He states that this kind of activity consumes about 50 percent of his work time. He also fills a 3-1/2 gallon pump tank with pesticide and then he primes it by pumping it. He then hangs the tank from his shoulders with a strap and uses a spray nozzle to spread the mist. He also has to negotiate uneven terrain in order to do this and he also has to perform some squatting, kneeling and climbing, including uneven terrain, as well as ladders and fences.

Another method by which he distributes the pesticide is to use a hand-held fogger which holds about one gallon of material. Another way is by utilizing chemical briquettes; these are loaded on paper, he will peel one off and place the briquette into water or an area that will become wet. Apparently the chemicals within the briquette are activated by the water to release a pesticide. He describes these briquette materials as quite light.

Mr. Beard states that he sustained an injury to his left knee on 10.26.88 when he was descending an embankment. He slipped and fell onto his buttock and then was sliding down the slope when his left foot caught in something in the downslope resulting in a forced hyperflexion injury of the knee. He underwent no surgery. He underwent no MRI scan. He underwent physical therapy on a few occasions and it was felt that he had a quadriceps problems and/or a patellofemoral problem. He did receive a 9.3 percent permanent disability award which appears to have been awarded in 1993 according to the copy of the Stipulations with Request for Award that was signed by him on 4.13.93.

Mr. Beard states that that knee has continued to be a problem since that time, particularly with anterior knee pain, especially with bent knee activities, including kneeling, squatting,

climbing, crawling and negotiating uneven and broken terrain; therefore, he would try to keep these activities to a minimum and, at the very least, would try to avoid performing them on a prolonged basis.

He did, however, continue to perform this job fully and on 6.22.95, while he was walking along a bar ditch to inspect the water within it, the ground gave way causing his left knee to once again be forced into a flexed and twisted position. He noted the immediate onset of pain followed shortly thereafter by swelling of the knee. He reported the injury to his supervisors and went to Dameron Hospital by the next day. He was evaluated and released to full duty and referred to physical therapy (although the Doctor's First Report of Injury indicates that he was released to modified duty initially).

He continued to follow-up with the doctors at the Industrial Medicine Clinic at Dameron Hospital and he notes that over a short period of time, the swelling in the knee resolved but the pain continued at what he recalls to have been an even greater degree of intensity. He was experiencing locking. He then changed physicians to Dr. Cahill, an orthopedic surgeon, who suspected internal derangement and obtained an MRI scan which showed a torn cartilage.

He then underwent arthroscopy of his left knee on 1.18.96 consisting of a medial meniscectomy with chondral shaving of the medial femoral condyle and the lateral tibial plateau. He returned to work at light duty on 5.2.96 and then full duty at the end of June of 1996.

Review of medical records indicates that following his initial treatment through Dameron Hospital he was seen in orthopedic surgery consultation by Dr. Bielejeski, who on 6.22.95 declared him permanent and stationary and returned him to full duty. I did not see any medical records between that point in time and when he presented to Dr. Cahill in November of 1995.

At that time Dr. Cahill did refer to ongoing problems that he was having in his knee since the 1988 injury. He also referred to the May 1995 injury and then indicated that there was another injury associated with one of Mr. Beard's giving way episodes in November of 1995. Dr. Cahill suspected internal derangement and requested an MRI scan that was performed on 12.7.95 that showed a large horizontal tear of the posterior horn of the medial meniscus and some indication of both lateral and medial collateral ligament injuries. On 7.3.96, Dr. Cahill authored a note stating that he felt that Mr. Beard's condition was permanent and stationary and he indicated that a QME could be performed to determine his level of disability.

When I asked Mr. Beard about the nature of his knee condition since, he maintains that he continued to be symptomatic following

his 1988 injury and he considers that he was having progressive symptoms with pain and swelling for the immediate couple of years prior to his 6.95 injury; at that point, he noted an acute increase in his symptoms which then subsided to a level of pain greater than he was experiencing prior to June of 1995 and he also had new symptoms of catching, both of which became more frequent as his time and activity continued to progress.

