Nhung Phan, Psy.D.
PSY28271
Mailing Address:
1680 Plum Lane
Redlands, California 92374
(909) 335-2323

May 17, 2021

Subsequent Injures Benefit Trust Fund
Department of Industrial Relations
Division of Workers' Compensation
1750 Howe Avenue, Suite 370
Sacramento, California 95825-3367

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

In Reference:	**Doran, Daniel**
Social Security #:	XXX-XX-1885
Date of Birth:	June 4, 1966
Date of Injury:	SI: July 11, 2012
Employer:	Benedict & Benedict Plumbing
Occupation:	Plumber
WCAB	ADJ8760713
SIF Case No:	SIF8760713
Date of Examination:	May 17, 2021

Please do not release this report directly to the examinee. This psychological report is CONFIDENTIAL. Showing or allowing the claimant to read this report could be detrimental and psychologically harmful to this individual. Misunderstandings, misinterpretations, and severe emotional reactions are often encountered when this happens without the presence of a qualified and competent psychological expert Therefore, in the best interest of the claimant, with rare exceptions, it is advisable to discuss only pertinent findings with the applicant. Any emotional distress or violent reaction and other risk will be the responsibility of the person who allows the applicant to read or copy this report.

COMPREHENSIVE INDEPENDENT MEDICAL-LEGAL EVALUATION SUBSEQUENT INJURY BENEFITS TRUST FUND

Dear Workers Defenders Law Group,

Per your request I performed an Independent Medical-Legal Evaluation of the above-noted applicant to determine eligibility for the Subsequent Injury Benefits Trust Fund pursuant to Labor Code 4751. This evaluation is not for the applicant's current function and is not related to their above-noted industrial injury. This evaluation is being performed to address the applicant's pre-existing disability to differing body parts, other than the industrial injury. I have been requested to evaluate the industrial injury and any pre-existing problems. I have also been advised to order further evaluations if needed from other specialists.

The Applicant was informed that a doctor-patient relationship was not established today and that a copy of my medical-legal report would be sent to the requesting parties. This history and physical are not intended to be construed as a general or complete medical evaluation; it is intended solely for medical-legal purposes and focuses on those issues in question by the parties. By performing this medical-legal examination, no treatment relationship is established or implied.

This evaluation was performed in my office in Huntington Park, California on May 17, 2021. I have personally evaluated this patient and the following represents my findings, opinions, and conclusions in this matter.

Per code of regulation 9795, this report is billed as ML 201-96 (Comprehensive Initial Medical Legal Evaluation by PsyD) and an ML-PPR, which is used to identify charges for review of records in excess of pages included in medical-legal numerical billing codes.

MLPRR - In addition, I have received and reviewed medical records which included a declaration and attestation (copy enclosed). The total attested pages reviewed was *1,647.*

INTRODUCTION

Per labor code 4751: If an employee who is permanently partially disabled receives a subsequent compensable injury resulting in **additional** permanent partial disability so that the degree of disability caused by the **combination of both disabilities** is greater than that which would have resulted from the subsequent injury alone, and the combined effect of the last injury and the previous disability or impairment is a permanent disability equal to **70% or more** of total, he shall be paid in addition to the compensation due under this code for the permanent partial disability caused by the last injury compensation for the remainder of the combined permanent disability existing after the last injury as provided in this article; provided, that either (a) the previous disability or impairment **affected** a hand, an arm, a foot, a leg, or an eye, and the permanent disability resulting from the subsequent injury **affects the opposite and corresponding member**, and such latter permanent disability, when considered alone and without regard to, or adjustment for, the occupation or age of the employee, is equal to **5%** or more of total, **or** (b) the permanent disability resulting from the subsequent injury, when considered alone and without regard to or adjustment for the occupation or the age of the employee, is equal to **35%** or more of total.

The Subsequent Injury Benefits Trust Fund (SIBTF) liability deals with pre-existing impairment and/or pre-existing disability. In other words, disability which was present prior to the industrial injury noted above. In essence, we are looking into the past to determine to what extent the injured worker was disabled, at some time prior to the settled industrial injury noted above.

A contemporaneous and retrospective review of the medical history and medical records is performed to determine if it is medically probable that there was labor disabling impairment, which pre-existed the date of the last injury in question and whether or not the sum of the combined industrial and nonindustrial impairment rates to 70% disability or more. Prior impairment ratings for industrial injuries are reviewed for accuracy and if necessary, re-rated.

INITIAL SIBTF SUMMARY:

1. **Did the worker have industrial injury?**

   Yes. The applicant suffered a specific injury on SI: July 11, 2012.

2. **Did the industrial injury rate to 35% disability without modification for age and occupation?**

   Defer to orthopedic specialist.

3. **Did the worker have a preexisting labor disabling permanent disability?**

   Yes— He had pre-existing labor disablement, evidenced by his time off work to grieve over his first wife's death, psychotherapy treatment for his marriages, and incarceration for alcohol abuse and rehab treatment.

4. **Did the preexisting disability affect an upper or lower extremity, or eye?**

   Defer to Orthopedic specialist.

5. **Did the industrial permanent disability affect the opposite and corresponding body part?**

   Defer to Orthopedic specialist.

6. **Is the total disability equal to or greater than 70% after modification?**

   Unknown at this time.

7. **Is the employee 100% disabled or unemployable from other preexisting disability and work duties together?**

   The patient is currently not working. Once the total disability is determined, it would be prudent for the patient to undergo an evaluation with a licensed vocational rehabilitation specialist to determine employability.

8. **Is the patient 100% disabled from the industrial injury?**

No.

9. Additional records reviewed?

Yes, defer to review of records for summary of pertinent records reviewed.

10. Evaluation or diagnostics needed?

Referred to a neurologist to further examine Parkinson's disease.

COMPLAINTS SECONDARY TO THE INDUSTRIAL INJURY OF SI: July 11, 2012

1. After 2012:	Began developing strokes and mini strokes
2. After 2012:	Feeling depressed due to not being able to work, being homeless, and being in constant pain, which is overwhelming sometimes and makes him physically sick
3. 2012-2014:	Received counseling for subsequent injury for two years with benefits
4. 01/15/2013:	Diagnosed with mild right carpal tunnel syndrome
5. 2015:	Diagnosed with Parkinson's disease six years ago
6. March 2015:	Diagnosed with high blood pressure
7. December 2015:	Diagnosed with a fistula for "growth in the rectum"
8. June 2016:	Reached MMI
9. 2016:	Third wife died from a heart problem and he began having suicidal ideations
10. 2018:	Sister died from a stroke
11. 2019:	Became homeless for the past two years
12. 05/15/2021:	Beloved dog died and he also felt suicidal
13. May 2021:	5th anniversary of his third wife's death
14. May 2021:	Currently smokes half a pack of cigarettes per day

COMPLAINTS SECONDARY TO PRE-EXISTING INJURIES OR CONDITIONS

1. Childhood:	First experienced emotional difficulties in his life from his dad physically/ verbally/emotionally abusing him and hitting him with a leather belt
2. Age 14:	Began smoking one pack of cigarettes per day and ongoing for 40 years
3. 1980s:	Head injury after he was struck in the head while being robbed

4. 1985: Arrested for drunk driving and spent a couple of hours in jail for a DUI
5. 1980s-1990s: Married to first wife for 11 years
6. 1990s: Digestive problems
7. 1992-1993: Ulcers/stomach pain
8. 1998: Father died from a stroke
9. Early 2000: Attended AA mandated by the court and had treatment with a psychiatrist, needing support to cope with his failed marriages
10. Early 2000s: Vision or hearing issue
11. Early 2000s: Received psychological counseling after split from second wife
12. December 2001: First wife committed suicide and died from a gun inflicted wound to her heart
13. December 2001: He took a six week leave of absence to work for an NFL player and take care of his first wife's father during her death
14. 2005: Diagnosed with breast cancer
15. 2006: Diagnosed with diabetes
16. 2006: Married to third wife for ten years
17. 2007: Mother died from a stroke
18. Date unknown: Motor vehicle accident resulting in head injury/concussion
19. Date unknown: Received EDD benefits after laid off from employment, Dr. Drain
20. Date unknown: Married to second wife for 11 months; she was unfaithful
21. Date unknown: History of hypercholesterolemia
22. Date unknown: Got acid in his one eye while working for Benedict & Benedict and was off work for 10 days

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PRE-EXISTING DISABILITY HISTORY

In order to adhere to the required format of an SIBTF medical-legal report I have demarcated the specific issues unique to this case. I have separated from the subsequent injury all the prior industrial injuries and pre-existing conditions and disorders that were present before the subsequent injury of SI: July 11, 2012 as established by the orthopedic QME evaluation of Dr. Soheil M. Aval, M.D. dated 06/30/15.

The following sections of this report will address the pre-existing disabilities, pre-existing labor disablement and pre-existing work restrictions. Below is a narrative of Mr. Doran's disability history prior to the date of his subsequent work injury.

Identifying Information:

Mr. Doran is a 54-year-old widowed Caucasian male who is currently "disabled" and receives disability benefits, which is his current source of income. Interpreting service was not provided, as Mr. Doran was English speaking. Mr. Doran reported his employment duties as a Lead Plumber included working on all types of plumbing.

According to the medical record of Initial Comprehensive Psychological Consultation Report by Dr. Heath Hinze, Psy.D. at Hinze Psychological Services, PC dated 05/07/13, Mr. Doran's employment duties included traveling to different job sites, loading and unloading material and tools 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 would make holes on the ground and break walls. He also utilized various hand-held and power tools.

History of Childhood Events:

Mr. Doran was born and raised in Pasadena, California. He was raised by both parents. His father was an attorney/life insurance vice president and his mother was a full-time mom/housewife. He has two brothers and one sister. Mr. Doran was the youngest child.

He reported his family was close and supportive. His childhood feelings were happy and he was in good health as a child. He denied ever having any sexual abuse during his childhood.

Mr. Doran first experienced emotional difficulties in his life during his childhood. He reported "for a long time" during his childhood he was physically and verbally/emotionally abused by his father. His father hit him with a leather belt. His father was demeaning, "he was done being a father," and father was angry at times. The physical and verbal/emotional abuse "messed him up" and still affect him, explaining that when he was working he was "very serious and was all business."

His father died from a stroke in 1998, his mother died from a stroke in 2007, and his sister died from a stroke in August three years ago.

Academic History:

Educationally, Mr. Doran reported doing adequately in school completing up to 11th grade. He did not graduate from high school. He denied ever having any history of learning disabilities and was never involved in special educational classes. Behaviorally, the examinee denied any history of being suspended or expelled from school. The examinee never attended college or vocational school.

Military Service:

The examinee has never served in the armed forces.

Relationship History (before and after subsequent injury):

Mr. Doran had three marriages. He was married to his first wife for 11 years. She had bipolar disorder and committed suicide in December 2001. He was married to his second wife for 14 months. She was unfaithful with his first wife's nephew who lived with them. He was married to his third wife for 10 years and she died five years ago from heart problems. Prior to his wives' death, he was happy. He does not have any children.

Mr. Doran lives in Monrovia, California. He reported he has been homeless for the last two years due to his friend's daughter stealing $30,000 of his funds, "leaving him living on the streets." His dog died on Saturday, May 15, 2021. He is still "very sad over it." He was also very sad, because this was the 5th anniversary of his wife's death.

During today's evaluation, I inquired the examinee if there were any coexisting family stressors that could be contributing to his presenting psychological complaints, and he denied this to be the

case.

Work History:

Prior to the subsequent injury, Mr. Doran worked for the following employers:

Employer	Start Date	Position Held	Reason for Leaving
Security Fire Protection	1983	Sprinkler fitter	He left
Benedict & Benedict Plumbing		Plumber	Jobs due to moving
Mesquite Plumbing		Plumber	
Dean Plumbing		Plumber	
East Plumbing		Plumber	
Reichert Plumbing		Plumber	
Double D Plumbing		Plumber	
Dr. Drain Plumbing		Plumber	Laid off

The examinee represented he had an unstable work history, working for several companies. He does not recall the employment dates or other information related to his prior employments. He has generally worked as a plumber and indicated he had been content in this occupational choice. He has worked for approximately eight different companies in his career. Mr. Doran was "let go" from his employment with Dr. Drain, because he did not have any work for a while due to the owners being out of town for a long time. He collected unemployment benefits (E.D.D.) after he was terminated by Dr. Drain. Prior to this workers' compensation claim, he has never received disability benefits.

Medical History (before and after subsequent injury):

Mr. Doran had medical conditions both before or after the subsequent injury. There is a family history of strokes that were the cause of death of his mom, dad, and sister. There is also a family history of cancer. He was involved in an automobile accident requiring emergency treatment and sustained a head injury/concussion. He also sustained a head injury in the 1980s after he was robbed and struck on the head, in which he woke up in the hospital. Before the subsequent injury, he has never been medically disabled, but he had prior non-work-related injuries, including head injuries from a motor vehicle accident (MVA) and being struck in the head while being robbed. After the subsequent injury, he developed a stroke and subsequent mini strokes. He was diagnosed with Parkinson's disease six years ago.

Prior to the current industrial injury, the examinee indicated he was in reasonably good health. He did not use sick leave excessively during his employment.

According to the medical record of Neurological Eval by Dr. Mohsen Ali, M.D. at Foothills Neurological Med Group dated 01/02/13, Mr. Doran had a history of hypercholesterolemia. He had been smoking tobacco for 40 years.

According to the medical record of EMG/NCV of RUE interpreted by Dr. Pouya Lavian, M.D. dated 01/15/13, the examinee presented with the impression of mild right carpal tunnel syndrome.

According to the medical record of Initial Comprehensive Ortho Eval and RFA by Dr. Edwin Haronian, M.D. dated 02/18/13, Mr. Doran had 12 sessions of physical therapy to her right ® hand/wrist and thumb. He had no known history of heart disease, high blood pressure, kidney disease, tuberculosis, cancer, ulcers, pneumonia, lung disease, eye problems, skin problems, asthma, hepatitis, liver disease, thyroid disease, gout, rheumatoid arthritis, lupus, or arthritis. He denied having any previous surgeries. He denied any previous or subsequent accidents or injuries. Dx: 1) R carpal tunnel syndrome s/p R thumb fracture, healed. 2) R hand contusion.

According to the medical record of Whole Person Impairment by Dr. Edwin Haronian, M.D. dated 02/18/13, Mr. Doran's whole person impairment was 11 %. Left upper extremity (LUE) combined WPI was 2%. Right upper extremity (RUE) combined WPI was 9%.

According to the medical record of Follow-up Report by Dr. Edwin Haronian, M.D. dated 04/01/13, reported Neurontin made him feel spacey. He had evidence of some depression. Psychotherapy had been authorized.

According to the medical record of Pain Management Follow-up Report by Dr. Jonathan F. Kohan, M.D. dated 09/04/14, Mr. Doran had recent spinal cord stimulation (SCS) implantation.

According to the medical record of PQME by Dr. Soheil M. Aval, M.D. at West Coast Orthopedics, Inc. dated 06/30/15, the examinee was cutting into a very heavy wall made of floating cement. An upper portion of the wall fell down upon him. He placed his right hand over his head to protect it, at which time the wall struck his right hand. Due to this injury, Mr. Doran developed stress, anxiety, and depression due to his pain and inability to work. He received group counseling for approximately two years. He had reached MMI. Apportionment: 100% due to injury of 07/11/12. Impairment Rating: R Wrist 25% WPI. Work Restrictions: Precluded from activities of repetitive or forceful gripping, fine manipulation, torquing, and heavy lifting with RUE.

Current Medications:	Dosage	Frequency
Lantus	Insulin pen	
Metformin	1000 mg	2 x a day
Gabapentin	300-400 mg	
Lisinopril	20 mg	1 x a day
Montaluce	10 mg	1 x a day

Mr. Doran denied having any side effects from the medications. He relayed he began to use cannabidiol (CBD) to manage his pain. He had not begun to drink alcohol to manage his pain.

Medical/Psychological Conditions and Incidences (before subsequent injury)

Childhood:	First experienced emotional difficulties in his life from his dad physically/verbally/emotionally abusing him and hitting him with a leather belt
Age 14:	Began smoking one pack of cigarettes per day and ongoing for 40 years
1980s:	Head injury after he was struck in the head while being robbed

1985:	Arrested for drunk driving and spent a couple of hours in jail for a DUI
1980s-1990s:	Married to first wife for 11 years
1990s:	Digestive problems
1992-1993:	Ulcers/stomach pain
1998:	Father died from a stroke
Early 2000:	Attended AA mandated by the court and had treatment with a psychiatrist, needing support to cope with his failed marriages
Early 2000s:	Vision or hearing issue
Early 2000s:	Received psychological counseling after split from second wife
December 2001:	First wife committed suicide and died from a gun inflicted wound to her heart
December 2001:	He took a six week leave of absence to work for an NFL player and take care of his first wife's father during her death
2005:	Diagnosed with breast cancer
2006:	Diagnosed with diabetes
2006:	Married to third wife for ten years
2007:	Mother died from a stroke
Date unknown:	Motor vehicle accident resulting in head injury/concussion
Date unknown:	Received EDD benefits after laid off from employment, Dr. Drain
Date unknown:	Married to second wife for 11 months; she was unfaithful
Date unknown:	History of hypercholesterolemia
Date unknown:	Got acid in his one eye while working for Benedict & Benedict and was off work for 10 days

<u>Medical/Psychological Conditions and Incidences (after subsequent injury)</u>

After 2012:	Began developing strokes and mini strokes
After 2012:	Feeling depressed due to not being able to work, being homeless, and being in constant pain, which is overwhelming sometimes and makes him physically sick
2012-2014:	Received counseling for subsequent injury for two years with benefits
01/15/2013:	Diagnosed with mild right carpal tunnel syndrome
2015:	Diagnosed with Parkinson's disease six years ago
March 2015:	Diagnosed with high blood pressure
December 2015:	Diagnosed with a fistula for "growth in the rectum"
June 2016:	Reached MMI
2016:	Third wife died from a heart problem and he began having

suicidal ideations

2018:	Sister died from a stroke
2019:	Became homeless for the past two years
05/15/2021:	Beloved dog died and he also felt suicidal
May 2021:	5th anniversary of his third wife's death
May 2021:	Currently smokes half a pack of cigarettes per day

Hospitalizations (before subsequent injury)

1980s:	Woke up in the hospital after being struck in the head injury while being robbed
June 4, 2005:	Double mastectomy due to breast cancer

Hospitalizations (after subsequent injury)
None

Surgery (before subsequent injury)
June 4, 2005: Double mastectomy due to breast cancer

Surgery (after subsequent injury)
09/04/2014: Spinal cord stimulator implantation

Mental Health History (before and after subsequent injury):

Mr. Doran has never been hospitalized for emotional symptoms before or after his subsequent injury. He received psychological counseling for depression in the early 2000s after the split with his second wife. Before his subsequent injury, he had no thoughts of suicide and never attempted suicide. After his injury, he was prescribed amitriptyline for depression and pain. After the death of his third wife he had suicidal ideation, but never attempted suicide. He also currently feels suicidal after his dog died on May 15, 2021, the only love in his life. However, he insists he has no courage to commit suicide. Today, he denies having any suicidal ideations. There was no reported family history of mental illness.

He had psychological symptoms after his injury and had felt both worsening and improvement in the symptoms. He received psychological/psychiatric treatment for the subsequent injury in the form of group counseling at Synapse Group once a week for two years from 2012-2014. The treatment was helpful. He realized he was not the only one "in a mess," such as not being able to work.

