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December 4, 2017

S.C.I.F.
P.O. Box 22022
Santa Ana, CA 92702
ATTENTION: Ahda Sands, Esq.

S.C.I.F.
P.O. Box 3171
Suisun City, CA 94585-6171
ATTENTION: Jaime Keltner

EMPLOYEE: DORAN, Daniel
EMPLOYER: Benedict and Benedict Plumbing Company
DOI: 07/11/2012
CLAIM #: 05814232
WCAB #: ADJ8760713
DOB: 06/04/1966

REVISED VOCATIONAL EVALUATION REPORT

REFERRAL OBJECTIVE:

As requested, the following report outlines the vocational evaluation conducted regarding Mr. Doran's vocational feasibility as it relates to employability and ability to compete in the open labor market given his industrial injuries.

CONCLUDING OPINION AND AMENABILITY FOR VOCATIONAL SERVICES:

An extensive analysis was completed of Mr. Doran' employability as it relates to transferable skills, industrially related impairments and restrictions, and the effect that these have on his ability to work, including an analysis under *LeBoeuf v. Workers' Comp Appeals Board, with the following findings:*

Based on the reports of his doctors, Mr. Doran retains an ability to return to work in the open labor market in the below exampled selective Sedentary and Light Occupations when solely considering his industrially related orthopedic, neurological, and psychiatric medical work restrictions and while excluding his non-industrial medical conditions such as his diagnosed Parkinson's Disease, and Diabetes II. Absent the medically indicated non-industrial medical conditions as documented in the medical file, Mr. Doran retains an ability to compete, or be retrained for suitable gainful employment.

QUALIFICATIONS:

The undersigned holds a Master's Degree in Education Counseling; a Bachelor's Degree in Psychology; Diplomate of the Board of Vocational Experts (4/2017), Board Certified Rehabilitation Counselor, (CRC#27306); Board Certified Case Manager, (CCM #M-05138); Board Certified Associate Ergonomist (CAE#000-5-168); U.S., Department of Labor–OWCP Certified Rehabilitation Counselor (#13491; and Independent Vocational Evaluator (IVE-DWV Rehab, Unit) and for the past 27 years has been an actively practicing Vocational Expert in the field of Workers' Compensation in California and the Federal Court of the Office of Disability Adjudication Review of the Social Security Administration, Vocational Expert (BPA# 0747),

Witness Testimony, and Disability Management. Since 1989 under the auspices of Canizalez & Associates, work experience encompasses the functions of CEO, President, Senior Vocational Rehabilitation Counselor, Case Manager, and the provision of Vocational Expert Services assisting local State of California, national/out of-state and Republic of Mexico English/Spanish speaking industrially injured workers with disabilities by providing return to regular, modified and/or alternate work to include assessment of ergonomic accommodations; through full Vocational Evaluations inclusive of Initial Interviews, Vocational Testing, Essential Functions Job Analysis, Plan Development, Job Placement and Vocational Expert Services.

Since 2015 I have completed well over 520 LeBoeuf Labor Code §4662 Evaluations, 750 Diminished Future Earnings Capacity Evaluations, and on multiple occasions have acted as Agreed Vocational Expert, given Depositions and testified at trial on LeBoeuf/DFEC cases. (See enclosed Curriculum Vitae for more details)

BACKGROUND INFORMATION:

The following documents were reviewed in preparation this Vocational Evaluation:

- Pain Medicine Re-Evaluation Report of Gary L. Baker, M.D. dated 08/14/2017, 05/22/2017, 03/27/2017, 02/27/2017, 12/05/2016, 11/07/2016 and 10/10/2016.
    - Operative/Procedure Report of Gary L. Baker, M.D. dated 05/12/2017.
- Vocational Evaluation Report of Laura M. Wilson & Associates dated 07/10/2017.

- Neurological Agreed Medical Evaluation Report of Mark R. Pulera, M.D., Q.M.E. dated 12/15/2016.
- Internal Medicine Agreed Medical Evaluation Report of Jams F. Lineback, M.D., F.C.C.P. dated 12/15/2016.
- Psychiatric QME Report of Daphna Slonim, M.D. dated 07/18/2016
- Orthopedic Examination Report of Soheil M. Aval, M.D. dated 06/30/2015.
- Vocational Evaluation Report of Laura M. Wilson, MBA, dated 07/10/2017.

In addition, this Counselor conducted an Initial Interview conducted with Mr. Doran on 11/08/2017.

Mr. Doran arrived punctually for his appointment with this Counselor. The interview took place at our Escondido office located at 333 S. Juniper St., Escondido, CA. He was dressed casually, was well groomed. He appeared to co-operate to the best of his ability throughout the entire Initial Interview process.
Mr. Doran is a 51-year-old, male who sustained work-related injuries to right hand as a result of performing his usual and customary job duties as a Plumber. He was years 46 years of age at the time of his injury (07/11/2012).

Mr. Doran is a widower who lives in Lone Pine CA. He informed he is currently receiving $1,125.00 per month from Social Security Disability.

Mr. Doran reports he attended high school until 11th grade 1st semester at St. Francis in La Canada, CA. He attended plumbing courses at Citrus College. No other education was reported.

Mr. Doran is fluent in in English. Mr. Doran informed he has no computer skills other than use of his smart phone. No other education or formal training was reported.

VOCATIONALLY RELEVANT EMPLOYMENT BACKGROUND (Past 15 years-as reported by Mr. Doran) as provided to this Counselor per Mr. Doran:

2009 - 2012

Employer: Benedict & Benedict
Position: Plumber (Residential/Commercial)
Wages: $25.00 per hour
Duties: Mr. Doran worked as a plumber doing commercial or residential plumbing duties.

2002 - 2009

Employer: Dr. Drain, Mammoth Lakes, CA
Position: Plumber
Duties: Mr. Doran worked as a plumber doing commercial or residential plumbing duties.

Prior to 2002, Mr. Doran was self-employed. He had his plumbing company of Double D Plumbing. In the 1990's, he worked as a Plumber in Alabama. He also worked as a Pipefitter with Security Protection back in the 1980's. No other work was reported.

ADL FUNCTIONAL LIMITATIONS (Subjective) as reported by Mr. Doran on 11/08/2017:

Self-care, personal hygiene:	Transferring from bed to chair, going to the bathroom, (urinating, defecating), brushing teeth, grooming, (combing hair), bathing, dressing oneself, eating.

Experiences some difficulty when moving from bed to chair, bathing and dressing self.

Physical activity/mobility	Standing, sitting, reclining, walking (room-to-room and outside home) climbing stairs.

Difficult ability to climb stairs. He is limited in standing, sitting, and walking due hip problems.

Non-specialized hand activities	Grasping, lifting, tactile discrimination.

Experiences difficulties with forceful grasping and lifting with the right upper extremity.

Managing Household Affairs	Use telephone, do laundry, prepare meals, do housework, shop, take medications, manage transport and manage household finances.

His wife passed away and now he has difficulties performing house hold duties. Experiences some difficulty with meal preparation.

Travel	Riding, driving, and flying.

Difficult ability to drive and/or travel in car for 30 minutes at a time before pain starts.

Additionally, Mr. Doran indicated the following physical tolerance limitations:

Reported difficult ability to stand, walk and sit due to his hip problem.
Reported difficult ability to drive due to his hip problem.
Reported ability to lift and carry up to 10 lbs. w/ right upper extremity. No restriction with the left upper extremity.
Reported ability to push and pull up to 10 lbs. with right upper extremity. No restriction with the left upper extremity other than difficulties resulting from Parkinson's Disease.
Reported limited ability to bend and kneel.
Reported inability to squat/crouch.
Reported limited ability to twist/pivot.
Reported very limited to reach above shoulder level.
Reported ability to reach at shoulder level.
Reported limited ability to reach below shoulder level.
Reported some burning type pain when handling or feeling repetitively with right upper extremity.
Reported some difficulty with fine dexterity with the right upper extremity. No restriction with the left upper extremity.
Reported some difficulties with pain in his hip.
Reported some difficulties with climbing stairs/steps.
Reported inability to climb ladders or balance.
Reported noticeable limp.
Reported increase in pain with cold.
Reported vision restriction.
Mr. Doran experiences tremors and reported that he was diagnosed with Parkinson's disease in November of 2016.

EMPLOYABILITY:

Mr. Doran is medically precluded from returning to his Usual & Customary Occupation as a Plumber. The highest Specific Vocational Preparation level of his past work history per the US Dept. of Labor Dictionary of Occupational Titles is at level 7 (Plumber DOT# 862.381-030, SVP=7), the usual amount of time spent by the typical worker to learn the techniques, acquire the information, and develop the facility needed for average performance in a specific job. Includes vocational education, apprenticeship, in-plant training, on-the-job training, and essential experience gained on other jobs is over 2 years and up to 4 years and is considered skilled work. Furthermore, Mr. Doran' reported education and vocational training level of is consistent with the general educational development of his Usual & Customary Occupation. His vocationally relevant transferable skills consist of primarily of Structural Fabricating-Installing-Repairing. In addition, his vocationally relevant work history also involved Performing Attaining Precise set limits, Tolerances, and Standards; Performing a Variety of Duties; Making Judgments and Decisions; Precision Working; Compiling, and Taking Instructions.

In addition, per the medical file, Mr. Doran's medical work restrictions are indicted as follows:

***From a neurological standpoint (Per AME Mark R. Pulera, M.D.-AME Report of 12/15/2016):**

Only occasional simple grasping and coarse manipulation should be allowed, but no forceful gripping, fine manipulation, torquing, or heavy activity with the right upper extremity.

No walking on uneven ground, crouching or kneeling, crawling or climbing.

No driving or operating dangerous machinery, tools, or equipment while drowsy.

***From an orthopedic standpoint (Per Soheil M. Aval, M.D., QME Orthopedic Examination Report of 07/18/2016)**:

Mr. Doran is precluded from activities of repetitive or forceful gripping, fine manipulation, torquing, and heavy lifting with the right upper extremity. The left upper extremity does not require work restrictions.

