ERIC E. GOFNUNG CHIROPRACTIC CORP.

QME OF THE STATE OF CALIFORNIA

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

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

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

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

On 25 day of June 2021, I served the within concerning:

Patient's Name: Doran, Daniel

SIF Case: SIF8760713

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

[ ] MPN Request
[ ] Notice of Treating Physician
[ ] Medical Report __________
[ ] Itemized – (Billing) / HFCA
[ ] Doctor's First Report
[ ] RFA
[x] Review of Records

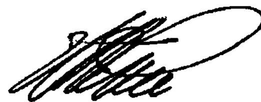
[ ] QME Appointment Notification
[ ] Designation Of Primary Treating Physician
[ ] Initial Comprehensive Report
[ ] Re-Evaluation Report / Progress Report (PR-2)
[ ] Agreed Medical Evaluator's ML 104 Report
Subsequent Injury Benefits Trust Fund
[ ] Permanent & Stationary
[ ] Authorization Request for Evaluation/Treatment

List all parties to whom documents were mailed to:

cc: Workers Defenders Law Group
Natalia Foley, Esq.
8018 E. Santa Ana Cyn Suite 100-215
Anaheim Hills, CA 92808

Subsequent Injury Benefits Trust Fund
160 Promenade Circle, Suite 350
Sacramento, CA 95834
Att: Jeff Souza, WC Consultant

I declare under penalty and perjury under the laws of the State of California, that the foregoing is true and correct, and that this Declaration was executed at Los Angeles, California on 25 day of June 2021.



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June 14, 2021

Subsequent Injury Benefits Trust Fund
160 Promenade Circle, Suite 350
Sacramento, CA 95834
Attn: Jeff Souza, WC Consultant

Workers Defenders Law Group
8018 E. Santa Ana Cyn., Ste. 100-215
Anaheim Hills, CA 92808
Attn: Natalia Foley, Esq.

Re:		
	Patient:	DORAN, Daniel
	SSN:	554-73-1885
	EMP:	Benedict & Benedict Plumbing
	SIBTF:	SIF8760713
	INS:	State Compensation Insurance Fund
	Claim #:	05814232
	EAMS #:	ADJ8760713
	DOI:	07/11/2012

AGREED MEDICAL EVALUATOR'S ML-201 REPORT
SUBSEQUENT INJURY BENEFITS TRUST FUND

ADDENDUM 3 - REVIEW OF RECORDS

Received medical records totaling 1152 pages. The total length of time for review of these records was 35 hours.

1. I reviewed the entire medical file with all pertinent patient information. I have reviewed my initial history, examination and medical file.

2. February 18, 2021, Cover Letter for SIBTF Evaluation In Chiropractic Specialty, From Natalia Foley, Esq (Workers' Defender's Law Group) to Eric Gofnung, DC: In this letter Ms. Foley indicated that Dr. Gofnung had been selected to act in the capacity of SIBTF Medical Evaluator in regard to the applicant's Subsequent Injury Benefit Trust Fund Claim in chiropractic specialty. He was specifically asked to provide a medical legal evaluation in his area of expertise as a chiropractic doctor. He was also provided with the medical records in this case for his review.

Ms. Foley requested Dr. Gofnung to address the following issues:

a) Please provide a medical legal evaluation and address the issue of causation (AOE/COE) of any injury within your area specialty. Specifically, it is requested that a determination be made regarding any pre-existing medical issues and disability within your area of specialty that were present at the time of the subsequent industrial injury.

b) Please provide a permanent impairment rating per the AMA guides 5th edition and address the issue of apportionment. Specifically, it is requested that you provide a determination as to the percentage of cause of disability to a pre-existing condition present at the time of the subsequent industrial injury, any contribution from the industrial injury(ies) and any further natural progression, which occurred after the industrial injury.

c) Please cover in your report the following topics:

- Subjective complaints
- Objective factors or findings
- Current diagnosis
- Occupational history
- Past medical history
- Prior injuries
- Pre-existing labor disabling condition
- Prior injuries causation
- Rating of pre-existing labor disabling conditions
- Pre-existing work restrictions
- History of subsequent injuries
- Impairment rating of subsequent injuries
- Subsequent injuries causation
- Apportionment
- Disability status & permanent work restrictions
- Activities of daily living

d) Please answer within the scope of your specialty:

- Did the worker have an industrial injury?
- Did the industrial injury rate to a 35% disability without modification for age and occupation?
- Did the worker have a pre-existing labor-disabling permanent disability?
- Did the pre-existing disability affect an upper or lower extremity or eye?
- Did the industrial permanent disability affect the opposite or corresponding body part?
- Is the total disability equal to or greater than 70% after modification?

- o Is the employee 100% disabled or unemployable from other pre-existing disability and work duties together?
- o Is the employee 100% disabled from the industrial injury?

e) In order to facilitate your evaluation, we provide medical records for the patient in our possession according to the exhibit list attached. If you need any additional testing, please advise so. If you believe that the applicant has health issues outside of your specialty, please defer these issued to the medical doctors of appropriate specialty, please indicate what specialty is recommended.

3. **Unidentified date of report, Description of Employee's Job Duties:** Job Description: The patient began employment with Benedict & Benedict Plumbing, as Plumber. His job included all types of commercial and residential plumbing/repairing. He worked 8 hours per day. His job duties included constant (6-8 hours) standing, repetitive use of right hand; frequent (3-6 hours) walking, standing, bending at neck and waist level, squatting, climbing, kneeling, crawling, twisting neck and waist, simple/power grasping & fine manipulation with both hands, pushing and pulling with both hands, reaching above and below both shoulder levels, lifting of 0-50 pounds and carrying of 0-100 pounds; as well as occasional (up to 3 hours) sitting, and occasional lifting of 50-100 pounds. His Job duties also included driving cars, trucks, forklifts and other equipment; working around equipment and machinery; walking on uneven grounds; exposure to excessive noise; exposure to extremes in temperature, humidity and wetness; exposure to dust, gas, fumes or chemicals; working at heights; operation of foot controls or repetitive foot movement; use of special visual or auditory protective equipment; and working with bio-hazards such as bloodborne pathogens, sewage and hospital waste.

4. July 13, 2012, Emergency Department Report, James D. Luna, MD: DOI: 07/11/2012. History of Present Injury: The patient presented with a left thumb injury that occurred 2 days prior while opening up a piece of wall for re-plumbing purpose, and the wall fell onto his left thumb, hitting on the top of it, resulting in a laceration on the side of the nail and ecchymosis of the nail itself and also pain at the first metacarpophalangeal joint. He tried to work but found the pain was too much, and he presented for evaluation. PMH: Gout and diabetes. Physical Examination: Extremities: The left thumb had minor laceration on the ulnar aspect of the nail. There was also a subungual hematoma, although it was small and did not appear to be drainable. The entire area was tender to palpation because of these injuries. There was also pain at the distal metacarpophalangeal joint. Diagnosis: Left thumb torus type fracture at the metacarpophalangeal joint, subungual hematoma and minimal distal thumb laceration. Treatment Plan: He would be placed in a thumb spica splint. X-ray of the right thumb was performed and reviewed. Work Status: He would be taken off work for a week.

5. July 13, 2012, X-ray of Right Thumb, Warren W. Lam, MD: Impression: 1) No fracture, dislocation or destructive bony change. 2) No arthritic change noted. 3) Some mild soft

tissues swelling around the thumb was noted in the hypothenar eminence. 4) No radiopaque foreign body.

6. July 17, 2012, Primary Treating Physician's Initial Orthopedic Evaluation (PR-1) – Periodic Report, George Tang, MD: DOI: 07/11/2012. HPI: On 07/11/2012, the patient was working his usual and customary job duties as a plumber when a structure came down and hit both his hands and thumb area. He had immediate pain and swelling to the right thumb. He was seen at the Huntington Hospital and was given a splint for his thumb. His symptoms were slightly better now. PMH: Diabetes. Medication: Metformin and Januvia. Physical Examination: He had some swelling, some bruising around the whole thumb area and some bruising around the nail area. He had tenderness in the distal part of the thumb as well as the metacarpophalangeal joint area. X-rays showed that he had non displaced fracture with first metacarpal fracture. Assessment: Right thumb first metacarpal fracture. Plan: He would need to have a spica cast. Work Status: Total disability until September 30, 2012.

7. July 20, 2012, DWC 1: DOI: 07/11/2012. Description of Injury: Injured right hand due to falling of rock wall.

8. July 20, 2012, Employee's Report of Injury: DOI: 07/11/2012. Description of Injury: "I was struck on hand by falling section of rock wall." Body Part Injured: **SAA/right hand.**

9. July 24, 2012, Primary Treating Physician's Progress Report (PR-2) – Periodic Report, George Tang, MD: Interim History: The patient was here for a follow-up visit of his right thumb. He sustained a right thumb metacarpal fracture on June 11, 2012. Currently, he reported having more pain in that thumb area. He was doing well until roughly about a few days prior. He had been more compliant and took care of his cast. Assessment: Right thumb first metacarpal fracture. Plan: He would continue with the cast treatment. Work Status: He would be on total disability until September 30, 2012.

10. August 14, 2012, Primary Treating Physician's Progress Report (PR-2) – Periodic Report, George Tang, MD: Interim History: The patient was here for a follow up visit of his right thumb metacarpal fracture. His cast was getting soft around the palm area and was having more pain in his right thumb area for the past week. He was here for a change of his cast. X-rays showed a good alignment of the fracture, some callus formation. Assessment: First metacarpal fracture, **right**. Plan: He had removed the thumb spica cast and was placed with a new one. Given some enteric-coated Naprosyn as an antiinflammatory medication; Prilosec to prevent stomach upset; Medrox as an antiinflammatory cream to use as necessary to decrease the symptoms around the thumb itself. Work Status: He would be on total disability until September 30, 2012.

11. September 04, 2012, Primary Treating Physician's Progress Report (PR-2) – Periodic Report, George Tang, MD: Interim History: The patient presented here for follow-up visit of his right thumb fracture. He had some discomfort without the cast in that thumb area.

Assessment and Plan: First metacarpal fracture, **right**: He was done quite well. He was recommended to have a thumb spica orthosis to transition him out of the cast area to wear nothing. Also recommended to have physical therapy. Work Status: He remained on total disability until October 31, 2012.

12. September 28, 2012, PT Treatment Summary, Aileen Elegado, MPT: The patient attended 12 physical therapy sessions from September 28, 2012 to November 12, 2012.

13. October 04, 2012, Primary Treating Physician's Progress Report (PR2) – Periodic Report, George Tang, MD: Interim History: The patient presented here for follow-up visit of his right thumb fracture. He was still feeling quite a bit of soreness over the right thumb. Physical Examination: He had some stiffness in the right thumb secondary to being in the cast for a while. He had some swelling and some slight tenderness in the thumb area. Review of x-ray: Positive for callus formation. Assessment: First metacarpal fracture, **right**. Plan: 1) Neurologist recommended an EMG to the right upper extremity. 2) Given some enteric-coated Naprosyn as an antiinflammatory medication; Prilosec to prevent stomach upset; Medrox as an antiinflammatory cream to use as necessary to decrease the symptoms around the thumb itself. Work Status: Remain on total disability until November 30, 2012.

14. November 08, 2012, Primary Treating Physician's Progress Report (PR2) – Periodic Report, George Tang, MD: Interim History: The patient presented for follow-up visit of his right thumb fracture. He still had a bit of limited range of motion throughout the hand and thumb area. He had a bit of pain in the hand and thumb area. Physical Examination: Right Hand: The hand was colder than the contralateral side. Right Wrist: He had pain with the range of motion and wrist flexion and extension. His wrist flexion had improved considerably. He was able to flex down to roughly about 35 degrees with the wrist extension. He had quite a bit of pain when extending to about 20 degrees. Thumb: Range of motion was somewhat limited secondary to the pain as well. He was stable to touch the small finger, but with the small finger extending into the thumb instead of the thumb going to the small finger. He had generalized pain throughout. Assessments: 1) First metacarpal fracture, **right**. 2) Reflex sympathetic dystrophy. Plan: 1) Neurologist recommended an EMG to the right upper extremity. 2) Given some enteric-coated Naprosyn as an antiinflammatory medication; Prilosec to prevent upset stomach; Medrox as an antiinflammatory cream to use as necessary to decrease the symptoms around the thumb itself. Work Status: Remain on total disability until December 31, 2012.

15. December 20, 2012, Primary Treating Physician's Progress Report (PR2) – Periodic Report, George Tang, MD: Interim History: The patient presented for follow-up visit of his right thumb. He saw the neurologist and the neurologist recommended an EMG to the right upper extremity. He complained of some numbness on the thumb area, in the palmar aspect of the thumb region. His range of motion was still decreased in the right thumb area. He had finished his physical therapy. The therapy had been helpful in terms of getting range of motion of his fingers and his wrist area. He had quite a bit of symptoms

of pain in that right thumb region. Physical Examination: Sensation was decreased in the thumb area. Range of motion was decreased compared to the other side. Assessments: 1) First metacarpal fracture, **right.** 2) Reflex sympathetic dystrophy. Plan: 1) Neurologist recommended an EMG to the right upper extremity. 2) Given some enteric-coated Naprosyn as an antiinflammatory medication; Prilosec to prevent upset stomach; Medrox as an antiinflammatory cream to use as necessary to decrease the symptoms around the thumb itself. Work Status: Remain on total disability until February 28, 2013.

16. January 02, 2013, Neurological Evaluation, Mohsen Ali, MD: DOI: 07/11/2012. History of Present Complaints: The patient indicated that his pain began since his injury for which he had physical therapy with no improvement. He also admitted to having numbness and tingling sensation around his wrist and the root of his thumb. He also admitted to having weakness of his right grip. PSH: Included **mastectomy.** PMH: Diabetes and hypercholesterolemia. Current Medications: He had been taking Januvia and Metformin. Neurological Exam: Sensory System: There was hyperalgesia of his right hand in the distribution of the right median nerve. Impression: 1) Carpal tunnel syndrome, **right.** 2) Possible reflexive pathetic dystrophy. Plan: He would be scheduled for EMG of the right arm.

17. January 15, 2013, Electromyography Report, Pouya Lavian, MD: Chief Complaint: Pain in the right wrist and thumb, numbness of right thumb and weakness of right hand. Review of Systems: Positive for muscle twitching in right forearm and bone pain in right wrist and hand. Impression: Mild right carpal tunnel syndrome.

18. January 17, 2013, Application of Adjudication of Claim: Employer: Benedict & Benedict Plumbing. DOI: 07/11/12. Injured Body Parts: Hand, psyche, unclassified, sleep dysfunction. Mechanism of Injury: Wall collapsed.

19. January 31, 2013, Primary Treating Physician's Progress Report (PR2) – Periodic Report, George Tang, MD: Interim History: The patient presented for a follow up visit of his right hand and wrist area. His hand was still painful and had an EMG done on January 15, 2013, which showed mild carpal tunnel syndrome. Physical Status: Pain throughout the whole right arm. Diagnoses: 1) First metacarpal fracture, **right.** 2) Possible reflex sympathetic dystrophy. Plan: He would start the physical therapy. Given some enteric-coated Naprosyn as an antiinflammatory medication; Prilosec to prevent stomach upset; Medrox as an antiinflammatory cream to use as necessary to decrease the symptoms around the thumb itself and Gabapentin as a medication to treat his possible reflex sympathetic dystrophy condition. Work Status: He was temporarily totally disabled from any work until approximately March 30, 2013.