Current Complaints: He states that he still is unable to run due to left knee pain and buckling. Uneven and broken terrain is painful and he tries to avoid this as much as possible. He notes that level walking is "okay." He feels that he is able to squat but on a limited basis and he avoids kneeling onto the left knee. He does consider that he has lost some capacity for lifting secondary to his inability to squat effectively and efficiently. He notes that he does have a continual limp.

He denies wearing any kind of brace. He uses no crutch or cane. He does take Vicodin usually twice a week, during his non-work hours. He did go through physical therapy postoperatively and then was placed on a home exercise program, and states that he has rehabilitated his knee through a health spa per physical therapy instructions, but states that the benefit of his membership in that spa will end as subsidized per Workers' Compensation in February of 1997. He states that he does have some home exercise equipment consisting primarily of a treadmill and weight lifting equipment specifically for quadriceps and hamstring exercise.

CHRONOLOGIC REVIEW OF RECORDS:

All medical records supplied by the referring party were reviewed.

10.14.88, return to work slip, G. Murata, M.D.: Return to work date illegible.

11.3.88, Doctor's First Report of Injury, J. Sepiol, M.D.: Date of injury: 10.26.88. Date of first examination: 10.26.88. Date last worked: 10.26.88. Patient states while at work slipped and fell in a ditch 1/4 mile from Escalon Bellota Road on Dodge Road. Complains of injury to left leg. Diagnosis: trauma, left quadriceps muscle. Medically managed with Ace wrap left thigh, crutches, ice, medications, follow-up Monday.

11.14.88, work status form, Dameron Hospital: Unable to return to work.

11.15.88, return to work slip, G. Murata, M.D.: Capable of returning to work as of 12.7.88.

11.16.88, initial evaluation, G. Murata, M.D.: While working for the San Joaquin County Mosquito Abatement Center, fell in a ditch on 10.26.88, sustaining a sever hyperflexion injury to his

left knee. As he was falling, his foot caught and he felt a pop just superior to his patella. Was seen at Dameron Emergency Room. X-rays were taken and he was given an Ace wrap as well as analgesia. Was started on physical therapy daily for quadriceps rehabilitation exercises. Assessment: partial quadriceps rupture. Rule out possible medial meniscus tear in light of his medial joint line tenderness. Should continue physical therapy. Should be disabled from any type of work except for a sitting type of job, which is unavailable at the Mosquito Control Center. To return in two weeks.

11.?.88 (day illegible), work status form, Dameron Hospital: unable to return to work until 11.9.88.

12.14.88, follow-up note, G. Murata, M.D.: Decreasing pain on the left thigh and knee, has been improving with physical therapy. Has been walking with a decreased limp and is generally happy with his progress. Has not been able to return to work, however, secondary to weakness in his quadriceps muscles and continuation of mild left knee discomfort. Assessment: improving quadriceps strength, possible medial retinacular plica versus a meniscal tear. Should continue to strengthen his quadriceps muscles via physical therapy. Cannot return to his present duties which include heavy lifting and working out in the field. To return to the office in two weeks for further evaluation.

12.29.88, follow-up note, G. Murata, M.D.: Applicant has finished his physical therapy program and has good functional use of the left leg. He has a minimal limp. He was still slightly tender over the distal anterior quadriceps mechanism. Assessment: He is doing quite well and should be able to return to full duties on 1.3.89. To return on a p.r.n. basis.

6.28.89, evaluation, P. Baker, M.D.: History as previously given. Current complaints involving his left knee include a feeling of aggravation, mostly when he is descending, when it feels weak and it can give way. There is some aching in the knee with cooler weather changes. "I interpret that the mechanism of injury did produce a partial tear of the patient's left quadriceps that has now healed strongly". There is no indication of internal derangement. There are no work limitations, nor any need for vocational rehabilitation. There is no need for future medical care.

10.3.89, note to Keenan and Associates, G. Murata, M.D.: "I have not been able to evaluate Mr. Beard since January, 1989. I would agree with Dr. Baker that the patient is not a qualified injured worker and there is no indication for a specific treatment.

1.11.90, work status form, Dameron Hospital: Released to regular work.