***From a psych standpoint (Per Daphna Slonim, M.D. Psychiatric QME Report of 07/18/2016):**

Mr. Doran should avoid stresses at work.

In addition, Dr. Slonim indicated the following Factors of Disability with regards to work functions:

(1) Ability to comprehend and follow instructions. **Slight**
(2) Ability to perform simple and repetitive tasks. **Very Slight**
(3) Ability to maintain a work pace appropriate to a given work load. **Slight**
(4) Ability to perform complex or varied tasks. **Moderate**
(5) Ability to relate to others beyond giving and receiving instructions. **Slight**
(6) Ability to influence people. **Slight/Moderate**
(7) Ability to make decisions, evaluations, judgements or generalizations without immediate supervision. **Moderate**
(8) Ability to accept and carry out responsibility for direction, control, and planning. **Moderate**

DISCUSSION/OPINION:

In reference to the opinions outlined in the Le Boeuf Analysis by Laura Wilson, MBA dated 07/10/2017; I respectfully disagree with the applicant's vocational expert's opinion that Mr. Doran may no longer have the ability to return to work in the open labor market when only considering his industrial injuries and residual medical work restrictions while excluding the non-industrial medical conditions documented in the medical file (i.e. Non-industrial Parkinson's Disease, non-industrial Diabetes II, and the 25 % of apportioned sleep disorder to non-industrial factors) as well as Mr. Duran's non-industrial and/or impermissible factors such as limited education (11th grade) and training (limited to Plumbing training).

However, when considering only Mr. Doran's industrially related orthopedic, neurological, and psychiatric conditions and above noted work restrictions and while excluding the non-industrial and/or Impermissible factors as outlined above, it is concluded that Mr. Doran is not precluded from all work and/or from being able to participate in vocational rehabilitation in the form of vocational training and/or employment services.

Under LeBoeuf v. Worker' Comp. Appeals Bd. (1983) 34 Cal.3d 234, it must be demonstrated that an applicant is not employable in the open labor market, including a determination that

he is no longer able to be retrained for any suitable gainful employment. This would then be considered in any determination of a permanent disability rating.[1]

Furthermore, as noted in "Ogilvie III[2]", the most widely accepted view of its holding, and that which appears to be most frequently applied by the WCAB, **is to limit its application to cases where the employee's diminished future earnings are directly attributable to the employee's work-related injury, and not due to nonindustrial factors**. .... *This application of Leboeuf applies more closely to an employer's responsibility under sections 3208 and 3600 to "compensate only for such disability or need for treatment as is occupationally related" (Livitsanos v. Superior Court, supra, 2 Cal. 4th at p.* 753) "Employers must compensate injured workers only for that portion of their permanent disability attributable to a current industrial injury, not for that portion attributable to previous injuries or to nonindustrial factors." (*Brodie v. Workers' Comp. Appeals Bd.,* supra, 40 Cal. 4th at p. 1321 [discussing apportionment]). Other factors excluded in this evaluation include impermissible factors such as general economic conditions or an employee's lack of education (Ogilvie III-2011).

Based on the above noted parameters and the industrially related orthopedic, neurological, and psych work restrictions and/or limitations; the following occupations were identified as medically appropriate occupations and with lower Specific Vocational Preparation (SVP) to that of Mr. Doran's usual and customary occupation (SVP = 7) and therefore feasible for direct job placement with a short period of on-the-job training. In addition, said occupations were found to be available in sufficient numbers in Mr. Doran' geographical area of residence (please refer to labor market information (EDD) outlined below).

The residual Light and Sedentary occupations identified within the above-mentioned parameters that would not require more than **occasional simple grasping and coarse manipulation**; **nor walking on uneven ground, crouching or kneeling, crawling or climbing; nor driving or operating dangerous machinery, tools, or equipment; are as follows:**

1- Customer Service- Consumer Relations Clerk: DOT#: 241.367-014; SOC Code: 43-4051
Sedentary Work Lifting, Carrying, Pushing, Pulling 10 Lbs. occasionally; mostly sitting; may involve standing or walking for brief periods of time; Occasional Reaching, Handling, and Fingering. SVP = 5 (skill level requiring over 6 months up to 1 year to attain.)

2- Information Clerk: DOT#: 237.367-022; SOC Code: 43-4171
Sedentary Work Lifting, Carrying, Pushing, Pulling 10 Lbs. occasionally. Mostly sitting, may involve standing or walking for brief periods of time. Reaching and Handling occasionally.
SVP =4 (skill level requiring over 3 months up to 6 months to attain.)

3- Rental Clerk: DOT#: 295.357-018; SOC Code: 41-2021
Light Work Lifting, Carrying, Pushing, Pulling 20 Lbs. occasionally or negligible amount constantly. Can include walking and or standing frequently even though weight is negligible. Occasional Reaching, Handling, and Fingering.
SVP =2 (skill level requiring over 0-1 months to attain.)

4- Usher: DOT#: 344.677-014; SOC Code: 38-3031
Light Work requiring Lifting, Carrying, Pushing, Pulling 20 Lbs. occasionally, frequently up to 10 Lbs., or negligible amount constantly. Can include walking and or standing frequently even though weight is negligible. Occasional Reaching, Handling, and Fingering.
SVP =2 (skill level requiring 0-1 month to attain)

Additional Labor Market research conducted by this Counselor provided the following information relevant to the above noted residual occupations in the geographical area of his U&C Occupation (Pasadena-L.A. County) as well as the in the closest metropolitan area to his current residence in Lone Pine, CA (i.e. Bakersfield, CA-Kern County):

Empirical Evidence and Employment Data:
At the time of the injuries of 2012 Mr. Doran was working as a Commercial and Residential Plumber and earned approximately $25.00 per hour or $52,000.00 annually (40 hour work week). When utilizing the EDD-2012 Wage Data Tables, this would place Mr. Doran's earning level at between the 25th oercentile wage level of $19.64/hr and and the 50th percentile level of $26.81/hr. for an average wage estimate of $23.23 or $48,318.40 annually.

Mr. Doran was declared Neurologically Permanent and Stationary in 2016, and in the event Mr. Doran had continued to perfrom his usual and customary occupation as a Plumber (i.e. absent the work-related injuries) by all reasonable assessment his wages would have increased in accordance with his longevity/seniority and entitlement to annual increases.

I. Pasadena-Los Ángeles County:

Per **the Employment Development Department, Occupational Employment (May 2015) & Wage (2016-1st Quarter) data Occupational Employment Statistics (OES) Survey Results, released June 2016, for Los Angeles-Long Beach, Glendale Metropolitan Division (Los Angeles County Counties)**, the Chart below provides the 2016 EDD Wage Data relative to Mr. Doran's usual and customary occupation of Plumber at the 25th, 50th, and 75th percentile hourly wage levels and further provides the estimated hourly wage levels taking into account the possible exampled direct placement employment options in the open Labor Market.

SOC Code	Occupational Title	May 2015 Employ-ment Estimates	Mean Hourly Wage	Mean Annual Wage	Mean Relative Std Error (1)	25th Percentile Hourly Wage	50th Percentile Median Hourly Wage	75th Percentile Hourly Wage
Usual and Customary Occupation								
47-2152	Plumbers, Pipefitters, and Steamfitters	7,850	$26.96	$56,085	4.50	$17.75	$25.15	$33.44
Post-injury Employment Options								
43-4051	Customer Service Representatives	57,620	$18.91	$39,327	1.00	$13.97	$17.47	$22.52
43-4171	Receptionists and Information Clerks	26,370	$14.91	$31,007	1.50	$11.35	$13.96	$17.47
41-2021	Counter and Rental Clerks	24,340	$14.03	$29,184	2.20	$9.49	$11.67	$15.89
39-3031	Ushers, Lobby Attendants, and Ticket Takers	4,680	$11.23	$23,352	3.00	$9.46	$9.76	$12.47

(See attached EDD Occupational Employment & Wage Data Sheets)

Per the 11/17/2017 State of California Employment Development Department Labor Market Information Division, Los Angeles-Long Beach-Glendale Metropolitan Division (Los Angeles County), the unemployment rate in Los Angeles County decreased over the month to 4.7 percent in October 2017, from a revised 4.9 percent in September 2017, and was below the rate of 5.1 percent one year ago. Civilian employment increased by 18,000 to 931,000 in October 2017, while unemployment declined by 5,000 to 246,000 over the month. The civilian labor force increased by 12,000 over the month to 5,176,000 in October 2017. (All of the above figures are seasonally adjusted.) The unadjusted unemployment rate for the county was 4.4 percent in October 2017.

Between September 2017 and October 2017, total nonfarm employment increased by 35,100 jobs to reach 4,485,400 in Los Angeles County. Between October 2016 and October 2017, Los Angeles Country total nonfarm employment grew by 40,400 jobs, or 0.9 percent.
(Source: For more statistics, see attached EDD Labor Market Information for 11/17/2017 for Los Angeles County)

The Employment Development Department, Labor Market Information Division (Published November 2016) 2014-2022 Occupational Employment Projections: Los Angeles-Long Beach-Glendale Metropolitan Division (Los Angeles County) indicate projected increase employment change of 1.9% with a total of 271 jobs relative to Mr. Doran usual and customary occupation of Plumber; with post-injury employment options indicating an increase ranging from 0.5%-1.1%, with a total of jobs ranging from 310-1,883, as follows:

Employment Development Department Labor Market Information Division Published: November 2016	2014-2024 Occupational Employment Projections Los Angeles-Long Beach-Glendale Metropolitan Division (Los Angeles County)								
SOC Code*	Occupational Title	Estimated Employ-ment 2014**	Projected Employ-ment 2024	Numeric Change 2014-2024 [1]	Percent Change 2014-2024	Annual Average Percent Change	Average Annual Job Openings: New Jobs [2]	Replace-ment Needs [3]	Total Jobs [4]
Usual and Customary Occupation									
47-2152	Plumbers, Pipefitters, and Steamfitters	8,420	10,030	1,610	19.1%	1.9%	160	111	271
Post-Injury Employment Options									
43-4051	Customer Service Representatives	56,160	61,160	5,000	8.9%	0.9%	500	1,383	1,883
43-4171	Receptionists and Information Clerks	26,260	29,110	2,850	10.9%	1.1%	285	708	993
41-2021	Counter and Rental Clerks	23,710	26,190	2,480	10.5%	1.0%	248	587	835
39-3031	Ushers, Lobby Attendants, and Ticket Takers	4,570	4,790	220	4.8%	0.5%	22	288	310

(For more statistics see attached EDD, 2014-2024 Occupational Employment Projections for Los Angeles County)

II. Bakersfield-Kern County:

Per **the Employment Development Department, Occupational Employment (May 2015) & Wage (2016-1st Quarter) data Occupational Employment Statistics (OES) Survey Results, released June 2016, for Bakersfield Metropolitan Statistical Area (Kern County)**, the Chart below provides the 2016 EDD Wage Data relative to Mr. Doran's usual and customary occupation of Plumber at the 25th, 50th, and 75th percentile hourly wage levels and further provides the estimated hourly wage levels taking into account the possible exampled direct placement employment options in the open Labor Market.