According to the medical record of Initial Comprehensive Psychological Consultation Report by Dr. Heath Hinze, Psy.D. at Hinze Psychological Services, PC. dated 05/07/13, the following were Mr. Doran's diagnoses (Dx): Axis I: 1) Depressive disorder not otherwise specified (NOS). 2) Anxiety Disorder NOS. 3) Sleep Disorder due to pain, insomnia type. 4) Male Erectile Dysfunction (ED). He was given a GAF of 56.

According to the medical record of Follow-up Report by Dr. Edwin Haronian, M.D. dated 05/31/13, Mr Doran was being seen by a psychologist. He presented with a clinical picture of complex regional pain syndrome (CRPS). Dx: 1) Wrist tendonitis/bursitis. 2) Hand contusion.

According to the medical record of Cognitive Behavioral Therapy dated 10/08/13 (1 visit), the examinee reported having more panic attacks, feeling that some were intense. He felt sweat and dizzy. He thought he was going to have a heart attack. His symptoms appeared to fall in criteria for panic disorder.

According to the medical record of Progress Note by Dr. Jonathan F. Kohan, M.D. dated 03/06/14, he remained under the care of a psychologist with weekly psychotherapy sessions. Dx: 1) Complex regional pain syndrome type 1, RUE. 2) Diabetes.

According to the medical record of Progress Note by Dr. Edwin Haronian, M.D. dated 08/04/14, Mr. Doran continued with significant pain in the RUE. Dx: 1) Anxiety disorder, NOS. 2) Depressive disorder NOS. 3) Male erectile disorder. 4) Sleep disorder due to pain insomnia type. Plan: Authorization provided for permanent placement of SCS. He was scheduled for surgery. Continue with Dr. Kohan and was temporarily totally disabled (TTD).

According to the medical record of P&S Comprehensive Psychological Eval by Dr. Health Hinze, Psy.D. dated 06/02/15, Mr. Doran was given a GAF of 60. The events of the employment were the predominate cause (>51%) of emotional psychological injury. Based on the results of the evaluation, Dr. Hinze determined that approximately >51% of the permanent impairment was caused by the direct result of the injury arising out of and occurring in the course of employment. There was no basis to apportion to a nonindustrial factor. There was some slight tension in the home in regards to a grown daughter of his girlfriend's that was living there; however, it was not contributory to the permanent psychological disability. In consideration of this, it was determined that 100% of the permanent psychological disability was apportioned to the 07/11/12 injury and resulting pain and physical limitations. Mr. Doran reached MMI on a psychological basis as of the date of this report. His psychological WPI rating based on the GAF was 15%.

According to the medical record of Psychiatric QME Report by Dr. Daphna Slonim, M.D. dated. 07/18/16, the examinee was diagnosed with diabetes 10 years ago. His high blood pressure was diagnosed in March 2015. He reported he had a "growth in his rectum." It was diagnosed as a fistula. It started in December 2015. He was given a GAF of 55 and 23% WPI. Disability Status: At no time was he ever TTD purely from a psychiatric point of view. At the time, his condition was regarded as permanent and stationary (P&S) with moderate psychiatric disability. Apportionment: 20% was apportioned to pre-existing and non-industrial factors. 20% was a result of financial worries. 60% was apportioned to the industrial injury of 07/11/12.

According to the medical record of Neurological AME by Dr. Mark R. Pulera, M.D. dated 12/15/16, Mr. Doran was employed by Benedict & Benedict Plumbing Company as a journeyman plumber in 2009. He did residential plumbing, but also some commercial plumbing. He would remodel a bathroom. He also worked on-call plumbing jobs, may have six or seven jobs a day. He sustained an injury in this previous period of employment with this employer. He could not recall the date and did not file a claim. He could not recall the details, except to note that he apparently

had a bruised coccyx. Mr. Doran believed he missed 3 or 4 days with this injury, but made 100% recovery. He suffered another injury after he restarted working for the company in approximately 2009, it was in 2010 or so. He was working on a drain that actually had acid in it without his knowledge. He cut an acid pipe in a basement and acid splashed in his eye. He missed a few days of work but made a 100% recovery.

The following were Mr. Doran's diagnoses by Dr. Pulera: 1) Traumatic injury to the distal RUE on 07/11/12, industrial. 2) Chronic Regional Pain Syndrome Type I/Reflex Sympathetic Dystrophy of RUE, industrial. 3) Potential movement disorder caused by the spinal cord stimulator implantation, industrial. 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 07/11/12 without permanent neurologic impairment for headache or impaired memory. 8) No definite right or L "evidence of carpal tunnel syndrome" due to the injury on 07/11/12. Causation: Industrial injury of 07/11/12. Impairment Rating: Sleep impairment: 5% WPI. Neurologic impairment: 0% WPI. RUE impairment: 53% WPI. 1% impairment due to impaired eye blinking and masked facies secondary to Parkinson's disease. 2% impairment for hypophonia due to Parkinson's disease. BLE due to Parkinson's disease: 5% WPI. Total neurologic impairment due to Parkinson's disease: 9%. Headaches: 0%. 60% total neurological impairment on an industrial basis. There is 9% nonindustrial impairment due to mild underlying Parkinson's disease. Disability Status: Mr. would be considered TTD neurologically from DOI: 07/11/12 to 11/17/16. He was neurologically P&S.

According to the medical record of Revised Vocational Eval by Alejandro A. Calderon, MA. dated 12/04/17, Mr. Doran worked for Benedict & Benedict from 2009-2012 as a Plumber (Residential/Commercial). He retained an ability to return to work (RTW) in the open labor market in sedentary and light occupations when solely considering his industrially related orthopedic, neurological, and psychiatric medical work restrictions and while excluding his non- industrial medical conditions such as his diagnosed Parkinson's disease and Diabetes II. Absent the medically indicated non-industrial medical conditions, Mr. Doran had the ability to compete, or be retrained for suitable gainful employment.

Current Psychological Symptoms:

Mr. Doran feels sad or depressed at this time due to not being able to work, being homeless, and being in constant pain that is overwhelming sometimes and it makes him physically sick. He had a depressed mood most of each day for the past two weeks. He had a decreased interest in most activities, including a decreased interest in golfing, making love, fishing, hunting, and engaging in outdoor activities.

He had feelings of worthlessness or low self-esteem. He has felt fatigue or loss of energy. He had problems with thinking, problems concentrating, or difficulty making decisions for most of each day for the past two weeks. He reported extreme difficulty, perhaps due to Parkinson's.

He had thoughts of wishing he was dead or of suicide since the subsequent injury related to his wife's and dog's deaths. He has never attempted suicide or made a plan to kill himself. Over the past three months his level of depression had stayed the same. He had a significant weight change

and had lost 80 pounds since the subsequent injury. Before the injury, he weighed 225 pounds and now he currently weighs 140 pounds. He had a change in his sleep since his subsequent injury.

He denies having any anxiety symptoms. He felt as if he had anxiety or panic-type symptoms at this time, the symptoms started a few years ago and he had them periodically, usually in the shower and anywhere as well. He has experienced his heart pounding or racing. He has experienced dizziness or lightheadedness. He has experienced discomfort/tightness in his chest. He has experienced shortness of breath/problems breathing. He has experienced feelings of choking or problems with swallowing. He has experienced nausea or abdominal distress not related to medication. He has experienced chills or hot flushes. He has experienced numbness or tingling in his body not related to physical injury.

He has anxiety and panic-type symptoms every month. He also experienced monthly anxiety or panic-type symptoms before his subsequent injury. He had felt unable to travel without a companion. He has experienced recurrent distressing dreams or nightmares of a traumatic event, of monsters or the devil. He has made efforts to avoid thoughts, feelings, or talking about the event (i.e., people, places, objects); trying to escape nightmares. He has experienced an increase in being very watchful about his surroundings, stating, "I have to really check the ground to be level."

Substance Abuse History (before and after subsequent injury):

Before the subsequent injury, he smoked one pack of cigarettes per day since age 14. He currently smokes one-half pack of cigarettes per day. Before the subsequent injury, when he was younger, he smoked marijuana, but it was too strong and he could not function. After the subsequent injury, he uses CBD oil. Before and after the subsequent injury, he never used any other drugs. Before the subsequent injury, he drank alcohol to excess. In early 2000, he went to Alcoholics Anonymous (AA) mandated by a court order and then sought a psychiatrist on his own. He needed a support group to cope with his failed marriages. He denied these events interfering with his work hours or work function. He denied misusing prescriptive medications in the recent or remote past.

Legal History:

In 1985, the examinee was arrested for drunk driving and spent a couple of hours in jail for driving under the influence (DUI). From a civil perspective, the examinee denied ever being involved in a lawsuit—whether it be as a plaintiff or as a defendant. Prior to this current workers' compensation claim, while working for Benedict & Benedict he got acid in one eye and was off work for 10 days. He received a settlement. There was no psychiatric component to the injury.

History of Crisis or Abuse:

The examinee was subjected to childhood physical or and verbal/emotional abuse, but no sexual abuse. His first wife shot herself in the heart in December 2001. He had taken a six week leave of absence to do a job for an NFL player and learned the news of her death, which was shocking and traumatic. As an adult, the examinee denied ever being the victim of an assault (i.e. whether it be physical or sexual). He was exposed to a traumatic natural disaster (e.g., fire, hurricane, etc.) while in Alabama with his first wife. The state underwent the coldest weather, below 0 degrees, and he

was working 80 hours per week. A pipe burst and sprayed water everywhere. He did not get injured. The examinee suffered major losses with the deaths of two wives, the deaths of three family members, and the recent death of his dog. These experiences still affect him.

BEFORE the LAST Work Injury (also known as Subsequent Injury), Mr. Doran did not have difficulty in any areas of functioning; such as self-care, communication, physical activity, sensory function, household activity, travel, sexual function, and sleep function.

Self-care and Personal Hygiene BEFORE the Subsequent Injury		✓	**No Difficulties**
	Urinating		Trimming toe nails
	Defecating		Dressing
	Wiping after defecating		Putting on socks, shoes, and pants
	Brushing teeth with spine bent forward		Putting on shirt/blouse
	Bathing		Combing hair
	Washing hair		Eating
	Washing back		Drinking
	Washing feet/toes		Shopping
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Communication BEFORE the Subsequent Injury			**No Difficulties**
	Speaking/talking	✓	Writing
	Hearing		Texting
	Seeing		Keyboarding
	Reading (including learning problems, vision, or attention deficits)		Using a mouse
	Using a phone		Typing
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Physical Activity BEFORE the Subsequent Injury			**No Difficulties**
	Walking		Sitting
	Standing		Kneeling
	Pulling		Climbing stairs or ladders
	Squatting		Shoulder level or overhead work
	Bending or twisting at the waist		Lifting and carrying
	Bending or twisting at the neck		Using the right or left hand
	Balancing		Using the right or left foot
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Right hand and fingers would shake.			
Sensory Function BEFORE the Subsequent Injury		✓	**No Difficulties**
	Smelling		Feeling
	Hearing		Tasting
	Seeing		Swallowing
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Household Activity BEFORE the Subsequent Injury			**No Difficulties**
	Chopping or cutting food		Mopping or sweeping
	Opening jars	✓	Vacuuming
	Cooking	✓	Yard work
	Washing and putting dishes away		Dusting
	Opening doors		Making beds
	Scrubbing		Doing the laundry
	Repetitive use of the right hand		Repetitive use of the left hand
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel: **Limited to using left hand only.**			

Travel BEFORE the Subsequent Injury		✓	**No Difficulties**	
	Riding as a passenger	If you have trouble sitting, approximately how long can you remain seated at a time?		
	Driving	If you have trouble driving, approximately how long can you drive before needing to rest?		
	Handling/lifting luggage	Approximately how many times per year do you travel BEFORE the Subsequent Injury?		
	Keeping arms elevated (right)		Holding or squeezing the steering wheel	
Other difficulties:				
If you indicated difficulties in this area, please describe how these difficulties make you feel:				

Sexual Function BEFORE the Subsequent Injury			**No Difficulties**
	Erection		Painful sex (in the genital area)
	Orgasm		Back pain with intimate relations
	Lubrication		Neck pain with intimate relations
	Lack of desire		Joint pain with intimate relations

Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel: **At times it was hard to get full night's rest.**			

Sleep Function BEFORE the Subsequent Injury		✓	**No Difficulties**	
	Falling asleep		Sleeping on the right side	
	Staying asleep		Sleeping on the left side	
	Interrupted/restless sleep		Sleeping on the back	
	Sleeping too much		Sleeping on the stomach	
	Daytime fatigue or sleepiness	Did you ever taken any medications to help you sleep BEFORE the Subsequent Injury?		
How many hours could you typically sleep at a time without waking up during the night?			How many hours total were you able to sleep at night?	
If you indicated difficulties in this area, please describe how these difficulties make you feel:				

Description of Pre-Existing Injury(ies):

Childhood:	First experienced emotional difficulties in his life from his dad physically/verbally/emotionally abusing him and hitting him with a leather belt
Age 14:	Began smoking one pack of cigarettes per day and ongoing for 40 years
1980s:	Head injury after he was struck in the head while being robbed
1985:	Arrested for drunk driving and spent a couple of hours in jail for a DUI
1980s-1990s:	Married to first wife for 11 years
1990s:	Digestive problems
1992-1993:	Ulcers/stomach pain
1998:	Father died from a stroke
Early 2000:	Attended AA mandated by the court and had treatment with a psychiatrist, needing support to cope with his failed marriages
Early 2000s:	Vision or hearing issue
Early 2000s:	Received psychological counseling after split from second wife
December 2001:	First wife committed suicide and died from a gun inflicted wound to her heart
December 2001:	He took a six week leave of absence to work for an NFL player and take care of his first wife's father during her death
2005:	Diagnosed with breast cancer

2006: Diagnosed with diabetes
2006: Married to third wife for ten years
2007: Mother died from a stroke
Date unknown: Motor vehicle accident resulting in head injury/concussion
Date unknown: Received EDD benefits after laid off from employment, Dr. Drain
Date unknown: Married to second wife for 11 months; she was unfaithful
Date unknown: History of hypercholesterolemia

Date unknown: Got acid in his one eye while working for Benedict & Benedict and was off work for 10 days

Periods of TTD from Pre-Existing:

December 2001: He took a six week leave of absence to work for an NFL player and take care of his first wife's father during her death

Date unknown: Got acid in his one eye while working for Benedict & Benedict and was off work for 10 days

Pre-existing Psych Symptoms:

Physically/verbally/emotionally abused by father
Major Depression
Panic attacks
Alcohol abuse
Bereavement

PRE-EXISTING PSYCHIATRIC DIAGNOSES

AXIS I: **EPISODE OF MENTAL/CLINICAL DISORDER**
Physical Abuse of Child (V61.21)
Major Depression, Recurrent, Moderate (296.3)
Panic Disorder without Agoraphobia (300.01)
Alcohol Abuse (305.00)
Bereavement (V62.82)

AXIS II: **PERSONALITY DISORDER**
No Diagnosis (V71.09)

AXIS III: **PHYSICAL DISORDERS AND CONDITIONS**
Status per the review of the medical records above.

AXIS IV: **SEVERITY OF PSYCHOSOCIAL STRESSORS**
Moderate

(1) Sequela to work-related injury, including cognitive, physical, and emotional problems, as well as occupational and financial problems.

(2) Non-Industrial and concurrent stressful issues were identified and these include: physical abuse by father as a child, deaths of wives, deaths of mother and father, two divorces, alcohol abuse resulting in incarceration, psychotherapy related to failed marriages, and medical problems.

AXIS V: **GLOBAL ASSESSMENT OF FUNCTIONING (GAF)**
Current - _54_

Please Note: Use of the DSM IV-TR is provided in the above instance as the DSM-5 no longer provides a GAF score, which is necessary in an evaluation of this nature.

DISCUSSION OF PRE-EXISTING DISABILITY RATING

Mr. Doran experienced symptoms of depression and impairment of his functional abilities. I conclude Mr. Doran experienced moderate work limiting impairments on a psychological basis prior to the subsequent industrial injury. The following issues contributed to his pre-existing psychological disability:

Mr. Doran has been experiencing feelings of depression since he was a child regarding his father's abuse. He experienced recurring depressive symptoms related to his first wife's death, second wife's infidelity, deaths of his parents, and failed marriages and divorces. In 1985, he received a DUI for drunk driving, was incarcerated as a result, and had to attend AA meetings. In early 2000, he sought treatment from a psychiatrist to cope with his failed marriages. In December 2001, he took a six week leave of absence to work for an NFL player and take care of his first wife's father during her death.

Based on this clinical picture and the impact on his functioning, it is my opinion that Mr. Doran met criteria for Physical Abuse of Child; Major Depression, Recurrent, Moderate; Panic Disorder without Agoraphobia; Alcohol Abuse; and Bereavement. Additionally, his GAF score was 54 - which is equivalent to a WPI of 24%. This GAF falls into the 51-60 decile, which is described by the 2004 Permanent Disability Rating Schedule as follows:

Moderate symptoms (e.g., flat affect and circumlocutory speech, occasional panic attacks) *or* moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

It is also my opinion that these disorders significantly impacted Mr. Doran's occupational functioning causing pre-existing labor disablement, evidenced by his time off work to grieve over his first wife's death, psychotherapy treatment for his marriages, and incarceration for alcohol abuse and rehab treatment. Mr. Doran's symptoms had reached a plateau and he was able to work for other companies for a brief period before he became industrially injured in spite of his psychological impairment. Thus, these psychological diagnoses were permanent and stationary prior to his subsequent industrial injury of SI: July 11, 2012. Consequently, the following actual psychological work restrictions existed prior to the subsequent injury:

- **Due to his symptoms of depression, Mr. Doran required a flexible work schedule to accommodate his need for weekly psychotherapy sessions and monthly psychiatric consultations.**

- **An understanding supervisory to provide feedback to Mr. Doran in a sensitive manner due to his fragile self-esteem.**

- **Slow increase in complexity of job duties and tasks given Mr. Doran's deficits with concentration, focus, and memory regarding his bereavement.**

- **Promoting as much predictability as possible in the employee's daily tasks.**

- **Providing clear guidelines and instructions, possibly in writing related to his vision impairment.**

- **Allowing for flexibility with regard to pace of work and timing of breaks.**

- **Working as part of a team to decrease the employee's sense of loneliness or isolation.**

- **Avoiding excessive work hours, overtime, and insisting on Mr. Doran taking normal breaks and a lunch.**

These actual pre-existing restrictions provide evidence of Mr. Doran's actual labor disablement that was present prior to his subsequent industrial injury.

SUBSEQUENT INDUSTRIAL INJURY

History of Subsequent Injury:
What follows is a narrative of Mr. Doran's subsequent injury, the resulting psychiatric disability, and existing work restrictions. Mr. Doran worked at Benedict & Benedict Plumbing beginning 1987-88 and last worked on July 12, 2012. Mr. Doran injured himself on SI: July 11, 2012 while employed as a Plumber. He injured his right wrist, right hand, and right thumb. He reported the following:

SI: July 11, 2012
"I was denied a helper that day for work. I ran a reciprocating saw and cut an opening in a loft ceiling at a house. I wanted to run the pipes from the bedroom wall. There was a huge mirror in the bathroom. I set the saw on the floor. I was sitting cross-legged. A big chunk of plaster cracked and I blocked my head with my hands while it fell down on me. The plaster injured my right hand. I could not work after that with only one hand, as plumbers need two hands."