1.19.90, Doctor's First Report of Injury, H. Kim, M.D.: Date of

injury: 10.26.88. Date of first examination: 1.12.90. Description: :Slipped in a ditch left knee got stuck while sliding down hill knee popped from sudden stop." Diagnosis: Left knee sprain. Referred to G. Murata, M.D.

1.22.90, evaluation, G. Murata, M.D.: Applicant returns with complaints of left knee pain which he states has been increasing over the last two months. Assessment: Continued symptoms after quadriceps strain. "I do not see any obvious need for further treatment including physical therapy. I believe the applicant is permanent and stationary." Only objective findings were a mild amount of quadriceps and calf atrophy.

7.18.91, evaluation, G. Murata, M.D.: Seen for long-term follow up about his left leg. Sustained a quadriceps strain in October 1988, which was treated with a knee immobilizer and physical therapy. However, he continues to complain of weakness and giving way about the left lower extremity. Has some swelling over the distal anterior aspects of the quadriceps muscle. Also complains of intermittent numbness in the leg. Physical examination shows weakness of the left quadriceps muscle, as it he can be broken from a straight leg raising position. Assessment: Continued giving way and pain, left quadriceps area. Another trial of physical therapy would be beneficial, specifically for quadriceps exercises. To be seen after completion of physical therapy.

8.30.91, follow-up note, G. Murata. M.D.: Applicant has had some improvement of strength in the left knee. Continues to complain of occasional pain in this area, as well as cramping in the thigh. Assessment: Improvement of left quadriceps strain. Should continue on physical therapy. Follow-up in three weeks.

9.20.91, follow-up note, G. Murata, M.D.: Has had some improvement with physical therapy. Still has some weakness in the left leg. Physical examination still reveals some mild quadriceps atrophy and weak extension of the left knee in comparison to hamstring strength. Assessment: Mild improvement with physical therapy. Applicant would benefit from a continuation of physical therapy as an outpatient. He is not a candidate for any type of surgical treatment. To return for follow-up.

11.22.91, follow-up note, G. Murata, M.D.: Applicant seen for follow-up of his chronic left quadriceps strain. Had been doing quite well with physical therapy until hospitalization on 10.7.91 for an unrelated medical condition. Has been unable to perform any heavy work or return to regular duties until 11.18.91. Continues to complain of weakness in the left knee. Physical examination still reveals considerable weakness of the left quadriceps. Assessment: Left quadriceps weakness secondary to quadriceps strain. Should resume physical therapy and return for follow-up in one month. After the physical therapy, it would

again be nice to obtain isokinetic studies to quantify his weakness of the left quadriceps muscle.

12.23.91, follow-up note, G. Murata. M.D.: Applicant is seen regarding left quadriceps strength and weakness about the left knee. He states he has had improvement with physical therapy, with increased strength in the left lower extremity with decreased sensation of giving way. There is still some mild tenderness noted over the the distal quadriceps area. Isokinetic studies performed 12.4.91 show 90% work repetition compared with the opposite knee, as well as a peak torque of 159 foot pounds compared to the right of 185 pounds which represents 86% compared with the uninvolved knee. Should continue on home therapy program; weight loss program was advised as well. Permanent and stationary. To return on a p.r.n. basis.

4.7.92, follow-up note, G. Murata, M.D.: Mr. Beard is permanent and stationary, but continues to have some complaints of weakness and giving way. Objectively, he underwent isokinetic studies which showed 90% quadriceps strength about the left knee compared to the opposite knee. "At the present time, I do not see any further need for medical care."

5.14.92, letter to Keenan and Associates from G. Westin, Jr. M.D.: While working for the San Joaquin Mosquito Abatement District, was descending an embankment and forcibly flexed his left knee. He received physical therapy and returned to work nine weeks later. Since that time, he has had a feeling he could not rely on his left leg when walking on uneven ground, as well as numbness to the anterior left thigh. He had no medical treatment for three years, then returned to Dr. Murata and was placed on physical therapy. Physical examination unremarkable, except for a 2cm atrophy of the left thigh. Diagnosis: pain and weakness, left knee. Symptoms most consistent with a retropatellar contusion or possibly a quadriceps muscle tear. Treatment to date has been appropriate, he is not a surgical candidate, he is permanent and stationary, and his minimal impairment should require periodic orthopedic re-evaluations by his treating physician.