SOC Code	Occupational Title	May 2015 Employ-ment Estimates	Mean Hourly Wage	Mean Annual Wage	Mean Relative Std Error (1)	25th Percentile Hourly Wage	50th Percentile Median Hourly Wage	75th Percentile Hourly Wage
Usual and Customary Occupation								
47-2152	Plumbers, Pipefitters, and Steamfitters	480	$23.74	$49,387	1.90	$19.54	**$23.29**	**$28.26**
Post-injury Employment Options								
43-4051	Customer Service Representatives	1,750	$16.95	$35,244	3.50	$12.64	$15.40	$19.09
43-4171	Receptionists and Information Clerks	1,790	$13.33	$27,723	2.10	$10.76	$12.60	$15.15
41-2021	Counter and Rental Clerks	1,260	$13.37	$27,819	3.60	$9.72	$11.49	$14.56
39-3031	Ushers, Lobby Attendants, and Ticket Takers	No Wage Data available for this SOC Code #						

(See attached EDD Occupational Employment & Wage Data Sheets)

Per the 11/17/2017 State of California Employment Development Department Labor Market Information Division, Bakersfield Metropolitan Statistical Area (Kern County), the unemployment rate in the Kern County was 7.5 percent in October 2017, down from a revised 8.1 percent in September 2017, and below the year-ago estimate of 9.1 percent. This compares with an unadjusted unemployment rate of 4.3 percent for California and 3.9 percent for the nation during the same period.
(Source: For more statistics, see attached EDD Labor Market Information for 11/17/2017 for Kern County)

The Employment Development Department, Labor Market Information Division (Published April 2017) 2014-2022 Occupational Employment Projections: Bakersfield Metropolitan Statistical Area (Kern County) indicate projected increase employment change of 2.6% with a total of 21 jobs relative to Mr. Doran usual and customary occupation of Plumber; with post-injury employment options indicating an increase ranging from 1.1%-2.7%, with a total of jobs ranging from 64-73, as follows:

Employment Development Department		2014-2024 Occupational Employment Projections							
Labor Market Information Division		Bakersfield Metropolitan Statistical Area							
Published: April 2017		(Kern County)							
SOC Code*	Occupational Title	Estimated Employ-ment 2014**	Projected Employ-ment 2024	Numeric Change 2014-2024 [1]	Percent Change 2014-2024	Annual Average Percent Change	Average Annual Job Openings: New Jobs [2]	Replace-ment Needs [3]	Total Jobs [4]
Usual and Customary Occupation									
47-2152	Plumbers, Pipefitters, and Steamfitters	530	670	140	26.4%	2.6%	14	7	21
Post-Injury Employment Options									
43-4051	Customer Service Representatives	1,810	2,100	290	16.0%	1.6%	29	44	73
43-4171	Receptionists and Information Clerks	1,840	2,050	210	11.4%	1.1%	21	50	71
41-2021	Counter and Rental Clerks	1,250	1,590	340	27.2%	2.7%	33	31	64
39-3031	Ushers, Lobby Attendants, and Ticket Takers	No Wage Data available for this SOC #							

(For more statistics see attached EDD, 2014-2024 Occupational Employment Projections for Los Angeles County)

VOCATIONAL OPINION/CONCLUSION:

Based on the reports of his doctors, Mr. Doran retains an ability to return to work in the open labor market in the above exampled selective Sedentary and Light Occupations when solely considering his industrially related orthopedic, neurological, and psychiatric medical work restrictions and while excluding his non-industrial medical conditions such as his diagnosed Parkinson's Disease, and Diabetes II. Absent the medically indicated non-industrial medical conditions as documented in the medical file, Mr. Doran retains an ability to compete, or be retrained for suitable gainful employment.

I reserve the right to modify, amend and or change our opinions in this report based upon review of additional information relative to Mr. Doran's medical status.

Declaration: In view of the passage of SB 863, I hereby declare under penalty of perjury under the laws of the State of California, that in the preparation of the foregoing Vocational Evaluation Report, and the attachments thereto, if any, that I personally read and reviewed the records in their entirety. As to the matters stated therein, the reports are true of my own personal knowledge and belief, except as to the information that I 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 therein, that I believe to be true and correct.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on the date of this report.

I hope this information is helpful. Should you have any questions, please do not hesitate to contact the undersigned.

Sincerely,
CANIZALEZ ASSOCIATES, INC.

Alex Cald.

Alejandro A. Calderón, MA, CRC, CCM, CAE, ABVE/IPEC
Diplomate, American Board of Vocational Experts

Enclosures:
Curriculum Vitae

REPORT ADDENDUM:

SUMMARY OF MEDICAL INFORMATION REVIEWED:

❖ **Per Gary L. Baker, M.D. Pain Medicine Re-Evaluation Report – Dated 08/14/2017**

DISCUSSION:
The patient is awaiting IMR response replacement SCS IPG/Battery.
Medtronic cervical SCS was implanted approximately 2014 by Dr. Cohen. Replacement of the new SCS IPG/Battery for reasons above will help to allow change to MMI status.

WORK STATUS:
Currently not working.
Based on the patient's current condition, the patient is considered total temporarily disabled and has been instructed to remain off work for 1 month.

DIAGNOSES (LCD-10):
Ongoing Type 2 Complex Regional Pain Syndrome, right upper extremity (G56.40); Peripheral Neuropathy (G60.9); status post spinal cord stimulator (SCS) implant (OOHUOMZ); Diabetes Mellitus, type 2 with hyperglycemia -stable (E11.65); hx. right thumb non-displaced fracture; malposition SCS IPG/Battery.

TREATMENT PLAN:
Treatment recommendations at this time are as follows:
Request Items/Request Providers:
Colorectal surgeon for evaluation and treatment of anal fistula as per AME.
Neurologist for evaluation of erectile dysfunction as per AME.

❖ **Per Mark R. Pulera, M.D., Q.M.E.**
Neurological Agreed Medical Evaluation Report – Dated 12/15/2016

DIAGNOSES:
1. Traumatic injury to the distal right upper extremity on 07/11/2012, industrial.
2. Chronic Regional Pain Syndrome Type1/Reflex Sympathetic Dystrophy of the right upper extremity, industrial.
3. Potential movement disorder caused by the spinal cord stimulator implantation, industrial.
4. Underlying mild Parkinson's disease, nonindustrial.
5. Multifactorial sleep disorder, with industrial component.
6. No neurologic injury or impairment or disability for impaired memory.
7. Mild closed head injury on 07/11/2012 without permanent neurologic impairment for headache or impaired memory.
8. No definite right or left "evidence of carpal tunnel syndrome" due to the injury on 07/11/2012.

CAUSATION:
The mechanism of injury in this case is a traumatic injury including essentially laceration and fracture of the right thumb on 07/11/2012. For the reasons discussed in this report this injury

resulted in Chronic Regional Pain Syndrome Type 1 /Reflex Sympathetic Dystrophy of the right upper extremity on an industrial basis.

Next, there is the multifactorial movement disorder. First, there is likely a component of movement disorder due to the spinal cord stimulator implantation based on available data, which I would consider to be industrial.

Then, there would be a movement disorder due to underlying mild Parkinson's disease which I would consider to be completely nonindustrial. Parkinson's disease has known genetic causes but is generally not caused by this type of trauma to an extremity. There is no industrial cause of the Parkinson's disease in this case.

In addition, there is a multifactorial sleep disorder with components such as pain including Reflex Sympathetic Dystrophy, which I opine to be industrial. Psychiatric QME, Dr. Slonim has indicated there are industrial psychiatric diagnoses, which are industrial. Therefore, there is at least an industrial component of the sleep disorder due to pain and psychiatric conditions. It remains to be determined if there is any underlying obstructive sleep apnea that could be aggravated by industrial medication use such as gabapentin or Elavil and/or potential industrial weight gain.

On 07/11/2012, there was a mild closed head injury, but this did not result in any temporary disability, permanent disability, or permanent neurologic impairment for symptoms including headache or depression.
In fact, there is no neurologic cause of complaints of persistent headaches except for potential use of spinal cord stimulator and memory loss in this case.

The injury on 07/11/2012 did not cause or aggravate right and left carpal tunnel syndrome.

IMPAIRMENT:
Neurological impairment is carried out according to Chapter 13, section 13.2 on page 308. I will summarize the involved neurological body parts.

First sleep is contemplated according to Table 13-4 on page 317. It should be noted that psychiatric QME, Dr. Daphne Slonim, opined that the normal Epworth Sleep Scale score in this case did not truly represent Mr. Doran's sleep related condition. I opine that the level of severity of pain in this case as well as the stimulator issues and emotional stress likely caused significant sleep disorder in this case. It is difficult to assess any daytime drowsiness due to the ongoing buzzing sensations from the stimulator, but I would opine within reasonable medical probability that there is some daytime drowsiness even with normal Epworth Sleep Scale scores as discussed by Dr. Slonim.