According to the medical record of Initial Comprehensive Ortho Eval and RFA by Dr. Edwin Haronian, M.D. dated 02/18/13, Mr. Doran was making an opening on a section of a wall, requiring him using a saw to cut through. A chunk of wall from above came down and struck him on his

right wrist and hand. He experienced immediate pain to the right wrist and hand and suffered an open wound to his right thumb.

His work duties and responsibilities did not change after the injury, because he was unable to work. Mr. Doran received positive feedback from his employer before the subsequent injury occurred. He reported, "The owner was happy with how much money I made for them." Mr. Doran worked 8+ hours per day, at least 5 days per week. He could not recall how much money he earned. He no longer works for the company and is no longer employed with the company. He is not currently working for any employer. He received disability benefits from Social Security Disability Insurance after the subsequent industrial injury.

According to the medical record of Initial Comprehensive Ortho Eval and RFA by Dr. Edwin Haronian, M.D. dated 02/18/13, Mr. Doran worked 6-12 hrs/day, 5 days/week, and worked on-call a couple of days a week.

Mr. Doran currently has constant pain in his right hand, right wrist, bilateral knees, and left hip. The pain in most areas is at a pain level of 7-8, (on a scale of 0-10, 10 being the most severe pain). During the evaluation, the pain in his right hand is 9 out of 10.

His treatment consisted of physical therapy. Treatment was helpful at first, especially the hot wax therapy for his right hand. The range of motion exercises for his right hand was very painful.

According to the medical record of Initial Comprehensive Ortho Eval and RFA by Dr. Edwin Haronian, M.D. dated 02/18/13, the examinee had 12 sessions of physical therapy to his right hand/wrist and thumb, with temporary pain relief.

He received spinal cord implant surgery for this injury; date unrecalled. The surgery was helpful but the spinal cord stimulator will be better once he gets a new battery. He currently has a lot of pain, because he needs a new stimulator/battery.

Mr. Doran reported the onset of depressive symptoms from this injury sometime after the injury in 2012. He reported:

"I started feeling depressed, because I am not able to work, homeless, and in constant pain (overwhelming sometimes and makes him physically sick)."

Additionally, since 2012, he has been dealing with chronic pain problems and has been taking pain-relieving medication since this time. This was initiated after he injured his right wrist, right hand, and right thumb during an industrial injury. He admitted having auditory or visual hallucinations of seeing animal shadows, but was told it could be from Parkinson's disease.

ACTIVITIES OF DAILY LIVING CHECKLIST

SELF-CARE/PERSONAL HYGIENE

Mr. Doran sometimes neglects to bathe or shower. He sometimes has no interest in his appearance. He sometimes has no interest in shaving. He sometimes has no interest in getting dressed. He often has problems sleeping at night because he cannot stop thinking or worrying. He often does not feel rested in the morning and often feels sleepy during the daytime. He sometimes lacks the desire to have sexual relations. He sometimes is physically unable to have sexual relations. He sometimes has no desire to travel.

HOUSEHOLD ACTIVITIES

He sometimes cannot prepare a meal for himself. He sometimes has a problem organizing or cleaning the house. He often has no energy to clean his house. He often has problems focusing and repairing things that are broken in the house.

FAMILY AND SOCIAL ACTIVITIES

He sometimes cannot take care of the people at home that he used to before his injury. He often spends many days in his room and has no interest in talking to others. He often has a problem listening to others or understand what they are saying to him. He sometimes lacks the cognitive stamina to be involved with friends and family. He sometimes does not want to initiate social contact with friends and family. He sometimes does not accept criticism appropriate from others.

RECREATIONAL ACTIVITIES

He sometimes has problems concentrating long enough to do his normal hobbies. He often has no interest in attending social gatherings, meetings, or church events. He sometimes has problems concentrating on art projects, music activities, or building projects. He sometimes cannot muster the energy or concentration to play board games, cards, or video games.

MEDICAL ACTIVITIES

He often forgets to take his medications. He sometimes forgets his doctors' appointments. He sometimes forgets what his doctors' instruct him to do. He sometimes has no energy to do home-based physical therapy exercises. He often loses important papers given to him by doctors or the insurance company. He often is unable to complete a project near others without being distracted. His day is often interrupted by his psychological symptoms.

MANAGING FINANCES AND PERSONAL ITEMS

He often has problems managing a checkbook. He often gets confused when paying for items at a store. He sometimes loses his wallet, keys or cell phone, or forgets where he parked his car. He often misplaces important financial papers or documents.

COMMUNICATION ACTIVITIES

He sometimes starts to fall asleep if he reads something for more than a few minutes. He sometimes loses interest when watching television and stops watching the show. He sometimes loses interest in communicating with others by email, text, or phone. He sometimes loses interest in reading the newspaper or watching the news on TV. He sometimes does not attend normal events and communicating activities (e.g. church, social clubs, volunteer events, visiting relatives, etc.).

EMOTIONAL AND OCCUPATIONAL FUNCTIONS

He agrees that he would have problems performing any job he may qualify for because of his emotions. He agrees he does not have the psychological energy to multi-task. He strongly agrees that he becomes emotionally overwhelmed when demands are placed upon him. He agrees his hypersensitive to environmental factors (e.g., noise, delays, disappointments, setbacks, etc.) and responds in anger when these occur. He agrees that he is not able to maintain a productive schedule where he completes the goals he sets for his household or family.

STRESS TOLERANCE

He finds himself on the verge of losing control over things as simple as television commercials. He finds himself highly irritated with changes in routine. He feels he might make hasty decisions and does wish to make independent decisions. His feeling of being overwhelmed has adversely affected his sleep.

MENTAL STATUS EVALUATION

General Appearance
Mr. Doran is a 54-year-old widowed Caucasian male who is 6'0" tall and weighs 140 pounds. He appeared to look his stated age and presented with acceptable personal hygiene. He was bald and wore a red handkerchief around his neck and a bright green thermal long sleeve shirt.

Manner of Relating
Mr. Doran related in reasonably open, self-disclosing fashion and generally waited for me to ask questions rather than talk about his issues freely. He demonstrated no difficulty maintaining eye contact. I did not sense any sign of defensiveness or evasiveness. He was amiable and amenable to answering all of my questions. Mr. Doran related in a rather distressed manner indicative of someone who is emotionally overwhelmed at this time. He became teary eyed when disclosing information about his injury and deaths of his dog and wife. He was cooperative with the evaluation process and completed the psychosocial questionnaires with relevant detail.

Psychomotor Activities
Mr. Doran walked slowly from the waiting room to my office. When he sat down, he did so gingerly and in a rigid manner. He had "bad" tremors from Parkinson's disease and he rubbed his right hand during the interview. While reaching for paperwork, he grimaced in pain.

Speech and Language
Mr. Doran spoke at a middle range volume; his speech was slurred and trembling from Parkinson's disease. The examinee was lucid and linguistically coherent. His ability to communicate was normal and his use of vocabulary and pronunciation was adequate given his level of experience and education. Slang or profanity was not used in conversation.

Orientation and Cognition
Mr. Doran appeared to be functioning at an average intellectual level, with a fund of knowledge appropriate for his age, educational level, and life experiences. He showed appropriate judgment and average abstract reasoning. Orientation in all spheres was intact. Ability to concentrate was impaired. Long-term memory was intact. His short-term memory was impaired. He began feeling confused during the interview for a moment. He did not understand why, but believed his blood sugar level was out of balance and asked for a piece of sugary gum.

Thought Content and Processes
Mr. Doran admitted having visual hallucinations of seeing animal shadows, but was told it could be from Parkinson's disease. He denied bizarre sensory experiences, heightened tactile sensitivities, or other gross perceptual disturbances. His thought processes did not show any signs of psychotic functioning. He did not express any paranoia, ideas of references, or admits to any delusionary beliefs. In general, he seemed rational and coherent, with no perceptual oddities observed.

Emotional Process
His emotional expression was most noteworthy for his tearful affect indicative of his underlying significant depressed state.

Impulse Control
Mr. Doran reported the presence of passive suicidal ideations where he sometimes thinks about death, but denied he would ever attempt suicide, because he does not have the "guts to do it." However, he denied having any current suicidal ideations and any active plan or intent to harm himself at this time. He also showed no propensity towards aggressive behavior.

PSYCHOLOGICAL TESTS ADMINISTERED AND RESULTS

- Beck Depression Inventory-II (BDI-II)
- Beck Anxiety Inventory (BAI)
- Epworth Sleepiness Scale (ESS)
- Hamilton Rating Scale for Depression (HAM-D)
- Montreal Cognitive Assessment (MOCA)
- Modified Somatic Perceptions Questionnaire (MSPQ)
- Pain Catastrophizing Scale (PCS)
- Pain Drawing (PD)
- AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, Chapter 18 (18-4, Page 576)

BECK DEPRESSION INVENTORY-II (BDI-II)

The BDI-II is one of the most widely used screening tests for depression. It is an easily scored test consisting of 21 items that are rated on a 4-point Likert scale ranging from 0 to 3. The maximum total score is 63. The test requires the examinee to rate himself across a wide range of common depressive symptoms including sadness, loss of pleasure, guilt, indecisiveness, changes in sleep patterns, fatigue, etc. The BDI-II items are consonant with the DSM-IV criteria for depressive based diagnoses. The cut off scoring criteria for the BDI-II is as follows:

TOTAL SCORE	RANGE
0-13	No or minimal depression
14-19	Mild depression
20-28	Moderate depression
29-63	Severe depression
Below 4	Possible denial of depression, faking good; lower than usual scores even for normal

On the Beck Depression Inventory, Mr. Doran obtained a score of 43, thereby placing him in the severe depression range of clinical depression. In examining his overall pattern of symptoms, the examinee's responses appear to emphasize both affective and cognitive symptoms of depression. In terms of suicide potential, the BDI-II manual recommends that the examinee pay careful attention to the examinee's responses to item #2 (pessimism) and item #9 (suicidal ideas). The combination of hopelessness with recurrent suicidal thoughts with intent are considered better indicators of self-destructive behavior than the emotional intensity of depression. On items #2 and #9, the examinee obtained a combined score of 3 indicating that there is likely to be low concern with suicidal potential.

BECK ANXIETY INVENTORY (BAI)

The Beck Anxiety Inventory (BAI) is a 21-item test that measures the severity of self-reported anxiety. The BAI requires the examinee to rate a set of symptoms across a 4-point Likert scale from 0-3. The maximum BAI score is 63. The cutoff scoring criteria for the BAI is as follows:

TOTAL SCORE	RANGE
0-7	Minimal anxiety
8-15	Mild anxiety
16-25	Moderate anxiety
26-63	Severe anxiety

The examinee obtained a total score of 28, which is suggestive of a severely anxious state.

EPWORTH SLEEPINESS SCALE (ESS)

The Epworth Sleepiness Scale (ESS) is a short test, recently developed at the Epworth Hospital in Australia that measures excessive daytime sleepiness. The ESS is an acceptable and well-regarded alternative for a time-consuming and expensive laboratory testing procedure. The ESS is a subjective, self-report instrument that describes eight different situations and four possible answers for each situation. Various authors have assigned differing cutoff scores to determine excessive daytime sleepiness. At the present time, there are no national norms available for the ESS. However, this instrument is likely the most widely used test for sleepiness.

The AME Guides define four sages of sleep-related impairment (pages 31 7-318). The ESS is an instrument that the clinician can utilize to assess sleep impairment vis-à-vis the effect of sleepiness upon alertness. However; it should be realized that the score obtained on the ESS is not norm-based and must be only used as general guide to assessing sleepiness or decreased alertness. An average score is probably 7-8. A score of more than 10 indicates the probable need for professional assistance. Sleep Apnea examinees score from 11.7 (CPAP) to 16 (no CPAP), Narcolepsy examinees score about 7.5. The maximum possible score on the ESS is 24.

John, MW. (1991) A new method for measuring daytime sleepiness: The Epworth sleepiness scale. Sleep, 14, 540-545. 1991

Scale
0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situations	**Score**
Sitting & Reading	1
Looking at TV	0
Sitting inactive in a public place	0
When a passenger in a car for 1 hour with no breaks	1
Lying down to rest in the afternoon	1
Sitting & talking to someone	0
Sitting quietly after lunch with no alcohol	1
In a car while stopped for a few minutes in traffic	0
Total Score = 4	

The examinee received a score of 4, reflecting that he is not excessively sleepy.

Prior to the subsequent injury, it varied on how long it took him to fall asleep, he slept for 6 hours each night, and he woke up a few times at night due to pain. After the subsequent injury in 2012, it still varies on how long it takes him to fall asleep. He currently sleeps in his vehicle. He sleeps 6 hours each night and he wakes up several times at night due to the sound of police as well as anxiety. Some nights he cannot sleep.

HAMILTON DEPRESSION RATING SCALE (HAM-D)

The test was developed by Dr. Hamilton and is not a "self-rating" test. Rather, applicants discuss their responses with the physician who rates their degree of depression and/or anxiety. Both are considered the most objective measure of an applicant's degree of depression and/or anxiety. Scores to determine the degree of depression and anxiety vary by clinician. The Hamilton Rating Scale for Depression is the most commonly used psychiatric test in psychiatric pharmacologic management and in research studies because of its objectivity. This test emphasizes vegetative depressive symptoms – such as sleep, appetite, and sexual disturbance – in contrast to the Beck Depression Inventory which emphasizes affective, cognitive and vegetative symptoms.

The Hamilton Rating Scale for Depression is used extensively to measure clinical improvement in levels of depression, and an antidepressant is considered efficacious if it results in 50% reduction in the applicant's scores on this test.

TOTAL SCORE	RANGE
0 – 7	None/Minimal Depression
8 – 13	Mild
14 – 18	Moderate
19 - 22	Severe
23+	Very Severe

On the HAM-D, Mr. Doran obtained a score of 30, thereby placing him in the very severe range of clinical depression.

MONTREAL COGNITIVE ASSESSMENT (MoCA)

The Montreal Cognitive Assessment, MoCA, was created in 1996 (Copyright Z. Nasreddine MD). It was validated by: Ziad S. Nasreddine, Natalie A. Phillips, Valerie Bedirian, Simon Charbonneau, Victor Whitehead, Isabelle Collin, Jeffrey L. Cummings and Howard Chertkow, The Montreal Cognitive Assessment, MoCA: A Brief Screening Tool for Mild Cognitive Impairment. J Am Geriatr Soc, 2005, 53:695-9. The MoCA test is a one-page 30-point test administered in 10 minutes. The test and administration instructions are freely accessible for clinicians at **www.mocatest.org**. The test is available in 34 languages or dialects. There are 3 alternate forms in English, designed for use in longitudinal settings.

The MoCA assesses several cognitive domains. The short-term memory recall task (5 points) involves two learning trials of five nouns and delayed recall after approximately 5 minutes. Visuospatial abilities are assessed using a clock-drawing task (3 points) and a three-dimensional cube copy (1 point). Multiple aspects of executive functions are assessed using an alternation task adapted from the trail-making B task (1 point), a phonemic fluency task (1 point), and a two-item verbal abstraction task (2 points). Attention, concentration and working memory are evaluated using a sustained attention task (target detection using tapping; 1 point), a serial subtraction task. (3 points), and digits forward and backward (1 point each). Language is assessed using a three-item confrontation naming task with low-familiarity animals (lion, camel,

rhinoceros; 3 points), repetition of two syntactically complex sentences (2 points), and the aforementioned fluency task.

MOCA SCORES			
	Normal Controls (NC)	**Mild Cognitive Impairment (MCI)**	**Alzheimer's Disease (AD)**
Number of Subjects	90	94	93
MoCA Average Score	27.4	22.1	16.2
MoCA Standard Deviation	2.2	3.1	4.8
MoCA score range	25.2 - 29.6	19.0 – 25.2	21.0 – 11.4
Suggested cut-off score	≥26	<26	<26ψ
Although the average MoCA score for the AD group is much lower that the MCI group, there is overlap between them. The suggested MoCA cut-off score is thus the same for both. The distinction between AD and MCI is mostly dependent on the presence of associated functional impairment and not on a specific score on the MoCA test.			

(MOCA Score is below 27;
Slight Behavioral Processing Difficulties Observed)

The MOCA has a maximum score of 30. A score of 26 or greater is considered normal. The examinee's cognitive performance on the MOCA was below the cut off score of 27. He received a preliminary score of **21, but** one point was added due to the examinee having less than 12 years of education. This resulted in a total score of **22**. This finding suggests that there may very well be some cognitive deficits that are interfering with his ability to sustain concentration, attend to task, and retain information. In examining his MOCA performance, the following cognitive processing areas showed the greatest deficits.

1. **Visuospatial/executive** skills are assessed using a clock-drawing task, trail-making B task, and copying the three-dimensional cube task. Visuospatial/executive skills revealed deficits in executive functions in drawing 10 past 11 on the clock. He received a score of 4 out of 5 for the Visuospatial/executive domain.

2. **Language** skills revealed deficit in verbal fluency as he was unable to generate more than (11) words beginning with a certain letter of the alphabet (F) in a specified time period. He generated **9 words.** This deficit could infer a problem in sustaining concentration as he may fatigue easily. Language deficit was also assessed using a three-item naming task with low-familiarity animals and repetition of two syntactically complex sentences. Language skills revealed deficit in repetition of two syntactically complex sentences. He received a score of 1 out of 2.

3. **Abstraction** abilities were assessed to be poor as he had difficulty in comprehending how discrete items could be alike. This finding could infer a difficulty in complex problem solving abilities. He received a score of 1 out of 2.

4. **Delayed Recall (Short-term memory recall)** was weak as evidenced by the fact that he recalled **0** items out of 5 items (e.g. face, velvet, etc.) after a five-minute time delay.

MODIFIED SOMATIC PERCEPTIONS QUESTIONNAIRE

The MSPQ is a 13 item self-report scale for patients with chronic pain or disabilities. It can help identify somatic complaints that may be associated with psychological responses such as anxiety or depression. The higher the score, the more marked the general somatic symptoms. The number of perceptions at each intensity level can help gauge the number of limiting symptoms. A person with significant somatic complaints would be a candidate for psychological interventions to aid coping.
Each item is scored on a scale from zero (0) to three (3). Patients who produce a score of 12 or greater (maximum score is 39) are at risk for a prolonged recovery. The questionnaire contains a total of 22 items, but only 13 are used to calculate the score. The remaining items are included to reduce the possibility of a response bias. The higher the score, the more hypersensitive the examinee is to bodily sensations, processes, and discomfort.

Mr. Doran received a raw score of 37, which reflects risk for a prolonged recovery and a likely pattern of somatic hypersensitivity.

PAIN CATASTROPHIZING SCALE (PCS)

Pain catastrophizing is characterized by the tendency to magnify the threat value of a pain stimulus and to feel helpless in the presence of pain, as well as by a relative inability to prevent or inhibit pain-related thoughts in anticipation of, during, or following a painful event (Quartana, Campbell, & Edwards, 2009). Pain catastrophizing affects how individuals experience pain. Sullivan et al. (1995) state that people who catastrophize tend to do three things, all of which are measured by the PCS questionnaire; They ruminate about their pain (e.g. "I can't stop thinking about how much it hurts"), they magnify their pain (e.g. "I'm afraid that something serious might happen"), and they feel helpless to manage their pain (e.g. "There is nothing I can do to reduce the intensity of my pain").

