ERIC E. GOFNUNG CHIROPRACTIC CORP.

QME OF THE STATE OF CALIFORNIA

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

6221 Wilshire Boulevard, Suite 604 • Los Angeles, CA 90048 • Tel: (323) 933-2444 • Fax: (323) 933-2909

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am a resident of the County aforesaid: and I am over the age of eighteen years and not a party to the within action: my business address is 6221 Wilshire Boulevard, Suite 604 Los Angeles, CA 90048.

On 09 day of March 2020, I served the within concerning:

Patient's Name: Young, Benetia
Claim Number: 19006760

On the interested parties in said action, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid in Los Angeles, California, to be hand delivered Via United States Mail.

[ ] MPN Request
[ ] Notice of Treating Physician
[ ] Medical Report __________
[ ] Itemized – (Billing) / HFCA 02/14/2020
[ ] Doctor's First Report
[X] Review of Records
[ ] Financial Disclosure
[ ] QME Appointment Notification
[ ] Designation Of Primary Treating Physician
[ ] Initial Comprehensive Report
[ ] Re-Evaluation Report / Progress Report (PR-2)
[ ] Med Legal Report
[ ] Permanent & Stationary
[ ] Authorization Request for Evaluation/Treatment 02/14/2020

List all parties to whom documents were mailed to:

cc: Law offices Of Natalia Foley
8306 Wilshire Blvd., Suite 115
Beverly Hills, CA 90211

Bethe C. Barley, Esq.
Stander Reubens Thomas Kinsey
200 N Pacific Coast Highway, Suite 1550
El Segundo, CA 90245

Athens Administrators
P.O. Box 696
Concord, CA 94522

I declare under penalty and perjury under the laws of the State of California, that the foregoing is true and correct, and that this Declaration was executed at Los Angeles, California on 09 day of March 2019.

Ilse Ponce

ERIC E. GOFNUNG CHIROPRACTIC CORP.

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February 14, 2020

Natalia Foley, Esq.
5733 E Santa Ana Cyn Rd., Ste. G#616
Anaheim, CA

Re:		
Re:	Patient:	Benetia Young
	SSN:	547-08-0936
	EMP:	Star View Adolescent Center
	INS:	Athens Administrators
	Claim #:	19006760
	WCAB #:	ADJ12620825
	DOI:	CT: 04/18/2019 – 10/10/2019
	Date of review	February 14, 2020

Primary Treating Physician's Prolonged Service Code Record Review

Dear Gentlemen:

This review is mandated by L.C. 4064 & 9785. The claims examiner should forward this report to the defense counsel.

Received was a 0.25 inch stack of medical documentations on claimant Benetia Young. A total of 27 pages have been received and reviewed. 25 pages were essential pages and 2 pages were non-essential pages which were not relevant to the current injury. The total time it took to perform this function was 1 hour. The following is a summary of those records:

My review of the records is as follows:

REVIEW OF RECORDS:

A. I reviewed the entire medical file with all pertinent patient information including our prior reporting.

B. November 18, 2019, Primary Treating Physician's Initial Comprehensive Report with Psychological Test Results, Gayle K. Windman, Ph.D.: Introduction: The patient reported that she had worked as a Shift Lead for Star View Adolescent Center from 12/10/18 to 10/25/19. Regarding her Workers' Compensation claim she reported that on 10/10/19, she had submitted an application of claim for WC benefits citing a CT injury

from 04/18/19 to 10/10/19 involving stress, anxiety, flashbacks, and headache/sleep loss. The undersigned indicated that that her claim had become admitted for her neck and left shoulder and Athens Administrators had provided WC disability payments; however, the psyche component was denied. He also indicated that indeed, on **07/22/19**, Athens Administrators issued a denial letter. He added that there was a letter dated 10/10/19 submitted by her attorney, Natalia Foley, Esq., referring her to Dr. Curtis for psychological evaluation and treatment (who was designated as the PTP as well). On 10/10/19, the patient's attorney requested medical-legal reporting from this office and Dr. Curtis designated the undersigned as the evaluating physician for this report. Job description: As a Shift Lead, her job included supervising, protecting and caring for "at risk youth," behavior intervention, crisis intervention and supervision, case management, documentation, providing direct/indirect service, typically developing peers in school, monitoring youth/student conduct, utilizing approved behavior management techniques to redirect and modify inappropriate behavior and participating in intensive behavior intervention staff development in-service. Regarding her job performance she stated that she had received above average written work performance evaluations and for her good work, she had also received raises in pay and verbal praise.

History of the work Injury: The patient's last day of work for the above-noted employer was on 10/25/2019. **She was placed on disability by Dr. Gofnung on 11/18/19.** Regarding her injury she explained that on 04/19/2019, as she completed her rounds, which included room and bed checks for the "at-risk youths" on probation and as she walked down the corridor, she passed two youths. She recalled that without warning one of the youths, Savannah, forcefully grabbed her hair and pulled her down to the floor and dragged her about 15 feet. Savannah viciously punched the patient's face and struck her head and face over and over. A client and colleague intervened and she was rushed out of the facility, into the open courtyard and she was passed out. Savannah once told the patient that she reminded her of a mother figure (Savannah's mother was committed suicide). She filed a police report and she pressed charges against Savannah. She was referred to the company doctor and was diagnosed with bruises and contusions and she followed up with Kaiser Permanente. She continued to work but was demoted to Youth Counselor and could no longer work in the unit where the trauma had transpired. She further reported that she had experienced post-traumatic stress reactions including fear and had become mistrustful, suspicious and felt like to watch her back. She added that later, she returned back to her job as Shift Lead and reported that on one occasion, a youth began to bang on the plastic partition. He was in a rage; attempted to strangle himself and began to punch the patient in the stomach. He was restrained but a co-worker accused her of instigating the outburst. The patient was accused of making a clinical error and was placed on suspension pending an investigation. She was given the choice to either resign or be terminated. She was referred to Dr. Gofnung; however, she remained symptomatic.