Page 317 somewhat vaguely refers to obtaining formal sleep studies such as a polysomnogram and/or multiple sleep latency tests. I admit that these recommendations are somewhat vague, but certainly this testing could be obtained by the parties if desired. In this case, the testing may be particularly relevant to rule out any underlying obstructive sleep apnea. If obstructive sleep apnea is present, a potential cause of the industrial weight gain, determining the cause of weight gain would be outside of my area of expertise as a neurologist. A medical consultation and weight gain could be obtained if desired by the parties. As noted previously, industrial medications utilized in this case such as gabapentin, Elavil, and/or narcotics could cause or aggravate obstructive sleep apnea.

I will make a sleep determination at this point without the formal sleep studies. If the parties desire to obtain the formal sleep studies, I can review the claimant's sleep condition upon request.

However, I am aware according to the Pena vs. Alvarado Hospital ease that a separate impairment for sleep according to Table 13-4 on page 317 may not be warranted for pain due to a body part if impairment for the body part has been awarded elsewhere in the Guides. This would be an issue for the trier of fact.
At this point, I will put the claimant in class 1 for sleep impairment according to Table 13-4 (1-9%) at 5%

There is 5% impairment for sleep with the caveats discussed.

The impaired memory is considered as indicated by psychiatric QME, Dr. Slonim, the psychiatric condition is associated with impaired concentration. It was noted that Mr. Doran after the injury apparently minimally reported any complaints of impaired memory to his treating evaluators after the injury. Mr. Doran did not appear to have dementia or encephalopathy on my examination. His Mini-Mental Status Examination score was essentially was within normal limits.

According to Table 13-5 of page 320, I would assign a Clinical Dementia Rating of 0 for categories of Memory, Orientation, Judgment and Problem Solving, Community Affairs, Home and Hobby, and Personal Care.

According to Table 13-6, on page 320, a clinical dementia rating of 0 equals 0% impairment for mental status.

There is 0% neurologic impairment for mental status.

I will discuss neurologic impairment for the right upper extremity Chronic Regional Pain Syndrome/Reflex Sympathetic Dystrophy.

It is noted that orthopedic. QME, Dr. Soheil Aval, on 06/30/2015 described full finger extension with relaxation and effort. As a result, Dr. Soheil only estimated a 50% loss of right hand function. Dr. Aval utilized Table 13-22 to award class 3% impairment of the dominant hand at 25%.

I again noted discrepancies in my examination where Mr. Doran verbally told me he could not write, but apparently did write in preparing paperwork for my examination and for the examination of Dr. Aval. To further complicate issues as described by Psychiatric QME, Dr. Slonim, Mr. Doran has psychiatric factors affecting his physical condition, the multiplicity of diagnoses affecting the function of the right upper extremity make impairment determination extremely difficult in this case.

I previously calculated 91% impairment of the right upper extremity due to impaired range of motion. Because of the above described discrepancies in right upper extremity strength, impaired range of motion, and function as described by Dr. Aval perhaps it would be reasonable to reduce the impaired range of motion to 50% for the upper extremity impairment on the right.

Page 496 describes the impairment determination method for complex regional pain syndrome type 1/Reflex Sympathetic Dystrophy, which is Mr. Doran's diagnosis in this case. There is no specific involved nerve structure as the entire distal right upper extremity is involved.

As noted, first the range of motion impairment is calculated. As noted I will utilize a 50% upper extremity impairment of range of motion as an adjusted value.

The AMA Guides on page 496 indicate that the sensory deficit and pain should be rated according to Table 16-10 and page 482. I would describe the right upper extremity in this case. the pain in the right upper extremity is severe and constant with substantial reduction of activities of daily living. However, there is evidence of the symptoms being out of proportion to objective findings of Dr. Solicit and other evaluators as well as the presence of psychiatric disorder affecting physical condition as per Dr. Slonim.

Dr. Soheil Aval, Jonathan Kohan. and I noted the impaired sensation of the right hand. On my examination, there was impaired light touch, pinprick, and proprioception of the right hand preventing some activities of daily living as Mr. Doran appears to at least intermittently be able to write, I would put the claimant in Category II (61%-80%) according to Table 16- 10A on page 482 at 75%.

There is 75% upper extremity impairment for sensation as per grade 2 according to Table 16-10A.

The 75% upper extremity impairment calculated according to table 16-10A is combined using the Combined Values Chart on page 604 with 50% impairment of the upper extremity for range of motion, equals to 88% upper extremity impairment.

According to Table 16-3 on page 439, 88% upper extremity impairment corresponds to 53% whole-person impairment.

There is 53% whole person impairment for the right upper extremity complex regional pain syndrome type 1/Reflex Sympathetic Dystrophy.

The reasons discussed in this report, there is no definite neurologic impairment for right or left carpal tunnel syndrome.

The involuntary movements will he discussed.

First there are the involuntary movements due to the spinal cord stimulator. The site of involvement would be the spinal cord causing involuntary movements in the bilateral arms and legs and gait disorder. The analysis of the involuntary movements in this case is extremely complex.

Regarding the bilateral lower extremities and gait, Table 13-15 on page 336 is utilized, 1 would place the claimant in class 1 (1-9%) at 5%.

There is 5% neurologic impairment for gait in the lower extremities due to the spinal cord stimulator.

There is tremor in the bilateral upper extremities due to the spinal cord stimulator, which I would evaluate according to Table 13-17 on page 340, I would put Mr. Doran in class 1(1-19%) at 5%.

I would include at this time any impairment due to headaches from the spinal cord stimulator with the upper extremity impairment rating.

There is 5% neurologic impairment for the bilateral upper extremities due to the spinal cord stimulator.

5% neurologic impairment for the upper extremities is combined with 5% impairment of bilateral lower extremities to yield 10% total impairment for the spinal cord stimulator.

There is 10% total impairment of the extremities due to the spinal cord stimulator.

Next, the involuntary movements due to the underlying Parkinson's disease would be considered. In the head and cranial nerves, there are subtle mild masked facies, impaired eye blink, and hypophonia. There is also tremor in the bilateral upper extremities and gait disorder affecting the lower extremities.

For the mild impaired eye blink and masked facies, Table 13-12 on page 312 was utilized, I would place the claimant in class 1 (1-4%) at 1%.

There is 1% impairment due to impaired eye blinking and masked facies secondary to Parkinson's disease.

Mild hypophonia due to Parkinson's disease is contemplated according to Table 13-14 on page 334. I will put the claimant in class 1(1-14%) at 2%.

There is 2% impairment for hypophonia due to Parkinson's disease.

Impairment of the bilateral lower extremities and gait due to Parkinson's disease is contemplated according to Table 13-15 on page 336. I will place the claimant in class 1 (1-9%) at 5%.

There is 5% neurologic impairment of the bilateral lower extremities due to Parkinson's disease.

There is a bilateral upper extremity tremor due to Parkinson's disease, which is contemplated according to Table 13-17 on page 340. I will put the claimant in class 1 (1-4%) at 1%.
There is 1% neurologic impairment of the bilateral upper extremity due to Parkinson's disease.

5% impairment of the lower extremities is combined with 2% impairment for hypophonia to yield 7% impairment. 7% impairment is combined with 1% impairment for the decreased eye blink/masked facies to yield 8%. 8% is combined with the upper extremity impairment to yield 9%.

There is 9% total neurologic impairment due to Parkinson's disease.

Next, headaches are considered the reasons discussed in this report. The closed head injury in this ease was not severe enough to cause permanent neurologic impairment or disability for headaches. The multiple primary treating doctors did not document complaints of headaches. Psychiatric QME, Dr. Daphne Slonim noted that there are psychological factors affecting the physical condition which could be a psychiatric cause of headaches.

Based on the above findings, within reasonable medical probability, there is no neurologic cause or resulting impairment for the claimant's current complaints of headaches.

There is 0% impairment for headaches including for the pain add-on according to chapter 18.

53% impairment for the right upper extremity CRPS/RSD is combined using the Combined Values Chart of page 604 with 10% impairment for movement disorder due to the spinal cord stimulator to yield 58% impairment. The 58% impairment is combined with 5% impairment for sleep to yield 60% impairment.

There is 60% total neurological impairment on an industrial basis. There is 9% nonindustrial impairment due to mild underlying Parkinson's disease.

DISABILITY:
Regarding the right upper extremity, **orthopedic QME Dr. Soheil Aval provided recommendations of no forceful gripping, fine manipulation, torquing, or heavy activity. He awarded no restrictions or limitations for left upper extremity.**

Primary treating physician Dr. Jonathan Kohan on 08/05/2015 recommended no use of the right upper extremity.

Psychiatric QME, Dr. Daphne Slonim noted that subjective factors of psychiatric disability included pain, headache, weakness, and nightmares. Objective factors of psychiatric disability included impaired sleep, impaired concentration, and impaired memory. Dr. Slonim provided psychiatric work restrictions and limitations of avoiding emotional stress. This finding would be supported neurologically in that emotional stress can aggravate symptoms of any neurological condition such as tremor. Emotional stress only temporarily worsens the neurological symptoms during the period of emotional stress, but does not permanently worsen the neurological disorder itself.

Regarding my restrictions and limitations for the CRPS/RSD of the right upper extremity, Mr. Doran would be considered temporarily totally disabled neurologically from the date of injury of 07/11/2012 to the date of my examination of 11/17/2016. On 11/17/2016, Mr. Doran is neurologically permanent and stationary; I do recognize the substantial discrepancies in right upper extremity motor strength, function, and range of motion. Dr. Soheil did note that with coaxing and relaxation he can eventually get full finger extension.

This would take some period of time and the extension would not occur instantaneously. How this finding translates into the ability to use the right upper extremity for work-related activities is not clear. For example, every time Mr. Doran needs to use the right hand, he cannot be coaxed and relax the hand for a period of time in order to use it. Even given this

finding, I cannot see Mr. Doran could use tools in the right hand, particularly power tools, in the capacity as a plumber. **I would favor the following permanent partial disability of the right upper extremity;**

Only occasional simple grasping and coarse manipulation should be allowed, but no forceful gripping, fine manipulation, torquing, or heavy activity with the right upper extremity.