Further, it is becoming increasingly clear that catastrophic thinking in relation to pain is a risk factor for chronicity and disability. In other words, catastrophizing not only contributes to heightened levels of pain and emotional distress, but also increases the probability that the pain condition will persist over an extended period of time. As such, this measure is helpful for examining the current thinking and coping process as it relates to the current physical state, and quantifying an individual's pain experience, as well as providing information related to future adjustment and recovery. The available research shows that a PCS raw score of 30 (which falls at the 75th percentile in clinical samples at chronic pain treatment centers) when coupled with a Beck Depression score greater than 16, predicts that more than 70% of these patients will be totally disabled from working a year following the date of injury. Thus, a raw score of 30 will be considered clinically significant in this analysis.

Mr. Doran received a raw score of 34 that reflects a nearly constant state of catastrophizing related to his pain condition.

PAIN DRAWING (PD)

The Pain Drawing (PD) is a pictorial representation of the human body on which examinees can indicate graphically where and how pain is affecting them. The PD is comprised of two images representing the front and back of the body respectively. A total pain score is calculated based on the extent of pain indicated on the diagrams. This score is useful both as a positive measure and as a guide for future treatment.

Scoring System for Pain Drawings
Unreal drawings. If one or more of the following pain localizations are drawn in, two points are assigned.

A. *Total leg pain*
B. *Frontal aspect of one or both legs*
C. *Unilateral or bilateral anterior tibial pain*
D. *Back of leg (isolated, knee included)*
E. *Circumferential thigh pain*

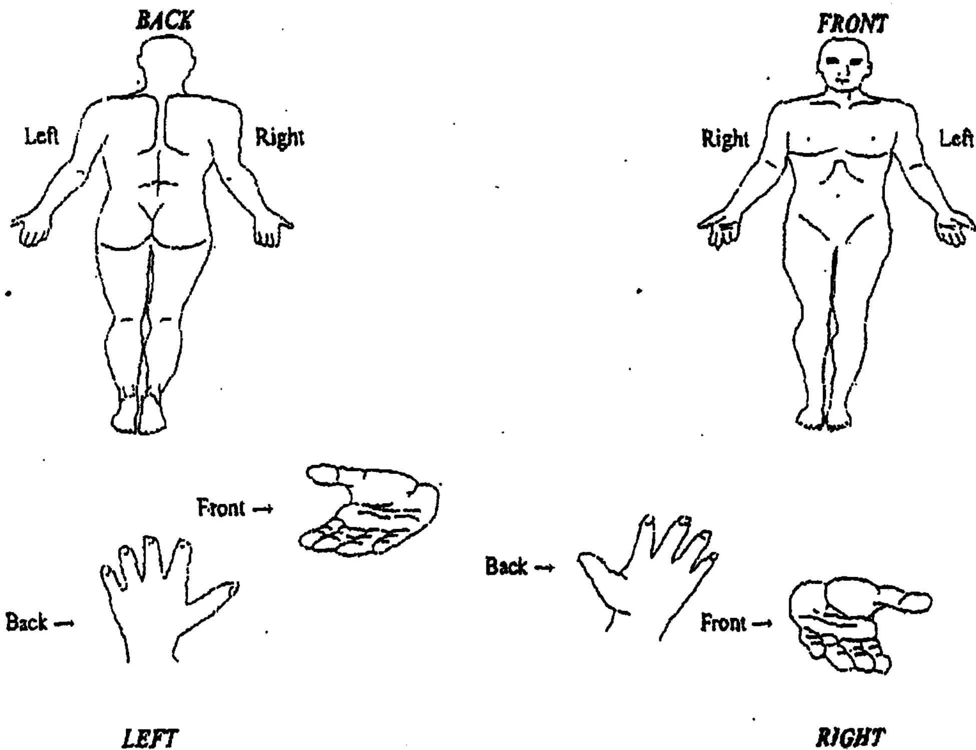
Drawings showing "expansion" or "magnification' of pain (one or two points per area, depending upon extent)

A. *Pain drawn outside the outline as an indication of magnification.*
"I particularly hurt here" indicators (each category scores one point).

1. *Additional explanatory notes*
2. *Circle painful areas*
3. *Draw lines to demarcate painful areas.*

D. Use arrows to describe anatomically not explainable pain. Use additional symbols.

With this rating system, a score of three or more is generally thought to represent a pain perception that may be influenced by psychological factors. Some of the readily apparent expressions of psychological distress include pain distributions that are non-anatomic or bizarre, drawings showing "magnification" or 'expansion" of symptoms, and drawings that demonstrate "look how bad I am indicators."
In reviewing the examinee's pain drawing, none of these domains were found.



On the front portion of this form, Mr. Doran complains of stabbing, burning, and radiation in the right wrist; numbness, tingling, and stabbing in the left hip; and numbness, tingling, and stabbing in the right knee. On the back portion of this form, he complains of stabbing, burning, radiation, numbness, and tingling in the left hip; and stabbing, burning, and numbness in the right wrist. In the last two months, his condition has worsened due to needing a new stimulator.

It should be noted that the examinee's pain drawing was consistent with his report of somatic health concerns. This consistency provides additional validation for my assessment that I find him to be a credible historian.

AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT, 5TH EDITION, CHAPTER 18

TABLE 18-4, PAGE 576

I. **Pain (Self-Report of Severity)**

A. Rate how severe your pain is **right now, at this moment**

0	1	2	3	4	5	6	7	8	9	10

No pain — Most severe pain can imagine

B. Rate how severe your pain is **at its worst**

0	1	2	3	4	5	6	7	8	9	10

None | Excruciating

C. Rate how severe your pain is **on the average**

0	1	2	3	4	5	6	7	8	9	10

None | Excruciating

D. Rate how much your pain is **aggravated by activity**

0	1	2	3	4	5	6	7	8	9	10

Activity does not aggravate pain | Excruciating following any activity

E. Rate how **frequently** you experience pain

0	1	2	3	4	5	6	7	8	9	10

Rarely | All of the time

II. Activity Limitation of Interference

A. How much does your pain interfere with your ability to **walk 1 block**?

0	1	2	3	4	5	6	7	8	9	10

Does not restrict ability to walk | Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of grocery)?

0	1	2	3	4	5	6	7	8	9	10

Does not prevent from lifting 10 pounds | Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for ½ hour**?

0	1	2	3	4	5	6	7	8	9	10

Does not restrict ability to sit for ½ hour | Impossible to sit for ½ hour

D. How much does your pain interfere with your ability to **stand for ½ hour**?

0	1	2	3	4	5	6	7	8	9	10

Pain does not interfere with ability to stand at all | Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep**?

0	1	2	3	4	5	6	7	8	9	10

Does not prevent me from sleeping | Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere | Completely interferes

with social activities | with social activities

G. How much does your pain interfere with your ability to **travel up to 1 hour by car?**

0	1	2	3	4	5	**6**	7	8	9	10

Does not interfere with ability to travel 1 hour by car | Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with your **daily activities**?

0	1	2	3	4	5	6	7	**8**	9	10

Does not interfere with my daily activities | Completely interferes with with my daily activities

I. How much do you **limit your activities to prevent your pain from getting worse**?

0	1	2	3	4	5	6	7	**8**	9	10

Does not limit activities | Completely limits activities

J. How much does your pain interfere with your **relationship with your family/partner/significant others**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere with relationships | Completely interferes with relationships

K. How much does your pain interfere with your ability to do **jobs around your home**?

0	1	2	3	4	5	6	7	**8**	9	10

Does not interfere | Completely unable to do any jobs around home

L. How much does your pain interfere with your ability to **shower or bathe without help from someone else**?

0	1	2	3	4	5	**6**	7	8	9	10

Does not interfere | My pain makes it impossible to at all shower or bathe without help

M. How much does your pain interfere with your ability to **write or type**?

0	1	2	3	4	5	6	**7**	8	9	10

Does not interfere at all | My pain makes it impossible to write or type

N. How much does your pain interfere with your ability to **dress yourself?**

0	1	2	3	4	5	6	**7**	8	9	10

Does not interfere at all | My pain makes it impossible to dress myself

O. How much does your pain interfere with your ability to **engage in sexual activities**?

0	1	2	3	4	5	6	7	8	9	10

Does not interfere at all — My pain makes it impossible to engage in sex

P. How much does your pain interfere with your ability to **concentrate**?

0	1	2	3	4	5	6	7	8	9	10

Never — All the time

III. Individual's Report of Effect of Pain on Mood

A. Rate your **overall mood** during the past week

0	1	2	3	4	5	6	7	8	9	10

Extremely high/good — Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10

Not at all — Extremely

C. During the past week, how **depressed** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10

Not at all — Extremely

D. During the past week, how **irritable** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10

Not at all — Extremely

E. In general, how anxious/worried are you about performing activities because they **might make your pain symptoms worse**?

0	1	2	3	4	5	6	7	8	9	10

Not at all — Extremely

RELIABILITY AND CREDIBILITY

After a careful review of the above information, it is the undersigned's professional opinion that Mr. Doran is a candid and generally credible historian who is not exaggerating his symptoms for secondary gain. I have factored in his self-reporting style of both over and under reporting of symptoms into my conceptualization of his diagnoses and level of impairment.

Mr. Doran's account of his injury corroborated with the narrative of the injury outlined in the medical records.

Mr. Doran's account of how his psyche and functions of daily living were impacted by his orthopedic injuries were reasonable. He was able to coherently address how the combination of depression and anxiety negatively affected his mood, cognition, and behavior.

During today's evaluation, I paid close attention to Mr. Doran's self-report of emotional pain and his non-verbal behavior. Generally speaking, if an individual complains of significant depression and anxiety, one would expect to see this manifested, to some degree in his body language during the examination. This observation practice represents one way of assessing an examinee's reliability, as emotional pain cannot be objectively measured. During today's interview, I observed the following relevant information pertaining to Mr. Doran's pain behavior:

- ✓ He began to cry spontaneously when talking about his chronic pain state and deaths of his dog and wife.
- ✓ He rubbed his right hand due to pain.

And finally, I turn to an analysis of the psychometric findings to gauge Mr. Doran's reliability and validity.

The psychological test results showed a consistent elevation across multiple tests measuring depression and anxiety.

After a careful review of the above information, it is the undersigned's professional opinion that Mr. Doran is a candid historian who is not exaggerating his symptoms for secondary gain. There is no psychological test data to support the phenomenon of pain amplification. There is no scientific basis to suggest that the examinee is consciously feigning malingering symptoms. He self- disclosed appropriately during the evaluation process and I did not sense that he was minimizing personal problems existing before or after the discussed industrial injury.

REVIEW OF RECORDS

In compliance with Labor Codes 4062.3 (d), 4628 (a) (2), and Title 8 CCR 10606 and Title 8 CCR 41 (b)(2), attached at the end of this report is a listing and summary of the records that I received, reviewed, and relied upon in the preparation of this report.

Per regulations 9793 (n), any documents sent to the physician for review must be accompanied by a declaration under penalty of perjury that the provider of the documents has complied with the provisions of Labor Code section 4062.5 before providing the documents to the physician. The declaration must also contain an attestation as to the total page count of the documents provided.

Per the attached declaration and attestation, 1647 pages of medical records were reviewed (see attached listing).

SUBSEQUENT INJURY PSYCHIATRIC DIAGNOSES

AXIS I: **EPISODE OF MENTAL/CLINICAL DISORDER**
Major Depression, Recurrent, Severe (296.3)
Anxiety Disorder Not Otherwise Specified (300.00)
Panic Disorder without Agoraphobia (300.01)
Pain Disorder Associated with Both Psychological Factors

and a General Medical Condition (307.89)
Insomnia Related to Anxious Disorder (327.02)
Other Specified Sexual Dysfunction (302.79)
Bereavement (V62.82)

AXIS II: **PERSONALITY DISORDER**
No Diagnosis (V71.09)

AXIS III: **PHYSICAL DISORDERS AND CONDITIONS**
Status per the review of the medical records above.

AXIS IV: **SEVERITY OF PSYCHOSOCIAL STRESSORS**
Severe

(1) Sequela to work-related injury, including cognitive, physical, and emotional problems, as well as occupational and financial problems.

(2) Non-Industrial and concurrent stressful issues were identified and these include: Homeless due to lack of work from industrial injury and friend stealing his money, not being able to sleep related to police patrolling area where he sleeps, seeing shadows as a result of Parkinson's disease, and grieving over his wife's and dog's deaths.

AXIS V: **GLOBAL ASSESSMENT OF FUNCTIONING (GAF)**
Current - 47

Please Note: Use of the DSM IV-TR is provided in the above instance as the DSM-5 no longer provides a GAF score, which is necessary in an evaluation of this nature.

DISCUSSION OF SUBSEQUENT INJURY PSYCHIATRIC DIAGNOSES

Major Depressive Disorder

Taking into consideration the available information, Mr. Doran's cluster of symptoms would best be categorized as a mood disorder. According to the DSM 5, the essential features of Major Depressive Disorder (MDD) include a total of nine (9) symptoms, of which an examinee must endorse at least five (5). Additionally, these symptoms must persist for a two-week period and represent a change from their previous level of functioning. Following his injury, Mr. Doran reported the following symptoms:

- "I feel sad or depressed at this time due to not being able to work, being homeless, and being in constant pain that is overwhelming sometimes, and it makes me physically sick. I have depressed mood most of each day for the past two weeks. I have decreased interest in most activities, including a decreased interest in golfing, making love, fishing, hunting, and

engaging in outdoor activities."

- "I had feelings of worthlessness or low self-esteem. I have felt fatigue or loss of energy. I had problems with thinking, problems concentrating, or difficulty making decisions. I have extreme difficulty, perhaps due to Parkinson's."

- "I had thoughts of wishing I was dead or of suicide since the subsequent injury related to my wife's and dog's deaths. I have never attempted suicide or made a plan to kill myself. Before the injury, I weighed 225 pounds and now I currently weighs 140 pounds. I had a change in my sleep since the subsequent injury."

Anxiety Disorder Not Otherwise Specified

Taking into consideration the available information, Mr. Doran's cluster of symptoms would best be categorized as an anxiety disorder. According to the DSM 5, the essential features of Generalized Anxiety Disorder (GAD) include a total of six (6) symptoms, of which an examinee must endorse at least three (3). However, Mr. Doran does not meet the full criteria for GAD, therefore, he falls under Anxiety Disorder Not Otherwise Specified. Additionally, these symptoms must persist for a 6-month period and represent a change from their previous level of functioning. Following his injury, Mr. Doran reported the following symptoms:

- "I have felt anxious and worried since July 2012. I have excessive worry or anxiety. I always worry, all day, every day. I experience feeling restless, anxiety causing fatigue, anxiety causing irritability, anxiety causing problems concentrating, and anxiety causing problems sleeping."

Panic Disorder without Agoraphobia

Taking into consideration the available information, Mr. Doran's cluster of symptoms would best be categorized as an anxiety disorder. According to the DSM 5, the essential features of Panic Disorder without Agoraphobia include recurrent unexpected panic attacks and an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes. A total of four (4) or more symptoms of the 13, must be met. Additionally, these symptoms must persist for a 6-month period and represent a change from their previous level of functioning. Following his injury, Mr. Doran reported the following symptoms:

- "I felt as if I had anxiety or panic-type symptoms at this time, the symptoms started a few years ago, usually in the shower and anywhere as well. I have experienced my heart pounding or racing. I have experienced dizziness or lightheadedness. I have experienced discomfort/tightness in my chest. I have experienced shortness of breath/problems breathing. I have experienced feelings of choking or problems with swallowing. I have experienced nausea or abdominal distress not related to medication. I have experienced chills or hot flushes. I have experienced numbness or tingling in my body not related to physical injury."

- "I have anxiety and panic-type symptoms every month. I also experienced monthly anxiety or panic-type symptoms before my subsequent injury. I feel unable to travel without a companion. I have recurrent distressing dreams or nightmares of a traumatic event, of

monsters or the devil. I have made efforts to avoid thoughts, feelings, or talking about the event (i.e., people, places, objects); trying to escape nightmares. I have experienced an increase in being very watchful about my surroundings. I have to really check the ground to be level."

Pain Disorder Associated with Both Psychological Factors and a General Medical Condition

Taking into consideration the available information, Mr. Doran's cluster of symptoms would best be categorized as a somatic symptom and related disorder. According to the DSM 5, the diagnostic criteria for Pain Disorder Associated with Both Psychological Factors and a General Medical Condition include pain symptoms that cause clinically significant distress or impairment. The psychological or behavioral factors are judged to have an important role in onset, severity, exacerbation, or maintenance of pain symptoms. Following his injury, Mr. Doran reported the following symptoms:

- "I have the most pain in my hand, despite having physical therapy. Being in pain and homeless make me feel depressed."

Insomnia Related to Anxious Disorder

Taking into consideration the available information, Mr. Doran's cluster of symptoms would best be categorized as a sleep-wake disorder. According to the DSM 5, the essential features of Insomnia Related to Anxious Disorder include sleeplessness (individual receiving less than 5 ½ hours of sleep per night on average without medications), fatigue, difficulty falling asleep, and frequently interrupted sleep. These sleep disturbances have been persisting for more than one month. Following his injury, Mr. Doran reported the following symptoms:

- "Prior to the subsequent injury, it varied on how long it took me to fall asleep. I slept for 6 hours each night, and I woke up a few times at night due to pain. After the subsequent injury in 2012, it still varies on how long it takes me to fall asleep. I currently sleep in my vehicle. I sleep for 6 hours each night and wake up several times at night due to the sound of police, as well as anxiety. Some nights I cannot sleep."

Other Specified Sexual Dysfunction

Taking into consideration the available information, Mr. Doran's cluster of symptoms would best be categorized as a sexual dysfunction disorder. According to the DSM 5, the essential features of this category applies to presentations in which symptoms characteristic of a sexual dysfunction cause clinically significant distress in the individual predominate, but do not meet the full criteria for any of the disorders in the sexual dysfunctions diagnostic class. Mr. Doran meets this disorder, in which he has a specific reason of pain during intimate relations. Following his injury, Mr. Doran reported the following symptoms:

- "I would engage in sexual activity if I had a girl. I used to have sex daily, but now only if I find someone. I have pain in my genital, back, and joint areas during sexual activity."

Bereavement

Taking into consideration the available information, Mr. Doran's cluster of symptoms would best be categorized as an uncomplicated bereavement disorder. According to the DSM 5, this category

can be used when the focus of clinical attention is a normal reaction to the death of a loved one. As part of their reaction to such a loss, some grieving individuals present with symptoms characteristic of a major depressive episode- for example, feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss. Following his injury, Mr. Doran reported the following symptoms:

- "My wife died five years ago, and I miss her a lot. I'm still very sad over her death. My dog just died this month, and she was the love of my life. I'm grieving over my dog. I just had thoughts of killing myself because of the passing of my dog, but I have no guts to kill myself."

SUBSEQUENT INJURY IMPAIRMENT RATING

ANALYSIS AND EXPLANATION OF MR. DORAN'S PSYCHOLOGICAL IMPAIRMENT RATING

On page 365 of the AMA guides, Table 14-1 provides a guide for rating mental impairment in each of the four areas of functional limitation on a five-category scale that ranges from no impairment to extreme impairment. The following are recommended as anchors for the categories of the scale.

