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Hinze Psychological Services, PC.
A Professional Corporation
Heath Hinze, Psy D. *Clinical Psychologist*

Jonathan Kohan, M.D.
724 Corporate Center Dr. 2nd Floor
Pomona, CA 91768

Patient Name	: Daniel Doran
Claim Number	: 05814232
D.O.B.	: June 4, 1966
Employer	: Benedict & Benedict
Date Of Injury	: 07/11/2012
Date Of Evaluation	: June 2, 2015
Chart #	: 20015038

Dear Dr. Kohan

PERMANENT AND STATIONARY COMPREHENSIVE PSYCHOLOGICAL EVALUATION OF A SECONDARY PHYSICIAN

I had the pleasure of seeing Mr. Daniel Doran for a psychological evaluation. The entire evaluation was carried out at 724 Corporate Center Dr. 2nd Floor, Pomona, CA 91768.

This report contains material that may be misunderstood or misinterpreted by an examinee. For certain individuals, exposure could be destructive. If this report is to be discussed at all with the examinee, an appropriate professional who will ensure that the information is used therapeutically and not destructively should conduct it in a clinical setting. Please be advised that there is a duty to protect this material.

REPORT OF TIME SPENT:
(96101) Psychological Testing: Total time spent in the process of administration, scoring, interpreting and preparing results into the report: 360 Min.

Before the examination began, the patient was informed of being evaluated exclusively in connection with the Workers' Compensation claim. The examinee was also made aware that any communication between us is not privileged (doctor-patient confidentiality) and that any information provided, as well as the results of the psychological testing and my conclusions regarding this case would be included in a report that may be read by people involved in the resolution and/or litigation of the claim. The examinee understood the aforementioned and agreed to proceed with the evaluation.

Interim History:
Mr. Doran was seen for an initial psychological evaluation on May 07, 2013. He was diagnosed with depressive disorder, NOS; anxiety disorder, NOS; sleep disorder due to pain insomnia type; and male erectile disorder. The patient was started on a trial of cognitive behavioral therapy. At that time the patient was taking Lexapro 10 mg. A psychiatric consultation was also recommended. The patient returned and maintained active participation in treatment. On

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February 04, 2014, a psychological surgical clearance evaluation was conducted as the patient was pending a spinal cord stimulator trial. He underwent that trial in May 2014. The trial was successful and so he underwent permanent placement on August 27, 2014. The patient reports that his primary treating physician was changed to Dr. Kohan. The patient remains off work though apparently he was given a work restriction that he can return to work so long as he does not use his right hand. The patient apparently has a panel QME with Dr. Aval, orthopedist, on June 30, 2015. The patient returns today for further evaluation.

Mental Status:
The patient presented appearing his stated age. The patient presented with appropriate grooming and hygiene. He ambulated without the use of a physical aid.

The patient returns today appearing dysphoric and depressed. He has a tendency to become tangential initially responding to a question and then trailing off into other concerns most notably regarding his orthopedic condition, his pain, and the changes that have occurred with his life post-injury. Mood today is described as frustrated due to a recent termination of state disability benefits.

The patient related to the evaluator as candid and cooperative. He approached the evaluation process as open and responsive. He was alert.

Speech was a normal rate of responding and volume. Eye contact was normal. The patient showed no problems with expression. He spoke fluently in English and without the use of an interpreter.

The patient demonstrated intact memory with no apparent difficulty recalling personal events. The patient was oriented to person, place, time, and situation.

The patient's responses were coherent and easy to understand. The patient's concentration and attention was adequate.

The patient showed normal thought content. There was no presence of hallucinations or delusions. Judgment and insight were good.

The patient's intellectual ability was roughly average.

The patient expressed no suicidal or homicidal ideation. There is no apparent risk to self or others. The patient did not appear impulsive. Rapport was sufficiently established.