There are the involuntary movements apparently due to the spinal cord stimulator which would be permanent and stationary again on 11/17/2016. **In the absence of further manipulation of spinal cord stimulator, the intermittent persistent involuntary movements involving the whole body would result in the following permanent partial disability;**

No walking on uneven ground, crouching or kneeling, crawling or climbing.

Regarding sleep disorder, beginning the day of injury 07/11/2012 there would be temporary partial disability with the following restrictions and limitations:

No driving or operating dangerous machinery, tools, or equipment while drowsy.

As of 11/17/2016, the sleep disorder would be permanent, and stationary given the caveat that the parties may desire additional sleep related medical work-up. The above restrictions and limitations for sleep would now be the same as permanent partial disability.

If the above neurological restrictions and limitations cannot be honored, then the claimant would be a qualified injured worker who could not return to his usual and customary occupation as a plumber.

APPORTIONMENT:
Orthopedic QME, Dr. Soheil Aval **awarded 100% industrial apportionment for the right upper extremity**.

I will discuss apportionment for the right upper extremity complex regional pain syndrome type 1/Reflex Sympathetic Dystrophy. The cause would be trauma to the right upper extremity.

There is 0% preinjury nonindustrial apportionment and 0% postinjury nonindustrial apportionment.

There is a total of 0% nonindustrial apportionment for the CRPS/RSD impairment/disability.

There is 100% industrial apportionment for the right upper extremity CRPS/RSD impairment/disability due to the industrial injury of 07/11/2012.

There was the mild closed head injury on 07/11/2012 which did not result in any temporary disability, permanent disability, or permanent neurologic impairment. **Just to be clear, this closed head injury would add 100% industrial apportionment during the work exposure on 07/11/2012 and 0% nonindustrial apportionment.**

I will discuss apportionment of the involuntary movements and aberrant sensations secondary to spinal cord stimulator. The only cause is the spinal cord stimulator.

Therefore, there is 0% preinjury and 0% postinjury nonindustrial apportionment for these in voluntary movement apportionment.

There is 0% nonindustrial apportionment for the impairment of disability related to the involuntary movements caused by the spinal cord stimulator.

There is 100% industrial apportionment for the impairment/disability due to the abnormal movements and aberrant sensations caused by the spinal cord stimulator.

Then there is a movement disorder secondary to the underlying Parkinson's disease.
There would be 100% nonindustrial preexisting factors of apportionment and 0% postinjury factors of apportionment.

There is 100% nonindustrial apportionment for the impairment/disability related to Parkinson's disease.

There is 0% industrial apportionment for the impairment/disability due to Parkinson's disease related to the work exposure on 07/11/2012.

Regarding apportionment for the sleep disorder, preexisting, nonindustrial factors of apportionment include nonindustrial pain, unknown factors, and genetic causes of obstructive sleep apnea. I would award 25% preexisting nonindustrial apportionment for the sleep related impairment/disability.

There is 0% postinjury nonindustrial apportionment for the sleep impairment/disability.

There is 25% total nonindustrial apportionment for the sleep related impairment/disability.

Industrial factors of apportionment for the sleep impairment related disability.

There is pain due to the Reflex Sympathetic Dystrophy in this case which is accentuated by the fact that Mr. Doran has to turn off the spinal cord stimulator in order to sleep. There are psychiatric factors identified by Dr. Slonim that aggravate sleep that may or may not be underlying obstructive sleep apnea which could be potentially aggravated by industrial weight gain and/or medications which could be commented upon further.

I would award 35% industrial apportionment for the pain associated with the CRPS/RSD of the right upper extremity in case Pena vs. Alvarado Hospital is relevant, and 40% to apportionment to other industrial factors.

Based on the above findings, I would award 75% industrial apportionment for the sleep related impairment/disability.

PAST MEDICAL CARE:

I will defer orthopedic treatment including the diagnosis and management of the reported right thumb first metacarpal fracture to an orthopedist.

I would point out that medications were used for pain including neuropathic pain in this case such as Neurontin or gabapentin. Gabapentin is appropriately used for neuropathic pain and sometimes emotional disorders. Elavil was appropriately used in this case for pain, sleep, and psychiatric complaints. Additional medications such as Norco, pain creams, and NSAIDs were used. These medications were reasonable, necessary, and appropriate for treating right Lipper extremity CRPS/RSD.

On 08/19/2013, Dr. Edwin Haronian performed a stellate ganglion block.

On 08/22/2013, Dr. Jonathan Kohan noted that the stellate ganglion block was indicated due to failed multiple modes of conservative treatment for Chronic Regional Pain Syndrome.

California Medical Treatment Utilization Schedule (CA-MTUS) recommends that stellate ganglion blocks can be utilized for Chronic Regional Pain Syndrome. Therefore, the stellate ganglion blocks in this case would be reasonable, necessary, and appropriate.

Dr. Jonathan Kohan obtained psychiatric clearance and implanted a spinal cord stimulator for persistent pain due to CRPS/RSD.

CA-MTUS Guidelines indicate that spinal cord stimulators can be utilized for CRPS/RSD. Therefore, spinal cord stimulator would be considered reasonable, necessary, and appropriate.

The CA-MTUS Guidelines for the treatment of CRPS/RSD indicate treatment should include rehabilitation, psychiatric treatment, and pain management. Treatment for bone resorption with medications such as bisphosphonates can be considered. There is limited evidence that oral steroids and NSAIDs can help CRPS. The CA-MTUS indicate that treatment such as Elavil and anticonvulsants such as gabapentin as well as opiates, clonidine, tricyclic antidepressants, and GABAergic agents, and sympathetic blockers such as prazosin can be utilized to treat CRPS/RSD.

CA-MTUS Guidelines indicate that spinal cord stimulators can be utilized to treat CRPS/RSD, but somewhat controversially. Spinal cord stimulator should only be used after counseling and a multidisciplinary medical team approach which was done here. Physical therapy treatment should accompany the spinal cord stimulator implantation.

CA-MTUS Guidelines indicate that stellate ganglion blocks or lumbar sympathetic blockade can be used to treat CRPS/RSD. However, repeated blocks should only be allowed with observed continued improvement with the blocks. Clonidine epidurals or intrathecal baclofen could be considered after appropriate psychological counseling. Regional sympathetic blocks with guanethidine and lidocaine with physical therapy could be considered.

FUTURE MEDICAL CARE:

I would defer issues of orthopedic future medical care to the orthopedic QME, Dr. Soheil Aval. Psychiatric QME, Dr. Slonim recommended ongoing treatment including psychiatrist for management of psychotropic medication once a month for a minimum of two years and possibly more psychiatric treatment, Certainly, this psychiatric treatment could address the

psychological factors affecting pain and sleep. Ultimately such treatment could potentially alter my opinions, but it is not clear to what extent any of this psychiatric treatment is planned.

Regarding the right upper extremity CRPS/RSD, lifelong treatment is indicated as per the CA-MTUS Guidelines described in the **'PAST MEDICAL CARE"** section of this report. Lifelong access to a neurologist should be provided depending on future symptomatology, which was somewhat unpredictable as well as the specific wishes of the claimant. Visits to a neurologist may occur up to monthly, once a month or so.

Regarding involuntary movements due to the spinal cord stimulator, I would strongly recommend follow-up with a physician experienced in the management of spinal cord stimulators. Any complications should be ruled out definitively. Certainly, if the spinal cord stimulator physician recommends replacing or revising any component of the spinal cord stimulator and/or battery, this should be allowed.

For the mild closed head injury on 07/11/2012, for the reasons discussed in this report, I doubt there is any significant traumatic brain injury. However, for completeness sake, a brain MRI scan without contrast should be performed to rule out traumatic brain injury. I would anticipate the brain MRI scan would be negative. Once the brain MRI scan would be negative, this would confirm that there would be no future medical care indicated for the closed head injury including for complaints of headache or impaired memory.

Regarding sleep, lifelong access to physician knowledgeable on sleep disorders should be allowed. Again, if the parties desire a polysomnogram and multiple sleep latency test, it should be performed. These tests could help rule out obstructive sleep apnea, which could be potentially treated with CPAP. CPAP and related durable medical equipment should be provided for if indicated as diagnosed by the sleep specialist physician.

I would point out that page 317 of the AMA Guides vaguely recommends the polysomnogram and multiple sleep latency tests to document sleep related problems. In this case, in particular this testing could rule out obstructive sleep apnea. The obstructive sleep apnea could be aggravated by weight gain. A medical consultation with expertise in weight gain could be obtained if it is desired to pursue this issue further. Perhaps such weight gain specialist would only be necessary if a diagnosis of obstructive sleep apnea was made. It should also be noted that current medications such as gabapentin and Elavil as well as other medications could aggravate underlying obstructive sleep apnea.

For the mild underlying Parkinson's disease, this should be addressed by neurologist on a nonindustrial basis.

Finally, I would point out the substantial multiple discrepancies in this case such as the levels of severity of impaired range of motion, strength, and function of the distal right upper extremity. In addition, the multiplicity of diagnoses such as complex regional pain syndrome and psychological factors affecting the physical condition make analysis in this case extremely difficult. Based on this finding, if desired by the parties, I would be willing to reevaluate Mr. Doran to see if I could clarify further any of these discrepancies. If it is desired that I reevaluate the claimant in the future, I would strongly recommend the following take place prior to any reevaluation;

1. The claimant should reach permanent and stationary status with full treatment of the psychiatric conditions such as psychiatric disorders affecting pain, sleep and possible

somatization. Ideally the entire psychiatric condition should be permanent and stationary prior to any neurological reevaluation.

2. Aggressive analysis and repair of any spinal cord stimulator related issues. Then I would recommend spinal cord stimulator be turned off for three months or so if possible in order to assess any remaining aberrant sensory complaints and/or involuntary movements.
3. Prior to any neurological reevaluation, I would recommend repeating the bilateral upper extremity electromyogram and nerve conduction studies by a competent electromyographer.
4. If possible, prior to any reevaluation, eliminate medications such as gabapentin, which could be contributing to the movement disorder for three months or so.
5. In the absence of reevaluation, my current analysis and recommendations remain as described in this report.