4.13.93, Stipulations with Request for Award: stating that Tom Beard had injury to his left leg causing permanent disability of 9:3%.

5.23.95, Doctor's First Report, F.X. Schwartz, Jr., M.D.: Date of Injury: 5.22.95. Date of First Exam: 5.23.95. Date Last Worked: 5.22.95. Description: Patient states that he was out of vehicle inspecting the barrow pit, slipped and lost footing and left knee failed. (History of left knee injury in 1986). Left knee no laxity, full range of movement, tip at medial border of patella. No effusion. Positive mild crepitance or patellar ballottement. Diagnosis: Status post medial patellar dislocation; (2) left peripatellar bursitis, left CMP.

Treatment: Exam. Ice for 24 hours, then heat at least t.i.d. Lodine. Physical therapy. Quad strengthening. Knee brace or Ace wrap. Recheck on 6.1.95. Unable to perform usual work.

5.26.95, physical therapy note, Dameron Hospital, Curtis Owler, P.T.: This indicates that Mr. Beard injured his left lower extremity on 5.22.95 when he slipped and fell into a ditch. He was experiencing pain with prolonged walking or sitting and he reported a history of a torn quadriceps in 1986. Patient presented with decreased VMO activity of the left leg, as well as quadriceps weakness. He also has decreased proprioception and some ligamentous laxity in the patella to medial and lateral glide. He was provided with a home exercise program for early VMO retraining.

6.22.95, progress note, Stockton Orthopedic Medical Group: Diagnosis: Arthralgia, left knee. Negative exam. Return to regular work, 6.22.95. Permanent and stationary. He was seen on 6.22.95 by Thomas Bielejeski, M.D. - of the Stockton Orthopedic Medical Group at the request of the Dameron Occupational Injury Clinic with a history of slipping into a ditch at work on 5.22.95 followed up by left knee pain and swelling. Since that injury, the knee tends to buckle or give out from him without any swelling or without any pain involved in the buckling episodes. He gives a history of a knee injury eight or nine years ago and, at that time, was treated by Dr. Murata claiming that he recovered from that incident without any surgery. Dr. Bielejeski indicates details of a normal physical exam and normal x-rays and states that he could find nothing wrong with Mr. Beard's knee and presented the opinion that the giving out sensation was something that "we all kind of feel on occasion, it's more due to muscles not kicking into coordination correctly. It is not due to any intrinsic problem with the knee." Dr. Bielejeski considered Mr. Beard's condition to be permanent and stationary with no findings for rating and no need for any further medical care.

11.22.95, orthopedic note, Edward Cahill, M.D.: The history that Dr. Cahill gives is that Mr. Beard initially injured his left knee in 1986 when he fell into a ditch, sliding on his back side and as he went down the embankment he felt his knee pop. He since had had problems with his knee. He further related that on 5.25.95 he had a re-injury to his knee when he slipped down a five foot ditch. He also indicates a third injury on 11.19.95 when his knee gave way. Present complaints consist of left knee pain with giving way and swelling. The knee will lock sometimes and sometimes he has pain while working. He has pain with running activities. Assessment: He may have medial compartment early osteoarthritis. He may have a medial meniscal tear in light of his history of locking. An MRI scan has been ordered. Plan to re-evaluate him after the MRI scan. Plan arthroscopic surgery if there is evidence of a medial meniscal tear. Dr. Cahill urged weight loss.

12.7.95, left knee MRI scan report, W. Aubrey Federal, M.D.: Conclusion: (1) Large horizontal tear, posterior horn, medial meniscus; (2) grade II-III injury, lateral collateral ligament; (3) probable Grade I injury, MCL; (4) superior prepatellar soft tissue swelling most likely related to direct injury.