20. February 18, 2013, Initial Comprehensive Evaluation and Request for Authorization of a Primary Treating Physician/Doctor's First Report of Occupational Injury or Illness, Edwin Haronian, MD: DOI: 07/11/2012. Job Description: The patient began employment with Benedict & Benedict Plumbing in February 2010, as Plumber. He worked 6-12 hours per

day, five days per week, and worked on call "a couple of days a week". His duties at the time of injury entailed: Travelling to different job sites, loading and unloading material and tools from and onto a truck, carrying these to his immediate work site, repairing/removing/replacing toilets, sinks, bathtubs, and working on new water line and gas pipes. He was required to make holes on the ground and break walls. He utilized various hand-held and power tools. The precise activities required entailed: Prolonged standing and walking as well as continuous fine maneuvering of his hands and fingers, and repetitive bending, stooping, squatting, kneeling, crawling, twisting, turning, forceful pushing and pulling, forceful gripping and grasping, reaching to all levels, torqueing, lifting and carrying up to 100+ pounds, ascending stairs and ladders. History of Injury: Remained unchanged. Current Work status: He remained off work since July 12, 2012. Employment History: He stated that prior to working for Benedict & Benedict plumbing, he was self-employed as a Plumber. He had worked as plumber for close to 30 years. Present Complaints: 1) Right wrist/hand and thumb: He had continuously complained of aching in his right wrist, hand and thumb; at times becoming sharp, shooting and throbbing pain. His pain was radiating to his forearm. He had episodes of numbness and tingling and he complained of cramping and weakness in the right hand.

He was losing muscle tone in the right and thumb. His pain increased with gripping, grasping, and repetitive hand and finger movements. He had difficulty sleeping and was awakening with pain and discomfort. His pain level was varying throughout the day depending on activities. Pain medication provided him temporary pain relief. 2) Non orthopedic complaints: Depression/anxiety. Medications: He was taking prescribed medication for diabetes, Motrin 800 mg and Prevacid. Activities of Daily Living: Activities of Daily Living were reviewed. Physical Examination: Wrist & Hand: There was tenderness over the distal radius and the carpus on the right. Phalen and Reverse Phalen testing were positive on the right. Finger: Range of motion was painful over the right thumb without mechanical block. The thumb adduction/abduction was decreased over the right thumb. Review of Medical Records: Reviewed EMG/NCV of right upper extremity dated January 15, 2013. Diagnoses: 1) Right carpal tunnel syndrome status post right thumb fracture, which has healed. 2) Right hand contusion. Plan: 1) Consult for pain management to rule out reflex sympathetic dystrophy (RSD). 2) 4 sessions of psychotherapy for depression/anxiety. 3) Acupuncture 2 times a week for 3 weeks to right wrist to right hand. Medications: 1) Cream Baclofen. 2) Medrox patch. 3) Prilosec. 4) Relafen. 5) Thumb spica. 6) Ultram. Work Status/Restrictions: No use of the right hand. He should remain on TTD, if the work modifications could not be accompanied by the employer.

21. March 18, 2013, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right wrist and hand following previous fracture. Pain level was 7-8/10. He was awaiting pain management consultation to rule out reflex sympathetic dystrophy. PE: He was visibly uncomfortable. Significantly decreased grip strength was noted on the right side. Mottling and allodynia was noted. Diagnoses: 1) Wrist tendinitis/bursitis, right. 2)

Hand contusion, **right**. Plan: Recommended to refill therapeutic cream and to start Neurontin, Elavil and Vitamin C. Requests were placed for authorization for MRI of right wrist without contrast, consult with pain management to rule out reflex sympathetic dystrophy, four sessions of psychotherapy, psychological evaluation and acupuncture six times for the right wrist and hand. Advised to continue modified work duties.

22. April 01, 2013, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient presented complaining of right wrist/hand pain and numbness. He complained that the Neurontin was making him spacey. PE: He was guarding his right hand. There was some redness in the right hand. Diagnoses: 1) Wrist tendinitis/bursitis, **right**. 2) Hand contusion, **right**. Recommendation: Dr. Haronian opined that there was an increased suspicion for reflex sympathetic dystrophy and commented that the patient might be suffering from early complex regional pain syndrome. Request to be placed for formal authorization for a triple phase bone scan. Other plan was to wean the patient off Neurontin and to begin Lexapro instead of Elavil. He did have some evidence of depression and psychotherapy had been authorized.

23. April 11, 2013, Secondary Treating Physician Pain Management Initial Report and Request for Authorization, Jonathan Kohan, MD: DOI: 07/11/2012. History of Injury: Remained unchanged. Current Work Status: The patient was not working and was on temporary total disability status. He had not worked since July 12, 2012. Present Complaints: Right Hand/Wrist/Thumb: He experienced ongoing pain at the right hand/ thumb. He experienced numbness and tingling that extended to the forearm with radiation to the hand and fingers. He had difficulty bending his thumb. He noted grip weakness and had difficulty with holding objects and with fine motor coordination. His wrist pain increased with gripping, grasping, pushing and pulling, rotating, and repetitive hand and finger movements. The pain level became worse throughout the day depending on activities. He also had difficulty sleeping and awakens with pain and discomfort. Pain level was 8/10. He had continuous episodes of anxiety, stress and depression due to chronic pain and disability status. He had difficulty sleeping and was feeling fatigued through the day and was finding himself lacking concentration and memory at times. He worried over his medical condition and the future. Activities of Daily Living: Activities of Daily Living were reviewed. Current Medications: Metformin, Januvia, Baclofen Cream, Medrox Patch, Prilosec, Relafen, Neurontin and Lexapro.

    Social History: Widowed. He was a smoker for 30 years and smokes less than a pack of cigarettes per day. ROS: Anxiety, stress and depression. PE: Weight: 170 pounds. Diminished reflexes 1/2 in biceps, triceps and brachioradialis on the right. Decrease motor strength 4-/5 over the right wrist flexor and wrist extensors. Tenderness was noted over the entire elbow joint including the medial and lateral epicondyles on the left and right with swelling noted. There was significant mottling of the right hand with cooler temperature compared with the left hand. There was mild hyperhidrosis on the right. Diagnostic Studies: Reviewed the right upper extremity electrodiagnostic studies dated January 15, 2013. Impression: 1) History of right hand contusion. 2) Sympathetically-mediated

neuropathic pain, right upper extremity, possible mild complex regional pain syndrome. Recommendation: Medication regimen that included Neurontin and Elavil to be optimized. Dr. Kohan opined that triple phase bone scan would help with the diagnosis in an objective manner. He added that if no other pathology could be noted over the right wrist requiring surgery, the patient could be recommended to undergo a series of stellate ganglion injection to address his symptomatology. Disability and work status: Deferred to PTP.

24. April 29, 2013, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient presented with a complaint of significant pain in his right wrist and hand with weakness. He was seen by Dr. Kohan to evaluate him for reflex sympathetic dystrophy. Diagnoses: 1) Wrist tendinitis/bursitis. 2) Finger fracture. 3) Hand contusion. Plan: Medications would be refilled. Authorization for the bone scan was provided to cure and relieve the effects of the subject industrial injury. Disability Status: Remained unchanged. Followup: 4 weeks.

25. May 07, 2013, Initial Comprehensive Psychological Consultation and Report, Heath Hinze, Psy. D: DOI: 07/11/2012. Interim History: The patient had suffered work injuries and was currently under the care of Dr. Haronian who was referred him for a psychological evaluation. History of Injury: Remained unchanged. Current Work Status: He was currently not working and had last worked on July 12, 2012. Current Physical Complaint: He complained of continues aching in his right wrist, hand and thumb at times becoming sharp, shooting and throbbing pain. Current Psychological Complaints: He endorsed the following symptoms: Forgetting things, anxiety, unable to concentrate, agitated, lacking motivation, depressed, unable to enjoy activities, indecisive, feeling helpless/hopeless, moody, nauseated, losing things, restless, feeling tired, losing appetite, sleep disturbances, sexual problems, and crying spells.

    Diagnoses:

    Axis I: 1) Depressive disorder. 2) Anxiety disorder. 3) Sleep disorder due to pain, insomnia type. 4) Male erectile disorder.

    Axis II: Psychological and environmental problems-chronic pain, disability status, ongoing need for medical attention and financial strain.

    Axis III: GAF score of 56.

    Causation/Apportionment: Based on the currently available information, Dr. Hinze opined that the causation was industrial. Any issues of apportionment would be discussed in detail once the patient has reached maximum medical improvement. Work Status/Restrictions: Deferred to primary treating physician. Recommendation: He would be administered diagnostic measures to assess change in his condition. Psychiatric consultation was recommended. Authorization had been provided for 4 psychotherapy sessions.

26. May 09, 2013, Secondary Treating Physician Pain Management Follow-Up Report/Review of Diagnostic Reports and Request for Authorization, Jonathan Kohan, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right hand with numbness and tingling. Pain level was 7/10. He was maintained on Medrox patches, Relafen and Lexapro. His pain was suboptimally controlled. MRI of the right wrist dated April 11, 2013 was reviewed, which showed osteoarthritis at the first carpometacarpal and first metacarpophalangeal joints. PE: He was visibly uncomfortable. Allodynia was noted. Decreased grip strength was noted on the right. Impression: 1) Wrist bursitis. 2) Rule out complex regional pain syndrome type 1. Recommendations: Dr. Kohan opined that it did not appear a full picture of complex regional pain syndrome type 1. Elavil to be started to address pain, insomnia and depression. Recommended trial of Vitamin C. Lexapro to be stopped and rest of meds to be refilled. Formal request to be placed for authorization for purchase of wrist support to increase his range of motion and functional capacity status. Work Status: Deferred.

27. May 31, 2013, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right wrist and hand with numbness and tingling. Pain level was 6/10. PE: He was visibly uncomfortable. Decreased grip strength was noted. Change in the temperature was noted when compared to the other upper extremity. Diagnoses: 1) Wrist tendinitis/bursitis. 2) Hand contusion. Plan: Dr. Haronian opined that the patient presented with a clinical picture of complex regional pain syndrome. Recommended to increase dose of Neurontin and Elavil. Work Status: Remained unchanged.

28. June 11, 2013, Physician's Progress Report (PR2), Heath Hinze, Psy. D: Subjective Complaints: The patient reported to have anger, anxiety, fear, feeling hopeless and inability to gain pleasure in life. Objective Findings: He appeared to be angry, anxious, depressed and hopeless. Diagnoses: 1) Anxiety disorder. 2) Depressive disorder. Treatment Plan: Recommended 4 sessions of cognitive behavioral therapy and relaxing training sessions. Work Status: Deferred to PTP.

29. June 12, 2013, Radiology Consultation Report, Bharat Kumar, MD: Procedure Performed: Nuclear Medicine Three Phase Bone Scan with Vascular Flow, Immediate, and Delayed Static Images of Both Distal Ulnae and Radii, Both Wrists and Both Hands. Opinion: Increased activity in the 1st right metacarpophalangeal joint. Radiographic correlation is recommended. Increased activity in the right wrist with focal evidence of increased activity in the right trapezium and scaphoid.

30. July 09, 2013, Physician's Progress Report (PR2), Heath Hinze, Psy. D: Subjective Complaints: The patient reported to have anger, anxiety, fear, feeling hopeless and inability to gain pleasure in life. Objective Findings: He appeared to be angry, anxious, depressed and hopeless. Diagnoses: 1) Anxiety disorder. 2) Depressive disorder.

Treatment Plan: Recommended 4 sessions of cognitive behavioral therapy and relaxing training sessions.

31. July 11, 2013, Secondary Treating Physician Pain Management Follow-Up Report/Review of Diagnostic Reports and Request for Authorization, Jonathan Kohan, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right wrist and hand with numbness and tingling. He was on Neurontin and Elavil. PE: He was visibly uncomfortable. Allodynia was noted. Decreased grip strength was noted. Impression: 1) Wrist tendinitis/bursitis. 2) Rule out complex regional pain syndrome type Recommendations: Medications to be refilled. Elavil to be increased. Formal request to be placed for authorization for purchase of wrist support to increase his range of motion and functional capacity status. Work Status: Deferred.

32. July 22, 2013, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient presented with a complaint of persistent pain in his right wrist and hand and forearm, which was not well controlled. He did not tolerate an increase in the dose of Elavil. PE: He was visibly uncomfortable. Decreased grip strength was noted. Diagnoses: Wrist tendinitis/bursitis. Plan: Recommended to taper down Elavil and to add Norco. Recommended that his medication to be managed by Dr. Kohan. Formal request for authorization to be placed for purchase of right wrist support. Work Status: Continue modified work duties.

33. July 25, 2013, Secondary Treating Physician's Pain Management Follow-Up Report, Jonathan Kohan, MD: Interim History: The patient presented with a complaint of a chronic pain in his right upper extremity. Pain level was 6/10. He was maintained on Neurontin, therapeutic cream, Docuprene, Relafen, Elavil and Norco. PE: He was visibly uncomfortable. Allodynia was noted on the right hand and wrist. Decreased grip strength was noted. Impression: 1) Rule out complex regional pain syndrome type 1. 2) Chronic wrist and hand pain. Recommendations: Neurontin to be increased. Rest of the medications would be continued. Work Status: Deferred.

34. August 06, 2013, Physician's Progress Report (PR2), Heath Hinze, Psy. D: Subjective Complaints: The patient reported to have anger, anxiety, fear, feeling hopeless and inability to gain pleasure in life. Objective Findings: He appeared to be angry, anxious, depressed, fearful and hopeless. Diagnoses: 1) Anxiety disorder. 2) Depressive disorder. Treatment Plan: He was requested for 4 sessions of cognitive behavioral therapy and relaxing training sessions. Work Status: Deferred to PTP.

35. August 19, 2013, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient presented with a complaint of chronic pain in his right wrist and hand, which was burning in nature with radiation to the tips of his fingers. PE: He was visibly uncomfortable. Decreased grip strength was noted on the right side. Allodynia was noted. Diagnosis: Wrist tendinitis/bursitis. Plan: Recommended to refill Elavil with addition of Norco. Dr. Haronian opined that stellate ganglion block could be considered

and after that spinal cord stimulator placement might also be considered if the patient remained to be symptomatic. Advised to continue modified work duties.

36. August 22, 2013, Secondary Treating Physician Pain Management Follow-Up Report/Review of Diagnostic Reports and Request for Authorization, Jonathan Kohan, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right upper extremity including wrist and hand. Pain level was 6/10. PE: He was visibly very uncomfortable. Allodynia was noted on the right hand and wrist. Decreased grip strength was noted. Impression: 1) Rule out complex regional pain syndrome type 1. 2) Chronic wrist and hand pain on the right side. Recommendations: Dr. Kohan indicated that the patient had exhausted all conservative treatment at this point. Formal request to be placed for authorization for stellate ganglion injection on the right side. He added that if the patient remained symptomatic after the injection the next further logical step would be to consider a spinal cord stimulator trial. Work Status: Deferred.