- **Per James F. Lineback, M.D., F.C.C.P.**
  Internal Medicine Agreed Medical Evaluation Report – 12/15/2016

DIAGNOSIS:

1. Sleep disorder (insomnia)
2. Chronic constipation
3. Adult onset diabetes mellitus.
4. Hypertension.
5. Resting tremor.
6. Shortness of breath.
7. Anal fistula.
8. Right hand pain.
9. Reflex Sympathetic dystrophy.
10. Status post spinal cord stimulator implantation.
11. Status post-crush injury, right hand.
12. Complex regional pain syndrome
13. Positive family history of hypertension.
14. Erectile dysfunction.

STATUS:

Permanent and Stationary

DISCUSSION:

In summary, **this middle-aged male has carried a diagnosis of diabetes since mid-2005**. His blood sugar is currently reasonably well controlled on two diabetes medications. He sustained a crush injury to his right hand in 2012 that eventually required treatment with narcotic analgesics. The patient developed chronic constipation and subsequently an anal fistula. His blood pressure was noted to be elevated in 2015, at which time a diagnosis of hypertension was made. At this time, his blood pressure reasonably well controlled on a single antihypertensive agent. The patient subsequently developed sleep disorder (insomnia) as a result of his orthopedic pain. His sleep is partially improved after treatment with Elavil. The patient continues to experience erectile dysfunction, right upper extremity pain, and has also developed a left upper extremity resting tremor.

As stated previously, this patient's diabetes was diagnosed prior to the time of his employment with Benedict Plumbing Company. Therefore, his diabetes represents a pre-

existing condition and should be treated on a nonindustrial basis. There is no medical evidence at this time that his diabetes has been aggravated or accelerated as a result of this injury.

The patient's erectile dysfunction has apparently been a problem since 2015. It is unclear as to the precise etiology of his erectile dysfunction at this time. I would highly recommend the patient be referred to an urologist for further comment regarding the etiology of his erectile dysfunction.

There is no evidence in these medical records that the patient had any prior history of a sleep disorder before his 2012 industrial injury. At this time, he sleeps approimate1y four hours per night and experiences over one-hour latency to fall asleep. He states the following day, he is tired, though does not sleep during the day.

Certainly, chronic pain can be a major source of insomnia. Based on this fact pattern, it is medically probable that this patient's right upper extremity symptoms resulting from his crush injury to his right hand in 2012 is the proximate cause of his sleep disorder. Therefore, his insomnia should be considered job related and should be treated on an industrial basis.

There is no evidence this patient had any prior' history of hypertension before his 2012 industrial injury. In 2015, his blood pressure was noted to be elevated and since that time, he has required treatment with a single antihypertensive medication.

Hypertension is a rather common cardiovascular disorder that involves an elevation of blood pressure that predisposes these patients to premature atherosclerosis. The pathophysiology of hypertension involves a hyperactive sympathetic nervous system that stimulates the heart to beat faster and more forcefully. In addition, stress hormones, such as epinephrine and norepinephrine cause not only vasoconstriction, but also increase in circulating blood volume, both of which serve to increase blood pressure.

Several articles in the medical literature have demonstrated that chronic pain (a source of physiologic stress) may cause and/or aggravate hypertension Since there is no evidence of any pre-existing hypertension before this patient's 2012 industrial injury, it is <u>reasonably medical probable</u> that his hypertension is a direct result of the chronic pain resulting from his industrial injury to his right hand. Therefore, his hypertension should be considered job related and should be treated on an industrial basis.

The patient has experienced symptoms of 5hortness of breath over the last several years. It should be noted that the medical records show that he smoked between one-half and one pack of cigarettes per day for approximately years Therefore, it is medically probable that his shortness of breath is more likely related to chronic obstructive, lung disease secondary to his cigarette smoking. There is no evidence in these medical records that exposure to any type of dusts, fumes or chemicals in an industrial setting caused or aggravated his pulmonary disease. Therefore, his respiratory symptoms should be considered nonindustrial and should be treated on a nonindustrial basis.

As stated previously, this patient's chronic pain required treatment with a narcotic analgesic, Norco. One of the primary ingredients of Norco is hydrocodone, which is a form of codeine and a known narcotic analgesic. Unfortunately, one of the major side-effects of narcotic analgesics is constipation. Unfortunately, chronic constipation may cause an anal fistula which is basically a connection between the rectum and the perirectal skin. Since chronic constipation

is a major cause of anal fistula, it is medically probable that this patient developed his anal fistula as a result of the chronic constipation that in turn resulted from the chronic use of narcotic analgesics necessitated for his crush injury to his right hand. Therefore, his constipation and his anal fistula should be considered job related and should be treated on an industrial basis.

RESTRICTIONS:

This patient fits the criteria for Class 1 (3%) impairment of the whole person as per the AMA Guidelines pertaining to sleep disorders. He also fits the criteria for Class 1 (5%) impairment of the whole person as per the AMA Guidelines pertaining to hypertension. He now fits the criteria for Class 1 (7%) impairment of the. whole person as per the AMA Guidelines pertaining to his anal fistula and constipation.

APPORTIONMENT:

One hundred percent of this patient's disability with respect to his sleep disorder should be apportioned to industrial factors. There is no evidence of any nonindustrial factors playing a role in his insomnia.

As stated previously, both of this patient's parents have a history of hypertension. Therefore, 25% of his disability with respect to his hypertension should be apportioned to his nonindustrial family history. The remaining 75% of his disability with respect to his hypertension should be apportioned to industrial factors.

FUTURE MEDICAL CARE:

As stated previously, **this patient's diabetes represents a pre-existing condition and should be treated on a nonindustrial basis.** I would also recommend the patient be referred to an urologist for further workup of his erectile dysfunction. In addition, I am recommending the patient be referred to a neurologist for evaluation of his left upper extremity resting tremor to rule out Parkinson's disease. Since it is unclear as to the etiology of that symptom, that evaluation should be provided on an industrial basis.

The patient's sleep disorder will require treatment, preferably by either a sleep specialist or a general internist. That treatment should be provided on aft industrial basis. Similarly, the patient should be provided with access to treatment by a general internist for treatment of his industrially related hypertension. Any and all medications for his hypertension, as well as any further diagnostic testing should be provided on an industrial basis.

As stated previously, the patient's shortness of breath is most likely related to his nonindustrial smoking habit. Therefore, any further diagnostic testing or treatment for his respiratory complaints should proceed on a nonindustrial basis.

This patient should be provided with access to treatment by a general internist for treatment of his constipation and should also be evaluated by a colon-rectal surgeon for his anal fistula. Since it is medically probable that his constipation and his anal fistula is related to his industrial injury, treatment for both of those problems should proceed on an industrial basis. If, indeed, the patient's anal fistula requires surgical treatment, that treatment should be provided on an industrial basis. I am recommending the patient's constipation be treated with metoclopramide, as well as a stool softener, such as Metamucil.

WORK ACCOMMODATIONS/VOUCHER:
This issue would obviously be best addressed by an orthopedist since the patient's right hand remains his primary complaint.

- **Per Daphna Slonim, M.D.**
  Psychiatric QME Report– Dated 07/18/2016

DIAGNOSIS:
Use of the DSM-IV-TR multiaxial classification ensures that attention is given to certain types of disorders, aspects of the environment, and areas of functioning that might be overlooked if the focus were on assessing a single presenting problem.

There are five axes in the DSM-IV-TR multiaxial classification. The first three axes constitute the official diagnostic assessment.

	Axis I	Clinical Syndromes:
1.	296.23	Major Depression, Single Episode, Severe.
2.	300.00	Anxiety Disorder NOS.
3	316.00	Psychological Factors Affecting Medical Condition.
4.	780.52	Insomnia Due to Orthopedic Pain.
5.	307.42	Insomnia Due to Axis I Diagnoses.
6.	Rule out:	Pain Disorder with Both Psychological Factors and a Medical Condition.
	Axis II	Personality Disorders and Specific Developmental Disorders:
		Immature, Histrionic, and Avoidant Personality Traits.
	Axis III	Physical Disorders and Conditions:

(Obtained from medical records and/or patient information).
1. RSD, right wrist and hand.
2. Musculoskeletal complaints
3. Cardiovascular complaints
4. Gastrointestinal complaints
5. Headaches
6. High blood pressure, by history, controlled with medications
7. Diabetes, Type II - controlled with medications
8. Neurological problems

Axis IV:	Psychosocial and Environmental Problems
	Occupational Problems.
	Problems with Primary Support Group
	Economic Problems
Axis V:	Global Assessment of Functioning (GAF)
	Current GAF: 55. This is equivalent to 23% WPI.

SUMMARY AND DISCUSSION:
Mr. Doran is a 50-year-old Caucasian male who was employed as a plumber by Benedict & Benedict Plumbing Company from 2009 until 7/11/12, when he was injured on the job. While he was cutting through a wall, a chunk of the wall fell on Mr. Doran's right hand. He sustained an open wound to his right thumb. He cleaned the wound and put tape on it. He was in a lot of pain.

A couple of days later, Mr. Doran reported he was examined at the ER at Memorial Hospital in Pasadena, and he was told he had a fracture in the right thumb. Records from Huntington Hospital from 7/13/12 showed X-rays with some gauging near the first MCP joint distally, like a small torus or gauge in the bones. This is a result of the axial load blow to the tip of the finger.
Mr. Doran was seen by George Tang, MD, PTP orthopedic surgeon, on 7/17/12, who wrote that X-rays showed a non-displaced fracture with first metacarpal fracture. He put the thumb in a cast. Mr. Doran continued treatment with Dr. Tang, who prescribed Naprosyn and Prilosec and kept extending his medical leave.

Later on, the doctor also prescribed Medrox. On 11/8/12, Dr. Tang noted the possibility Reflex Sympathetic Dystrophy (RSD) and referred Mr. Doran to a neurologist, as well as to physical therapy. He also referred him for EMG/NCS. Neurological evaluation was done by Moshen Ali, MD, on 1/2/13, who scheduled Mr. Doran for EMG.