The patient's report of emotional symptoms: She reported persistent depressive mood plus symptoms including changes in appetite and weight, decreased interest, insomnia, decreased energy, difficulty thinking and feelings of inadequacy. She had experienced recurring periods of anxiety with symptoms including recurrent panic attacks, excessive worry/difficulty controlling worry, restlessness, and feeling "keyed up" or on edge, difficulty concentrating, irritability, muscle tension, abdominal distress, jumpiness and pressure. There were unprovoked crying episodes that had occurred multiple times daily. She had also experienced stress-intensified medical symptoms with worsened headache, neck/shoulder/low back tension/pain, temporomandibular joint/dental reaction, nausea, chest pain, shortness of breath, peptic acid reaction, constipation, abdominal pain/cramping, diarrhea and possible stress-aggravated high BP. In addition, she reported symptoms of post-concussive symptoms including, blurred vision, dizziness, faintness, loss of balance, phobia to bright light and loud noises and ringing in the ears. Work history: Prior to the working with Star View Adolescent Center, she had worked for Early Strides from about 2018 to 12/10/2018. The reason given for leaving this job was to work closer to her home and there, her work performance was rated above average. Before that, she had worked for Kedren from about 2008 to about 12/2017. The reason given for leaving this job was her department was closed down and there her work performance was rated above average.

Medical history: The patient reported that she was diagnosed with migraine headache, irritable bowel, high blood pressure and chronic fatigue syndrome by Dr. Cho. The undersigned indicated that these conditions might have become aggravated by her work stress, in part, as compensable consequences. Current medication: Recently, she had taken Trazodone, pain medication and high blood pressure medication. Diagnoses as per DSM-5 (Diagnostic and Statistical Manual of Mental Disorders): 1) Major depressive disorder, single episode. 2) Generalized anxiety disorder. 3) Psychological factors affecting medical condition (stress-intensified headache, neck/shoulder/low back tension/pain, temporomandibular joint/dental reaction, nausea, chest pain, shortness of breath, peptic acid reaction, constipation, abdominal pain/cramping, diarrhea and possible stress-aggravated high BP). Summary: The undersigned indicated that the patient was found to be temporarily totally disabled on a combined physical and psychological basis. He also indicated that the events of injury arising from work were predominantly causative of injury to the psyche. It would be estimated that 100% would be industrially caused by the events described above with 0% caused by the past and personal life events and other factors. He added that the patient was found to be in need of emotional treatment and had indicated the following recommendations: 1) Requested authorization for 6 cognitive behavior psychotherapy (CBT) sessions. 2) She was provided with instruction on sleep hygiene. 3) There would also be the provision of psychotropic medication and management, and the prescriptions would be provided as needed through

the medical staff at this office. 4) Also, he requested the patient's all medical/personnel records, investigative reports or any other relevant discovery material for his review.

C. November 18, 2019, Hamlin Psyche Center Progress Note, Thomas A. Curtis, M.D.: Presenting complaints: 1) History of depression: Depression, decreased energy, changes in appetite, lack of motivation, difficulty getting to sleep, changes in weight, difficulty thinking, difficulty staying asleep. 2) History of anxiety: Excessive worry, panic attacks, restlessness, jumpiness, tension, agitation, feeling "keyed up" or on edge, inability to relax, pressure, agoraphobia. 3) History of post-traumatic stress disorder: Disturbing memories, reliving of the trauma, flashbacks. 4) History of stress related medical complaints: Tension headaches, increased pain, peptic acid reaction, abdominal pain/cramping, sexual dysfunction, dermatological reaction, muscle tension, temporomandibular joint/jaw clenching. Diagnoses: Remained unchanged. Prescriptions: Wellbutrin 100 mg, Buspar 10 mg, Ambien 5 mg.

D. January 21, 2020, Primary Treating Physician's Progress Report (PR-2), Thomas Curtis, M.D. Subjective complaints: Continued symptoms of both anxiety and depression. Objective findings: Continued objective functional improvement as documented on progress note. Diagnoses remained unchanged. Treatment plan: 1) Psychiatric medication. 2) Cognitive behavior psychotherapy. 2) All as needed and all as requested by RFA in effect according to guidelines. Work status: The undersigned the patient was found to be temporarily totally disabled on a combined physical and psychological basis. Also, he indicated that in the initial evaluation of 11/18/19 it was not possible to estimate the return to work date for regular or modified work, which at this time, he deferred to 2 to 3 months from same day (01/21/20).

DISCUSSION AND COMMENTS:

After review of the above records, it was noted that the patient is currently under the care of a psychiatrist and additional treatment is being requested. In addition, Dr. Curtis found the patient to be on temporary total disability on combined physical and psychological basis as of his January 21, 2020 report for two to three months forward. I am in agreement with all of the above opinions as expressed by Dr. Curtis. All of our opinions remain the same as stated in our prior reporting.

I am sure you will find this report helpful in the management of the patient's case. The review of these records provided me with a better understanding of the patient's condition and a greater ability to render appropriate care for the patient's condition. Please contact me at my office if I can answer any additional questions that I have left unanswered.

WCAB Declaration

I declare under penalty of perjury, that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as the information that I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I spent 60 minutes on reviewing the records/medical file, as well as 30 minutes preparing this report, including dictation and editing.

Sincerely,

Eric E. Gofnung, D.C.
Manipulation Under Anesthesia Certified
State Appointed Qualified Medical Evaluator
Certified Industrial Injury Evaluator

Signed this 28th day of February, 2020, in Los Angeles, California.

EG:hr/