12.13.95, progress note, Dr. Cahill: The MRI scan of Mr. Beard's left knee was reviewed and Dr. Cahill felt that ligamentous reconstruction was not necessary due to satisfactory overall knee stability, however, he felt that it would be appropriate to proceed with arthroscopic evaluation with possible meniscectomy or meniscal repair and chondral shaving, as indicated.

1.18.96, operative report, Edward Cahill, M.D.: Preoperative Diagnosis: Left knee medial meniscus tear. Postoperative Diagnosis: Left knee medial meniscus tear. Operation: Left arthroscopic partial medial meniscectomy and chondral shaving. Arthroscopic findings included Grade I and II chondromalacia areas of the medial aspect of the medial femoral condyle. Grade I chondromalacia of the lateral tibial plateau.

4.15.96, orthopedic note, Dr. Cahill: Almost three months status post arthroscopic partial medial meniscectomy (and chondroplasty medial femoral condyle and lateral tibial plateau). Overall knee strength has improved significantly according to the most recent LIDO isokinetic strength evaluation. Hopefully he will be able to return to work at the Mosquito Abatement District on 4.22.96. There is no effusion. No ligamentous laxity. Range of motion is 0-130 degrees. Return in two weeks for recheck. He indicates there is no light duty available to him.

5.6.96, progress note, E. Cahill, M.D.: Overall applicant feels his knee is improving with physical therapy. He is pleased with his general activities. He had concerns about returning to work, in that he did not wish to return to office activities. It would be reasonable, since it is now 4 1/2 months after his left knee arthroscopy, to proceed to light duty work with no lifting or carrying greater than 25 pounds, and no hiking up hills.

5.29.96, progress note, E. Cahill, M.D.: Status post arthroscopic partial medial meniscectomy and chondral shaving. Should continue the office work he has been performing. Lifting limitations are 10-15 pounds. He should sit as much as possible.

6.12.96, progress note, E. Cahill, M.D.: Status post left knee arthroscopic partial medial meniscectomy. Released to return to regular duties.

7.3.96, progress note, Dr. Cahill: He has been back at his regular job duties. He occasionally has to carry a can but it is not a problem. He carries a small hand can. Overall, he feels he is doing satisfactory. There is no effusion. Range of

movement is 0 to 120 degrees bilaterally. No ligamentous laxity. No joint line tenderness. Assessment: Status post arthroscopic partial medial meniscectomy. Dr. Cahill recommended that he continue his regular job duties. He felt he was permanent and stationary and that a QME could be performed to determine his level of disability secondary to his industrial injury.

ORTHOPEDIC EXAMINATION

Height is 5 feet, 10 inches tall. Weight is 327 pounds.

Gait demonstrates a slight limp favoring the left lower extremity; this is duplicated with heel and toe walking.

Examination of the left knee reveals well-healed arthroscopic portals about the knee. There is a trace effusion of the left knee. There is tenderness to palpation along the posterior one-half of the medial joint line. There is mild crepitance and tenderness to compression of the patellofemoral joint and tenderness to palpation of the patellar facets.

There is normal range of movement of the patella and normal stability, i.e., no laxity to stress testing and no apprehension sign. Supine range of movement of the knees is equal from full extension to 120 degrees of flexion, at which point the soft tissue bulk of his thigh and calf stopped further flexion. When asked to squat, he demonstrates a squat to a point of only 75 percent of normal complaining of pain about the anterior and medial aspect of the left knee and he uses a hand-hold to balance himself to help himself back up into a standing position. When asked to kneel he does so onto both knees but complains of pain in the left knee and then alters his kneeling so that he is kneeling onto the right knee as opposed to the left.

Girth measurements of the lower extremities consist of the following: At four inches proximal to the superior poles of the patellae, girth measurement of the right thigh is 26 inches, left thigh is 25-1/2 inches; at the joint lines of the knees, girth measurement of the right knee is 19-1/4 inches, left knee is 19-1/2 inches; calf circumferences are equal at 19 inches, four inches distal to the tibial tubercle.