37. September 10, 2013, Physician's Progress Report (PR2), Heath Hinze, Psy. D: Subjective Complaints: The patient reported to have anger, anxiety fear, feeling hopeless and inability to gain pleasure in life. Objective Findings: He appeared to be depressed, and hopeless and affect was restricted. Treatment Plan: Requested for 4 sessions of cognitive behavioral therapy and relaxing training sessions.

38. September 16, 2013, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD. Interim History: The patient presented with a complaint of a chronic unremitting pain in his right upper extremity including wrist and hand. Pain level was 6/10. PE: He was visibly uncomfortable. Decreased grip strength was noted on the right side. Allodynia was noted. Diagnosis: Wrist tendinitis/bursitis. Plan: He had been approved for steroid ganglion injection from Dr. Kohan. Recommended to refill Elavil. Work Status: Remained unchanged.

39. September 19, 2013, Secondary Treating Physician Pain Management Follow-Up Report, Jonathan Kohan, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right wrist, hand and distal forearm. Pain level was 8/10. He was maintained on Neurontin, Relafen, Elavil and Norco. His pain was suboptimally controlled. Received approval for one right stellate ganglion injection. PE: He was visibly uncomfortable. Allodynia was noted in his right hand and wrist with colder temperature when compared to opposite extremity. Decreased grip strength was noted. Impressions: 1) Complex regional pain syndrome type 1. 2) Chronic wrist and hand pain on the right side. Recommendation: Refilled medications. Lyrica to be started. Work Status: Deferred.

40. October 08, 2013, Physician's Progress Report (PR2), Heath Hinze, Psy. D: Subjective Complaints/Objective Findings/Plan: Remained unchanged. Diagnoses: 1) Anxiety disorder. 2) Depressive disorder. 3) Sleep disorder due to pain, insomnia type.

41. October 14, 2013, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right hand and wrist. He was diagnosed with complex regional pain syndrome type 1. On physical examination, decreased grip strength was noted on the right hand. He was obviously uncomfortable. Allodynia was noted. Diagnoses: 1) Wrist tendinitis/bursitis. 2) Hand contusion. Plan: He was going to have stellate ganglion shots by Dr. Kohan. Work Status: Remained unchanged.

42. October 16, 2013 Operative Report, Jonathan Kohan, MD. Pre and Postoperative Diagnosis: Complex regional pain syndrome, right upper extremity. Procedures: 1) Stellate ganglion injection on the right.

43. October 17, 2013, Secondary Treating Physician Pain Management Follow-Up Report, Jonathan Kohan, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right wrist, hand and forearm. Pain level was 7/10. He had undergone a stellate ganglion injection the day before. He did not report any significant amount of improvement at this point. He was maintained on Lyrica, Elavil and Norco. PE: He was visibly uncomfortable. Allodynia was noted in his right distal forearm, hand and wrist. Decreased grip strength was noted. Impression: 1) Complex regional pain syndrome type 1 of the right forearm, wrist and hand. Recommendations: Lyrica to be stopped. Neurontin to be tapered. Formally requested the psychologist to provide with psychological clearance to establish realistic expectations after the implantation of a spinal cord stimulator. Work Status: Deferred.

44. November 11, 2013, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient was status post stellate ganglion block on the upper extremity conducted on October 16, 2013. He stated minimal benefit from this intervention provided by the pain management physician, Dr. Kohan. He continued to complain of right hand pain with hypersensitivity and reduced function. He was status post a right thumb fracture with closed treatment only. Physical examination showed hyperesthesia over the whole right upper extremity. He presented wearing a thumb spica splint. He held the limb in unnatural position and was reluctant to utilize the hand. There was significantly decreased range of motion in the hand and wrist. The grip strength was significantly reduced. There was some skin and hair atrophy noted. Diagnoses: 1) Hand contusion. 2) Wrist tendinitis/bursitis. 3) Finger fracture. Plan: He had now failed to respond to stellate ganglion block. Dr. Haronian opined that the spinal cord stimulation was the next appropriate step. He reported that the patient had significantly reduced function, and he was using opioid pain medication. He opined that the spinal cord stimulator was likely to reduce the patient's pain level and reduce his usage of opioid pain medication, and improve his function. Work Status/Restrictions: No use of the right hand. He should remain on temporary total disability if the work modifications could not be accommodated by the employer. Return to clinic in 6 weeks.

45. November 12, 2013, Physician's Progress Report (PR2), Heath Hinze, Psy. D: Subjective Complaints: Remained unchanged. Objective Findings: The patient appeared to be angry, depressed, fearful and hopeless and affect was restricted. Diagnosis/Treatment Plan: Remained unchanged.

46. November 14, 2013, Secondary Treating Physician Pain Management Follow-Up Report and Request for Authorization, Jonathan Kohan, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right wrist, hand and distal forearm. Pain level was 9/10. The control of neuropathic pain was suboptimal. He was maintained on Lyrica, Elavil and Norco. He was deemed to be a candidate for spinal cord stimulator trial. He was unable to obtain the clearance from psychologist to series of vicissitudes. PE: He was visibly uncomfortable. Allodynia was noted. Decreased grip strength was noted. Impression: 1) Rule out complex regional pain syndrome type 1. 2) Chronic wrist and hand pain on the right side. Recommendation: Lyrica to be stopped. Neurontin to be tapered. Formal request to be placed for authorization for psychological consultation to provide the patient with clearance in order to establish realistic expectations after the implantation of a spinal cord stimulator. Work Status: Deferred.

47. December 10, 2013, Physician's Progress Report (PR2), Heath Hinze, Psy. D: Subjective Complaints: The patient reported to have anger, anxiety and inability to gain pleasure in life. Objective: He appeared to be angry, depressed and hopeless and affect was restricted. Diagnoses: 1) Anxiety disorder. 2) Depressive disorder. 3) Sleep disorder due to pain, insomnia type. Treatment Plan: Requested for 4 sessions of cognitive behavioral therapy and relaxing training sessions.

48. December 10, 2013, Psychotherapy Treatment Summary, Heath Hinze, Psy. D: The patient attended cognitive behavioral therapy sessions from 09/10/13 to 12/10/13.

49. December 12, 2013, Secondary Treating Physician Pain Management Follow-Up Report and Request for Authorization, Jonathan Kohan, MD: Interim History: The patient presented with a complaint of a chronic pain in his right forearm, wrist and hand. Pain level was 6-7/10. He was diagnosed with complex regional pain syndrome type 1 of the right upper extremity and was being considered for spinal cord stimulator as he failed to improve with other means. PE: He was visibly very uncomfortable. Allodynia was noted on the right distal forearm, hand and wrist. Decreased grip strength was noted. Impression: Complex regional pain syndrome type 1 with right forearm, wrist and hand. Recommendation: Continued to await authorization for psychological consult for clearance for spinal cord stimulator. Dr. Kohan opined that the patient had failed to improve with a plethora of conservative treatment and remained to be very symptomatic and he was a strong candidate for the recommended treatment. Formal request to be placed for authorization for purchase of right wrist brace. Work Status: Deferred.

50. January 06, 2014, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient continued to complain of significant pain in the right upper

extremity. Diagnoses: 1) Reflex sympathetic dystrophy of lower limb. 2) Anxiety disorder, not otherwise specified. 3) Depressive disorder, not otherwise specified. 4) Male erectile disorder. 5) Sleep disorder due to pain, insomnia type. 6) Hand contusion. 6) Wrist tendinitis/bursitis. 7) Finger fracture. Plan: He was being seen by Dr. Kohan who diagnosed him with reflex sympathetic dystrophy. Dr. Kohan had requested spinal cord stimulator; however, the patient required to be cleared psychologically prior to that procedure.

51. January 09, 2014, Secondary Treating Physician Pain Management Follow-Up Report, Jonathan Kohan, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right forearm, wrist and hand. Pain level was 9/10. He was diagnosed with complex regional pain syndrome type 1 of the right upper extremity. PE: He was visibly very uncomfortable. Allodynia was noted on the right distal forearm, hand and wrist. Decreased grip strength was noted. Impression: Complex regional pain syndrome type 1 with right forearm, wrist and hand. Recommendations: Norco and Neurontin would be increased. Dr. Kohan reinstated that the patient was a good candidate for the spinal cord stimulation trial. Work Status: Deferred.

52. February 06, 2014, Secondary Treating Physician Pain Management Follow-Up Report and Request for Surgical Authorization, Jonathan Kohan, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right forearm, wrist and hand with numbness, tingling and burning sensation in his right upper extremity. Pain level was 8-9/10. `He was diagnosed with complex regional pain syndrome type 1 of the right upper extremity. PE: He was visibly very uncomfortable. Allodynia was noted on the right distal forearm, hand and wrist. Decreased grip strength was noted. Difference in temperature was noted compared to the opposite distal forearm, hand and wrist. Impression: Complex regional pain syndrome type 1 with right forearm, wrist and hand. Recommendation: Formal request to be placed for authorization for spinal cord stimulator trial on industrial basis. Work Status: Deferred.

53. February 17, 2014, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient continued to experience significant symptomatology of chronic regional pain syndrome in the right upper extremity. Physical examination showed extreme hypersensitivity and hyperesthesia over the right hand. He had significantly reduced range of motion. Skin atrophy was noted. Diagnoses: 1) Hand Contusion. 2) Wrist tendinitis/bursitis. 2) Finger Fracture. Plan: Dr. Haronian recommended that the patient required continued and uninterrupted access to his medical therapy. He explained that there were significant effects of discontinuing this patient's medications in an abrupt fashion and that he required the medical therapy in order to function. Work Status/Restrictions: Remained unchanged.

54. March 06, 2014, Secondary Physician Progress Report (PR-2), Jonathan Kohan, MD: Subjective Complaints: The patient reported depressed mood. Objective Findings: He

appeared depressed and the affect was flat. Treatment Plan: Norco, Neurontin and Levaquin. Work Status: Deferred to PTP.

55. March 06, 2014, Secondary Treating Physician Pain Management Follow-Up Report, Jonathan Kohan, MD: Interim History: The patient reported no changes in his symptoms and continued to be treated for diabetes. He also remained under the care of psychologist with weekly psychotherapy sessions. He had longstanding right upper extremity symptoms of complex regional pain syndrome, which did not respond to multiple interventions. He reported some increasing level of pain after his most recent medication regimen were delayed. PE: Mottling and cold temperature were noted in the right upper extremity with decreased grip. Impressions: 1) Complex regional pain syndrome type 1 of right upper extremity. 2) Diabetes. Recommendations: Formal request would be submitted for medication regimen including Norco, Neurontin and Amitriptyline. Dr. Kohan opined that the neurostimulation trial was the only option available and the patient might be a candidate to undergo permanent placement. Disability and Work Status: Deferred.

56. March 31, 2014, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient was still complaining of pain. He had been cleared from a psychological point of view for the spinal cord stimulator. Diagnoses: 1) Reflex sympathetic dystrophy of lower limb. 2) Depressive disorder, not otherwise specified. 3) Male erectile disorder. 4) Sleep disorder due to pain, insomnia type. 5) Hand contusion. 6) Wrist tendinitis/bursitis. 7) Finger fracture. Plan: Formal authorization was being requested for the spinal cord stimulator. Dr. Haronian recommended that the patient remain off of work as he had significant difficulty with the use of his right arm.

57. April 03, 2014, Secondary Treating Physician's Pain Management Follow-Up Report and Request for Surgical Spinal and Nonsurgical Authorization, Jonathan Kohan, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right arm with numbness, tingling and burning sensation, which precluded him from performing activities of daily living. He was diagnosed with complex regional pain syndrome type 1 of the right upper extremity. He was also receiving treatment for his diabetes. Spinal cord stimulator trial was requested. PE: He was visibly uncomfortable. Mottling and cold temperature of the right upper extremity were noted with decreased grip strength. Impression: 1) Complex regional pain syndrome type 1 of right upper extremity. 2) Right wrist tendinitis/bursitis. Recommendations: Formal request to be placed for authorization for spinal cord stimulator trial on industrial basis and for refill of Norco, Neurontin and Elavil. Work Status: Deferred.

58. May 01, 2014, Secondary Physician's Progress Report (PR-2), Jonathan Kohan, MD: Interim History: The patient complained of depression with anxiety and reported depressed mood. Objective Findings: He appeared agitated and depressed. Diagnoses: 1) Wrist tendinitis/bursitis. 2) Hand contusion. 3) Reflex sympathetic dystrophy of lower limb. Treatment Plan: Norco 10/325 mg, Neurontin 900 mg and Levaquin 500 mg. Work Status: Deferred.

59. May 01, 2014, Secondary Treating Physician Pain Management Follow-Up Report and Request for Authorization, Jonathan Kohan, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right arm with numbness, tingling and burning sensation, which precluded him from activities of daily living. He was scheduled for the spinal cord stimulator trial on May 14, 2014. He was diagnosed with complex regional pain syndrome type 1 of the right upper extremity. He was also receiving treatment for his diabetes. PE: He was visibly uncomfortable. Mottling and cold temperature of the right upper extremity were noted with decreased grip strength. Impression: 1) Complex regional pain syndrome type 1 of right upper extremity. 2) Right wrist tendinitis/bursitis. Recommendation: Formal request to be placed for authorization for refill of Norco, Neurontin and Elavil. Provided prescription for Levaquin. Work status: Deferred.

60. May 12, 2014, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient presented with the complaint of pain. He had been cleared to proceed with the spinal cord stimulator. Diagnoses: 1) Reflex sympathetic dystrophy of lower limb. 2) Anxiety disorder, not otherwise specified. 3) Wrist tendinitis/bursitis. 4) Depressive disorder, not otherwise specified. 5) Male erectile disorder. 6) Sleep disorder due to pain, insomnia type. Plan: He was noted to be smoking. He was instructed in regards to smoking cessation as well as its negative effect on wound healing. Advised to continue off of work.

61. May 14, 2014, Operative Report, Jonathan Kohan, MD: Pre and Postoperative Diagnosis: Sympathetically-mediated neuropathic pain, right upper extremity. Procedures: 1) Percutaneous implantation of spinal cord stimulation leads x 2, cervical spine. 2) Myelogram. 3) Complex programming. 5) Fluoroscopy.

62. May 19, 2014, Secondary Treating Physician Pain Management Follow-Up Report, Jonathan Kohan, MD. Interim History: The patient was continued on Norco and Gabapentin. Impression: Complex regional pain syndrome. Recommendation: A request would be submitted for permanent placement of the spinal cord stimulator unit. Requested authorization for Elavil as well. Neurontin and Norco would be refilled. Disability and work status were deferred.

63. June 19, 2014, Secondary Treating Physician Pain Management Follow-Up Report and Request for Authorization, Jonathan Kohan, MD: Interim History: The request for permanent placement of his neuromodulation unit had been submitted for review on June 13, 2014. Physical Examination: There were no changes in his left upper extremity mottling and hyperhidrosis. Impression: 1) Complex regional pain syndrome, right upper extremity type 1. 2) Right wrist tendinosis. Recommendation: Authorization and request would be submitted for his medication regimen of Elavil, Neurontin and Norco. Disability and work status were deferred.