Area of Aspect of Functioning	Class 1 No Impairment	Class 2 Mild Impairment	Class 3 Moderate Impairment	Class 4 Marked Impairment	Class 5 Extreme Impairment
Activities of Daily Living				✓	
Social Functioning			✓		
Concentration					✓
Adaptation		✓			

ACTIVITIES OF DAILY LIVING

SELF CARE/PERSONAL HYGIENE ACTIVITIES	LEVEL OF IMPAIRMENT			
1. I neglect to bathe or shower.	Often	**Sometimes**	Never	Not Applicable
2. I neglect to brush my teeth.	Often	Sometimes	**Never**	Not Applicable
3. I have no interest in my appearance.	Often	**Sometimes**	Never	Not Applicable
4. I have no interest in shaving or putting on make-up.	Often	**Sometimes**	Never	Not Applicable
5. I have no interest in getting dressed on most days.	Often	**Sometimes**	Never	Not Applicable
6. I have problems sleeping at night because I can't stop thinking or worrying.	**Often**	Sometimes	Never	Not Applicable

7. I do not feel rested in the morning when it is time to get up.	Often	Sometimes	Never	Not Applicable
8. I feel sleepy during the daytime.	Often	Sometimes	Never	Not Applicable
9. I lack the desire to have sexual relations.	Often	Sometimes	Never	Not Applicable
10. I am physically unable to have sexual relations.	Often	Sometimes	Never	Not Applicable
11. I no longer have a desire to travel (e.g., road trips or by airplane).	Often	Sometimes	Never	Not Applicable

HOUSEHOLD ACTIVITIES	LEVEL OF IMPAIRMENT			
1. I can't prepare a meal by myself.	Often	Sometimes	Never	Not Applicable
2. I forget to turn off the stove or close the refrigerator.	Often	Sometimes	Never	Not Applicable
3. I can't seem to organize the house. Everything is messed up.	Often	Sometimes	Never	Not Applicable
4. I have no energy to clean my house.	Often	Sometimes	Never	Not Applicable
5. I can't focus and repair things that are broken in the home.	Often	Sometimes	Never	Not Applicable

SOCIAL FUNCTIONING

FAMILY AND SOCIAL ACTIVITIES	LEVEL OF IMPAIRMENT			
1. I lack the energy to take care of children or pets.	Often	Sometimes	Never	Not Applicable
2. I can't take care of the people at home that I used to do before my injury.	Often	Sometimes	Never	Not Applicable
3. I spend many days in my room and have no interest in talking to others.	Often	Sometimes	Never	Not Applicable
4. I can't seem to listen to others and understand what they are saying to me.	Often	Sometimes	Never	Not Applicable
5. I lack the cognitive stamina to be involved with friends or family.	Often	Sometimes	Never	Not Applicable
6. I don't get along well with others.	Often	Sometimes	Never	Not Applicable
7. I don't want to initiate contact with friends and family.	Often	Sometimes	Never	Not Applicable
8. I don't think I can accept criticism appropriately from others.	Often	Sometimes	Never	Not Applicable

RECREATIONAL ACTIVITIES	LEVEL OF IMPAIRMENT			
1. I have no ability to concentrate and do my normal hobbies (e.g., gardening, fishing, etc.).	Often	Sometimes	Never	Not Applicable
2. I have no interest in attending social gatherings, meetings, or church events.	Often	Sometimes	Never	Not Applicable
3. I do not trust my driving abilities.	Often	Sometimes	Never	Not Applicable

4. I cannot concentrate on completing art projects, doing music activities, or building projects.	Often	Sometimes	Never	Not Applicable
5. I could not muster the energy and concentration to play board games, cards, or video games.	Often	Sometimes	Never	Not Applicable

CONCENTRATION

MEDICAL ACTIVITIES	LEVEL OF IMPAIRMENT			
1. I forget to take my medications.	Often	Sometimes	Never	Not Applicable
2. I forget my doctor's appointments.	Often	Sometimes	Never	Not Applicable
3. I can't seem to remember what my doctors instruct me to do.	Often	Sometimes	Never	Not Applicable
4. I have no energy to do home-based physical therapy exercises.	Often	Sometimes	Never	Not Applicable
5. I lost important papers that doctor gives me or the insurance company sends me.	Often	Sometimes	Never	Not Applicable
6. I am unable to complete a project near others without being distracted.	Often	Sometimes	Never	Not Applicable
7. My day is interrupted by my psychological symptoms.	Often	Sometimes	Never	Not Applicable

MANAGING FINANCES AND PERSONAL ITEMS	LEVEL OF IMPAIRMENT			
1.I cannot manage a checkbook.	Often	Sometimes	Never	Not Applicable
2. I get confused when paying for items at a store.	Often	Sometimes	Never	Not Applicable
3. I lose my wallet or purse or cell phone.	Often	Sometimes	Never	Not Applicable
4. I lose my keys or forget where I parked my car.	Often	Sometimes	Never	Not Applicable
5. I misplace important financial papers or documents.	Often	Sometimes	Never	Not Applicable

ADAPTATION

COMMUNICATION ACTIVITIES	LEVEL OF IMPAIRMENT			
1. I start to fall asleep if I read something for more than a few minutes.	Often	Sometimes	Never	Not Applicable
2. I lose interest when watching television and stop watching the show.	Often	Sometimes	Never	Not Applicable
3. I have lost interest in communicating with others by email or by phone.	Often	Sometimes	Never	Not Applicable
4. I have lost interest in reading the newspaper or watching the news on T.V.	Often	Sometimes	Never	Not Applicable

5. I have stopped attending normal events and communicating activities (e.g., church, social clubs, volunteer events, visiting relatives, etc.).	Often	Sometimes	Never	Not Applicable

EMOTIONAL AND OCCUPATIONAL FUNCTIONS	**LEVEL OF IMPAIRMENT**			
1. I feel that I would be able to perform any job I am qualified for without problems at this time.	Strongly Agree	Agree	Disagree	Strongly Disagree
2. I feel I would be able to interact with coworkers respectfully and without any problems on my part.	Strongly Agree	Agree	Disagree	Strongly Disagree
3. I don't have the psychological energy to multi-task.	Strongly Agree	Agree	Disagree	Strongly Disagree
4. I become emotionally overwhelmed when demands are placed upon me.	Strongly Agree	Agree	Disagree	Strongly Disagree
5. I am hypersensitive to environmental factors (e.g., noise, delays, disappointments, setbacks, etc.) and respond in anger when these occur.	Strongly Agree	Agree	Disagree	Strongly Disagree
6. I have difficulty controlling my emotions and this causes problems when I interact with people.	Strongly Agree	Agree	Disagree	Strongly Disagree
7. I am not able to maintain a productive schedule where I complete the goals I set for my household, family, and work (if employed).	Strongly Agree	Agree	Disagree	Strongly Disagree

Comparison of Daily Life BEFORE and AFTER SUBSEQUENT INJURY

Normal life shortly BEFORE the final (SUBSEQUENT) industrial injury

Please describe what a typical **weekday** was like for you shortly **before** the injury.

1. What time did you wake up? **"5am"**
2. How often would you take a shower or bath? **"2x day"**
3. How many hours a day did you work on average? **"7-8 hours"**
4. Did you participate in any exercise or sports team? **"Yes"** If yes, please describe **"Played golf with 9 handicap"**
5. What types of activities did you do after you finished work? **"Cook, play with dog, sex."**
6. What would you normally do for fun during the week? **"Anything I could"**
7. What time did you typically go to bed during the week? **"11pm"**

Please describe what a typical **weekend** was like for you shortly **before** the injury:

1. What time would you typically wake up on the weekend? **"5am"**
2. What was a typical weekend day for you like? **"Do something outdoors"**
3. What type of social activities was normal for you to do on the weekends? **"Cook for my**

family"

4. If you were sexually active shortly before the injury, how often was it normal for you to engage in sexual activity? **"Daily"**

<u>**Normal Life at this time (Currently)**</u>

Please describe what a typical **weekday** is like for you **at this time after** your injury:

1. What time do you typically wake up? **"Varies on when I finally relax"**
2. How often do you take a shower or bath? **"2x week"**
3. How do you spend most of your weekdays? **"Doing whatever I can if I can"**
4. Do you participate in any exercise or sports at this time? **"No"** If yes, please describe
5. What time do you typically go to bed? **"1am"**
6. What do you normally do for fun/socializing during the week? **"Nothing"**

Please describe what a typical **weekend** is like for you **at this time after** your injury:

1. What time do you typically wake up? **"Don't know"**
2. How do you spend a typical weekend day? **"Looking for cans/bottles"**
3. What type of social activities are you doing on the weekend at this time? "**Nothing"**
4. Are you sexually active at this time? **"Yes"** If so, how many times on average is it normal for you to engage in sexual activity? **"If I can get with a girl"**
5. If you are not active, or less active, when did you notice this change? **"Recent"**
6. What do you think caused this change? **"My miserable condition"**

AFTER or BECAUSE of the SUBSEQUENT INJURY, Mr. Doran indicated difficulties or limitations in areas below.

Self-care and Personal Hygiene CURRENTLY			**No Difficulties**
	Urinating	✓	Trimming toe nails
✓	Defecating		Dressing
✓	Wiping after defecating		Putting on socks, shoes, and pants
✓	Brushing teeth with spine bent forward		Putting on shirt/blouse
✓	Bathing		Combing hair
	Washing hair	✓	Eating
✓	Washing back		Drinking
✓	Washing feet/toes		Shopping
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Communication CURRENTLY			**No Difficulties**
	Speaking/talking	✓	Writing
	Hearing	✓	Texting
✓	Seeing		Keyboarding
✓	Reading (including learning problems,		Using a mouse

	vision, or attention deficits)		
✓	Using a phone		Typing
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Physical Activity CURRENTLY			**No Difficulties**
✓	Walking		Sitting
	Standing	✓	Kneeling
✓	Pulling		Climbing stairs or ladders
✓	Squatting		Shoulder level or overhead work
✓	Bending or twisting at the waist		Lifting and carrying
✓	Bending or twisting at the neck	✓	Using the right or left hand
✓	Balancing		Using the right or left foot
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Sensory Function CURRENTLY			**No Difficulties**
	Smelling	✓	Feeling
	Hearing	✓	Tasting
	Seeing	✓	Swallowing
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Household Activity CURRENTLY			**No Difficulties**
✓	Chopping or cutting food		Mopping or sweeping
	Opening jars	✓	Vacuuming
✓	Cooking		Yard work
✓	Washing and putting dishes away		Dusting
	Opening doors	✓	Making beds
	Scrubbing	✓	Doing the laundry
✓	Repetitive use of the right hand		Repetitive use of the left hand
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Travel CURRENTLY		**No Difficulties**	
	Riding as a passenger	If you have trouble sitting, approximately how long can you remain seated at a time?	✓
	Driving	If you have trouble driving,	✓

		approximately how long can you drive before needing to rest?	
✓	Handling/lifting luggage	Approximately how many times per year do you travel AFTER the Subsequent Injury?	
✓	Keeping arms elevated		Holding or squeezing the steering wheel
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Sexual Function CURRENTLY			**No Difficulties**
	Erection	✓	Painful sex (in the genital area)
	Orgasm	✓	Back pain with intimate relations
	Lubrication		Neck pain with intimate relations
	Lack of desire	✓	Joint pain with intimate relations
Other difficulties:			
If you indicated difficulties in this area, please describe how these difficulties make you feel:			

Sleep Function CURRENTLY				**No Difficulties**
✓	Falling asleep			Sleeping on the right side
✓	Staying asleep			Sleeping on the left side
	Interrupted/restless sleep		✓	Sleeping on the back
	Sleeping too much		✓	Sleeping on the stomach
✓	Daytime fatigue or sleepiness		Have you ever taken any medications to help you sleep AFTER the Subsequent Injury?	
How many hours can you typically sleep at a time without waking up during the night?		**2 hours**	How many hours total are you able to sleep at night?	**4 hours**
If you indicated difficulties in this area, please describe how these difficulties make you feel:				

Collectively, the above outlined impairments suggest that Mr. Doran is markedly impaired. The Schedule of Rating Disabilities (January 2005) provided the following guidelines for rating patients' GAF.

Starting at the top level of the GAF scale, evaluate each range by asking, "Is either the individual's symptom severity OR level of functioning worse than what is indicated in the range description?"

[**Author's Comment:** *Mr. Doran is not gravely disabled, but does have visual hallucinations possibly related to his medical condition, and has passive suicidal ideations related to the deaths of his wife and dog. These descriptions are for individuals who fall in the serious symptom category. Due to his marked impairment as mentioned above, he falls in the serious symptoms GAF range. Therefore, I have placed him in the severe range of the symptoms scale*].
Using these guidelines, Mr. Doran's psychiatric disability falls into the 41-50 decile. This is the range of functioning described as:

Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

All of his psychological testing combined indicates he is in the severe range of both symptom severity and functional impairment (i.e., BDI, BAI, and etc.). Mr. Doran describes limited social interactions as a consequence of both his physical limitations and psychological status following the industrial injuries. Whereas Mr. Doran previously enjoyed a rather active social life of playing golf, following the industrial injury this has been reduced and more limited to sedentary and solitary life.

Thus, after careful consideration of all of the information contained in this report, Mr. Doran's score is placed at the level of 47, which translates to a Whole Person Impairment (WPI) of 36%.

Arousal and Sleep Disorder Impairment:
The AMA Guides on Page 317, Table 13-4, provides a guide for rating arousal and sleep disorder impairment on a four-category scale that ranges from no impairment to extreme impairment. In reviewing the medical records and incorporating the findings of the psychological testing, namely the clinically significant Epworth Sleepiness Scale, Mr. Doran appears to have developed a Class 1 Impairment related to his chronic sleep disorder.

Table 13-4	Class 1	Class 2	Class 3	Class 4
	Impairment	Impairment	Impairment	Impairment
	1-9%	10-29%	30-49%	70-90%
Sleep & Arousal Disorders	Reduced daytime alertness, sleep pattern such that individual can perform most activities of daily living	Reduced daytime alertness, interferes with ability to perform some activities of daily living	Reduced daytime alertness, ability to perform activities of daily living significantly limited	Severe reduction of daytime alertness, individual unable to care for self in any situation or manner
WPI %				

Sleep disorders are ratable in Chapter 13 of the AMA Guides under Sleep and Arousal Dysfunctions. Table 13-4 of the AMA Guidelines states that a Class 1 Sleep and Arousal Disorder

is one in which an individual experiences "Reduced daytime alertness, sleep pattern such that individual can perform most activities of daily living." A score of 4/24 is not equal to excessive sleepiness, or class 1 impairment. **Based upon his mild sleep dysfunction, and his Epworth Sleepiness Scale score of 4, the level of his current sleep impairment is equal to a 2% disability rating attributed to the chronic pain and psychological symptoms that arose as a result of his subsequent injury.**

He reported, "Prior to the subsequent injury, it varied on how long it took me to fall asleep, I slept for 6 hours each night, and I woke up a few times at night due to pain. After the subsequent injury in 2012, it varies on how long it takes me to fall asleep. I sleep in the vehicle. I sleep for 6 hours each night and wake up several times at night due police, as well as anxiety. Some nights I can't sleep."

Sexual Dysfunction Disorder Impairment:

The AMA Guides on Page 156, Table 7-5, provides a guide for rating permanent impairment due to penile disease on a three-category scale that ranges from no impairment to extreme impairment. This particular table covers abnormalities involving male reproductive organs. Per AMA Fifth Edition Guides, Table 7-5, page 156, and other tables under Section 7.7 and other do not cover the issues adequately. In reviewing the medical records and incorporating the findings of the psychological testing, namely the clinically significant difficulties or limitations chart, Mr. Doran appears to have developed a Class 2 Impairment related to his sexual dysfunction disorder.

Table 7-5 Criteria for Rating Permanent Impairment Due to Penile Disease		
Class 1 0%- 10% Impairment of the Whole Person	Class 2 11%- 19% Impairment of the Whole Person	Class 3 20% Impairment of the Whole Person
Sexual function possible but with varying degrees of difficulty of erection, ejaculation, or sensation	Sexual function possible with sufficient erection but with impaired ejaculation and sensation	No sexual function possible

Sexual Dysfunction Disorders are ratable in Chapter 7 of the AMA Guides under Male Reproductive Organs Table 7-5 of the AMA Guidelines states that a Class 2 Male Reproductive Organs Impairment is one in which an individual experiences "Sexual function possible with sufficient erection but with impaired ejaculation and sensation." Mr. Doran reportedly has pain in his back, genital, and joint areas during sexual intimacy. He went from having sex daily to sometimes, only when he can meet a woman.

Based upon his moderate sexual dysfunction of Class 2 impairment, the level of his current sexual impairment is equal to a 13% disability rating attributed to the chronic pain and psychological symptoms that arose as a result of his subsequent injury.

Please note that the Sexual Dysfunction Whole Person Impairment should follow along orthopedic lines, because sexual dysfunction is rooted in the examinee's orthopedic injuries.

CAUSATION OF SUBSEQUENT DISABILITIES AND LABOR IMPAIRMENT

Mr. Doran injured himself at Benedict & Benedict Plumbing on SI: July 11, 2012 while employed as a Plumber. Specifically, he injured his right wrist, right hand, and right thumb when a big chunk of ceiling plaster cracked and fell. He blocked his head from the falling plaster with his hands, which got injured. As a result of this subsequent injury, Mr. Doran developed psychiatric symptoms. My evaluation on May 17, 2021 consisted of a clinical interview, mental status exam, review of medical records, and psychological testing. The results of my evaluation found that Mr. Doran currently suffers from Major Depression, Recurrent, Severe; Anxiety Disorder Not Otherwise Specified; Panic Disorder without Agoraphobia; Pain Disorder Associated with Both Psychological Factors and a General Medical Condition; Insomnia Related to Anxious Disorder; Other Specified Sexual Dysfunction; and Bereavement.

These disorders and his functional limitations qualified him for a GAF of 47 - which is equivalent to a WPI of 36%.

Mr. Doran has been diagnosed with Insomnia Related to Anxious Disorder caused by the subsequent injury. Sleep disorders are ratable in Chapter 13 of the AMA Guides under Sleep and Arousal Dysfunctions. Table 13-4 of the AMA Guidelines states that a Class 1 Sleep and Arousal Disorder is one in which an individual experiences "Reduced daytime alertness, sleep pattern such that individual can perform most activities of daily living." A score of 4/24 is not equal to excessive sleepiness, or class 1 impairment. **Based upon his chronic sleep dysfunction that arose out of his subsequent injury, the level of his sleep impairment is equal to a 2% disability rating.**

Mr. Doran has been diagnosed with Other Specified Sexual Dysfunction caused by the subsequent injury. Sexual Dysfunction Disorders are ratable in Chapter 7 of the AMA Guides under Male Reproductive Organs Table 7-5 of the AMA Guidelines states that a Class 2 Male Reproductive Organs Impairment is one in which an individual experiences "Sexual function possible with sufficient erection but with impaired ejaculation and sensation." His problem with pain in his back, genital, and joint areas during sexual intimacy, and reduction of sex daily to sometimes is equal to moderate impairment, or class 2 impairment. **Based upon his chronic sexual dysfunction that arose out of his subsequent injury, the level of his sexual impairment is equal to a 13% disability rating. Based on his history, his condition is attributable to compensable consequences of orthopedic issues.**

SPECIALTY REFERRAL

It is my medical opinion that the examinee needs the following specialist evaluations to more specifically address possible impairment and disabilities which are outside my scope of expertise:

Neurologist: Based upon my examination and consultation with this applicant as well as upon review of the Activities of Daily Living and MOCA tests noted above, it is my opinion that there are some medical/psychological factors that need to be addressed. Therefore, this examinee will require an evaluation with a neurologist specialist in nervous system conditions to determine issues

relative to the applicant's SIBTF claim and examine the progression of his diagnosed underlying mild Parkinson's disease back on 12/15/16 by Neurologist, Dr. Mark R. Pulera, M.D.