DIAGNOSTIC IMPRESSIONS:

(1) Chronic left knee pain, status post arthroscopy with partial medial meniscectomy and chondroplasty of chondromalacia of medial femoral condyle and lateral tibial plateau - surgery performed on 1.18.96.

DISCUSSION

Tom Beard is currently a 47-year-old man who has worked for the

San Joaquin Mosquito and Vector Control Unit since March of 1972. He denies any knee injuries, disability or treatment until he sustained a work-related injury on 10.26.88, when he slipped and fell in a ditch; he was sliding down an embankment when his left foot caught on something on the downslope causing him to experience a forced hyperflexion injury of the knee.

Medical records indicate that he had continued complaints of giving way and pain in the left knee over the next few years with diagnostic impressions including injury to the distal left quadriceps musculotendinous unit, such as a partial tear, as well as retropatellar contusion. He underwent a few episodes of physical therapy and ultimately was considered permanent and stationary and received a 9.3 percent permanent disability award in 1993.

There is no indication that Mr. Beard rehabilitated himself. He sustained another injury with the same type of mechanism on 5.22.95 when he fell down in a ditch causing a hyperflexion and twisting injury of the left knee. This resulted in an increase in his pain and a new onset of locking and catching of the knee. After an initial period of treatment in the industrial medicine clinic at Dameron Hospital he was seen for treatment by Dr. Bielejeski, an orthopedic surgeon, who considered that his giving way episodes were not anything pathologic and declared him permanent and stationary in June of 1995 indicating no disability. Mr. Beard continued to work at his full duty thereafter but continued to experience pain, catching and buckling of his knee on a slightly progressive basis until he was seen by Dr. Cahill, an orthopedic surgeon, on 11.22.95.

Although Mr. Beard does not relate a history of any specific injury that occurred in November of 1995, Dr. Cahill's note indicates that there was another injury or, at the very least, another flare-up of Mr. Beard's knee condition when he had one of his giving way episodes on 11.19.95. Thereafter followed an MRI scan that was positive for a large horizontal tear of the posterior horn of the medial meniscus and arthroscopy on 1.18.96 revealing tearing of the posterior horn of the medial meniscus which was treated with partial medial meniscectomy and chondromalacia of the medial femoral condyle and the lateral tibial plateau, both of which were treated with chondroplasty.

Postoperatively, Mr. Beard went through physical therapy and my information is that he returned to work at light duty on 5.2.96 and full duty at the end of June of 1996, ultimately being considered permanent and stationary by Dr. Cahill on 7.3.96.

My interpretation of Dr. Cahill's permanent and stationary note of that date is that he was deferring any comments regarding disability issues to QME process. It does appear that Mr. Beard sustained an injury to his left knee in 1988, for which he was awarded a 9.3 percent permanent disability award, having received

it in 1993. There is no indication that he rehabilitated himself from this injury and, in fact, his knee condition worsened particularly with the 5.22.95 injury and then continued to worsen until he underwent his 1.18.96 surgical procedure.

SUBJECTIVE FACTORS OF DISABILITY

Subjective factors of disability consist of pain in the left knee that is occasional and moderate.

OBJECTIVE FINDINGS

Objective findings include the MRI scan of the left knee on 12.7.95 positive for a large horizontal tear of the posterior horn of the medial meniscus, the findings of the 1.18.96 arthroscopy consisting of tearing of the posterior aspect of the medial meniscus, as well as chondromalacia of the medial femoral condyle and the lateral tibial plateau.

Physical examination findings include a slight limp favoring the left lower extremity. There are well-healed arthroscopic portals about the left knee. There is a trace effusion of the left knee. There is tenderness to palpation along the medial joint line. There is tenderness to compression of the patellofemoral joint and to palpation of the patellar facets. There is a mild degree of crepitance palpable from within the patellofemoral joint during active movement.

He demonstrates an inability to squat normally and without pain, lacking 25 percent of a full squat and utilizing a hand-hold. He also demonstrates an inability to maintain any kneeling onto his left knee for any length of time other than briefly. Girth measurements are unequal, i.e., there is 1/2 inch thigh circumference atrophy on the left compared to the right and there is 1/4 inch enlargement of the left knee compared to the right consistent with a trace effusion.