Psychological Testing:
The following tests were assessed for their use in this evaluation based on recommendations by Medical Treatment Utilization Schedule (MTUS) of the American College of Occupational and Environmental Medicine (ACOEM Practice Guidelines) as well as other considerations. Other psychosocial instruments were selected based on their utility or relevance to a cognitive therapeutic approach. Tests are also included that assess concepts utilized within a stress-appraisal-coping model of pain based on the current psychosocial pain research literature and adapted from Lazarus and Folkman's (1984) transactional model of stress. These are tests that assess individual's beliefs, attitudes, cognitions and cognitive coping. An ideal test battery provides a road map for intervention and provides a method of tracking progress. These tests

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can be used as part of a pre-, ongoing, and post-treatment evaluation.

Beck Anxiety Inventory (BAI)
The Beck Anxiety Inventory is a 21-question self-report inventory, which asks the patient to choose from a hierarchy of levels of anxiety-related symptomatology for each question.
Client Score: 35
Interpretation: [Severe] level of subjective anxiety.

Beck Depression Inventory (BDI)
The Beck Depression Inventory (BDI) has been widely used for the assessment of cognitions associated with depression for both psychiatric patients as well as depression in normals.
Client Score: 46
Interpretation: [Severe] level of subjective depression.

Pain Appraisal Inventory (PAI)
Developed by Unruh and Ritchie (1998), the PAI is designed to assess the primary appraisal process of people experiencing troubling pain. The scale is designed to assess if the person tends to appraise pain as a threat or a challenge. The PAI has been found to have good internal consistency (Chronbach's alpha: Threat Subscale = .86; Challenge = .81). The 16-item measure combines the primary appraisal categories of threat and harm/loss into one factor labeled the Threat/Loss scale and a second factor labeled the Challenge scale.

Interpretation:
The high score on Threat/Loss suggests the patient may view any pain stimulus as a signal of danger and leading to avoidance. Exercise and other behavioral assignments may be viewed as having a high potential for causing reinjury or triggering a pain episode. The patient may judge that the pain has robbed him of all pleasurable aspects of life.

Pain Catastrophizing Scale (PCS)
Developed by Sullivan (1995) to measure pain catastrophizing and better understand the mechanism by which catastrophizing impacts the experience of pain. The PCS is reliable, valid, and robust in its prediction of pain and adaption to chronic pain. Negatively distorted pain-related cognitions involving magnification of the threat value of pain, rumination about pain, and perceived inability to control pain. The scale has 13 items with three subscales (Magnification, Rumination, Helplessness). A clinically relevant and significant score is >38.
Client Total Score: 30
Interpretation:
The results are *non-significant* and suggests an adequate adjustment to chronic pain, decreased perceived disability, decreased occupational impairment, less emotional distress, and decreased medication use and use of healthcare services.

Coping Strategies Questionnaire-Revised (CSQ-R)
Revised CSQ 1997 (Riley and Robinson) of the original CSQ (Rosenstiel, 1983). The Coping Strategies Questionnaire (CSQ) uses a 27-item, 7-point rating scale to measures the frequency of use for common pain coping strategies. The CSQ is commonly used in pain studies and is appropriate for use in non-clinical and clinical populations. The scale has two general factors comprised of six scales. The Cognitive Coping Factor (Ignoring Pain, Praying, Distancing from the Pain, and Coping Self-Statements) is related to higher activity levels in patients with chronic pain. The Catastrophizing/Distraction Factor (Distraction and Catastrophizing) is related to poor

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indicators of adjustment to chronic pain.
Interpretation:
Results place the patient in the *low responder* subgroup indicating the patient scored low on all measures.

Pain Patient Profile (P-3)
The P-3 is a 44-item, self-report, multiple-choice instrument designed to identify patients who are experiencing emotional distress associated with primary complaints of pain. The P-3 is appropriate for patients suffering pain as a result of disease, illness, or physical trauma (e.g., motor vehicle accidents and work-related injuries). The P-3 has three clinical scales (Depression, Anxiety, and Somatization) and a Validity Index that assesses the probability of random responding, inadequate reading comprehension, and magnification of symptoms.