64. June 23, 2014, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient continued with significant right hand and right upper extremity pain with numbness, weakness, and a "pins and needles" sensation. He complained of temperature changes as well as color changes of the right upper extremity. He was status post right thumb fracture with resultant complex regional pain syndrome. He underwent a spinal cord stimulator trial on May 14, 2014 with fairly significant improvement in his pain and range of motion. He had developed left wrist pain with decreased range of motion, weakness, and numbness as a compensatory consequence of favoring his right upper extremity. On examination, the patient was wearing a Thumb Spica brace for the right hand. Significantly reduced grip strength was noted in both hands. Allodynia and color changes were noted over the right wrist. Edema was noted of the right forearm. Diagnoses: 1) Hand contusion. 2) Wrist tendinitis/bursitis. 3) Finger fracture. 4) Reflex sympathetic dystrophy of upper limb. Plan: Advised to continue with Gabapentin, Norco and Elavil and Dr. Haronian opined that it could be dangerous to the patient's health if these medications were non-certified and/or discontinued. Work Status/Restrictions: Remained unchanged.

65. July 17, 2014, Secondary Treating Physician Pain Management Follow-Up Report, Jonathan Kohan, MD: Interim History: The patient reported no changes in his complaints in his upper extremities, which were more severe on the right side. There was complaint of weakness and numbness in his left upper extremity. His current regimen of medication included Gabapentin, Norco and Elavil. Plan: He was awaiting spinal cord stimulation implantation, which was scheduled for late August 2014. A request for 10 tablets of Levaquin 500 mg would be requested for prophylaxis purposes afterwards. He should be considered total and temporarily disabled for at least three months after the procedure was performed. Advised to followup on 09/04/14.

66. August 04, 2014, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient continued to complain of significant pain in the right upper extremity. Diagnoses: 1) Anxiety disorder, not otherwise specified. 2) Depressive disorder, not otherwise specified. 3) Male erectile disorder. 4) Sleep disorder due to pain, insomnia type. Plan: Authorization had been provided for permanent placement of the spinal cord stimulator and the surgery was scheduled for August 28, 2014. Dr. Haronian indicated that the patient would remain on temporary total disability since he was significantly symptomatic.

67. August 27, 2014, Operative Report, Jonathan Kohan, MD: Pre and Postoperative Diagnosis: Complex regional pain syndrome. Procedures Performed: 1) Percutaneous implantation of spinal cord stimulation leads x 2, cervical spine. 2) Implantation of pulse generator. 3) Myelogram. 4) Complex programming. 5) Somatosensory evoked potential.

68. September 04, 2014, Secondary Treating Physician Pain Management Follow-Up Report, Jonathan Kohan, MD: Interim History: The patient was status post percutaneous implantation of spinal cord stimulator. Impressions: 1) History of complex regional pain

syndrome. 2) Status post recent spinal cord stimulation implantation, cervical spine. Recommendations: Both incisions were redressed. Recommended to continue Levaquin and soft cervical collar. Disability Status: Total and temporarily disabled for at least three months.

69. September 09, 2014, Secondary Treating Physician Pain Management Follow-Up Report, Jonathan Kohan, MD: Interim History: The patient underwent permanent replacement of his cervical neural modulation system on August 27, 2014. His burning pain had resolved with the use of the stimulator. Impression: 1) History of complex regional pain syndrome. 2) Status post recent neural modulation implantation. Recommendations: Refill of medication would be provided. Dose of Norco and Gabapentin would be reduced. Continue with Elavil to benefit both pain and insomnia.

70. September 15, 2014, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient was last seen on April 14, 2014. He continued to complain of neck and back pain radiating into the upper and lower extremities with pain, paresthesia, and numbness. He continued to experience anosmia and he stated that this was due to chemical exposure in the work place. Dr. Haronian opined that this should be addressed on an industrial basis. The patient was status post medical legal evaluation during the month of July 2014 and that report was requested for Dr. Haronian's review. Review of Diagnostic Studies: The neuro-diagnostics of the lower extremities conducted on April 2, 2014 was reviewed, which showed left peroneal entrapment neuropathy. Physical Examination: Showed spasm, tenderness and guarding in the paravertebral musculature of the cervical and lumbar spine with loss of range of motion in both. Diagnoses: 1) Cervical radiculopathy. 2) Lumbosacral radiculopathy. 3) Wrist tendinitis/bursitis. Plan: Dr. Haronian reported receiving a denial for the medical therapy, which had been appealed. The patient was at his usual and customary work and was self-regulating to avoid exacerbating his industrial injury. He was advised to followup in four weeks.

71. October 16, 2014, Secondary Physician's Progress report (PR-2), Jonathan Kohan, MD: Subjective Complaints: The patient reported to be adjusting with the spinal cord stimulator but was feeling sharp pain in abrupt movements. He reported still struggling with financial strain, which was a constant stressor for him. He reported that he was feeling as if he was devalued as a person by the lack of respect he was receiving from his attorneys and doctors, which had impacted his self-esteem and mental status. He reported feeling angry, anxious, depressed mood, loss of control, hopeless, inability to gain pleasure in life, irritability, isolation from others, loss of appetite, sleep disturbances, struggling with activities of daily living, withdrawing from family and friends, worry about financial strain, worry about pending deposition, and worry about persistent pain. Objective Findings: He appeared apathetic, dysphoric, euthymic and fatigued. Affect was flat. Diagnoses: 1) Hand contusion. 2) Wrist tendinitis/bursitis. 3) Finger Fracture. 4) Anxiety disorder. Treatment Plan: Same day's evaluation showed Beck Anxiety Score of 43 (severe) and Beck

Depression Score of 42 (severe). Prescribed Elavil 50 mg, Neurontin 300 mg and Norco 7.5/325 mg. Work Status: Deferred to PTP.

72. October 16, 2014, Secondary Treating Physician Pain Management Follow-Up Report, Jonathan Kohan, MD: Interim History: The patient was seen for follow up visit and he was recovered from his recent procedure in the form of implantation of his spinal cord stimulation and continued benefitting from it. He had been using the unit around-the-clock and reported 50% improvement in his right upper extremity symptoms and particularly reported improvement of the burning pain, which was his major issues before the implantation was done. He had some symptoms on the left upper extremity, but not as severe. Currently he was on Gabapentin 1800 mg a daily with Norco 10 mg and Elavil 50 mg at night. Physical Examination: Well healed incisions were noted over the thoracic spine and lower back on the left. Color change and some mottling were noted on the left upper extremity with weak grip. Impressions: 1) Complex regional pain syndrome right upper extremity. 2) Status post spinal cord stimulation implantation. Recommendations: He reported 50% improvement overall and his unit was reprogrammed further same day. Gabapentin and Norco dose would be reduced. Elavil to be continued. He was advised to rely on the use of his stimulator and attempt to take less medication. Advised to followup in 4 weeks.

73. December 08, 2014, Follow-up Report and Request for Authorization of a Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient was significantly depressed, anxious, describes insomnia and was stressed. He was taking Elavil previously, which helped to improve his mood and help to reduce his anxiety and depression. He was treating with Dr. Kohan who was the pain management physician. He performed surgery for spinal cord stimulator implantation. He indicated that the spinal cord stimulator had helped to reduce his pain and increased his functional capacity; however, he did continue to be symptomatic. He had difficulty with his daily activities as well as gripping, grasping, lifting, pushing, and pulling. He had difficulty sleeping and was awakening due to pain and discomfort. Diagnoses: 1) Mononeuritis, not otherwise specified. 2) Reflex sympathetic dystrophy of upper limb. 3) Reflex sympathetic dystrophy of lower limb. 4) Hand contusion. 5) Wrist tendinitis/bursitis. 6) Finger fracture. Plan: Requested authorization for 12 sessions of physical therapy. Dr. Haronian indicated that the patient was also describing pain in his left upper extremity due to favoring of the right upper extremity. Advised to remain on temporary total disability.

74. June 02, 2015, Permanent and Stationary Comprehensive Psychological Evaluation of a Secondary Physician, Heath Hinze, Psy. D: Interim History: The patient was seen for an initial evaluation on May 07, 2017. He was diagnosed with depressive disorder, not otherwise specified; anxiety disorder, not otherwise specified; sleep disorder due to pain insomnia type; and marked erectile disorder. He was started on a trial of cognitive behavioral therapy. At that time he was on Lexapro. A psychiatric consultation was also recommended. He returned and maintained active participation in treatment. As he was pending a spinal cord stimulator trial, a psychological surgical clearance evaluation was

conducted on 02/04/14. He underwent the trial in May 2014 and permanent placement on 08/27/14. He reported that his primary treating physician was changed to Dr. Kohan. He remained off work though apparently he was given a work restriction that he could return to work so long as he did not use his right hand. He apparently had a PQME with Dr. Aval, orthopedist on June 30, 2015. Review of Records: Dr. Hinze reviewed Dr. Kohan's followup report dated May 13, 2015.

Diagnoses:

Axis I: 1) Anxiety disorders, not otherwise specified. 2) Depressive disorder, not otherwise specified.

Axis II: No diagnosis.

Axis III: Deferred to appropriate medical specialist.

Axis IV: Psychological and environmental problems: Financial hardship, ongoing need for medical attention and chronic pain.

Axis V: Global Assessment of Functioning (GAF): 60 (time of evaluation).

Discussion: The patient reported that due to overuse, he gradually developed compensatory left hand pain, which at times was worse even than the right hand. He stated that he could not find work with the imposed work restrictions since plumbing requires use of both hands. Dr. Hinze opined that the patient had reached a point where he was struggling to use his left hand due to overuse. He reported that there were financial hardships and tension with his girlfriend due to his state disability benefit was ending a couple of months before they became exhausted. He stated that he was going through episodes of depression because of his ongoing life changes and struggles to meet the financial obligations each month. He added that there had been a gradual worsening of his anxiety. He stated that out of the blue he would be experiencing rapid heart rate, shortness of breath and trembling. He complained of deficits of sleep onset and maintenance due to increased pain to the right upper extremity. He stated that he was awakening feeling lethargic. He complained of continued erectile dysfunction and general loss of his libidinal drive. He complained of forgetfulness and low appetite. He was continuing with Elavil. Dr. Hinze opined that the patient had been left with residual psychiatric impairment secondary to this work injury.

Causation/Apportionment: Dr. Hinze opined that the events of the employment were the predominate cause (greater than 51%) of this patient's emotional psychological injury. No apportionment was indicated for nonindustrial factors. AMA Impairment Rating: WPI: 15% (mild impairment that was equivalent to GAF 60). Work Restrictions: Dr. Hinze opined that any duties that would exacerbate the patient's 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. He was advised to avoid taking on high pressure positions or those requiring strict adherence to production quotas. He was also recommended to avoid taking on night shift positions as that might further disrupt his sleep cycle. Future Psychological Recommendations: Recommended 24 behavioural therapy and relaxation training sessions to be set aside and used intermittently to maintain stability and to confront this chronic condition. He should have access to psychiatric consultations for medication management. Further evaluations and diagnostic studies should be available to assess his progress in treatment.

Patient Work Function Impairment:

a) The patient's level of impairment for ability to comprehend and follow instructions, relate to other people beyond giving and receiving instructions, and accept and carry out responsibility for direction, control, and planning was slight to moderate.

b) His level of impairment for ability to perform simple and repetitive task, influence people, and make generalizations, evaluations or decisions without immediate supervision was slight.

c) His level of impairment for ability to maintain a work pace appropriate to a given work load and perform complex or varied tasks was moderate.

75. June 30, 2015, Panel Qualified Medical Evaluator Orthopedic Evaluation, Soheil M. Aval, M.D.: DOI: 07/11/12. History of Injury: Remained unchanged. Current Complaints: The patient complained constant pain to the right wrist, hand and thumb, which radiated to the right forearm with a burning sensation. He had pins and needles sensation to the right hand, wrist and forearm with sharp pain to the back of the hand. He also noted numbness and tingling to the right hand and all fingers. His pain increased with usage of the right hand, carrying, lifting and writing. The pain did awaken him from sleep. The left wrist and hand pain was intermittent and localized with numbness and tingling to the left hand and fingers. He related difficulty sleeping in addition to anxiety and depression. He also described stomach upset and difficulty with sexual functions. Activities of Daily Living: Activities of Daily Living were reviewed. Past Medical History: Eyes injury in 2010 after acid splashed into his eyes; diabetes. Current Medications: He was on Metformin, Neurontin, Elavil, and Norco. Review of Records: Dr. Aval reviewed the patient's medical/nonmedical records dated from July 13, 2012 to May 27, 2015. PE: He was right hand dominant and had difficulty using the right hand and upper extremity. There was diffuse swelling apparent about the entire right hand. There was tenderness to palpation over the entire right hand in addition to diffuse allodynia. He had difficulty with movement and usage of the right hand, a lot of this was guarding. Phalen's and Tinel's signs were equivocal bilaterally. There was hyperesthesia to the entire right hand, with decreased sensation, grade 4/5, about the tips of all digits on the right hand. He had grip loss secondary to pain with attempts at grasping. There was abnormal cooler temperature about

the right hand. Diagnostic Studies: X-rays of the bilateral hands were performed and reviewed, which did not reveal any acute abnormalities.

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: Dr. Aval opined that though the patient had received appropriate treatment for his injury; however, he unfortunately developed chronic regional pain syndrome in the right upper extremity. He was advised to remain under the care of Dr. Kohan for medication and future injections. Dr. Aval did not recommend surgery given the patient's sympathetically mediated pain. According to him, if the patient were to undergo carpal tunnel release surgery, most likely his symptoms would significantly worsen. MMI Status: He had reached MMI status. Causation/Apportionment: Dr. Aval opined that the causation was 100% industrial. Impairment Rating: Right Upper Extremity: 25% WPI. Work Restrictions: He was precluded from activities of repetitive or forceful gripping, fine manipulation, torqueing, and heavy lifting with the right upper extremity based on which permanent work restrictions were indicated. If his employer could not accommodate these restrictions, he would be unable to return to his prior occupation. Future Medical Care: He 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 and he should remain under the care of Dr. Kohan, for provision of various injections and monitoring, adjusting, and dispensation of medications. The spinal cord stimulator should be monitored as well.

76. <u>June 21, 2016, Psychiatric QME Report, Daphna Slonim, M.D.</u>: DOI: 07/11/12. History of Injury: Remained unchanged. Interim History: Dr. Kohan diagnosed reflex sympathetic dystrophy and the patient was given a neck injection, which did not help. In August 2014, Dr. Kohan installed a spinal cord stimulator. He released the patient from his care in September 2015 and stopped his spinal cord stimulator without even notifying him. It was only in February 2016, when the attorney was able to refer the patient to Dr. Baker (pain management specialist) for treatment. He also saw a psychologist Dr. Hinze, about 2-3 times over a couple of years. He only received group therapy once a week, with different therapists. He did not receive any individual psychotherapy. He felt it was "informative" but did not help much. He was released by Dr. Hinze around May 2015, around the same time he saw QME orthopedist, Dr. Aval. He reported that he was never referred for psychiatric evaluation nor received any psychotropic medications, other than Elavil. He reported that when the spinal cord stimulator turns high, it would take the burning pain in the right forearm from 10/10 to 5-6/10 but he also had a buzz in his knees, ankles, and hips. Since the subject work accident, he had a jerky tremor of the left upper and lower extremity. He was told by one of PA's at the Dr. Kohan's office that it could be the side effects of Neurontin. He was taking 800 mg four times per day and when the dose was cut down, the pain would be increasing. Dr. Baker had prescribed him Elavil 50 mg,

to be taken in the evening. Other than Dr. Baker, he was only seeing his general practitioner, Dr. Bao Thai, under MediCal. She was treating him for his diabetes and high blood pressure conditions. He was prescribed Metformin 1000 mg, Glipizide 5 mg as well as an unrecalled medication for blood pressure. Both his blood pressure and diabetes had been under control.