DISABILITY

I would consider that Mr. Beard's left knee condition is permanent and stationary, having become so in July, 1996.

Due to his inability to squat normally and effectively, I would contemplate that he has lost between 15-20 percent of his capacity for lifting. Further preclusions would include no running, no prolonged negotiation of uneven or broken terrain, no prolonged squatting, no full squatting and no kneeling onto the left knee. He should also be precluded from prolonged climbing.

APPORTIONMENT

There is apportionment at issue in this case. Mr. Beard did receive a prior permanent disability award of 9.3 percent from

which he did not rehabilitate himself. I would consider that any increase in his degree of disability is due to the specific injury of 5.22.95 and cumulative trauma through the date of his surgery, i.e., 1.18.96, shared equally by both of those factors.

PROVISION FOR FUTURE MEDICAL CARE

Future medical care should be provided.

VOCATIONAL REHABILITATION

I would not consider Mr. Beard to be a Qualified Injured Worker.

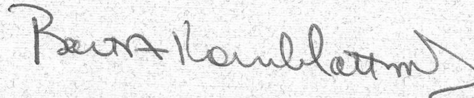
Comments on the opinion of the treater: As per the 7.3.96 note from Dr. Cahill he has deferred comments regarding disability to the QME.

Disclosures and declarations

In accordance with Labor Code Section 4628 (b), (c) and (j) and 8 California Code of Regulations, Rule 10978 let it be known that: I performed all medical aspects of this document. Clerical assistance rendered to me, without charge, may have included transcription, word-processing, editing for form, consistency and completeness, publication, billing, the recording of incident and employment dates and related history, and/or medical records abstracting. Names of participating editorial personnel in this office include Trudi Angel, Rene'e Knox, Robin Miller, Wendee Marcotti, Aurora Navarro and Suzi Pinkham. 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 be true. Exception: Where the report is recounting the history given by the applicant, or restating the observations or opinions of others, there is no implication that I believe it or disbelieve it, except insofar as that emerges from my comments. I supply this document, in response to request, for use only in connection with the proof or disproof of claim(s) in a court of law or in judicial arbitration. This evaluation complies with minimum time guidelines as stated in Article 4.5 of the Labor Code. I further declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that I have not offered, delivered, received, or accepted

any rebate, fund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

I appreciate the opportunity of participating in this evaluation.



BART A. KORNBLATT, M.D.
Qualified Medical Examiner, # 004275
Orthopaedic Surgery

12.31.96
date

Signed in the County of Sacramento

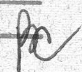
DECLARATION OF SERVICE BY MAIL

I am employed in the County of Sacramento. I am over the age of eighteen years and not a party to the within above entitled action. My business address is 9856 Business Park Drive, Suite A, Sacramento, California, 95827.

On this date I served the foregoing document, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States Post Office mail box at Sacramento, California, addressed in the manner set forth immediately above this declaration.

I declare under penalty of perjury that the foregoing is true and correct.

See bill and report attached.
Dated at
Sacramento, California on DEC 31 1996



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PROOF OF SERVICE

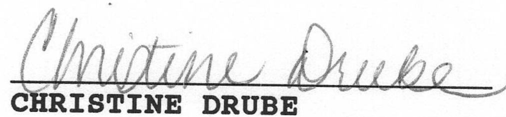
I am a citizen of the United States and employed in Sacramento County, California; I am over the age of eighteen (18) years and not a party to the within action; my business address is 2315 Capitol Avenue, Sacramento, California 95816; on this date I served the **DECLARATION OF READINESS TO PROCEED** a true copy thereof, postage prepaid, in the United States Post Office mail box at Sacramento, California, addressed as set forth below:

Thomas Beard
2937 Tonyon Drive
Stockton, CA 95203

KEENAN & ASSOCIATES
392 D Conners Court
Chico, CA 95929

I declare under penalty of perjury that the foregoing is true and correct.

Executed on April 16, 1997 at Sacramento, California.



CHRISTINE DRUBE