Validity Index: 11
(Valid) The patient's score on the Validity Index suggests that he was able to read the items and appropriately attended to item content. It appears that he approached the test in an open and honest manner. His score suggests that his test results can be interpreted with confidence. professional who chooses to interpret the scores should do so with extreme caution.
Interpretation:
The Depression Scale:
Above-Average (55-71): Patients with scores above the average pain patient score on the Depression scale usually experience chronic fatigue, sadness, listlessness, and appetite and sleep disturbances associated with pain. The patient may have given up hope and may lack the motivation required for participating in a treatment program. (A psychological evaluation is strongly recommended for these patients.)
The Anxiety Scale:
Above-Average (56-71): Patients with scores above the average patient score on the Anxiety scale typically experienced significant agitation, generalized fear and apprehension, and inner turmoil. Temper and impulse control may be affected, and he may feel an increasing loss of control as a result of the complexity, scope, and magnitude of their pain. When Anxiety scores are considerably higher than average, psychological symptoms are likely to seriously interfere with physical treatment.
The Somatization Scale:
Above-Average (56-69): An above-average score on the Somatization scale suggests that the patient is troubled by physical problems, pain, and health-related issues that are having a negative effect on life. Pain and suffering may occupy a disproportionate amount of the patient's attention and concentration, causing the patient to be easily distracted. As scores a rise on the Somatization scale, the likelihood increases that the patient has an obsessional level of somatic concentration that is likely to interfere with treatment participation and rehabilitation efforts.

Review of Records:
Primary treating physician pain management follow up report and request for authorization May 13, 2015, Dr. Kohan. The patient returns and is not having any issues with his spinal cord stimulator. It is helping him by about 40%-50% for his right upper extremity complaints. There is less sensitivity to touch in the form of the burning pain. The patient is not undergoing any therapy. He maintains his visits with the psychologist. Based on the improvement in the stimulator Norco will be decreased. He will remain on Neurontin and Elavil. The patient should continue with the psychologist as this has been beneficial. The patient is given the work restriction of not using his right upper extremity.

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Conceptualization:
Mr. Doran returns today regarding his psychological condition. Mr. Doran was seen for an initial psychological evaluation on May 07, 2013. He was diagnosed with depressive disorder, NOS; anxiety disorder, NOS; sleep disorder due to pain insomnia type; and male erectile disorder. The patient was started on a trial of cognitive behavioral therapy. At that time the patient was taking Lexapro 10 mg. A psychiatric consultation was also recommended. The patient returned and maintained active participation in treatment. On February 04, 2014, a psychological surgical clearance evaluation was conducted as the patient was pending a spinal cord stimulator trial. He underwent that trial in May 2014. The trial was successful and so he underwent permanent placement on August 27, 2014. The patient reports that his primary treating physician was changed to Dr. Kohan. The patient remains off work though apparently he was given a work restriction that he can return to work so long as he does not use his right hand. The patient apparently has a panel QME with Dr. Aval, orthopedist, on June 30, 2015. The patient returns today for further evaluation.

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The patient returns today indicating that the spinal cord stimulator has led to approximately 50% improvement in pain management; however, there is a trade-off. He reports that over time he has needed to increase the level of stimulation. When he moves there is an electrical buzzing sensation that he experiences all the way down to his toes and as well as his upper extremities. He describes this as a very uncomfortable pain as though he is being shocked. However, if he does not increase the stimulation there is increased pain to the right upper extremity. Over time the patient reports that overusing the left hand has led to pain that at time is even worse than the right hand. Recently, he was given a work restriction, but he is unable to find work noting that his career is 30 years in plumbing, which requires the use of both hands. He has also reached a point where he is struggling to use his left hand due to overuse. Apparently, his state disability benefit ended a couple of months before they became exhausted. The reason for this is unclear at this time. However, as a result there has been even further financial hardships placed on him. He is living with his girlfriend of seven years. She purchased a trailer and he is responsible for paying for the rental space. He has been unable to pay that now for quite some time and this does lead to financial hardships and tension between him and his girlfriend.

On most days, the patient has minimal activities other than doing very light chores around the home. He points out that he can at least dust with his left hand. He may watch some television. He goes outside for fresh air and takes his dog for a walk with his girlfriend. Last year, the patient reports that he reconnected with one of his siblings. He and his brother now have ongoing communication.