He had been seeing Dr. Baker once a month. Workers' Compensation paid temporarily total disability checks for two years. He then was getting money from State Disability until August 2015. When Dr. Kohan cut his off, he then got welfare and food stamps. Dr. Baker, again put him on spinal cord stimulator. He applied for social security in January 2015, but it was denied. He appealed it with attorney and was scheduled for a hearing on September 12, 2016. He would have to go back on welfare. He was living with his girlfriend for eight years and she had been supporting him. She had been on Social Security Disability, as well as her late husband's Social Security. Because of his financial problems, he had to sell most of his belongings, including his truck. He had been living in constant fear that his girlfriend would kick him out. Current complaints: He had a burning pain in the right forearm up to his elbow, rated 6/10, with the stimulator, going up to 10/10 when he turned it off. He had pain in the left wrist rated 9/10; with the stimulator, rated 5/10. He had pain in the anal area constantly, rate 5-10/10. He had pain in both knees when moving, 5-9/10. He had headaches 2-3 times per week, lasting about one hour, rated 7-8/10. He was impotent since shortly after the accident. He had shaking/twitches in his left leg and hand. The left side of his mouth seemed to be paralyzed. He had pressure in the chest a few times a day almost every day, lasting about 10-15 minutes. Sometimes he had it when he took a shower with rapid heartbeats. His throat was very dry, and it made him feel he was choking. He also had difficulty swallowing because of it. He had abdominal pain daily with nausea. He had constant ringing in his ears. He felt physically weak and was extremely constipated and had to take stool softeners.

Emotional complaints: The patient felt sad, discouraged and dissatisfied all the time. He had suicidal ideation. He lost his self-confidence and felt he looked ugly. He had no energy and motivation. He had no appetite. He lost interest in other people. He felt fatigued and could not sleep properly. He was worried about his physical and financial health. He felt tensed, impatient, anxious, restless, nervous, and was unable to relax. He had problems with his short term memory. Employment History: At age 17, he worked for a fire sprinkler company, first in manufacturing and then installing. He worked there until age 22. He then started working as a plumber at Benedict & Benedict until 1999. Then he moved to Nevada doing plumbing on new homes for 3 years. He came back to assist his mother after an accident. He then moved to Alabama and worked as a plumber for Dean plumbing for 3 years. He then worked for East Plumbing for a few years. Then he moved to Indiana and worked there as a plumber for 3 companies until November, 1997. He came to California to work where he worked as a self-employed plumber. He worked for Dr. Drain from where he was laid off and was on unemployment. He re-started working for Benedict & Benedict in 2009. PMH: Anal fistula. Current medications: Neurontin, Elavil,

Metformin, Glipizide. Review of records: Dr. Slonim reviewed the patient's medical/nonmedical records dated from 07/13/12 to 04/11/16.

Diagnoses:

Axis I: 1) Major depression, single episode, severe. 2) Anxiety disorder, not otherwise specified. 3) Psychological factors affecting medical condition. 4) Insomnia due to orthopedic pain. 5) Insomnia due to Axis I diagnoses. 6) Pain disorder with both psychological factors and a medical condition.

Axis II: Immature, histrionic, and avoidant personality traits.

Axis III: 1) Reflex sympathetic dysfunction, 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: 1) Occupational problems. 2) Problems with primary support groups. 3) Economic problems.

Axis V: 1) Current GAF: 55. That was equivalent to 23% WPI.

Disability Status: Dr. Slonim opined that the patient's was never temporarily totally disabled purely from a psychiatric point of view. He also opined that the patient's condition could be regarded as permanent and stationary with moderate psychiatric disability. Causation: Dr. Slonim opined that industrial causation was preponderant to all other causes combined in the psychiatric disability of this patient. He indicated that good faith personnel action was not a substantial factor. He added that; however, AOE/COE (Arising Out of Employment/during the Course of Employment) was a legal and not a medical decision, so he would leave it to the Trier of Fact. Nonindustrial Stressors: Anal fistula that was causing pain and discomfort. He also admitted being worried by his financial situation and problems with his girlfriend that were caused by these but also by his impotence, depression, and inability to function. He reported difficult childhood caused by his father's "military style" of being strict and critical and being very disappointed in his failure in school. He 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. He reported his 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. In addition, he had preexisting diabetes. He also had 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. He had preexisting personality traits as well.

Apportionment: Dr Slonim indicated that 20% was apportioned to pre-existing and non-industrial factors as outlined above, 20% was a result of financial worries and 60% was apportioned to the industrial injury of 07/11/12. Impairment rating: 23% WPI (Current GAF was 55). Recommendations: 1) Recommended referring the patient to a proctologist for consultation to rule out industrial causation. Dr. Slonim commented that it was probable that it resulted from the patient's constipation, which was probably a side effect of the Neurontin. 2) A neurological consultation was also recommended given the fact that Neurontin might also cause Parkinson's-like shaking on the left side, which was interfering significantly with his ability to function. 3) Dr. Slonim added that even though the patient scored only 2 on the Epworth Sleepiness Scale, the score of 23 (severe insomnia) on the Insomnia Severity Index was much more accurate in this case. He recommended polysomnogram in a good place to more accurately determine WPI for sleep and arousal issues. Work Restrictions: He should avoid stresses at work. Vocational Rehabilitation: Not indicated from a psychiatric point of view. Future Psychiatric Care: He would benefit from psychotropic medication and should be under psychiatric care once a month for at least 2 years. More intensive psychological or psychiatric care should be made available in case of deterioration in the future.

AMA Disability Rating:

1) Disability to perform activities of daily living identified as slight/moderate impairment. Social function - slight/moderate impairment.

2) Concentration, persistence and pace - slight impairment.

3) Deterioration or decompensation in complex or work like setting - moderate impairment.

77. <u>August 15, 2016, Pain Medicine Re-Evaluation, Gary L. baker, MD, QME:</u> DOI: 07/11/12. Interval History: The patient had completed a fluoroscopic evaluation of the spinal cord stimulator on 03/15/16 as well as it's reprogramming. Insomnia secondary to pain was worsening. He has had ongoing difficulty charging the spinal cord stimulator IPG/battery due to malposition of the battery and he had limited use of right hand to position charger to overcome malposition. He also reported night-time aggravation of right upper extremity symptoms as he was not protecting the arm adequately while sleeping. He was requesting splint to protect right wrist/hand for night-time use only. Instructed to avoid daytime use to avoid atrophy or loss of ROM. Subjective Complaints: 1) Neck pain: The pain was radiating down the bilateral upper extremities. 2) Upper extremity pain: The pain was in the right wrist, hand, fingers and thumbs with radiation to the right forearm. The pain occurred constantly and was aggravated by hand function. He described the pain as burning, electricity, sharp and moderate in severity. His pain was accompanied by muscle weakness, numbness and tingling. Pain was rated as 7/10 in intensity with medications. Pain was rated 10/10 in intensity without medications. Also, there was intermittent pain in the left wrist and hand with numbness and tingling. 3) Non-orthopedic

complaints: a) Insomnia. b) He reported continuous nausea. c) He also reported constipation. Activities of Daily Living: Activities of Daily Living were reviewed. Current Medications: 1) Amitriptyline Hcl 50 mg. 2) Neurontin 800 mg. 3) Glipizide 10 mg. 4) Metformin 2000 mg. Physical Exam: Height: 6'0." Wight: 175 pounds. **Hand Dominance: Ambidextrous.**

The patient was observed to be in moderate distress. Cervical Spine: Spinal vertebral tenderness was noted in the cervical spine C5-C7 dermatome. The range of motion of the cervical spine was moderately limited due to pain. Pain was significantly increased with flexion, extension and bilateral rotation. Sensory examination showed decreased sensitivity to touch along the C5-C7 dermatome in the right upper extremity. Upper Extremity: The range of motion exam of the right hand showed limited extension of fingers. Grip strength testing with the Jamar Hand Dynamometer (lbs.) was 60, 60 and 50 on the left and was not possible to perform on the right. Diagnoses: 1) Ongoing type 2 complex regional pain syndrome; right upper extremity. 2) Peripheral neuropathy. 3) Status post spinal cord stimulator; implant. 4) Diabetes mellitus, type 2 with hyperglycemia - stable. 5) History of right thumb non-displaced fracture; malposition spinal cord stimulator/IPG/battery. Treatment Provided: Spinal cord stimulator system adjusted with Medtronic rep to optimize pain coverage. System otherwise was working well but having continued problem with properly charging the spinal cord stimulator unit. Work Status: Currently not working. Based on his current condition, he was considered total temporarily disabled and had been instructed to remain off work for 1 month. Treatment Plan: Right wrist/hand splint with thumb spica. Additional Treatment Recommendation: He was awaiting replacement of a spinal cord stimulator battery. The battery migrated and was poorly positioned for the charger. Follow up: He would return to the clinic for follow up in 1 month.

78. September 12, 2016, Pain Medicine Re-Evaluation, Gary L. baker, MD, QME: Interval History: The patient's insomnia secondary to pain was worsening. He was requesting to replace current spinal cord stimulator's IPG/Battery with a non-rechargeable one. He has had ongoing difficulty charging the spinal cord stimulator IPG/Battery due to malposition of the battery and he had limited use of right hand to position charger to overcome malposition. The spinal cord stimulator IPG/Battery appeared to have either moved or was malpositioned initially so that it did not flush with his skin. It was also painful in its current position. The spinal cord stimulator was working well so the leads would not have to be replaced. He also reported night-time aggravation of right upper extremity symptoms as he was not able to protect the arm adequately while sleeping. Splint was received and was helpful with sleep but it was 1 size too small. He was in the process of getting it re-done. Subjective Complaints: 1) Neck pain - the pain was radiating down the bilateral upper extremities. 2) Upper extremity pain: There was constant pain in the right wrist, hand, fingers and thumbs that was radiating to the right forearm. His pain was accompanied by muscle weakness, numbness and tingling. Pain was rated as 8/10 in intensity with medications. Pain was rated 9/10 in intensity without medications. There was intermittent pain in the left wrist and hand with numbness and tingling. His pain was reported as

recently worsened. 3) Non-orthopedic complaints: a) Insomnia. b) He reported continuous nausea. c) He also reported moderate constipation. Activities of Daily Living: Activities of Daily Living were reviewed. Current Medications/Physical Exam/Diagnoses/Work Status: Remained unchanged. Treatment Provided: Spinal cord stimulator system adjusted with Medtronic rep to optimize pain coverage. System was otherwise working well but having continued problem with properly charging the spinal cord stimulator unit.

79. <u>November 17, 2016, Neurological Agreed Medical Evaluation, Mark R. Pulera, M.D., Q.M.E.:</u> DOI: 07/11/2012. Employment History: The patient stated he began working for Benedict & Benedict Plumbing Company in approximately 2009 as a journeyman plumber. He had done primarily residential plumbing but also some commercial plumbing. He had performed plumbing activities such as remodeling a bathroom. He would typically report to the shop at the beginning of the day. Then he would drive a company vehicle typically with automatic transmission to the worksite. The work sites were typically 10 miles or less from the shop. He would typically drive a maximum of less than 100 miles a day. He would be on call to receive new plumbing jobs. He would receive a call and go to the job site. He would have six or seven jobs a day. He would install water heaters, kitchen faucets, or copper piping. He would clean drains with a snake cable. He would install dishwashers or garbage disposals. He indicated that his job as a plumber would require a lot of lifting. Typically, the heaviest item he would lift would be a water heater at a height of 17 inches above the ground. He estimated the weight of the water heater to be a few hundred pounds. Other physical demands included lots of crawling, kneeling, and bending. He indicated that on certain plumbing jobs he would have a helper if he requested one from his employer. Typically, he would be on call at a week at a time every other week. He worked 40 hours per week on average. He noted he first began working for this company in approximately 1986 until early 1990s. He has had the same job duties as a journeyman plumber. Then, after the early 1990s, he left to take another plumbing job in Nevada with the same employer.

    The patient did report an injury in this previous period of employment with this employer. He could not recall the date and did not file a claim. Regarding the previous injury, he stated that the owner at that time, Steve Teitz, sent him to a physician. He could not recall the details except to note that he apparently had a bruised coccyx. He estimated he missed three or four days with this injury but made 100% recovery. He reported that he suffered another injury after he restarted working for the company in approximately 2009. He was working on a drain that actually had acid in it without his knowledge. He cut the pipe, which contained acid in a basement. The acid from the cut pipe splashed in his eye. He was in Arcadia, California at that time. He went to an urgent eye care center through workers' compensation insurance. He missed a few days of work but made a 100% recovery. He stated the next injury, which occurred at work through this employer was the one on 07/11/2012. HPI: Remained unchanged. Interim History: He stated that Dr. Kohan first implanted a temporary spinal cord stimulator in May 2014 and a permanent spinal stimulator on 08/28/2014. Over the last six months or so, with the spinal cord stimulator,

his typical pain level was 5/10. He estimated that on treatment with Gabapentin alone without the spinal cord stimulator, the pain levels would typically be at 7 or 8/10. Once he stopped the Gabapentin, the pain level would reach 10/10. Once this spinal cord stimulator was implanted on 08/28/2014, the insurance company did not approve Gabapentin treatment. However, currently he was on Gabapentin and was taking it along with Elavil. He indicated that since the injury on 07/11/2012, he had increased headaches. He stated that he had memory problems as well.

The patient added that his girlfriend noticed involuntary movements, which he stated he had reported to his private physician, Dr. Bahthoi. He did note some level of frustration, anxiety, and/or depression as a result of this injury. He had seen a mental health provider regarding this. He had complained of sleep difficulty after the injury. He stated that once he was in bed, he would turn the stimulator off essentially every night and he would feel increased pain, but he was able to fall asleep. He stated that the stimulator caused essentially a constant buzzing, which might mask a drowsy feeling. In addition, he reported that he might rarely snore but was unsure when snoring started in his life. He also noted he had 10-15 weight gain since the date of injury. Furthermore, there was mild gait instability since at least the time that the spinal cord stimulator was implanted on 08/28/14. Current Symptoms: 1) Emotional dysfunction such as frustration, anxiety, or depression. 2) Sleep complaints. 3) Headache. 4) Two types of pain in the right thumb, hand, wrist, and proximal forearm. 5) New onset abnormal involuntary movements of unknown etiology with complaints of decreased speech volume. 6) Memory complaints. 7) A buzzing sensation in the body after spinal cord stimulator implantation. 8) Mild unsteady gait. PMH: History of fall with a bruised coccyx, umbilical hernia. Medications: Gabapentin, Elavil, BP medication, Metformin, Glipizide, allergy medication.