CONCLUSIONS

It is my opinion that Mr. Doran's subsequent psychiatric injury was predominantly caused by the actual events of employment. I reason that, given the longitudinal nature of Mr. Doran's emotional difficulties, they are more than a mere "lighting-up" of his previous depressive and chronic pain symptoms typically seen during an exacerbation. Rather, they have been permanent and are more accurately described as an "aggravation."

This issue is clearly seen via an examination of his GAF and WPI scores prior to and subsequent to his injuries. Mr. Doran's prior GAF score of 54 equates to a WPI of 24%. Following his subsequent injury, his psychiatric condition deteriorated significantly. The increase in depressive and anxiety symptoms resulted in a decrease of his GAF to 47 - which means his disability increased by 12% to 36%. The subsequent injury disability represents the predominant cause of his overall disability rating.

MR. DORAN'S PRE-EXISTING PSYCHOLOGICAL ISSUES WERE PERMANENT & STATIONARY (P&S) PRIOR TO THE SUBSEQUENT INDUSTRIAL INJURY OF SI: JULY 12, 2012. *GIVEN THE LENGTH OF TIME THAT HAS EXPIRED AND THE CONSISTENCY OF PSYCHIATRIC SYMPTOMS SINCE THEIR INCEPTION, IT IS MY OPINION THAT MR. DORAN'S CURRENT PSYCHIATRIC DISABILITY IS NOW PERMANENT AND STATIONARY.*

Mr. Doran's psychiatric injury is labor disabling and requires the following work restrictions:

- **Part-time schedule with frequent breaks due to his fragile and emotional states (from his depression, anxiety, and Parkinson's disease).**
- **Flexible schedule to accommodate Mr. Doran's need for weekly psychotherapy.**
- **Flexible schedule to accommodate Mr. Doran's sleep disorder.**
- **No distracting noise as he has been bothered by the police and activities while sleeping in his car.**

Due to his cognitive difficulties from his depression, anxiety, and Parkinson's disease, Mr. Doran requires the following:

- **Accommodation of increased time due to slower pace and persistence.**
- **Understanding supervisor to break larger tasks into a series of smaller ones.**
- **Frequent feedback on performance with sensitivity to Mr. Doran's struggles.**
- **Time to reconnect with co-workers given Mr. Doran's deteriorated social skills**

(resulting from his depressive symptoms of social withdrawal).

- **Frequent feedback on performance by an understanding supervisor to accommodate Mr. Doran's low self-esteem (due to his depression, incontinence, and inability to function sexually).**

APPORTIONMENT BETWEEN DISABILITY STEMMING FROM SUBSEQUENT INJURY AND PRE - EXISTING DISABILITIES

As stated above, Mr. Doran had a pre-existing psychiatric disability that was permanent and stationary, ratable, and work limiting. His rating was as follows:

Preexisting Psychiatric Impairment: 24% WPI from GAF of 54

I believe that Mr. Doran's psychiatric condition was aggravated by the subsequent injury and he subsequently experienced a significant psychiatric deterioration. I believe the increase of his psychiatric impairment is not due solely to the subsequent injury as he is currently homeless, struggling with Parkinson's disease, and is grieving over his dog and wife's deaths. Mr. Doran's current psychiatric disability rating is as follows:

Current Psychiatric Impairment: 36% WPI from GAF of 47

The subtraction method is applied 36% WPI minus 24% WPI = 12%
12% WPI apportioned to the Subsequent Injury

PRE-EXISTING DISABILITY	SUBSEQUENT DISABILITY
Psychiatric disability - 24%	Psychiatric disability increased by 12% to 36%

Please note: The preponderance of psyche impairment only goes to causation of the psyche injury, not causation of the psyche disability.

The aforementioned ratings are unmodified and uncombined. Mr. Doran's disability from the subsequent and pre-existing is greater than that which resulted from the subsequent alone.

I reserve the right to alter any opinions noted above if provided further medical records which may warrant a change of my opinions.

REASONS FOR OPINION

1. History as related by the patient.

2. Findings on examination.
3. Review of the medical file.
4. Consistency of the objective findings with subjective complaints.
5. Genuineness of the patient.

DISCLOSURE/AFFIRMATIONS AND SIGNATURE

"I personally evaluated this patient and prepared this report. If others have performed any services in connection to this report, outside of clerical preparation, their name and qualifications are noted herein. I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe to be true."

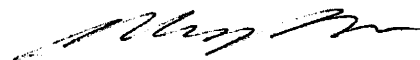
All measurements were taken in accordance with the AMA Guides, Fifth Edition, and a goniometer or dual inclinometers were used. Any reference to the Guides in this report refers to the 'Guides to the Evaluation of Permanent Impairment, Fifth Edition.'

I came to the above opinions based on the current physical examination findings, available medical records/diagnostic reports for review, credibility of the patient, historical information as provided by the patient, and clinical experience both evaluating and treating individuals with the same or similar conditions.

Thank you for asking me to see and evaluate Mr. Daniel Doran. I will be available for review of medical records or to produce supplemental reports at the request of parties concerned.

Signed this 24th day of June, 2021.

Respectfully,



Nhung Phan, Psy.D.
Clinical Psychologist
Ca. License No. PSY28271

Attached: Review of medical records

<u>REVIEW OF MEDICAL RECORDS:</u>
DORAN, Daniel
DOB: 06/04/66

Pages Reviewed 1647
No Declaration

<u>Job Description:</u> *Employed by Benedict & Benedict Plumbing as a journeyman (plumber). Responsible to do all types of plumbing repair, commercial and residential.* ***<u>Physical Demands:</u>*** *Occasionally (up to 3 hrs): Sitting. Frequently (3-6 hrs): Walking, standing, bending (neck/waist), squatting, climbing, kneeling, crawling, twisting (neck/waist), simple grasping B/L hands, power grasping B/L hands, fine manipulation B/L hands, pushing/pulling B/L hands, and reaching above/below shoulder level. Constantly (6-8+ hrs): Standing, and repetitive R hand use. Lifting: Occasionally (up to 3 hrs) up to 50 lbs. Frequently (3-6 hrs) from 51-100+ lbs. Carrying: 100+ lbs. Heaviest item carried was water heater and the distance to be carried varies. Job Requires: Driving cars, trucks, forklifts and other equipment. Working around equipment and machinery. Walking on uneven ground. Exposure to excessive noise. Exposure to extremes in temperature, humidity or 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. Working with bio-hazards such as bloodborne pathogens, sewage, hospital waste, etc. Use of both hands and legs through the course of daily job routine.*

WC Claim Form dated 07/13/12, w/DOI: 07/11/12. Pt sustained R thumb injury.

WC Claim Form dated 07/20/12, w/DOI: 07/11/12. Pt sustained injury to R hand, due to falling of rockwall.

WC Claim Form dated 01/17/13, w/DOI: 07/12/12. Pt sustained injury to R hand, wrist, developed sleep problems and depression.

Application for Adjudication dated 01/17/13, w/DOI: 07/11/12. Pt sustained injury to hand, developed psych problems and sleep dysfunction due to wall collapsed. Employed by Benedict & Benedict Plumbing as a Plumber.

Compromise and Release dated 08/09/18, w/DOI: 07/11/12. Pt injured UE, LE, digestive system, circulatory system and developed psych problems. Employed by Benedict & Benedict Plumbing Company as a Plumber. Settlement amount was $300,000.00.

Employee's Rpt dated 07/20/12. Employer: Benedict & Benedict Plumbing. DOI: 07/11/12. Pt was struck on hand by falling section of rock wall. Injured SAA/R hand. Date last worked: 07/12/12. Pt will be unable to work until 09/30/12.

Undated - Payment History Inquiry.

Undated - Pain Questionnaire. Pt reports mild symptoms of N/T, shaky, difficulty breathing, faint. Moderate symptoms of feeling hot and wobbliness in legs, dizzy or lightheaded, heart pounding or racing, unsteady, terrified, hands trembling, fear of losing control, scared, face flushed and sweating (not due to heat). Severe symptoms of fear of the worst happening, unable to relax, nervous, fear of dying, indigestion or discomfort in abdomen. Denies feelings of choking.

07/13/12 - ED Note by James D. Luna, MD. Pt presents with L thumb injury occurred 2 days ago while opening up a piece of wall for re-plumbing purposes. Wall fell onto L thumb hitting on top resulting in laceration on the side of the nail and ecchymosis of the nail, also pain at the first MCP joint. He tried to work yesterday but found the pain was too much. He is unsure when his last tetanus shot. PMH: Gout and diabetes. ED Course: X-ray of R thumb showed some gauging near the first MCP joint distally, like a small torus or gauge in the bone, this is the result of the axial load blow to the tip of the finger. No other fractures are seen. Dx: L thumb torus type fracture at the MCP joint, subungual hematoma and minimal distal thumb laceration. Rx: Vicodin and Norco. Plan: Advised thumb spica splint. Referral Orthopedist or WC. Off work x 1 week. Discharged home in a stable condition.

07/13/12 - X-ray of R Thumb interpreted by Robert W. Hayward, MD at Huntington Hospital. Positive Findings/Impression: No fracture, dislocation or destructive bony change. No arthritic change noted. Some mild soft tissue swelling around the thumb is noted in the hypothenar eminence. No radiopaque FB.

07/16/12 - Utilization Review Determination.

07/17/12 - Initial Eval Rpt by George Tang, MD at Huntington Ortho Surgical Med Grp. DOI: 07/11/12. Pt sustained injury to R thumb when a structure fall and hit both hands and thumb area. States R thumb is slightly better, still very symptomatic. He was seen at the Huntington Hospital and given thumb splint. Taking Metformin and Januvia. PE: Aler and oriented. X-ray of R thumb shows nondisplaced fracture with first metacarpal fracture. Dx: R thumb first metacarpal fracture. Plan: Advised thumb spica cast. TTD until 09/30/12.

07/18/12 – Letter from Claims Examiner.

07/19/12 - Notice of Pharmacy Claimant Handbook Mailing.

07/19/12 - MPN Implementation Notice.

07/20/12 - Utilization Review Determination.

07/24/12 - PR-2 Rpt by George Tang, MD. Pt was doing well until roughly about a few days ago, he had more pain in thumb area. He has been more compliant and taking care of cast. X-ray of R thumb showed good alignment of the fracture. Dx: R thumb first metacarpal fracture. Plan: Continue cast. TTD until 09/30/12.

08/14/12 - PR-2 Rpt by George Tang, MD. Pt presents to appointment earlier than scheduled, cast is getting soft around palm area and having more pain in R thumb area x past week or so. Requests cast change. X-ray of R thumb showed good alignment of the fracture, some callus formation. Dx: First metacarpal fracture. Rx: Enteric-coated Naprosyn and Prilosec. Plan: New thumb spica cast placed. During his next visit, a thumb spica orthosis will be provided. TTD until 09/30/12.

09/04/12 - PR-2 Rpt by George Tang, MD. Cast removed. He is having some discomfort without cast in thumb area. X-ray of R thumb shows scar formation at fracture site. Dx: First metacarpal fracture. Rx: Enteric-coated Naprosyn, Prilosec and Medrox cream. Plan: Recommended thumb spica orthosis x 2-3 weeks. Referral PT 2x/week x 6 weeks. TTD until 10/31/12.

09/10/12 - Utilization Review Determination.

09/20/12 - Utilization Review Determination.

09/28/12-10/03/12 (2 visits) - PT Notes from US HealthWorks Med Grp. Completed 2 sessions of PT for R hand/wrist and thumb. Pain level is 5-8/10. Continue per POC. (There is Illegible Information on this page)

10/04/12 - PR-2 Rpt by George Tang, MD. Pt is still feeling quite a bit of soreness over the R thumb especially with yesterday's PT treatment. Completed 2/12 visits of PT.

10/08/12-11/02/12 (8 visits) - PT Notes from US HealthWorks Med Grp. Completed 8 sessions of PT for R hand/wrist and thumb. Pain level is 8/10. Reports increased pain with yesterday's treatment. Pt with increased guarding today during manual therapy. Continue per POC.

11/08/12 - PR-2 Rpt by George Tang, MD. Pt reports improvement with wrist flexion, still has quite a bit of pain and limited ROM throughout the hand and thumb area. Undergoing PT. X-ray of R thumb shows good callus formation of the fracture area, well healed. Dx: 1) First metacarpal fracture, healed. 2) Reflex sympathetic dystrophy possibility. Plan: Referred to neurologist. Continue PT. Recommended PT 2x/week x 6 weeks. Rx: Enteric-coated Naprosyn, Prilosec and Medrox cream. TTD until 12/31/12.

11/08/12 - Letter at US HealthWorks. Pt has completed 10/12 PT visits. His progress has been slow thus far with treatments. Treatments consisted of modalities, soft tissue mobilization, joint mobilization and therapeutic exercises. ROM of R wrist and thumb continues to be limited and he continues to c/o moderate-to-severe pain levels. Given the slower progress with ROM, this examiner recommended Dynasplint for R wrist.

11/08/12 (1 visit) - PT Re-eval Notes from US HealthWorks Med Grp. Completed a session of PT for R hand/wrist and thumb. Pain level is 8/10. C/o still having a lot of pain. Pt tolerated treatment.

11/08/12 – Billing Information.

11/12/12 (1 visit) - PT Notes from US HealthWorks Med Grp. Completed a session of PT for R hand/wrist and thumb. Pain level is 8/10. C/o increased pain. Pt is making improvement with PT. ROM gradually improving. Pt awaits authorization for further treatment. (There is Illegible Information on this page).

11/13/12 – Letter from Claims Examiner.

11/30/12 - Utilization Review Determination.

12/20/12 - PR-2 Rpt by George Tang, MD. C/o some numbness on thumb area in the palmar aspect. ROM is still decreased in R thumb area. Completed PT, helpful in getting ROM to fingers and wrist. Still has quite a bit of R thumb pain symptoms. Pt saw neurologist, he recommended EMG/NCV of RUE. Dx: 1) First metacarpal fracture. 2) Reflex sympathetic dystrophy. Rx: Enteric-coated Naprosyn, Prilosec and Medrox cream. Plan: Agree with requested EMG/NCV of RUE per neurologist. TTD until 02/28/13.

01/02/13 - Neurological Eval by Mohsen Ali, MD at Foothills Neurological Med Grp. DOE: 12/17/12. Pt indicated his pain began since injury. States had PT without improvement. Also admits N/T sensation around wrist and root of thumb and weakness of R grip. Denied any associated neck pain or any exacerbation of symptoms upon coughing or sneezing. PMH: DM x 5 years, taking Januvia 100 mg and Metformin 1000 mg. Also had h/o hypercholesterolemia. PSH: Mastectomy. Social Hx: Smoking x 40 years. Denied alcohol. MSE: Awake, oriented, attentive and cooperative. Dx: 1) Possible CTS. 2) Possible reflexive pathetic dystrophy. Plan: Requested EMG/NCV of RUE.

01/04/13 - Utilization Review Determination.

01/06/13 - Utilization Review Determination.

01/15/13 - EMG/NCV of RUE interpreted by Pouya Lavian, MD.
Impression: Mild R carpal tunnel syndrome.

01/30/13 - Corrected Notice Regarding Temporary Disability Benefits.

01/31/13 - PR-2 Rpt by George Tang, MD. Pt's hand is still very painful and unable to use it effectively. He had EMG/NCV on 01/15/13, revealed mild carpal tunnel syndrome. X-ray of R thumb shows fracture is well healed. Dx: 1) First metacarpal fracture. 2) Possible reflex sympathetic dystrophy. Rx: Enteric-coated Naprosyn, Prilosec, Medrox cream and Gabapentin. Plan: Recommended to start PT. Recommended f/u with neurologist. If indeed his carpal tunnel is an issue, then he may need to have a carpal tunnel release, but PT will be done first. TTD until 03/31/13.

02/18/13 - Initial Comprehensive Ortho Eval and RFA by Edwin Haronian, MD. DOI: 07/11/12. Pt sustained industrial injuries while working as a Plumber for Benedict & Benedict Plumbing.

During the course of employment, he was making an opening on a section of a wall, requiring him using a saw to cut through. States a chunk of wall from above came down and struck him on R wrist and hand. Experienced immediate pain to R wrist and hand and suffered an open wound to R thumb. He washed and applied tape on it. Reported injury to supervisor and went home in pain. He had restless night and returned to work next day. Completed shift in pain. A couple of days later, provided with a helper and soon after referred for medical care. He was initially examined in ER at Memorial Hospital in Pasadena. X-ray of R wrist/hand and thumb revealed fracture in R thumb. R hand and thumb were splinted and taped. Within a week, was examined by company ortho surgeon. R hand and thumb was set in hard cast, which was removed in late 09/2012, at this time R hand was set in a removable cast. Pt had 12 sessions of PT to R hand/wrist and thumb, with temporary pain relief. Remains off work since 07/12/12. Worked 6-12 hrs/day, 5 days/week and worked on-call a couple of days a week. Currently not working, receiving state disability benefits. Prior working for Benedict & Benedict Plumbing, he was self-employed as a plumber for close to 30 years. Currently, c/o continuous aching pain in R wrist, hand and thumb at times becoming sharp, shooting and throbbing pain. Pain travels to forearm. He has episodes of N/T in R hand. C/o cramping and weakness in R hand. He is losing muscle tone in R hand and thumb. His pain increases with gripping, grasping and repetitive hand finger movements. He has difficulty sleeping and awakens with pain and discomfort. Pain level varies throughout the day depending on activities. Pain meds provided temporary relief. PMH: DM. No known h/o heart disease, high BP, kidney disease, tuberculosis, cancer, ulcers, pneumonia, lung disease, eye problems, skin problems, asthma, hepatitis, liver disease, thyroid disease, gout, rheumatoid arthritis, Lupus, or arthritis. PSH: Denies previous surgeries. Prior/Subsequent Injuries: Denies any previous or subsequent accidents or injuries. Current Meds: Taking meds for DM. Motrin 800 mg and Prevacid. Social Hx: Smokes 1 ppd. Denied alcohol. Widower. Family Hx: H/o HTN, diabetes and cancer in immediate family. Reports difficulty performing ADLs since injury with R hand. PE: Wrists and Hands: Tenderness over distal radius and carpus on right. ROM was painful over R thumb. Thumbs abduction and adduction was decreased over R thumb. X-ray of R hand AP revealed relatively normal findings, no articulation of the scaphoid and lunate. No evidence of any fractures. Dx: 1) R carpal tunnel syndrome s/p R thumb fracture, healed. 2) R hand contusion. Rx: Medrox patch. Discussion: Pt is also describing anxiety and depression due to industrial injuries. He has been exposed to chronic pain for longer than 3 months. Plan: Requested acupuncture therapy 6 sessions, MRI of R wrist and hand, psychological evaluation along with 4 sessions of psychotherapy and R wrist support with thumb spica. Referred to pain management consultation with Dr. Kohan. Pt would like to proceed with diagnostic studies prior to considering surgical intervention. Causation: Industrial injury to R wrist, hand and thumb. Modified duty, without use of R hand. If modified work is not available, the pt can remain on TTD.

02/18/13 - Whole Person Impairment - Edwin Haronian, M.D. - The final whole person impairment is 11 %. LUE combined WPI is 2%. RUE combined WPI is 9%.

02/27/13 - Request for Authorization by Edwin Haronian, MD.
03/18/13 - F/u Rpt by Edwin Haronian, MD. C/o chronic unremitting pain in wrist and hand on R side following previous fracture. Pain level is 7-8/10. Pt awaits MRI of R wrist without contrast authorization, pain management consultation, 4 sessions of psychotherapy and acupuncture of R

wrist and R hand. Dx: 1) Wrist tendonitis/bursitis. 2) Hand contusion. Rx: Neurontin 300 mg, Elavil 25 mg, and trial of Vitamin C 500 mg. Plan: Re-requested MRI of R wrist without contrast authorization, pain management consultation, 4 sessions of psychotherapy and acupuncture 6 sessions for R wrist and R hand.