On 1/31/13, Dr. Tang added Gabapentin for pain. This was the last appointment with Mr. Doran, as his attorney assigned Edwin Haronian, MD, as PTP orthro. In his report dated 2/18/13, Dr. Haronian requested authorization for acupuncture, MRI of the right wrist and hand, and a referral for Dr. Kohan at the same office for consultation to rule out RSD and for EMG. He also referred Mr. Doran for psychological evaluation and requested four sessions of psychotherapy.

Dr. Haronian provided thumb spika and prescribed Medrox patch. He found that Mr. Doran could work modified duties, but kept him as temporarily totally disabled if modified work was not available. He determined 9% WPI for the right upper extremity.

On 3/18/13, Dr. Haronian prescribed therapeutic cream, Neurontin, 300mg, Elavil, 25mg, and Vitamin C, 500mg.

On 4/1/13, Neurontin was stopped because it gave no benefits but made Mr. Doran "spacey." Mr. Doran did not like the Elavil, so was switched to Lexapro, and the doctor requested authorization for triple phase bone scan.

In his initial report dated 4/11/13, Dr. Kohan, a pain specialist, noted that EMG by Dr. Levin done on 1/15/13 showed mild right carpal tunnel on the right. The doctor diagnosed possible mild CRPS and recommended to restart Neurontin and Elavil. He wanted to review results of the triple phase bone scan before deciding a trial of stellate ganglion block.

On 04/29/13, Dr. Haronian reviewed MR1 of the right wrist and noted it to be normal. On 5/31/13, Dr. Haronian noted that the depression and sleep improved on Elavil, 50mg, and Mr. Doran has less numbing and burning pain on Neurontin, 300mg three times per day.

On 6/12/13, Three Phase Bone Scan with Vascular Flow Was done by B. Kumar, MD. It showed increased activity in the first right MCP joint, and the right trapezium and scaphoid. On 6/22/13, Dr. Haronian started tapering down Neurontin and started Norco.

On 7/11/13, Dr. Kohan requested authorization for stellate ganglion injection, even though the patient did not present with the required criteria for CRPS (Complex Regional Pain Syndrome).

Mr. Doran did not tolerate the Elavil, 100mg; well. Dr. Kohan increased Neurontin and prescribed Lyrica.

On 10/16/13, Dr. Kohan did stellate ganglion injection on the right. It did not help. On 10/17/13, Dr. Kohan noted Mr. Doran was on Norco, 7.5 mg, twice per day; Norco, 5mg, once per day; Elavil, 50mg, and Lyrica, 50mg. The doctor requested psychological clearance for a trial of spinal cord stimulator.

On 03/31/14, Dr. Haronian diagnosed RSD, Depressive Disorder NOS, Male Erectile Disorder, and Sleep Disorder Due to Pain.

On 5/14/14, Dr. Kohan had a trial of spinal cord stimulation, with 70% improvement.

On 08/27/14, Dr. Kohan installed the permanent electrodes of the spinal cord stimulator leads.

On 9/9/14, Dr. Kohan noted that Mr. Doran's burning pain has resolved with the use of the stimulator. He continues with Neurontin, 900mg, three times per day, in addition to Norco and Elavil. The doctor instructed Mr. Doran to reduce Neurontin gradually, one tablet every fourth day and to decrease Norco from three to two times a day.

On 10/16/14, Dr. Kohan noted that Mr. Doran uses the unit around the clock and reported 50% improvement in his symptoms and in particular the burning pain.

On 12/12/14, Dr. Kohan noted that Elavil was denied as psych is not an accepted body part. Dr. Kohan appealed it.

On 1/16/15, Dr. Kohan noted 40% improvement. Is undergoing physical therapy but reported buzzing in the left leg.

On 1/5/15, Norco, Elavil, and Neurontin were certified.

On 3/18/15, Dr. Kohan wrote that Mr. Doran's issues of depression and anxiety should be treated aggressively, yet no referral to a psychiatrist was given, nor did Dr. Kohan prescribe any additional psychotropic medications.

On June 20, 2015, Mr. Doran was evaluated by Soheil M. Aval, MD, QME ortho. His diagnoses were: (1) right hand trauma with reported non-displaced fracture of the right thumb with possible first metacarpal fracture per initial medical records; (2) subsequent right hand sympathetically mediated pain, most consistent with chronic regional pain syndrome; (3) mild right carpal tunnel syndrome per electrodiagnostic evaluation of January 15, 2013; (4) mild left hand strain, secondary to overcompensation.

Dr. Aval found Mr. Doran's condition to be permanent and stationary with 25% WPI. Work restrictions precluded repetitive or forceful gripping, fine manipulation, torquing, and heavy lifting with the light upper extremity. Future care -to include orthopedic consultation for flare-up with physical therapy or acupuncture and diagnostic studies Mr. Doran should remain under the care of Dr. Kohan for monitoring adjusting, and dispensation of medications or injections.

Dr. Aval determined 100% industrial causation with no apportionment.

As Dr. Kohan and Dr. Haronian released Mr. Doran from under their care, he was referred to Edward G. Stokes, MD, PTP ortho. In his report dated 10/15/15, Dr. Stokes noted left upper extremity intermittent tremors. He noted to rule out degenerative disease and recommended neurological consultation on a private basis. He referred Mr. Doran for pain management consultation to Gary Baker, MD, and to transfer care as PTP.

In his initial report dated 02/15/16, Dr. Baker noted pain rated 5/10 with medications and 10/10 without medications. The patient reported continuous nausea and moderate constipation. Dr. Baker renewed prescriptions for Elavil, 50mg, and Gabapentin, 600mg, four times per day. On 04/11/16, Dr. Baker reported pain level of 6-7/10 with medications. The patient completed fluoroscopic evaluation of the spinal cord stimulation on 3/15/16 and reprogramming of the SCS. Insomnia secondary to pain was worsening. Blood pressure was 158/97. Score on the Insomnia Severity Index was 23, indicating severe clinical insomnia. He scored 45 (severe depression) on the Beck Depression Inventory, and Dr. Baker considered a referral to a qualified psychiatrist.

I reviewed an initial psychological evaluation by Heath Hinze, PsyD, dated 5/7/13. At that time, Mr. Doran scored 37 (severe depression) on the Beck Depression Inventory and 29 (moderate anxiety) on the Beck Anxiety Inventory. Dr. Hinze diagnosed Depressive and Anxiety Disorders NOS, Insomnia Due to Pain, and Male Erectile Disorder, No Axis II Diagnosis, and a GAF of 56.

I reviewed numerous notes and PR-2's, all signed by Dr. Hinze, even though Mr. Doran told me he only saw Dr. Hinze for a total of 2-3 times over the duration of two years. Group therapy was conducted by different counselors.

On 2/4/14, Dr. Hinze conducted an evaluation for the purpose of giving psychological clearance for spinal cord stimulator. Beck Depression Inventory was 51; Beck Anxiety Inventory was 41, showing worsening of symptoms. Yet, the doctor stated that Mr. Doran benefitted from the psychological treatment and was more optimistic and clear for the SCS trial. On 6/2/15, Dr. Hjnze wrote his Permanent and Stationary Report, with the same diagnoses, but a GAF of 60, Equivalent to 15% WPI.

It is of note that the psychological treatment that was given to Mr. Doran was less than adequate. While he received very excessive group therapy sessions for years with documented severe depression and anxiety, he was never referred for psychiatric evaluation and treatment, and the only psychotropic medication that has been prescribed, other than a short time with Lexapro is Elavil, 50mg. This dose is totally inadequate for depression. He Was never provided with individual psychotherapy.

According to Mr. Doran, weekly sessions of group therapy were of minimal help. He stated he told it to Dr. Hinze and to the different group therapists. He also requested psychiatric referral for medications. Reportedly he was told by Dr. Hinze that he did not need medications.

Mr. Doran admitted his anxiety and depression are to some extent the result of his financial worries. He denied ever getting Permanent Disability checks, which I find difficult to believe. He is awaiting a hearing at the Social Security office in September and expects retroactive pay to January 2015.

Mr. Doran has a severe Parkinson-like tremor in his left upper and lower extremities and paralysis of the left side of his mouth. I agree with Dr. Stokes that he needs to be evaluated by a neurologist to rule out Parkinson's disease or any other degenerative disease. However, Mr. Doran reported that he was told the tremor was a side effect of Neurontin. This is a possibility. Therefore, I. believe the neurologic evaluation should be done on an industrial basis.

I agree with Dr. Baker that Mr. Doran would benefit from adequate psychiatric treatment, as this was never provided. However, we are almost four years after the injury and after an extensive course of two years of group therapy. Therefore, I chose to write this report as a Permanent and Stationary Report.

If, indeed, the parties would choose to send Mr. Doran for psychiatric treatment, then his psychiatric condition would be considered as temporarily partially disabled, until he would be released as permanent and stationary by the treating psychiatrist.

Currently, Mr. Doran's condition meets DSM-IV-TR criteria for Major Anxiety Disorder NOS, and Insomnia Due to Axis I Diagnoses and Orthopedic Pain. The diagnosis of Pain Disorder needs to be ruled out.

He also meets DSM-IV-TR criteria for Psychological Factors Affecting Medical Condition, as it is clear that at least part of his physical complaints are stress related.

Mr. Doran denied any previous psychiatric history. He admitted other recent sources of stress in his life, especially an anal fistula that causes pain and discomfort. He also admitted being worried by his financial situation and problems with his girlfriend that are caused by these but also by his impotence, depression, and inability to function.

Mr. Doran reported a difficult childhood caused by his father's "military style" of being strict and critical and being very disappointed in Mr. Doran s failure in school. Mr. Doran reported stress being cheated out of his inheritance by his siblings and not talking with them since his mother's death in 2007. For many years, he was his mother's caregiver after her strokes.