Previous employment: From approximately 1983 to 1988, the patient worked for a fire sprinkler company. From 1986 to late 1990s, he first worked for Benedict & Benedict Plumbing Company and had injury to the coccyx. Then he worked for short time for Mesquite Plumbing. He also worked for a few years for Alhambra Plumbing and East Plumbing. Then he moved to Indiana and was the union plumber for several companies. Then he moved to California and was self-employed as a plumber for many years. In 2006, he worked for a plumbing company in Bishop, California. Then he began working for Benedict & Benedict Plumbing again in 2009. Review of Records: Dr. Pulera reviewed the patient's medical/nonmedical records dated from 07/11/2012 to 09/12/2016.

Dr. Pulera ROR also included following medical records that were not provided for Dr. Gofnung's review:

a. **<u>02/04/2014, Psychological Consultation, Heath Hinze, Ph. D</u>: On mental status examination, the patient appears slightly nervous with trembling in the left hand. The patient reported increased pain in the left hand that he relates to overuse. The patient demonstrated intact memory and orientation. Psychological testing was performed showing severe levels of subjective anxiety and depression. The patient had been receiving cognitive behavioral therapy from this office. Conservative care brought**

no improvement to the symptoms of the physical injury. The patient was hoping for at least a 50% reduction of the pain with the spinal cord stimulator. The patient continued to have neurovegetative signs with impaired sleep. Apparently, the Elavil now was described as causing grogginess resulting in the dosage decreased from 50 mg to 40 mg at night. At night, it is difficult for him to sleep because he feels "too wound up." He reported problems in concentration, focus, and memory. It was stated based on available information, the patient does not present with a major mood disorder or anxiety disorder that is sufficiently severe to interfere with the success or failure of the spinal cord stimulator trial. Therefore, he presents as a qualified candidate from a psychological perspective to undergo the recommended spinal cord stimulator trial. Authorization was requested for six treatments of cognitive behavioral therapy.

b. **<u>02/11/2014, Psychological Progress Note, Heath Hinze, Ph. D</u>: There was anxiety and depression requiring treatment.**

c. **<u>05/08/2014, Internal Medicine Evaluation Report, Malu Reddy, M.D</u>: This was a preoperative consultation for the surgical spinal cord stimulator. Medications were only described as Metformin and Neurontin 900 mg three times a day. On physical examination, he was in no acute distress. Diagnosis were neuropathy, diabetes, benign essential hypertension, and fracture of the hand. He was medically cleared for the surgery.**

d. **<u>09/16/2014, Psychological Progress Note, Heath Hinze, Ph. D</u>: Diagnoses were reflux sympathetic dystrophy, hand contusion, wrist tendonitis and bursitis, and finger fracture. The patient had ongoing psychological symptoms.**

e. **<u>10/14/2014, Psychological Progress Note, Heath Hinze, Ph. D</u>: There was anxiety disorder, depressive disorder, erectile disorder, and sleep disorder noted.**

f. **<u>12/12/2014, Pain Management Follow Up Note, Jonathan Kohan, M.D</u>: The patient has the spinal cord stimulator implanted and is taking Norco 7.5 mg, Gabapentin 300 mg, and Elavil 15 mg. He is having difficulty obtaining medication from the insurance provider. In particular, there was a denial for Elavil indicating that psyche was not an accepted body Part. Authorization was requested for Norco, Gabapentin, and Elavil.**

g. **<u>01/16/2015, Pain Management Follow Up Note, Jonathan Kohan, M.D</u>: The patient continues to benefit from the spinal cord stimulator reporting no less than 40% improvement in the upper extremity symptoms. There is no burning in the upper extremities. The patient denied any aberrant sensation or issues with charging the unit. He does report feeling buzzed in the right, leg which he attributes to the spinal cord stimulator. Overall, the amount of medications needed for pain were less with the spinal cord stimulator, but some medications were still needed. X-ray of the cervical spine did not show movements of the leads but to assess the buzzing sensation in the leg reprograming of the stimulator was recommended.**

h. 02/17/2015, Primary Treating Physician's Follow Up Report, Jonathan Kohan, M.D: **The patient had continuous right upper extremity pain and burning. It was stated that implantation of the spinal cord stimulator improved the symptoms by 50%. In addition, there was ongoing need for Gabapentin, Norco, and Elavil to control pain, but side effects were denied. The Elavil improved sleep. He stated that Norco reduced the pain allowing facilitation of activities of daily living. Diagnosis was complex regional pain syndrome type 1 of the right upper extremity. Requests were made to refill Norco, Elavil, and Gabapentin. Work restrictions remained unchanged, which would be temporary total disability. It was noted that the cervical spine and bilateral upper extremities were not considered part of the patient's claim. This was puzzling considering the patient's right hand and wrist were injured and the hand and wrist are obviously part of the upper extremity.**

i. 03/18/2015, Primary Treating Physician's Pain Management Follow Up Report, Jonathan Kohan, M.D: **The patient continues to have significant improvement in the upper extremity symptoms as a result of the spinal cord stimulator, which he uses all day. There is a buzzing sensation that becomes worse in the supine position. Apparently, therefore he was not been able to use the stimulator overnight. Despite the improvement with the stimulator, he still needed medications for residual pain, which included Gabapentin 1800 mg a day. Despite the fact that the stimulator has been helping significantly, the patient reports residual pain, which is being addressed by Gabapentin. For dull achy pain, he is benefited from Norco as well as Elavil at night time. He denied side effects. It was stated that he did not report any significant issues or problems apparently with the spinal cord stimulator. It is unclear whether or not the programming could be adjusted to eliminate the buzzing sensation in the supine position. X-ray did not show abnormality in the leads. Current medication regimen: Should continue at 800 mg of Neurontin a day, Elavil 50 mg at night, and reduction in Norco at 7.5 mg, but ongoing medication use would likely be necessary. The psychological symptoms should be treated aggressively.**

j. 03/25/2015, Psychological Progress Note, Heath Hinze, Ph. D: **Cognitive behavioral therapy and relaxation training session was recommended for the psychological condition.**

k. 04/15/2015, Primary Treating Physician's Pain Management Follow Up Report, Jonathan Kohan, M.D: **The patient is benefiting greatly from the stimulator even though he has residual pain. He uses it almost around the clock and charges it twice a month. He still has a zapping sensation when he lies flat. Overall he has less pain. For the residual pain, numbness, and tingling, he uses gabapentin 1800 mg a day and benefits from Elavil 50 mg at night. He takes Norco 7.5 mg once or twice a day for residual pain. There were no reported side effects. No programing in the unit was required at that time. Ongoing treatment with Norco, Gabapentin, and Elavil were recommended.**

l. 05/13/2015, Pain Management Follow Up Report, Jonathan Kohan, M.D: **Stimulator helps about 40% to 50% for the right upper extremity complaints. There is much less sensitivity to touch and the burning pain improved. There is residual pain in the neck and right upper extremity. He was taking Norco 7.5 mg once or twice a day,**

Gabapentin 800 mg a day, and Elavil 50 mg at night. He denies side effects. On physical examination, there were described mild dysesthesias over the right upper extremity but no allodynia, swelling or hyperhidrosis. Impression was complex regional pain syndrome of the right upper extremity. Medications would continue but Neurontin would be decreased to 600 mg twice a day. Psychology treatment should continue.

m. <u>06/10/2015, Primary Treating Physician's Pain Management Follow Up Report, Jonathan Kohan, M.D</u>: Patient continued to benefit from the stimulator and reported no issues charging the unit. He did report with certain positions, he feels a shocking sensation going all the way through his body. Patient was taking Neurontin 800 mg a day, Norco 7.5 mg once day, and Elavil 50 mg at night. There was discussion of over compensation symptoms of the left upper extremity. With respect to the shocking sensation, the patient was to avoid any position that causes the shocking sensation. They have not been able to program the unit to avoid the shocking sensation. This sensation is seen in some cases even when the x-rays show no malalignment or movement of the leads. The medication should continue.

n. <u>07/08/2015, Primary Treating Physician's Pain Management Follow Up Report, Jonathan Kohan, M.D</u>: The medications and stimulator have continued to help the pain. At nighttime, he lies on his back, which causes the shocking sensation; however, he continues to benefit from the stimulator at about 50%. The recommendations of orthopedic QME, Dr. Aval were noted. Dr. Kohan was not sure if there is anything else that can be done for the residual pain. He continued to benefit significantly from the stimulator but the coverage was not 100%. It has been sufficient enough to require less medication to control pain and function better. Patient would remain temporarily totally disabled. Patient could be seen back on a regular basis without change in the current regimen.

o. <u>08/05/2015, Primary Treating Physician's Pain Management Follow Up Report, Jonathan Kohan, M.D</u>: It was stated that the patient does not report any issues with the stimulator, which has continued to help his symptoms. The medications also help such as Neurontin, Elavil, and Norco without side effects. There are ongoing symptoms in the left upper extremity. It was felt due to the ongoing complex regional pain syndrome despite improvement with the stimulator and medications, it was best that the patient not be subjected to any work involving the right upper extremity at all. Followup was in a month.

p. <u>09/02/2015, Primary Treating Physician's Pain Management Follow Up Report, Jonathan Kohan, M.D</u>: Patient did not report any issues with the stimulator, which continues to help greatly with the right upper extremity symptoms of chronic regional pain syndrome. Medications also help without side effects. It was stated that the patient is able to do daily chores with the help of this medication regimen. It was not stated if he performs any of these chores with the right upper extremity as opposed to the left upper extremity. Since he is doing well on medications, monthly follow-up was not recommended. It was still recommended that the patient not be subjected to any use of the right upper extremity.

q. 10/15/2015, Primary Treating Physician's Initial Comprehensive Orthopedic Evaluation Report, Edward Stokes, M.D: There was an injury noted on 07/11/2012 involving the right hand, sleep and psychiatric. The patient did not recall specific details of the treatment. He attempted to prevent impact of the object from striking the head by putting his hands up. As a result, a piece of the wall broke over the hand. There was no discussion of an actual head injury here; however, and there were no complaints of headaches. On physical examination, weight was described as 180 pounds. The circumference of the forearm 3 inches below the olecranon process was 21.5 cm on the right and 24.5 cm on the left. He had difficulties holding on to the dynamometer and squeezing it with the right hand. On the right hand, metacarpophalangeal flexion was 50 degrees at the thumb and 80 degrees at digits 2 through 5. Metacarpal extension of the thumb was 30 degrees and 20 degrees at digits 2 through 5. Proximal interphalangeal joint flexion was 70 degrees at the thumb and 100 degrees in digits 2 through 5. Proximal interphalangeal joint extension was 30 degrees at the thumb and 0 degrees in digits 2 through 5. Distal interphalangeal joint flexion was not recorded at the thumb and 70 degrees in digits 2 through 5. Distal interphalangeal joint extension was not recorded at the thumb and 0 degrees in digits 2 through 5. Upper extremity reflexes were normal.

Upper extremity sensation and motor strength was normal. Epworth Sleepiness Scale score was 0. Diagnoses: (1) Chronic Regional Pain Syndrome of the right upper extremity. (2) Left upper extremity intentional tremors, rule out neurodegenerative disease, deferred to appropriate specialists. (3) Crush injury of the hand. (4) Depression, major depressive disorder, recurrent, not specified. Encounter for examination and observation following a work accident. (6) Anxiety, unspecified. (7) Status post spinal cord stimulator placement with residuals. The mechanism of injury was consistent with that described by the patient. It was felt this was an industrial injury. Patient did not reach maximum medical improvement status. A neurological consultation was recommended. A pain management consultation with Dr. Gary Baker was recommended. The patient will be placed on temporary total disability. He should be referred to a pain management specialist as discussed by Dr. Aval and pain management specialist.

r. 02/15/2016, Initial Pain Medicine Evaluation, Gary Baker, M.D: There was the injury described when a piece of a wall struck the right hand when it went over the head to protect the head. There was no discussion of a head injury or headaches here. Current medications were Elavil, glipizide, metformin and Neurontin. On physical examination, there was vertebral tenderness at C5 through C7 of the cervical spine. There was moderately limited cervical spine range of motion due to pain. There was decreased sensitivity to touch along the C5 through C7 dermatomes in the right upper extremity. The range of motion of the hand showed limited extension of the fingers. There was a discussion of shocks to the body with the spinal cord stimulator when in the sitting and/or lying position. It was stated that the permanent spinal cord stimulator was not helping like the temporary trial did. Currently, there is less than 50% pain control. The spinal cord stimulator needs adjustment. Patient was considered temporarily totally disabled. Diagnoses included ongoing type 2 complex regional pain syndrome of the right upper extremity, peripheral neuropathy, diabetes mellitus type 2 with hyperglycemia and right thumb nondisplaced fracture.