04/01/13 - F/u Rpt by Edwin Haronian, MD. Still c/o pain and numbness. Also indicating Neurontin makes spacey. Pt does have evidence of some depression. Psychotherapy has been authorized, pt will be scheduled accordingly. Pt is still guarding R hand. There is an increased suspicion for reflex sympathetic dystrophy. Dx: 1) Wrist tendonitis/bursitis. 2) Hand contusion. Rx: Lexapro. Plan: Requested triple phase bone scan. Wean off Neurontin.

04/11/13 - Secondary Physician Pain Management Initial Rpt & RFA by Jonathan F. Kohan, MD. DOI: 07/11/12. Pt sustained an industrial injury while performing usual and customary duties while working for Benedict & Benedict Plumbing as a plumber. He had been utilizing a saw to cut through an opening in a wall when a large piece of the wall came down and forcefully struck R wrist and R thumb. He experienced immediate pain at R wrist and hand. He sustained a laceration to R thumb. He cleaned his laceration and bandaged his thumb. He notified employer; however, no immediate medical treatment was provided. He went home in pain, He returned to work the following day despite ongoing pain. He was provided with a helper. He notified his employer again on the third day and was sent to Memorial Hospital in Pasadena. He was examined in ER and x-rays were obtained. He was provided with medication. He was diagnosed with a fracture of R thumb. His R hand/thumb were splinted and taped. Within a week, he was evaluated by an orthopedic surgeon. He was placed in a short arm cast. Once the cast was removed, he underwent PT with only temporary relief. He underwent EMG studies of RUE. He was diagnosed with carpal tunnel syndrome at R wrist. Currently not working, pt is on TTD status. Not worked since 07/12/12. Pt experiences ongoing pain at R hand/thumb. He experiences N/T extends to forearm and radiates to hand and fingers. He has difficulty bending thumb. He notes grip weakness and has difficulty with holding objects and with fine motor coordination. His wrist pain increases with gripping, grasping, pushing and pulling, rotating, and repetitive hand and finger movements. The pain level becomes worse throughout the day depending on activities. He also has difficulty sleeping and awakens with pain and discomfort. Pt indicates hand/wrist/thumb pain is rated 8/10. Pt has continuous episodes of anxiety, stress and depression due to chronic pain and disability status. He denies suicidal ideation. Pt has difficulty sleeping, often obtaining a few hours of sleep at a time. He feels fatigued through the day and finds himself lacking concentration and memory at times. He worries over his medical condition and the future. Reports difficulty performing ADLs. Current Meds: Metformin 2000 mg, Januvia 100 mg, Baclofen Cream 60 g, Medrox Patch, Prilosec 20 mg, Relafen 750 mg, Neurontin 300 mg, Lexapro 10 mg. Social Hx: Smokes less than a pack of cigarettes per day. He has been a smoker for 30 years. Denies alcohol. ROS: C/o anxiety, stress and depression. PE: No distress secondary to pain. Dx: 1) H/o R hand contusion. 2) Sympathetically-mediated neuropathic pain, RUE, possible mild CRPS. Plan: Triple phase bone scan will help with the diagnosis in an objective manner. He may undergo a series of stellate ganglion injection.

04/15/13 - Request for Authorization by Edwin Haronian, MD.

04/29/13 - F/u Rpt by Edwin Haronian, MD. Pt continues to c/o significant pain in R wrist and hand with weakness. MRI of R wrist was reviewed today and was relatively normal. Pt was seen by Dr. Kohan to evaluate him for reflex sympathetic dystrophy. Bone scan was requested previously and authorization is pending. Dx: 1) Wrist Tendonitis/Bursitis. 2) Finger Fracture. 3) Hand Contusion. Disability status remains unchanged.

05/02/13 - Request for Authorization.

05/07/13 - Initial Comprehensive Psychological Consultation Rpt by Heath Hinze, PsyD at Hinze Psychological Services, PC. DOI: 07/11/12. Employed by Benedict & Benedict Plumbing as a plumber in 02/2010. He worked 6-12 hrs/day, 5 days/week and worked on-call "a couple of days a week." His duties at the time of injury entailed, traveling 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. During the course of employment, he was making an opening on a section of a wall, requiring him using a saw to cut through. He states a chunk of wall from above came down and struck him on R wrist and hand. He experienced immediate pain to R wrist and hand and suffered an open wound R thumb. Remains off since 07/12/12. Pt reported for an Orthopedic evaluation with Dr. Haronian on 02/18/13. Radiographs were performed. Medication for pain was prescribed and PT was recommended. Currently not working. He last worked on 07/12/12. Pt c/o continuous aching in R wrist, hand, and thumb, at times becoming sharp, shooting, and throbbing pain. Pt endorsed forgetting things, anxious, 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. He has worked as a plumber for close to 30 years. Pt has never been arrested. Pt has never been imprisoned. Pt has never filed for bankruptcy. Pt has never been involved in an act of domestic violence. He does not drink and does not smoke. He denies h/o drug use. Denies h/o prior injury. Denies h/o surgery/hospitalization. Denies h/o mental illness or treatment. Denies h/o suicidal ideation/attempt. Pt has never been hospitalized for danger to self, or others or due to grave disability. MSE: Cooperative. Alert. Normal speech. No difficulty comprehending questions. Intact memory. Oriented to person, place, time, and situation. Responses were coherent and easy to understand. Concentration and attention was adequate. Normal thought content. No presence of hallucinations or delusions. Judgment and insight were good. Intellectual ability was roughly average. No SI/HI. There is no apparent risk to self or others. Pt did not appear impulsive. Rapport was easily established. Beck Anxiety Inventory Score: 29. Beck Depression Inventory Scores: 37. Pain Appraisal Inventory Score: Threat/Loss Score: 4.00. Challenge Score: 1.00. Survey of Pain Attitudes-Revised: Control: 4. Emotion: 7. Solicitude: 0. Medication: 7. Medical Cure: 9. Disability: 16. Harm: 11. Pain Catastrophizing Scale: Client Total Score: 25. Coping Strategies Questionnaire-Revised: Low responder. Pain Patient Profile: T-score: Depression: 58. Anxiety: 44. Somatization: 46. Validity Index: 10. The Anxiety Scale: T-score: Below average. The Somatization Scale: Pt considers the somatic problems serious and feel somewhat threatened and vulnerable. Somatic problems are of significant concern, and pt is cognitively and emotionally

distressed about the physical symptoms, but pt is usually capable of participating fully in physical treatment for pain relief. Individuals with a clearly defined organic basis for pain often respond in this manner. Dx: Axis I: 1) Depressive disorder NOS. 2) Anxiety Disorder NOS. 3) Sleep Disorder due to pain, insomnia type. 4) Male ED. Axis II: No diagnosis. Axis III: Deferred to appropriate medical specialist. Axis IV: Psychosocial and Environmental Problems: Chronic pain, disability status, ongoing need for medical attention, financial strain. Axis V: GAF: 56. Causation: Industrial injury. Work Restrictions: Deferred to PTP. Recommendation: Requested 4 sessions of psychotherapy and will be scheduled accordingly. Recommended psychiatric consultation. Pt will be administered intermittent diagnostic measures to assess change in condition.

05/09/13 - Pain Management F/u Rpt & RFA by Jonathan F. Kohan, MD. C/o chronic unremitting pain in R hand with N/T. Pain level is 7/10. He is presently maintained on Medrox patches, Prilosec 20 mg, Relafen 750 mg, and Lexapro 10 mg. No side effects have been reported. However, his pain is suboptimally controlled. Awaits bone scan authorization. Pt is being seen by a psychologist. He is also awaiting authorization for acupuncture therapy. MRI of R wrist performed on 04/11/13, revealed OA at the first carpometacarpal and first MCP joints. Dx: 1) Wrist bursitis. 2) R/o complex regional pain syndrome type 1. Rx: Trial of Elavil 50 mg, Neurontin 300 mg, trial of Vitamin C 500 mg. Plan: Stop Lexapro. Requested authorization for purchase of wrist support to increase pt's ROM and functional capacity status. Work Status and further course of conservative treatment deferred.

05/31/13 - F/u Rpt by Edwin Haronian, MD. Pain 6/10. States obtaining meds from Dr. Kohan. Sleep and depression have improved after start of Elavil 50 mg. Pt also has less N/T and burning pain after Neurontin 300 mg. He is scheduled for the bone scan of the right hand and wrist. He is being seen by a psychologist. Pt presents with a clinical picture of complex regional pain syndrome. PE: Pt is visibly comfortable. Defer further handling of meds to Dr. Kohan. Dx: 1) Wrist tendonitis/bursitis. 2) Hand contusion. Rx: Neurontin 600 mg and Elavil 100 mg. Plan: Increase Neurontin and Elavil. Work Status: Remains to be unchanged at the present moment.

06/11/13 - PR-2 Rpt by Heath Hinze, PsyD. Pt reports anger, anxiety, fear, feeling hopeless, and inability to gain pleasure in life. Pt appears angry, anxious, depressed, hopeless, affect normal. Pt was administered BAI: Severe 39. BDI: Severe 41. Dx: 1) Anxiety disorder, NOS. 2) Depressive disorder, NOS. Plan: Requested 4 sessions of CBT and relaxation training sessions. Work Status: Deferred to PTP.

06/12/13 - Nuclear Medicine Three Phase Bone Scan, B/L Wrists & B/L Hands interpreted by Bharath Kumar, MD at San Gabriel Valley Diagnostic Ctr.
Impression: Opinion: Increased activity in the first R MCP joint and R wrist with focal evidence of increased activity in the R trapezium and scaphoid. 2) There is a suggestion of hyperemia in L hand and wrist secondary to L antecubital injection. 3) There is a suggestion of diffusely increased activity in R wrist with a focal component in R wrist with a focal component in R trapezium and R scaphoid. This may suggest focal cortical injury. The intensity of activity is less than what would be seen with an acute fracture. There is evidence of increased activity in the 1st R MCP joint.

Posttraumatic arthropathy would be one of the concerns. Radiographic correlation is recommended. The remainder of the examination is unremarkable.

06/24/13 - Utilization Review Determination.

07/09/13 - PR-2 Rpt by Heath Hinze, PsyD. Pt reports anger, anxiety, fear, feeling hopeless, and inability to gain pleasure in life. Pt appears angry, anxious, depressed, hopeless, affect normal. Pt was administered BAI: Severe 38. BDI: Severe 39. Dx: 1) Anxiety Disorder NOS. 2) Depressive Disorder NOS. Plan: Requested transportation required, 4 sessions of CBT and relaxation training sessions. Work Status: Defer to PTP.

07/11/13 - Pain Management F/u Rpt & RFA by Jonathan F. Kohan, MD. Three-phase bone scan was reviewed, revealed increased activity in first R MCP joint. Pt is presently obtaining Neurontin 600 mg and Elavil 50 mg. His sleeping pattern has improved significantly. He has decreased sensation of N/T. He still remains to be symptomatic. PE: Visibly uncomfortable. Dx: 1) Wrist tendinitis/bursitis. 2) Rule out complex residual pain syndrome type 1. Plan: Requested wrist support. Work status and further course of conservative treatment deferred.

07/22/13 - F/u Rpt by Edwin Haronian, MD. Pt presents with c/o persistent pain in R wrist, hand and forearm. He is also being seen by pain management specialist He was prescribed Elavil 100 mg in light of his good response to 50 mg. However, he did not tolerate it well. His pain is not well controlled. PE: Visibly uncomfortable. Dx: Wrist tendonitis/bursitis. Rx: Elavil 75 mg and Trial of Norco 5 mg. Plan: Requested wrist support. Taper down Elavil. Activities which do not aggravate symptoms can be maintained. Modified duty.

07/25/13 - Pain Management F/u Rpt by Jonathan F. Kohan, MD. Pain in RUE 6/10. Presently maintained on Neurontin 600 mg, therapeutic cream, Docuprene and Relafen. He is also obtaining Elavil 75 mg and Norco 5 mg from Dr. Haronian. His neuropathic pain has improved after the doubling dose of Neurontin. Pt did not tolerate Elavil 100 mg well. His sleeping patterns and depression have improved after the initiation of Elavil overall. PE: Visibly uncomfortable. Dx: 1) R/o complex regional pain syndrome type 1. 2) Chronic wrist and hand pain. Rx: Neurontin 700 mg. Plan: Increase Neurontin. Defer other medications to Dr. Haronian. Work status and further course of conservative treatment deferred.

08/06/13 - PR-2 Rpt by Heath Hinze, PsyD. Pt reports anger, anxiety, fear, feeling hopeless, and inability to gain pleasure in life. Pt appears angry, anxious, depressed, hopeless, affect normal. Pt was administered BAI: Severe 37. BDI: Severe 41. Dx: 1) Anxiety Disorder NOS. 2) Depressive Disorder NOS. Plan: Requested transportation required, 4 sessions of CBT and relaxation training sessions. Work Status: Defer to PTP.

08/19/13 - Progress Note by Edwin Haronian, MD. Pt c/o chronic pain in R hand and wrist. Pain is burning with radiation to tips of fingers. Pt has also been seen by Dr. Kohan, who is providing him with med. Pt is responding well to 75 mg Elavil which improves and controls insomnia and neuropathic pain. PE: Visibly uncomfortable. Dx: Wrist trend/burs. Rx: Elavil 50 mg and Norco 5

mg. Plan: Recommended stellate ganglion injection. After that, pt remains to be symptomatic, spinal cord stimulator could be considered. Activities which do not aggravate his symptoms can be maintained. Modified duty.

08/19/13 - F/u Rpt by Edwin Haronian, MD. Pt presents with c/o chronic pain in R hand and wrist. Pain is burning with radiation to the tips of his fingers. He will also be seen by Dr. Kohan who is providing him with medications, Pt is responding well to Elavil 75 mg, which improves and controls insomnia and his neuropathic pain. PE: Visibly uncomfortable. Dx: Wrist tendonitis/bursitis. Rx: Elavil and Norco 5 mg. Plan: Requested wrist support. It is opined for stellate ganglion injections. After that, pt remains to be symptomatic, spinal cord stimulator could be considered. Work status and further course of conservative treatment deferred.

08/22/13 - Pain Management F/u Rpt by Jonathan F. Kohan, MD. Pain 6/10. Presently obtaining Neurontin 700 mg, Relafen 750 mg, Norco 5 mg and Elavil 50 from Dr. Haronian. He is also obtaining Elavil 75 mg and Norco 5 mg from Dr. Haronian. His neuropathic pain has improved after the doubling dose of Neurontin. Pt did not tolerate Elavil 100 mg well. His sleeping patterns and depression have improved after the initiation of Elavil overall. PE: Visibly very uncomfortable. Dx: 1) Rule out complex regional pain syndrome type 1. 2) Chronic wrist and hand pain. Rx: Neurontin 700 mg. Plan: Requested one stellate ganglion injection on right side. It is important to mention that if pt remains to be symptomatic, the next logical step would be to consider a spinal cord stimulator trial with prior psychological clearance.

09/10/13 - PR-2 Rpt by Heath Hinze, PsyD. Pt reports anger, anxiety, fear, feeling hopeless, and inability to gain pleasure in life. Pt appears depressed, hopeless, affect restricted. Pt was administered BAI: Severe 34. BDI: Severe 41. Dx: 1) Anxiety Disorder NOS. 2) Depressive Disorder NOS. Plan: Requested transportation required, 4 sessions of CBT and relaxation training sessions. Work Status: Defer to PTP.

09/16/13 – Progress Note by Edwin Haronian, MD. Pt c/o chronic unremitting pain in RUE including wrist and hand. Pain is 6/10. Pt has been approved for steroid ganglion injection from Dr. Kohan. PE: Visibly uncomfortable. Dx: Wrist trend/burs. Rx: Elavil 50 mg. Plan: Continue to observe unfolding events in regard to injection. Work status remains unchanged at the present moment.

09/17/13 (1 visit) - Cognitive Behavioral Therapy. Pt completed a session of CBT. Pt did not speak. Pt actively distended. Pt attends regularly and appears to benefit to benefit by listening to others concerns/stories. Continue CBT.

09/19/13 – Secondary Physician Pain Management F/u Rpt by Jonathan F. Kohan, MD. Pt c/o chronic unremitting pain in R hand, wrist and distal forearm. Pain 8/10. Presently obtaining 700 mg of Neurontin, Relafen 75 mg, Norco 5 mg and Elavil 50 mg. No side effects. However, pain is suboptimally controlled with present pharmacological regimen. Approved for R stellate ganglion injection. PE: Visibly very uncomfortable. Dx: 1) R/o complex regional pain syndrome type 1. 2) Chronic wrist and hand pain on R side. Rx: Lyrica 50 mg. Plan: Will refill meds. Norco increased

to 75 mg. Pt will be scheduled for the procedure accordingly. If pt remains symptomatic, would consider spinal cord stimulator with prior psychological clearance. Work status deferred.

10/08/13 (1 visit) - Cognitive Behavioral Therapy. Pt completed a session of CBT. Pt discussed his sense of hopelessness, stating he has reached out for help and no one has been there to help him. Pt has hopelessness and extreme pain. Pt is struggling with day to day living activities because he feels hopeless about life. He states everything takes more effort and feels disappointed in his capabilities. Pt has made motivating statements that he needs to be stronger. Pt reports having more panic attacks, feeing that some were intense. Reports feeling sweaty, dizzy. Thought he was going to have a heart attack. Pt's symptoms appear to fall in criteria for panic disorder. Continue CBT.

10/08/13 - PR-2 Rpt by Heath Hinze, Psy. D at Hinze Pyschological Services. Pt reports anger, anxiety, fear, feeling hopeless, and inability to gain pleasure in life. PE: Pt appears angry, depressed, fearful, hopeless. Affect is restricted. BAI: Severe 32 and BDI severe 41. Not at all: Terrified, feeling of choking and scared. Mildly: Wobbliness of legs, unsteady, fear of losing control, difficulty breathing, faint and face flushed. Moderately: N/T, feeing hot, fear of the worst happening, dizzy or lightheaded, heart pounding or racing, hands trembling, shaky, and sweating (not due to heat). Severely: Unable to relax, nervous, fear of dying and indigestion or discomfort in abdomen. Dx: 1) Depressive disorder. 2) Anxiety disorder. 3) Sleep disorder due to pain, insomnia type. Plan: Requested CBT and relaxation training sessions. Work status by PTP.

10/14/13 – Progress Note by Edwin Haronian, MD. Pt c/o chronic unremitting pain in R hand and wrist. Pt was dx'd with complex regional pain syndrome type 1. Pt is going to have stellate ganglion shots by Dr. Kohan. PE: Obviously uncomfortable. Dx: 1) Wrist trend/burs. 2) Hand contusion. Plan: Deferring further course of pain management tx to Dr. Kohan. Work status remains unchanged at the present moment.

10/16/13 - Procedure Rpt by Jonathan F. Kohan, MD at Jonathan F. Kohan, MD at Osteon Surgery Ctr. Pre/Post-op Dx: Complex regional pain syndrome, RUE. Procedures: 1) Stellate ganglion injection on the R. 2) Gangliogram. 3) Injection of Marcaine. 4) Fluoroscopy.