The patient describes his mood as fluctuating throughout the day. He goes through episodes of depression because of his ongoing life changes and struggles to meet the financial obligations each month. He is limited into how much he can help around the home. At times he feels that he is becoming dependent upon his girlfriend. She must remind him of tasks to be completed because he has become so forgetful. She writes things down on a list for him. The patient

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2 3745666 000000001 039 043 05814232

reports that there has been a gradual worsening of his anxiety. Out of the blue he experiences rapid heart rate, shortness of breath, and trembling. These symptoms last 10-20 minutes and come out of the blue. During these times he feels that his senses become amplified and he becomes more sensitive to light and sound. There are times that he is afraid that he will "drop dead." He does not avoid anything because the attacks come out of the blue and so he does not associate them with any environment.

The patient reports that he feels like his situations is only worsening. He commented, "Every day is more discouraging." He has been without health insurance now for a year. He is diabetic and is medication-dependent. He has a two-month supply remaining and then does not know how he will have access to further care.

Neurovegetative complaints are described by the patient. The patient has deficits of sleep onset and maintenance primarily due to pain. He often goes to bed around 1 o'clock in the morning. He first dozes off in his recliner. Once he lies down to sleep he has to turn off his spinal cord stimulator because movement causes electric shocks to go through his body. The trade-off then is that there is increased pain to the right upper extremity, which wakes him in the middle of the night. He wakes feeling lethargic, but avoids taking naps during the day. The patient reports continued erectile dysfunction, which was present at the initial evaluation. With the ongoing stress there is also general loss of his libidinal drive. He complains of ongoing problems and forgetfulness. He points out that if he is not focused on something right away the thought will be lost. This becomes discouraging as his girlfriend has to remind him of things and give him lists to complete. The patient complains of a low appetite. He has to force himself to eat, but is discouraged by the fact that he has a "beer belly" even though he does not drink.

The patient is smoking approximately one pack of cigarettes per day. He uses this as a coping strategy. Unfortunately, this causes further financial drain.

The patient reports that his attitude has seen some improvement through psychotherapy. He feels mostly stable in this regard. When he becomes irritable or upset dealing with the stress from these injuries he goes out for fresh air and goes for a walk and tries not to dwell on the circumstances. He acknowledges that the greater concerns are his depression and the anxiety symptoms that appear to be increasing with time.

The patient has now concluded his trial of psychotherapy. He remains on a dose of 50 mg of Elavil. He is pending a panel QME in orthopedics; however, there are no other procedures pending that I am aware of. He has been left with residual psychiatric impairment secondary to this work injury. There are continued anxiety symptoms as well as depression as a result of his physical limitations and pain. He is discouraged by the continued pains that are developing especially now to the left upper extremity, which is his only useful hand. He does not know what career opportunities he has available to him as he has worked his entire life in the plumbing industry. Future psychological services should be afforded to this person as he continues to cope with this chronic condition.

DSM-IV-TR Diagnosis:

Axis I: 300 Anxiety Disorder, NOS
311 Depressive Disorder, NOS

Axis II: V71.09 No Diagnosis

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Axis III: Deferred To Appropriate Medical Specialist

Axis IV: Psychosocial And Environmental Problems: Financial hardship, ongoing need for medical attention and chronic pain

Axis V: GAF: 60 (Time Of Evaluation)

Causation/Apportionment:
It is my opinion that the work related accident detailed above is consistent with the psychological findings in today's examination of occupational problems. His psychological injuries are directly related to the injuries sustained in the work environment described herein. Per LC 3208.3 (d) this claim is compensable as the psychological injury occurred in connection with a physical injury. I have not found any evidence to suggest the presence of a pre-existing psychological disorder.

The events of the employment were the predominate cause (>51%) of emotional psychological injury.