Additional treatment included a fluoroscopic evaluation of the spinal cord stimulator in the Lakewood office. Amitriptyline 50 mg at night and Neurontin 600 mg q.6 hours as needed for pain were recommended.

s. **03/15/2016, Procedure Note, Dr. Gary Baker: Diagnosis was right upper extremity complex regional pain syndrome, malfunction of the spinal cord stimulator needed to be ruled out. There will be a fluoroscopically-guided evaluation of the spinal cord stimulator. Patient tolerated the procedure well without complications. Plan would be to contact the Medtronic representative to assist in evaluating the cause of the positional shocks and suboptimal pain coverage.**

t. **04/11/2016, Pain Medicine Re-Evaluation, Gary Baker, M.D: The right upper extremity pain is rated as 6 or 7 out of 10 in intensity with medications and 8 or 9 out of 10 in intensity without medications. The pain recently worsened. Current medications were amitriptyline 50 mg at night, Neurontin 600 mg every 6 hours as needed and glipizide and metformin. On physical examination, the range of motion of the right hand was limited in extension of the fingers. Grip strength testing was not possible with the dynamometer on the right. Patient is currently not working. Gabapentin and Elavil will be renewed. There was no discussion of adjusting the Medtronic spinal cord stimulator due to any untoward symptoms here.**

u. **05/09/2016, Pain Medicine Re-Evaluation, Gary Baker, M.D: There was pain in the neck radiating to the bilateral extremities as well as pain in the distal right upper extremity, which is constant and aggravated by hand function. The pain is rated as a 7/10 in intensity with medications and 9/10 in intensity without medications. The pain recently worsened. Patient completed a fluoroscopic evaluation of the spinal cord stimulator on 03/15/2016 and reprograming. It helps but does not completely relieve the pain. There was no discussion of involuntary movements or buzzing sensation possibly caused by the spinal cord stimulator here. Medications were amitriptyline, Neurontin, glipizide, and metformin. It was stated that the patient did have positional shocks with the spinal cord stimulator either in a sitting position or lying position. The Medtronic cervical spinal cord stimulator was implanted in approximately 2004 by Dr. Kohan. The permanent implant is not helping like the temporary trial implant. Currently, there is less than 50% pain control. Therefore, the stimulator needs adjustment. Patient will follow up in a month. Elavil and gabapentin would be refilled. The gabapentin was now at 800 mg every 6 hours.**

v. **06/06/2016, Pain Medicine Re-Evaluation, Gary Baker, M.D: There was ongoing pain in the right upper extremity and neck pain described as radiating down the bilateral upper extremities. The pain was described as 6/10 with medications and 9/10 without medications. The pain was recently unchanged. Current medications were Neurontin, glipizide, amitriptyline, and metformin. There was a discussion of positional shocks with the spinal cord stimulator either in the sitting and/or lying position. Again, it was stated that there was suboptimal pain control of less than 50% and the spinal cord stimulator needed adjustment. However, the treatment plan did not mention adjusting the spinal cord stimulator. Treatment plan included ongoing Neurontin 800 mg every 6 hours and amitriptyline 50 mg at night.**

w. **07/18/2016, Pain Medicine Re-Evaluation, Gary Baker, M.D: There was ongoing pain in the neck radiating to both upper extremities as well as right upper extremity pain worsened with activity. Medications were amitriptyline, Neurontin, glipizide, and metformin. The spinal cord stimulator system was adjusted with a Medtronic representative to optimize pain coverage. The system otherwise works well but there is continued problems with properly charging the unit. There was again discussion of currently less than 50% pain control with the spinal cord stimulator but this statement appears somewhat confusing. It again stated in the discussion session that the spinal cord stimulator needs adjustment. Treatment would be with right hand and wrist splint as well as refilling Elavil, amitriptyline, and Neurontin.**

PE: The patient wore a Neoprene cast over the distal right upper extremity, which was removed for the examination. He repeatedly complained of severe pain in the distal right upper extremity. There was approximately an 8 cm scar on the dorsal left lower aspect of the lumbar spine area due to implantation of the battery pack, which was nontender. There was a midline surgical scar in the area of C7 to T2 for implantation of the spinal cord stimulator, which was also nontender. The distal right upper extremity appeared slightly cooler to touch compared to the left upper extremity. There was slight, patchy, reddish, and pinkish discoloration of the right hand and right wrist area, which was present to a mildly lesser degree in the left hand and wrist area. There were dry callused appearing fingertips in the second and third digits on the right and to a mildly lesser degree on the first, second, and third digits on the left. The skin of the distal right upper extremity appeared mildly drier than the left upper extremity. There appeared to be mildly excessively smooth and non-elastic skin in the distal right upper extremity. There appeared to be subtle, mildly decreased hair growth of the distal right upper extremity compared to the left upper extremity. There was slight swelling of the dorsal carpal-metacarpal area of the first digit (thumb) and second digit (index finger). There was moderate-to-severe tenderness to palpation of the right thumb and index finger metacarpal area. There was loss of right upper extremity range of motion.

On mental status examination, the patient appeared to have some degree of underlying frustration, anxiety, and/or depression regarding his injury. His Mini-Mental State exam score was 26/28. Speech appeared mildly hypophonic and he complained of a softer voice for at least the last few months. On cranial nerve exam, there might be subtle mild masked facies present with decreased eye blink. There was mild-to-moderate atrophy of the right thenar and hypothenar eminences of the right hand. There were multiple, intermittent, spontaneous, jerky, involuntary movements involving predominantly the left upper extremity, but also other body parts such as the head, trunk, and bilateral lower extremities. The abnormal involuntary movements also involved the right upper extremity to a lesser degree. The involuntary movements had elements of Parkinson's disease like tremor, but also elements of the rapid movements of chorea and the slower movements of athetosis. The movements occurred at rest and were slightly worsened with movement including fine finger movement and finger-nose-finger testing. It appeared that the movements persisted with gait and probably interfered with gait. He noted that when he turned off the stimulator; those movements occurred perhaps 50% less than with the stimulator on. The right thumb

was slightly flexed with essentially minimal volitional movement with severely restricted passive range of motion. The fingers, hand, and wrist on the right could be actively moved throughout approximately 50% of normal range of motion in all planes with pain except for flexion of distal interphalangeal joint, proximal interphalangeal joint and metacarpal phalangeal joint flexion of digits 2, 3, 4, and 5. He could not oppose the right thumb to the right fifth digit.

The gait was slightly wide based. While walking, there was minimal decreased arm swing worse on the right compared to the left. Attempting to walk on the toes hurt the stimulator site. Heel walking gait was also uncomfortable. Tandem gait was minimally unsteady. The patient noted that he has had this gait problem at least since the stimulator was implanted. There was decreased sensation to light touch and pinprick in a patchy non-dermatomal or peripheral nerve distribution below the right elbow, worse in the whole right hand and particularly worse in the entire right thumb. The sensory impairment involved the palmar and dorsal aspect of the entire right hand and all five digits to a mild degree in a patchy distribution. Two-point discrimination was impaired in the right thumb, second digit, and fifth digit at approximately 10 mm. Diagnoses: 1) Traumatic injury to the distal right upper extremity on 07/11/2012, industrial. 2) Chronic regional pain syndrome type 1/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 was 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 was the multifactorial movement disorder. First, there was likely a component of movement disorder due to the spinal cord stimulator implantation based on available data, which Dr. Pulera considered to be industrial. Then, there was a movement disorder due to underlying mild Parkinson's disease, which was considered being completely nonindustrial. In addition, there was a multifactorial sleep disorder with components such as pain including reflex sympathetic dystrophy, which were also indicated as industrial by this examiner. Psychiatric QME, Dr. Slonim had indicated that there were industrial psychiatric diagnoses, which were had industrial causation as well. Dr. Pulera opined that there was at least an industrial component of the sleep disorder due to pain and psychiatric conditions. He explained that it remained to be determined if there was 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 07/11/12, there was a mild closed head injury but this did not result in any temporary or permanent disability, or permanent neurological impairment for symptoms including

headache or depression. Dr. Pulera further opined that there was no neurologic cause of complaints of persistent headaches except for potential use of spinal cord stimulator and memory loss in this case. He added that the subject industrial injury did not cause or aggravate the patient's right and left carpal tunnel syndrome. Impairment: a) There was 5% impairment for sleep with the caveats discussed. b) 0% neurologic impairment for mental status. c) 53% whole person impairment for the right upper extremity.

d) 5% neurologic impairment for gait in the lower extremities due to the spinal cord stimulator; 5% neurologic impairment for the bilateral upper extremities due to the spinal cord stimulator. Combining both there was 10% total impairment of the extremities due to the spinal cord stimulator. f) There was 1% impairment due to impaired eye blinking and masked facies secondary to Parkinson's disease; 2% impairment for hypophonia due to Parkinson's disease; 5% neurologic impairment of the bilateral lower extremities due to Parkinson's disease; 1% neurologic impairment of the bilateral upper extremity due to Parkinson's disease. 9% total neurologic impairment was indicated due to Parkinson's disease. Total WPI: Dr. Pulera estimated that there was 60% total neurological impairment on an industrial basis and there was 9% nonindustrial impairment due to mild underlying Parkinson's disease. Disability: The patient would be considered temporarily totally disabled neurologically from the date of injury of 07/11/2012 to the date of this examination of 11/17/2016. He was considered as neurologically permanent and stationary at this point. 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, Dr. Pulera opined that the sleep disorder would be permanent and stationary given the caveat that the parties might desire additional sleep related medical workup. He indicated that the above restrictions and limitations for sleep would now be the same as permanent partial disability. If the above neurological restrictions and limitations could not be honored then, he would be a qualified injured worker who could not return to his usual and customary occupation as a plumber. Apportionment: Dr. Pulera estimated that there was 100% industrial apportionment for the right upper extremity chronic regional pain syndrome/reflex sympathetic dystrophy impairment/disability due to the industrial injury of 07/11/2012.

He also estimated that there was 100% nonindustrial apportionment for the impairment/disability related to Parkinson's disease. There was 25% total nonindustrial apportionment for the sleep related impairment/disability. He added that he would award 35% industrial apportionment for the pain associated with the chronic regional pain syndrome/reflex sympathetic dystrophy of the right upper extremity in case **Pena vs. Alvarado Hospital** was relevant, and 40% to apportionment to other industrial factors, which would give a total 75% industrial apportionment for the sleep related impairment/disability. Future Medical Care: Commenting further on orthopedic future medical care were deferred to the orthopedic QME, Dr. Soheil Aval. Dr. Pulera opined that the psychiatric treatment recommended by psychiatric QME, Dr. Slonim could address the psychological factors affecting pain and sleep. He also opined that ultimately such

treatment could potentially alter his opinions as well. Regarding the right upper extremity chronic regional pain syndrome/reflex sympathetic dystrophy, lifelong treatment was indicated including lifelong access to a neurologist. Regarding involuntary movements due to the spinal cord stimulator, Dr. Pulera would strongly recommend follow up with a physician experienced in the management of spinal cord stimulators. He opined that any complications with respect to spinal cord stimulator should definitively be ruled out. For the mild closed head injury on 07/11/2012, for completeness sake, Dr. Pulera recommended that a brain MRI scan without contrast should be performed to rule out traumatic brain injury. Furthermore, recommended that lifelong access to physician knowledgeable on sleep disorders should be allowed regarding the sleep concerns. He recommended that if the parties so desire, a polysomnogram and multiple sleep latency tests should be performed. He added that the patient's mild underlying Parkinson's disease should be addressed by a neurologist on a nonindustrial basis.

80. December 15, 2016, Internal Medicine Agreed Medical Evaluation, James F. Lineback, M.D., F.C.C.P.: DOI: 07/11/2012. HPI: Remained unchanged. Interim History: The patient was initially noted to have an elevated blood sugar in 2005. Eventually, a diagnosis of diabetes was made and he was subsequently started on oral hypoglycemic therapy. He remained on two diabetes medications to date. For management of the pain related to the subject industrial injury, he was treated with a narcotic analgesic and developed chronic constipation in 2014. He continued to require narcotic analgesics for pain control, causing constipation to persist. Eventually, he developed anal fistula in 2016 that continued to cause recurrent rectal pain. In November of 20115, he was noted to have an elevated blood pressure while experiencing severe hand pain. He was started on a single antihypertensive agent at that time and subsequently developed erectile dysfunction. His hypertension was currently under good control on a single antihypertensive agent at this time. He subsequently developed difficulty sleeping and was awakening several time during the night due to the pain. Current Complaints: 1) Right hand pain. 2) Intermittent constipation and erectile dysfunction. 3) Resting tremor in the left upper extremity. Current Medications: Metformin, Glipizide, Lisinopril, Gabapentin, and Elavil.

    PE: He had a wrist brace in place and a noticeable left upper extremity resting tremor. His BP was 130/80. The breath sounds were slightly decreased bilaterally. The bowel sounds were somewhat hyperactive. The range of motion of the right wrist was decreased due to pain. There was decreased grip strength of the right hand. A surgical scar from a spinal cord stimulator was noted. An obvious left upper extremity resting tremor was noted. Review of records: Dr. Lineback reviewed the patient's medical/nonmedical records dated from 07/13/12 to 11/11/16. Diagnoses: 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. Disability Status: Reached permanent and stationary status. Discussion/Causation: Discussed with the patient that his diabetes was diagnosed prior to

the time of his employment with Benedict Plumbing Company. Dr. Lineback opined that diabetes represented a pre-existing condition and should be treated on a nonindustrial basis. With regard to his erectile dysfunction, the patient to be referred to a urologist for further comment regarding the it's etiology. With respect to the sleep disorder, there was no evidence in the medical records that he had any prior history of a sleep disorder before his 2012 industrial injury. Dr. Lineback opined that the chronic pain could be a major source of insomnia and it was medically probable that the patient's right upper extremity symptoms resulting from his crush injury to his right hand in 2012 was the proximate cause of his sleep disorder.

He added that the patient's insomnia should be considered job related and should be treated on an industrial basis. With regard to hypertension, he opined that it was a direct result of the chronic pain resulting from the patient's industrial injury to his right hand and his hypertension should be considered job related and should be treated on an industrial basis. Regarding shortness of breath, Dr. Lineback opined that it was more likely related to chronic obstructive lung disease secondary to the patient's cigarette smoking. He further opined that the patient's respiratory symptoms should be considered nonindustrial and should be treated on a nonindustrial basis. Regarding anal fistula, this examiner described that the patient's constipation due to chronic pain treatment with narcotic analgesic the use of which was necessitated by the crush injury might have caused his anal fistula. These issues should also be considered job related and should be treated on an industrial basis. Impairment Rating: Sleep disorders: 3% WPI. Hypertension: 5% WPI. Anal fistula and constipation: 7% WPI. Apportionment: 100% of the patient's disability with respect to his sleep disorder should be apportioned to industrial factors as there was no evidence of any nonindustrial factors playing a role in his insomnia. 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. 100% of his disability with respect to anal fistula and his constipation should be apportioned to industrial factors as well.

Future medical care: The patient's diabetes represented a pre-existing condition and should be treated on a nonindustrial basis. He should be referred to an urologist for further workup of his erectile dysfunction. Also recommended a referral to a neurologist for evaluation of his left upper extremity resting tremor to rule out Parkinson's disease. Since it was unclear as to the etiology of this symptom, that evaluation should be provided on an industrial basis. His sleep disorder would require treatment, preferably by either a sleep specialist or a general internist. That treatment should be provided on an 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, his shortness of breath was 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. He 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 was medically probable that his constipation and his anal fistula was related to his industrial injury, treatment for both of these problems should proceed on an industrial basis. Also, the patient's anal fistula might require surgical treatment, and that treatment should be provided on an industrial basis. Dr. Lineback recommended to treat the constipation with Metoclopramide, as well as a stool softener, such as Metamucil.

81. July 10 2017, Vocational Evaluation Report, Laura M. Wilson, VREW: DOI: 07/11/2012. History: The patient was employed as a Plumber at the time of his industrial injury. During that period, he suffered injuries to his arm-above wrist, arm-elbow, hand, shoulders (scapula and clavicle), digestive system (stomach), nervous system-stress, and nervous system – psychiatric/psych. Educational and vocational background: He graduated from Citrus College taking plumbing course in 1980. At the time of his industrial injury he was employed with Benedict & Benedict as a plumber for 4 years earning $25.00 per hour. Prior to this, he was employed with Dr. Drain in the City of Mammoth Lake as a Plumber for 1.5 years. Prior to this, he was self-employed with Double D Plumbing for 8 years. Prior to this, he was employed as a Pipe Fitter at the age of 17. Since his industrial injury, he had not been employed. On March 17, 2017, he was deemed unemployable by the United States Federal Government and awarded society security benefits. He was receiving $1,040.00 per month. Review of records: Ms. Wilson reviewed the patient's medical records dated from June 30, 2015 to December 15, 2016. Medications: Amitriptyline Hcl, Metformin, Montelukast, Gabapentin, Lisinopril, Glipizide. Ms. Wilson listed the limitations for the patient as described in various medical reports as follows: 1) Dr. Aval reported that the patient was precluded from activities of repetitive or forceful gripping, fine manipulation, torqueing, and heavy lifting with the right upper extremity. 2) Qualified Medical Examiner in Psychiatry Dr. Slonim indicated that the patient should avoid stresses at work. 3) Qualified Medical Examiner Dr. Soheil M. Aval expressed in terms of self-care activities that, the patient had moderate difficulties with brushing and washing his hair in addition to bathing and showering and brushing his teeth.