Mr. Doran reported his first wife, who suffered from Bipolar Disorder, committed suicide while he was away in 2001. His second wife, who was reportedly a "gold digger", cheated on him and then divorced him a year after they got married.

Mr. Doran has pre-existing diabetes. He also has left-sided neurological symptoms with Parkinson's-like movements of the left lower and upper extremities, as well as left sided paralysis of his mouth.

Mr. Doran also has pre-existent personality traits.

DISABILITY STATUS:

At no time ever was Mr. Doran temporarily totally disabled purely from a psychiatric point of view. At this time, his condition is regarded as permanent and stationary with moderate psychiatric disability.

CAUSATION:
Industrial causation is preponderant to all other causes combined in the psychiatric disability of Mr. Doran. Good faith personnel action was not substantial factor. However, AOE/COE is a legal and not a medical decision, so I would leave it to the Trier of Fact.

APPORTIONMENT:
20% is apportioned to pre -existing and non-industrial factors as outlined above.
20% is a result of financial worries.
60% is apportioned to the industrial injury of 7/11/12.

RECOMMENDATION:
It is recommended to refer Mr. Doran to a proctologist for consultation to rule out industrial causation. It is probable that it resulted from his constipation, which is probably a side effect of the Neurontin.

Given the fact the Neurontin may also cause Parkinson's-like shaking on the left side, which is interfering significantly with his ability to function, a neurological consultation is also recommended.

Even though Mr. Doran scored only 2 on the Epworth Sleepiness Scale, this is not a good reflection of his sleep/arousal disability. This is because he cannot sleep during the day when the stimulator is on because it causes buzzing. Yet, since he turns off the stimulator at night, he cannot sleep well because of the pain and is, indeed, extremely fatigued during the day. The score of 23 (severe insomnia) on the Insomnia Severity Index submitted by Dr. Baker is much more accurate in this case. Therefore, I recommend polysomnogram in a good place to more accurately determine WPI for sleep and arousal issues.

OPINION AS TO DISABILITY RATING:
On the basis of this present psychiatric study, I believe that Mr. Doran has been vocationally disabled as a result of the above-described work-related accident. He reports himself suffering from a combination of physical and emotional disabilities.

The readers of this report are advised that the assessment, treatment, and rating of his physical disability are beyond the purview of the undersigned examiner, and rightfully belong under the jurisdiction of other medical specialists.

From a psychiatric viewpoint, I believe he has suffered emotional, mental, psychological, and personality distresses as a direct result of the industrial injury and continued inability to work at his usual/former occupation. The combination of physical and emotional disabilities have caused him to have difficulties in functioning in his everyday world. I believe that his present disabilities are due in part, at least, to psychological factors, and in my opinion, these psychological factors are the result of the claimed accident.

It is my opinion that for Workers' Compensation rating purposes., Mr. Doran's psychological status is permanent and stationary, and is of a moderate degree of impairment.

OBJECTIVE FACTORS OF DISABILITY:
Being socially withdrawn, impaired sleep, indecisiveness, not functioning in hobbies and in the household, impaired concentration and memory, avoiding driving the freeway.

SUBJECTIVE FACTORS OF DISABILITY:
Pain in upper extremities, pain in anal area, depression, anxiety, worries, tension, nervousness, irritability, anhedonia, headaches, weakness, fatigue, lack of energy, loss of self-confidence, lack of motivation, guilt feelings, difficulty swallowing, choking feelings, nightmares, suicidal ideation, fear of being left alone/traffic/crowds.

WORK RESTRICTIONS:
Mr. Doran should avoid stresses at work.

VOCATIONAL REHABILITATION:
This is not indicated from a psychiatric point of view.

FUTURE PSYCHIATRIC CARE:
Mr. Doran would benefit from psychotropic medication and should be under psychiatric care once a month for a least two years.

No more psychotherapy is indicated at this time.

More intensive psychological or psychiatric care should be made available in case of deterioration in the future.

WORK FUNCTION IMPAIRMENT FORM:

Work Function	Level of Impairment	Supporting Data (Cite Findings)
1. Ability to comprehend and follow instructions.	Slight	Impaired concentration and memory.
2. Ability to perform simple and repetitive tasks.	Very Slight	
3. Ability to maintain a work pace appropriate to a given workload.	Slight	As above.
4. Ability to perform complex or varied tasks.	Moderate	Impaired concentration and memory
5. Ability to relate to other people beyond giving and receiving instructions.	Slight	Being socially withdrawn. Irritability. Losing his temper.
6. Ability to influence people	Slight/ Moderate	As above. Lack of energy and motivation. Lack of self-confidence.
7. Ability to make generalizations, evaluations or decisions without immediate supervision.	Moderate	Indecisiveness. Lack of self-confidence. Lack of energy and motivation. Impaired concentration and memory.
8. Ability to accept and carry out responsibility for direction, control and planning.	Moderate	As above.

AMA DISABILITY RATING:

1. Disability to perform activities of daily living: Slight/moderate impairment.
2. Social Function: Slight/Moderate impairment.
3. Concentration, persistence and pace: Slight impairment.
4. Deterioration or decompensation in complex or work like setting: Moderate impairment.

- **<u>Per Soheil M. Aval, M.D.</u>**
  QME - Orthopedic Examination Report– Dated 07/18/2016

DIAGNOSES:

1. Right hand trauma with reported non-displaced fracture of the right thumb with possible first metacarpal fracture per initial medical records.
2. Subsequent right hand sympathetically mediated pain, most consistent with chronic regional pain syndrome.
3. Mild right carpal tunnel syndrome, per electrodiagnostic evaluation of January 15, 2013.
4. Mild left hand strain, secondary to overcompensation.

DISCUSSION:

Daniel Doran sustained an injury to his right forearm, wrist and hand on July 11, 2012, when a wall fell on him. He received initial treatment with his right thumb with application of a hard cast, which he wore until late September 2012, which was followed by provision of a removable hard cast for the next month or two. Mr. Doran has been treating with Dr. Haronian and Dr. Kohan, pain management specialist, to the current date for his chronic regional pain syndrome. He has undergone ganglion injections with a trial of a spinal cord stimulator in May 2014, with good success, and as such, the spinal cord stimulator was permanently implanted in August 2014, which has provided benefit to the current date. Mr. Doran has also developed left wrist and hand complaints due to favoring the right wrist and hand, which is a common mechanism of injury. It was thought by the patient's treating physicians that the left wrist and hand also suffered from chronic regional pain syndrome, but I do not see this on my examination. Mr. Doran presents for Orthopedic Panel Qualified Medical Evaluation.

At this time, Mr. Doran can be considered to have reached Maximal Medical Improvement as further formal medical treatment will not change his impairment.

Clinical examination of the right wrist and hand reveals diffuse swelling of the entire right hand with allodynia. There is hypesthesia about the entire right hand with sensory deficit, grade 4/5, about the tips of all digits on the right hand. Mr. Doran has grip loss secondary to pain with attempts at grasping. There is abnormal/cooler temperature about the right hand with normal sweating. There is decreased range of motion of the right thumb. With regard to the left hand and wrist, clinical examination is essentially negative. Although there is some strain due to overcompensation, there is no obvious impairment resulting from that.

Mr. Doran has received appropriate treatment for his injury. Unfortunately, Mr. Doran developed chronic regional pain syndrome in the right upper extremity, but currently he has good relief with the permanent spinal cord stimulator. Dr. Kohan also is continuing to refill his Neurontin and Elavil, which is appropriate for this condition. Mr. Doran will need to remain under the care of Dr. Kohan for medication and future injections.

The electrodiagnostic evaluation of January 15, 2013, revealed mild carpal tunnel syndrome, which is not supported by my clinical examination. I definitely do not recommend surgery given the patient's sympathetically mediated pain. If the patient were to undergo carpal tunnel release surgery, most likely his symptoms would significantly worsen.

STATUS:
The patient has reached **MAXIMAL MEDICAL IMPROVEMENT** in accordance with the AMA Guides to the Evaluation of Permanent Impairment (5th Edition).

AMA IMPAIRMENT ANALYSIS:
Today's examination confirms a diagnosis of chronic regional pain syndrome (CRPS). Even though Mr. Doran has difficulty with movement and usage of the hand, a lot of this is guarding. As stated above, with encouragement and with relaxation of the hand, I am able to get full passive extension of all the digits with the ability to make a fist. However, Mr. Doran has lost significant function of the right hand as a result of this injury, approximately 50%. I am not estimating a higher loss as Mr. Doran does have full extension and can make a fist and

was seen to write and fill out his paperwork today, supporting usage of the hand. Mr. Doran has significant interruption in ability to perform activities of daily living.

Per Chapter 13, Section 13.8, Table 13-22, it is my medical opinion that Mr. Doran meets the criteria for Class III of the dominant extremity as he can use the involved extremity, but has difficulty with self-care activities.

25% Whole Person Impairment.

FINAL AMA IMPAIRMENT RATING:
Right Wrist Whole Person Impairment 25%

RECOMMENDED WORK RESTRICTIONS:
Mr. Doran is precluded from activities of repetitive or forceful gripping, fine manipulation, torquing, and heavy lifting with the right upper extremity. The left upper extremity does not require work restrictions.

ABILITY TO RETURN TO WORK:
Based on the above, permanent work restrictions are indicated. Should the patient's employer be unable to accommodate these restrictions, he would be unable to return to his prior occupation.

FUTURE MEDICAL CARE:
Mr. Doran should be allowed future medical care which might include orthopedic consultations at times of flare-ups with a regimen of physical therapy and/or acupuncture. Updated diagnostic studies should be allowed. Mr. Doran should remain under the care of Dr. Kohan, his pain management specialist, for provision of various injections and monitoring, adjusting, and dispensation of medications. The spinal cord stimulator should be monitored.

CAUSATION AND APPORTIONMENT:
Daniel Doran sustained an injury on July 11, 2012, to his right upper extremity when a wall fell on him. This injury is documented by the medical records.

100% of the patient's impairment is due to the injury to July 11, 2012. I do not see evidence of other contributing factors to his impairment. My current radiographs of the hands today do not show any degenerative changes.