Per new Labor Code section 4663 and Labor Code 4664 and the Escobedo v. Marshall's case: Based on the results of this evaluation, I have determined that approximately >51% of the permanent impairment was caused by the "direct result of the injury arising out of and occurring in the course of employment" (LC§ 4633(c)). There is no basis to apportion to a nonindustrial factor. There is some slight tension in the home in regards to a grown daughter of his girlfriend's that is living there; however, this is not contributory to the permanent psychological disability. In consideration of this it is determined that 100% of the permanent psychological disability is apportioned to the July 11, 2012, injury and resulting pain and physical limitations. I reserve the right to change my opinion if additional medical records become available.

Levels of Mental Impairment:
In order to comply with the Labor Code SB 899 Section 4660 (d) regarding the permanent disability in this case I am submitting the following:

I have carefully consulted the relevant literature and particularly the American College of Occupational Environmental Medicine's Occupational Medicine Practice Guidelines as well as the Guides to the Evaluation of Permanent Impairment (Fifth Edition, 2001) by the American Medical Association.

The above literature provides a guide for rating mental impairment. This guide includes four areas of functional limitation on a five-category scale that ranges from no impairment to extreme impairment.
As identified in Table 14-1 of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition:

0%	Class 1. No Impairment
1-15%	Class 2. Mild Impairment
16-25%	Class 3. Moderate Impairment
26-50%	Class 4. Marked Impairment
51-100%	Class 5. Extreme Impairment

2 3745666 000000001 041 043 05814232

Impairment Level
1. Activities of Daily Living: Moderate to marked.
2. Social Functioning: Mild
3. Memory, Concentration, Persistence, and Pace: Moderate.
4. Deterioration or Decompensation in Complex or Work life Settings: Mild.

AMA Impairment Rating:
The patient has reached maximum medical improvement on a psychological basis as of the date of this report.

The patient's psychological whole person impairment rating based on the GAF is 15% in this case.

Work Restrictions/Abilities:
Any duties that would exacerbate his injury and increase his pain level would likely cause a corresponding worsening of his psychological symptoms and increase risk for relapse. As such any work restrictions outlined by the primary treating physician should be adhered to.

The patient is recommended to avoid taking on high pressure positions or those requiring strict adherence to production quotas.

The patient is recommended to avoid taking on night shift positions as this my further disrupt his sleep cycle.

Future Psychological Recommendation:
The patient is recommended for 24 future cognitive behavioral therapy and relaxation training sessions to be set aside and used intermittently to maintain stability as the patient confronts this chronic condition. The patient should have access to psychiatric consultations for medication management. Further evaluations and diagnostic studies should be available to assess his process in treatment.

Patient Work Function Impairment:
1. Ability to comprehend and follow instructions:
Level of Impairment: Slight to moderate.

2. Ability to perform simple and repetitive tasks:
Level of Impairment: Slight.

3. Ability to maintain a work pace appropriate to a given work load:
Level of Impairment: Moderate.

4. Ability to perform complex or varied tasks:
Level of Impairment: Moderate.

5. Ability to relate to other people beyond giving and receiving instructions:
Level of Impairment: Slight to moderate.

6. The ability to influence people:
Level of Impairment: Slight.

2 3745666 000000001 042 043 05814232

7. Ability to make generalizations, evaluations or decisions without immediate supervision:
Level of Impairment: Slight.

8. Ability to accept and carry out responsibility for direction, control and planning:
Level of Impairment: Slight to moderate.

Disclosure:
The psychological tests are administered at this clinic. Instructions are included on the tests themselves. All of the tests were interpreted by me. I reviewed any medical records set forth in the report. In addition to conducting the evaluation, I personally composed and drafted the conclusions of this report.

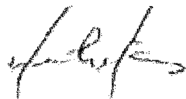
I declare under the penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, as to information that I have indicated I received from others. As to that information, I declare under the penalty of perjury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

I personally performed the clinical evaluation of the patient at 724 Corporate Center Dr, Pomona, CA 91768.

Except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the WC Medical Unit or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5370.6 of the California Labor Code. Please be advised that the itemization of the fees for this report is attached in a separate statement. Additional fees may be required for more extensive reports or more complex situations.

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

Signed this 2nd day of October, 2015, at Los Angeles County. Should any questions arise regarding this case, please do not hesitate to contact this office.



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