4) Dr. Aval also mentioned that the patient had moderate to severe difficulty with preparing meals. 5) Dr. Aval reported the patient had increased symptomatology and difficulty with activities of heavy lifting. 6) Dr. Aval noted the patient was unable to lift or carry even a gallon of milk. 7) Dr. Aval noted the patient had moderate symptomatology and difficulty with bending and twisting his neck, bending and twisting his back, lifting his arms overhead, typing and writing. 8) Dr. Aval stated the patient was unable to push or pull. 9) Dr. Aval indicated the patient had moderate to severe difficulty with kneeling, squatting, crawling, climbing. 10) Dr. Slonim noted the patient being socially withdrawn, impaired sleep, indecisiveness, not functioning in hobbies and in the household, impaired concentration and memory, avoiding driving the freeway. Analysis of Occupations: The analysis of the patient employment history demonstrated that he had occupationally performed in skilled work of medium physical requirements. Transferable skills analysis: He had very few if any transferable skills. Work context elements and temperaments considered physical and environmental work context elements: Sitting reduced to 2,

Standing reduced to 2, Walking/Running reduced to 2, Making repetitive motions reduced to 2, Hazardous conditions reduced to 2, Hazardous equipment reduced to 2, Hazardous situation reduced to 2, Cramped awkward reduced to 2, Bending/twisting of the body reduced to 2, Kneeling crouching reduced to 2, Climbing ladders reduced to 2, High places reduced to 2, Keeping regaining balance reduced to 2.9, Directing others reduced to 1, Repetitive moves reduced to 0.9, Influence people reduced to 1, Variety of duties reduced to 1, Expressing feelings reduced to 1, Alone working reduced to 1, Stress tolerance reduced to 0.9, Under instruction reduced to 1, People dealing with reduced to 1, and Judgments making reduced to 1.

Apportionment: No apportionment was indicated for nonindustrial factors. Conclusions: Ms. Wilson explained that from a vocational perspective, the fact that a patient might have multiple impairments and had an overlapping effect on an injured worker's ability to compete within the open labor market or whether separate injuries would have a "synergistic" effect on the individual capacity to perform a within the open labor market. She pointed out that the patient had a steady industrial history, he enjoyed his 4-year career as a Plumber for Benedict and Benedict Plumbing and she noted that prior to this industrial injury he was independent and enjoyed participating in physical activities such as working, fishing, golfing, and doing woodwork. These were some of the thing he was not able to do because of his physical limitations caused by his industrial injury. Since the injury, he had difficulties conducting activities of daily living such as driving, shopping, cleaning, and cooking and required constant assistance from his girlfriend and had no home healthcare. In addition, due to his industrial injury, he had chronic pain caused by impairments and had experienced loss of concentration, memory difficulties, low energy levels, sadness, and agitation on a constant basis. He expressed that since his industrial injury, he was in constant pain and was only able to sit for 45 minutes and then he needed to stand up. He noted he could only stand for 5 minutes with support. He indicated that he could walk very slowly for only 5 minutes for about 100 yards. Since his industrial injury he has had 1 spinal cord stimulator placed to manage his pain symptoms. Ms. Wilson commented that from an employment perspective as an employment specialist, each body part or impairment under the CVC gets compacted by the use of the Combined Value Chart. She opined that multiple injuries in the "real" labor market should not be compacted but should be added together to determine an overall disability or impairment.

She commented that a worker with multiple body parts or organ systems that were "injured "or have an" impairment" assigned to them were greater disadvantage of "real world" work because of the synergistic effect of one injured body part on the other. She further explained that this problem was also compounded by the effects of medication and the injuries themselves on what was called "pace" and "persistence," which is the ability of a person to maintain sufficient attention and focus to complete a given task in a reasonable amount of time, which was necessary to be productive and maintain employment. She opined that when a vocational expert considers these matters together, the sum would be always greater than the additional parts. She added that in the "real world" the patient with his multiple impairments would be unable to sustain productive and competitive gainful

employment and therefore, he was unable to compete within the open labor market and did not have any future earning capacity. She was asked as a vocational expert to determine if the patient was able to return to work in the current labor market. After careful review and consideration of his physical and emotional work limitations, dosage of medications that he was currently taking and its side effects, and his transferable skills, determined by McCroskey and Volcano 16.0 it was Ms. Wilson's professional opinion that based on his industrial related impairment and his industrial physical limitations that were provided in the medical reports of Agreed Medical Examiner Dr. James F. Lineback, Qualified Medical Examiner Soheil M. Aval, and Qualified Medical Examiner, Dr. Daphna Slonim, the patient was not amenable to vocational rehabilitation. He was not able to sustain gainful employment and therefore, was not able to compete in the open labor market and as result of his industrial related impairments provided by considering his pre injury capacity and abilities, he had at present no consistent and stable future earning capacity.

82. December 04, 2017, Revised Vocational Evaluation Report, Alejandro A. Calderon, MA, CRC, CCM, CAE, ABVE/IPEC: DOI: DOI: 07/11/2012. ADL functional limitations (subjective) as reported by the patient on 11/08/2017: Self-care personal hygiene: He experienced some difficulty when moving from bed to chair, bathing, and dressing self. Physical activity/mobility: He had difficulty in climbing stairs. His mobility was limited in standing, sitting, and walking due to hip problems. Non-specialized hand activities: He experienced difficulties with forceful grasping and lifting with the right upper extremity. Managing household affairs: His wife passed away and now he had difficulty performing house hold duties. He experienced some difficulty with meal preparation. Travel: He faced difficulty in driving and/or travelling in car for 30 minutes at a time before pain starts. Additionally, he indicated the following physical tolerance limitations: 1) Difficulty to stand, walk and sit due to his hip problem. 2) Difficulty to drive due to his hip problem. 3) Ability to lift and carry up to 10 lbs. with right upper extremity. 4) Ability to push and pull up to 10 lbs. with right upper extremity. 5) Limited ability to bend and kneel. 6) Inability to squat/crouch. 7) Limited ability to twist/pivot. 8) Very limited to reach above shoulder level. 9) Ability to reach at shoulder level. 10) Limited ability to reach below shoulder level.

11) Some burning type pain when handling or feeling repetitively with right upper extremity. 12) Some difficulty with fine dexterity with the right upper extremity. 13) Some difficulties with pain in his hip. 14) Some difficulties with climbing stairs/steps. 15) Inability to climb ladders or balance. 16) Noticeable limp. 17) Increase in pain with cold. 18) Vision restriction. In addition, the patient experienced tremors and reported that he was diagnosed with Parkinson's disease in November of 2016. Employability: He was medically precluded from returning to his usual & customary occupation as a Plumber. His vocational education, apprenticeship, in-plant training, on-the-job training, and essential experience gained on other jobs was over 2 years and up to 4 years and was considered as skilled work. Furthermore, he reported education and vocational training level 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. Work restrictions: 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, torqueing, 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., and QME Orthopedic Examination Report of 07/18/2016): He was precluded from activities of repetitive or forceful gripping, fine manipulation, torqueing, and heavy lifting with the right upper extremity. The left upper extremity did not require work restrictions.

From a psych standpoint (Per Daphna Slonim, M.D. Psychiatric QME Report of 07/18/2016): He 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, judgments or generalizations without immediate supervision: Moderate. 8) Ability to accept and carry out responsibility for direction, control, and planning: Moderate. Review of records: Mr. Calderon reviewed the medical records of the patient dated 08/14/2017, 12/15/2016 and 07/18/2016. Discussion/Opinion: In reference to the opinions outlined in the LeBoeuf Analysis by Laura Wilson, MBA dated 07/10/2017; Mr. Calderon respectfully disagreed with the patient's vocational expert's opinion that he might 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 his non-industrial and/or impermissible factors such as limited education (11th grade) and training (limited to plumbing training). However, when considering his 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 was concluded that he was 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.

Mr. Calderon pointed out that under LeBoeuf v. Worker' Comp. Appeals Bd. (1983) 34 Cal.3d 234, it must be demonstrated that the patient was not employable in the open labor market, including a determination that he was no longer able to be retrained for any suitable gainful employment. This would then be considered in any determination of a permanent disability rating. Mr. Calderon further explained that, as noted in "Ogilvie 1112", the most widely accepted view of its holding, which appeared to be most frequently applied by the

WCAB, was to limit its application to cases where the employee's diminished future earnings were directly attributable to the employee's work-related injury, and not due to nonindustrial factors. Mr. Calderon opined that 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. Other factors excluded in this evaluation include impermissible factors such as general economic conditions or an employee's lack of education (Ogilvie 111- 2011). Mr. Calderon added that 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 the patient'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 his geographical area of residence.

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: a) Customer service – Consumer relation clerk. 2) Information clerk. 3) Rental clerk. 4) Usher. Empirical Evidence and Employment Data: At the time of the injuries of 2012 the patient was working as a Commercial and Residential Plumber and earned approximately $25.00 per hour or $52,000.00 annually (40 hour work week). He was declared neurologically permanent and stationary in 2016, and in the event he had continued to perform 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. Vocational Opinion/Conclusions: Mr. Calderon opined that based on the reports of the patient's doctors, he retained 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 type 2 diabetes. He further opined that absent the medically indicated non-industrial medical conditions as documented in the medical file, the patient retained an ability to compete, or be retrained for suitable gainful employment.

83. August 09, 2018, Compromise and Release with Open Medical: WCAB No: ADJ8760713. DOI: 07/11/12. Injured Body Parts: Upper/lower extremities, psyche, digestive system, circulatory system. The parties agreed to settle the above claim on account of the injury by the payment of $300,000.

WORKERS DEFENDERS LAW GROUP

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CC: Workers compensation Consultant
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RE: DANIEL DORAN vs BENEDICT & BENEDICT PLUMBING, SIBTF
WCAB: ADJ8760713
SIBTF: SIF8760713

DATE:2/18/2021

COVER LETTER FOR SIBTF EVALUATION IN CHIROPRACTIC SPECIALTY

DEAR DR. ERIC GOFNUNG, DC:

This office represents the above referenced applicant. You have been selected to act in the capacity of SIBTF **Medical Evaluator** in regard to the applicant's Subsequent Injury Benefit Trust Fund Claim in chiropractic specialty.

You are specifically asked to provide a medical legal evaluation **in your area of expertise**.

Please provide a medical legal evaluation and address the issue of causation (AOE/COE) of any injury within your area specialty. Specifically it is requested that a determination be made regarding any pre-existing medical issues and disability within your area of specialty that were present at the time of the subsequent industrial injury.

Please provide a permanent impairment rating per the AMA guides 5th edition and address the issue of apportionment. Specifically, it is requested that you provide a determination as to the percentage of cause of disability to a pre-existing condition present at the time of the subsequent industrial injury, any contribution from the industrial injury(ies) and any further natural progression which occurred after the industrial injury.

Please cover in your report the following topics:

- Subjective complaints
- Objective factors or findings
- Current diagnosis
- Occupational history
- Past medical history
- Prior injuries
- Pre-existing labor disabling condition

- Prior injuries Causation
- Rating of pre-existing labor disabling conditions
- Pre- existing work restrictions
- History of subsequent injuries
- Impairment rating of subsequent injuries
- Subsequent injuries causation
- Apportionment
- Disability status & permanent work restrictions
- Activities of daily living

Please answer within the scope of your specialty:

- Did the worker have an industrial injury?
- Did the industrial injury rate to a 35% disability without modification for age and occupation?
- Did the worker have a pre-existing labor-disabling permanent disability?
- Did the pre-existing disability affect an upper or lower extremity or eye?
- Did the industrial permanent disability affect the opposite or corresponding body part?
- Is the total disability equal to or greater than 70% after modification?
- Is the employee 100% disabled or unemployable from other pre-existing disability and work duties together?
- Is the employee 100% disabled from the industrial injury?

In order to facilitate your evaluation, we provide medical records for the above applicant in our possession according to the exhibit list attached.

If you need any additional testing, please advise so.

If you believe that the applicant has health issues outside of your specialty, please defer these issued to the medical doctors of appropriate specialty, please indicate what specialty is recommended.

Thank you for your anticipated courtesy and cooperation herein.

Very truly yours,

By Natalia Foley, Esq
WORKERS DEFENDERS LAW GROUP

LIST OF THE EXHIBITS

DANIEL DORAN vs BENEDICT & BENEDICT PLUMBING, SIBTF
WCAB: ADJ8760713
SIBTF: SIF8760713

Exhibit 01	James F Lineback, MD, internal medicine agreed medical evaluation	12/15/2016
Exhibit 02	Mark Pulera MD, QME, Neurological Agreed Medical Evaluation	12/15/2016
Exhibit 03	Daphna Slonim, MD, Psychiatric QME report	07/18/2016
Exhibit 04	Soheil M Aval MD, PQME Orthopedic Evaluation	06/30/2015
Exhibit 05	Heath Hinze, PsyD, Permanent and Stationary comprehensive psychological evaluation of a secondary physician	06/02/2015
Exhibit 06	MH Express Pharmacy transcript	01/12/2018
Exhibit 07	Benefits Paid Report	09/11/2017
Exhibit 08	DEU rating	12/15/2016
Exhibit 09	Laura M WIlson, Vocational evaluation Report	07/10/2017
Exhibit 10	Alejandro Calderon, Vocational Evaluation Report	12/04/2017
Exhibit 11	C&R and court order	08/23/2018
Exhibit 12	Radiology Consultation Report	06/12/2013
Exhibit 13	UR review	06/224/2013
Exhibit 14	Subpoena response	03/27/2013
Exhibit 15	Heath Hinze, PsyD, Initial comprehensive psychological consultation and report	05/07/2013
Exhibit 16	Follow-up reports by Edwin Haronian, MD, PTP	
Exhibit 17	Jonathan F Kohan MD, secondary physician reports	
Exhibit 18	Work Status reports	
Exhibit 19	Operative report by Kohan, MD	09/03/2014
Exhibit 20	Daphna Slonim, MD, report	06/22/2016
Exhibit 21	Pain Medicine re-evaluation	09/12/2016

All exhibits can be downloaded here:

https://www.dropbox.com/sh/10b29yn68ok14n2/AAAzuvylLWMWjpILURCaqM3va?dl=0

PROOF OF SERVICE

1. I am over the age of 18 and not a party of this cause. I am a resident of or employed in the county where the mailing occurred. My residence or business address is
8018 E SANTA ANA CYN RD STE 100-215
ANAHEIM HILLS CA 92808.

2. I served the following documents:

COVER LETTER FOR SIBTF EVALUATION

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by enclosing a true copy in a sealed envelope addressed to each person whose name and address is shown below and depositing the envelope in the US mail with the postage fully prepaid.

- Date of Mailing: 2/18/2021
- Place of Mailing: Los Angeles, CA

3. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: 2/18/2021

By Irina Paleés, Legal Assistant
to Attorney Natalia Foley

Name and Address of each Person to whom Notice was Mailed

WCAB (AHM)
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STE 170
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1680 Plum Lane
Redlands CA 92374

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