10/17/13 - Pain Management F/u Rpt by Jonathan F. Kohan, MD. Pt c/o chronic unremitting pain in L forearm, wrist and hands on R side. Pain 7/10. Pt is s/p stellate ganglion injection. Pt tolerated procedure well, however, does not report any significant amount of improvement at this point. Pt is also being seen by psychologist. Maintained on combination of Norco 7.5 mg, Norco 5 mg ad Elavil 50 mg. Pt tolerated Lyrica 50 mg well without any side effects. PE: Visibly uncomfortable. Dx: Complex regional pain syndrome type 1 of R forearm, wrist and hand. Plan: Refilled meds. Increased Lyrica to 100 mg. Norco will be provided in quantity of 7.5 mg. In lack of improving from other means, would consider further alternative options. Pt does gravitate to SCS trial. Requested psychological clearance. Work status and further course of conservative tx shall be deferred.

10/22/13 (1 visit) - Cognitive Behavioral Therapy. Pt completed a session of CBT. Pt discussed frustration. Pt is engaged, open to considering impact of auto/negative thoughts. Pt continues to

explore how maladaptive thoughts increase and is at place of considering alternative Bx to negative thoughts. Continue CBT.

10/29/13 - Cognitive Behavioral Therapy. Pt completed a session of CBT. Pt discussed rumination about boss. Pt is sad, upset and angry. Pt examined why his symptoms have increased and that prompted him to ruminate over bosses' action. Asked pt if rumination exacerbated pain and he affirmed this. Motivational statement that he should try to distract self from maladaptive thoughts. Continue CBT.

11/11/13 – Progress Note by Edwin Haronian, MD. Pt is s/p stellate ganglion shots on UE. Pt had minimal benefit from this intervention. Pt returns with continued c/o R hand pain with hypersensitive and reduced function. S/o R thumb fx with closed tx only. Dx: 1) Wrist trend/burs. 2) Hand contusion. 3) Finger fx. Plan: Deferring meds to pain management. Requested psychological clearance and trial of SCS. Modified duty with no use of R hand.

11/12/13 (1 visit) - Cognitive Behavioral Therapy. Pt completed a session of CBT. Pt chose to be quiet in group. Pt attends regularly but chooses at time to not talk. Continue CBT.

11/12/13 - PR-2 Rpt by Heath Hinze, Psy. D. Pt reports anger, anxiety, inability to gain pleasure in life. PE: Pt appears angry, depressed, fearful, hopeless. Affect is restricted. BAI: Severe 36. BDI: Severe 44. Not at all: Dizzy or lightheaded and feelings of choking. Mildly: N/T, wobbliness in legs, heart pounding or racing, terrified, difficulty breathing and faint. Moderately: Feeling hot, unsteady, hands trembling, shaky, fear of losing control, fear of dying, scared, face flushed, and sweating (not due to heat). Severely: Unable to relax, fear of the worst happening, nervous, and indigestion or discomfort in abdomen. Dx: 1) Anxiety disorder. 2) Depressive disorder. 3) Sleep disorder due to pain, insomnia type. Plan: Requested CBT and relaxation training sessions. Work status will be directed by PTP.

11/14/13 - Pain Management F/u Rpt by Jonathan F. Kohan, MD. Pt c/o chronic unremitting pain in R hand, wrist and distal forearm. Pain 9/10. Pt is presently maintained on Lyrica 100 mg, Elavil 50 mg, Norco 7.5 mg. While pt tolerated Lyrica well, the control of neuropathic pain is suboptimal. Unfortunately, pt was unable to obtain the clearance from psychologist to series of vicissitudes. Pt was deemed to be a candidate for SCS. PE: Visibly uncomfortable. Dx: 1) R/o complex regional pain syndrome type 1. 2) Chronic wrist and hand pain on R side. Plan: Lyrica will be stopped. Neurontin will be tapered up to 800 mg. Maximum dose of particular med is 3600 mg. Pt felt much more comfortable with this particular med before intake of Lyrica. Requested for psychological consult to provide pt with clearance in order to establish realistic expectations after the implantation of SCS. Work status shall be deferred. Taper down Lyrica before starting Neurontin.

11/26/13 (1 visit) - Cognitive Behavioral Therapy. Pt completed a session of CBT. Pt discussed frustration. Pt is engaged. Pt is motivated to make changes with attorney because of reported lace of service. Pt is striving to advocate for his own health. Continue CBT.

12/03/13 - Cognitive Behavioral Therapy. Pt completed a session of CBT. Pt discussed his ways of fighting to resolve conflict. Pt is engaged. Pt continues to discuss difficult feelings and looks to resolve ways to manage emotions. Continue CBT.

12/10/13 - PR-2 Rpt by Heath Hinze, Psy. D. Pt reports anger, anxiety and inability to gain pleasure in life. PE: Pt appears angry, depressed, hopeless. Affect is restricted. BAI: Severe 41. BDI: Severe 49. Not at all: Feeling of choking. Mildly: N/T, shaky, difficulty breathing, and faint. Moderately: Feeling hot, wobbliness in legs, dizzy or lightheadedness, heart pounds or racing, unsteady, terrified, hands trembling, fear of losing control, scared, face flushed, and sweating (not due to heat). Severely: Unable to relax, fear of the worst happening, nervous, fear of dying and indigestion or discomfort in abdomen. Dx: 1) Anxiety disorder. 2) Depressive disorder. 3) Sleep disorder due to pain, insomnia type. Plan: Requested CBT and relaxation training sessions. Work status as directed by PTP.

12/10/13 (1 visit) - Cognitive Behavioral Therapy. Pt completed a session of CBT. Pt was quiet. Pt used this session to listen to others and reflect on his own management of emotion. Pt asked why doctor has not seen him. Referred to Liz. Continue CBT.

12/12/13 - Pain Management F/u Rpt by Jonathan F. Kohan, MD. Pt c/o chronic pain in L arm, wrist and hand on R side. Pain 6-7/10. In spite of the fact that pt failed to improve with other means, he is being considered for SCS to address his complex regional pain syndrome type 1 on R side. At this point, continue to await authorization for psychological consult for clearance. Presently maintained on Norco 7.5 mg, Neurontin 800 mg and Elavil 50 mg. Reports absence of side effects. PE: Visibly very uncomfortable. Dx: Complex regional pain syndrome type 1 with R forearm, wrist and hand. Plan: Requested R wrist brace. Work status deferred.

01/06/14 - Progress Note by Edwin Haronian, MD. Pt continues to c/o significant pain in RUE. Dr. Kohan Dx'd him with reflex sympathetic dystrophy. Dx: 1) Reflex sympathetic dystrophy of lower limb. 2) Anxiety disorder, OS. 3) Depressive disorder, NOS. 4) Male erectile disorder. 5) Sleep disorder due to pain, insomnia type. 6) Hand contusion. 7) Wrist tend/burs. 8) Finger frat. Plan: Authorized to see psychologist. Meds will be provided through PTP.

01/09/14 - Pain Management F/u Rpt by Jonathan F. Kohan, MD. Pt c/o chronic unremitting pain in R forearm, wrist and hand. Pain 9/10 with med. Pt is maintained on Neurontin 800 mg, Elavil 50 mg, and Norco 7.5 mg. Pt reports absence of side effects. Pain is notably controlled. At this point, awaiting authorization for psychological consult to be cleared for SCS trial as he failed to improve with other means. PE: Visibly very uncomfortable. Dx: Complex regional pain syndrome type 1 with R forearm, wrist and hand. Plan: Norco will be increased to 10 mg, Neurontin increased to 900 mg. Elavil tapered down to 40 mg as pt is not tolerating it well. Pt is a good candidate for SCS trial. Work status shall be deferred.

02/06/14 - Pain Management F/u Rpt by Jonathan F. Kohan, MD. Pt c/o chronic unremitting pain in R forearm, wrist and hand. Pain 8-9/10 with meds. C/o N/T and burning sensation in RUE. Pt tolerated increase of Neurontin 900 mg and Norco 10 mg without any side effects. Tolerated

decrease of Elavil 40 mg. Pt has been cleared by psychologist for SCS trial. PE: Visibly very uncomfortable. Dx: Complex regional pain syndrome type 1 with R forearm, wrist and hand. Plan: Requesting SCS trial on an industrial basis. Work status deferred.

02/17/14 - Progress Note by Edwin Haronian, MD. Pt is continuing to experience significant symptomatology of chronic regional pain syndrome in RUE. SCS was cleared by psychologist and awaiting its placement. Dx: 1) Hand contusion. 2) Wrist tend/burs. 3) Finger fx. Plan: Pt was declined his med at pharmacy. There are significant effects of discontinuing his meds in an abrupt fashion and he requires the medical therapy in order to function. Work restrictions will continue. No use of R hand in workplace.

03/06/14 – Secondary Physician's PR-2 by Jonathan F. Kohan, MD. Pt reports depressed mood. PE: Pt appears depressed. Affect is flat. BAI: 42. BDI: 50. Rx: Neurontin 900 mg, Norco 10 mg and Elavil 40 mg. Plan: Work status by PTP.

03/06/14 - Progress Note by Jonathan F. Kohan, MD. Pt reports no change in his symptoms and continues to be treated for diabetes. Also remains under the care of psychologist with weekly psychotherapy sessions. Pt has longstanding RUE symptoms of CRPS. These have not responded to multiple interventions and he reports some increasing level of pain after his most recent med regimen were delayed. Currently on Norco 10 mg with Elavil 40 mg and also Neurontin 2700 mg. PE: Pt is alert and oriented. Dx: 1) Complex regional pain syndrome type 1, RUE. 2) Diabetes. Rx: Norco 10 mg, Neurontin 900 mg and Amitriptyline 40 mg. Pt would like to proceed with neurostimulation trial. May be a candidate to undergo permanent placement. Disability and work status are deferred.

03/31/14 - Progress Note by Edwin Haronian, MD. Pt has been cleared for psychological point of view for SCS. Dx: 1) Reflex sympathetic dystrophy of lower limb. 2) Depressive disorder, NOS. 3) Male erectile disorder. 4) Sleep disorder due to pain, insomnia type. 5) Hand contusion. 6) Wrist tend/burs. 7) Finger fx. Plan: Pt is scheduled to be seen by Dr. Kohan. Will wait for Dr. Kohan to make the recommendations. This examiner is in agreement with the psychologist as well as Dr. Kohan to proceed with spinal cord stimulator. Remain off work as he has significantly difficulty with use of R arm.

04/03/14 - Pain Management F/u Rpt by Jonathan F. Kohan, MD. Pt c/o chronic unremitting pain in R arm with N/T and burning sensation. Pain precludes him from performing ADLs. Also receiving tx for his diabetes. PE: Pt is very uncomfortable. Dx: 1) Complex regional pain syndrome type 1 of RUE. 2) R wrist tendinitis/bursitis. Rx: Norco 10 mg, Neurontin 900 mg and Elavil 40 mg. Plan: Requested SCS trial on industrial basis. Work status deferred.

05/01/14 - PR-2 Rpt by Jonathan F. Kohan, MD. Pt c/o depression with anxiety. Pt reports depressed mood. PE: Pt appears agitated, depressed. Affect is normal. BAI: 43. BDI: 47. Dx: 1) Wrist tend/burs. 2) Hand contusion. 3) Reflex sympathetic dystrophy of lower limb. Rx: Norco 10/325 mg, Neurontin 900 mg and Levaquin 500 mg. Work status will be directed by PTP. This examiner recommends TTD for 6 weeks or until specified date.

05/12/14 - Progress Note by Edwin Haronian, MD. Pt still c/o pain. Pt has been cleared to proceed with SCS. Pt has been noted to be smoking. Dx: 1) Reflex sympathetic dystrophy of lower limb. 2) Depressive disorder, NOS. 3) Male erectile disorder. 4) Sleep disorder due to pain, insomnia type. 5) Hand contusion. 6) Wrist tend/burs. 7) Finger fx. Plan: Instructed regarding smoking cessation as well as negative effect on wound healing. Remain off work.

05/14/14 - Anesthesia Record by Joel Diaz, CRNA at Kinetix Surgery Ctr. ASA 2.

05/14/14 - Operative Rpt by Jonathan F. Kohan, MD at Kinetix Surgery Ctr. Pre/Post-op Dx: Sympathetically-mediated neuropathic pain, RUE. Procedure: 1) Percutaneous implantation of SCS leads x 2, C/S. 2) Myelogram. 3) Complex programming. 4) Fluoroscopy.

05/19/14 - Pain Management F/u Rpt by Jonathan F. Kohan, MD. Pt reports more than 70% improvement of UE symptoms after undergoing neuromodulation trial last week. No aberrant coverage or sensation and had benefited from the unit significantly over the trial period to the point that he was able to use it slightly more than average. Continued with Norco 10 mg and Gabapentin 300 mg but was not provided with Elavil. Dx: 1) Complex regional path syndrome. 2) Success with neuromodulation trial. Rx: Elavil 40 mg. Plan: Requested permanent placement of SCS unit. Pt is a candidate because of significant improvement. Refilled Norco 10 mg, Neurontin 300 mg. Disability and work status are deferred.

06/19/14 - Pain Management F/u Rpt by Jonathan F. Kohan, MD. Pt has significant improvement after undergoing the trial, but since then he has been using his med to address his current complaints which is providing partial improvement. PE: He is alert and oriented. Dx: 1) Complex regional pain syndrome, RUE type 1. 2) R wrist tendinosis. Rx: Elavil 50 mg, Neurontin 300 mg and Norco 10 mg. Plan: Requested permanent placement of neuromodulation unit.

06/23/14 - Progress Note by Edwin Haronian, MD. Pt with continued significant R hand and RUE pain with numbness, weakness, and pins and needles sensation. C/o temperature changes as well as color changes of RUE. Pt is s/p R thumb fx with resultant complex regional pain syndrome. Pt underwent SCS trial with fairly significant improvement in pain and ROM. Pending authorization for permanent SCS placement. Pt developed L wrist pain with decreased ROM, weakness and numbness as a compensatory consequence of favoring his RUE. Dx: 1) Hand contusion. 2) Wrist tend/burs. 3) Finger fx. 4) Reflex sympathetic dystrophy of upper limb. Sleep disorder due to pain, insomnia type. Rx: Gabapentin 300 mg, Norco 10 mg, Elavil 50 mg. Plan: TTD.

07/17/14 - Pain Management F/u Rpt by Jonathan F. Kohan, MD. There are no changes in complaints in UE which are more severe on R side. Currently, he is relying on med to address his complaints but is eager to proceed with SCS implantation. Even though bulk of his complaints remains over RUE due to Dx of CRPS, he also has been experiencing LLE symptoms with weakness and numbness. Will request for Levaquin 500 mg. Pt should be considered TTD at least 3 months after his procedure.

08/04/14 - Progress Note by Edwin Haronian, MD. Pt continues to c/o significant pain in RUE. Dx: 1) Anxiety disorder, NOS. 2) Depressive disorder NOS. 3) Male erectile disorder. 4) Sleep disorder due to pain insomnia type. Plan: Authorization provided for permanent placement of SCS. Pt is scheduled for surgery. Continue with Dr. Kohan. TTD.

08/27/14 - Operative Rpt by Jonathan F. Kohan, MD at Kinetix Surgery Ctr. Pre/Post-op Dx: Complex regional pain syndrome. Procedure: 1) Percutaneous implantation of SCS leads x 2, C/S. 2) Implantation of pulse generator. 3) Myelogram. 4) Complex programming. 5) Somatosensory evoked potential.

09/04/14 - Pain Management F/u Rpt by Jonathan F. Kohan, MD. Pt has been using the unit already and reports significant improvement of his neuropathic pain over RUE. Pt has continued on Levaquin with no side effects. Dx: 1) H/o complex regional pain syndrome. 2) S/p recent SCS implantation, C/S. Plan: Continue Levaquin for another few days. TTD for at least 3 months. Continue use soft cervical collar.

09/09/14 - Pain Management F/u Rpt by Jonathan F. Kohan, MD. Pt underwent permanent placement of cervical neural modulation and already has been benefited from it greatly. Burning pain has resolved with use of stimulator and he does not report any coverage or sensation nor any changes in changing of unit. Dx: 1) H/o complex regional pain syndrome. 2) S/p recent neural modulation implantation. Plan: Pt may discontinue antibiotic at this point. Refilled meds. Gabapentin will be reduced gradually. Norco will be decreased from 3 times a day to twice a day. Continue Elavil 50 mg.

09/15/14 - Progress Note by Edwin Haronian, MD. Pt is returning with continued neck and back pain radiating into UE and LE with pain, paresthesia, and numbness. He is relatively well controlled with OTC med and his HEP. However, he continues to experience anosmia and we have repeatedly requested authorization for ENT evaluation. This is due to chemical exposure in work place and as a result, it is this examiner's opinion this should be addressed on an industrial basis. Dx: 1) Cervical radiculopathy. 2) Lumbosacral radiculopathy. 3) Wrist tend/burs. Plan: Received denial of medical therapy, which has been appealed and awaiting the result. Pt is at his usual and customary work and is self regulating to avoid exacerbating his industrial injury.

10/16/14 - PR-2 Rpt by Jonathan F. Kohan, MD. Pt reports to adjusting with SCS and feeling sharp pain in abrupt movements, however, reports that he no longer feels burning sensation in his arms. Still struggling with financial strain which is a constant stressor for him. Pt feels as if he is devalued as a person by lack of respect he receives from his attorneys and doctors, which has impacted his self esteem, anger, anxiety, depressed mood, feeling a loss of control, feeling hopeless, inability to gain pleasure in life, irritability, isolation from others, loss of appetite, sleep disturbances, struggling with ADLs, withdrawing from family and friends, worry about financial strain, worry about pending deposition and worry about persistent pain. PE: Pt appears apathetic, dysphoric, euthymic, fatigued. Affect is flat. BAI: 43 severe. BDI: Severe 42. Dx: 1) Hand contusion. 2) Wrist tend/burs. 3) Finger fx. 4) Anxiety disorder. Rx: Elavil 50 mg, Neurontin 300 mg and Norco 7.5/325 mg. Plan: Work status per PTP.

10/16/14 - Pain Management F/u Rpt by Jonathan F. Kohan, MD. Pt is now recovered from his recent procedure in the form of implantation of his SCS, but continuous benefit from it. He has been using the unit around-the-clock and reports 50% improvement in his UE symptoms and particularly reports improvement of the burning pain which was his major issue before the implantation was done. He has had some symptoms on LUE, but not as severe, but reports that both are being covered by the stimulator and he does not report any advanced coverage or issues with the charging of the unit which has been every other week. Currently be is on Gabapentin 1,800 mg with Norco 10 mg and Elavil 50 mg. Dx: 1) Complex regional pain syndrome RUE. 2) S/p SCS implantation. Plan: Reprogrammed his unit today further and it will be able to give him additional programs which will also over his LUE. He is to reduce his Gabapentin. Norco will be reduced to 7.5 mg, but he may continue with the Elavil 50 mg. This examiner believes that, by the next visit, he will require less Neurontin and possibly Norco.

12/08/14 - Progress Note by Edwin Haronian, MD. Pt is significantly depressed, anxious, describes insomnia a, and is stressed. He was taking Elavil previously, which helped to improve his mood and help to reduce his anxiety and depression. Pt is treating with Dr. Kohan. Pt indicates that SCS has helped to reduce pain and increase functional capacity, however, he does continue to be symptomatic. He has difficulty with his daily activities and difficulty gripping, grasping, lifting, pushing, arid pulling. He has difficulty sleeping and is awakened due to pain and discomfort. C/o pain in LUE due to favoring of the RUE. Dx: 1) Mononeuritis NOS. 2) Reflex sympathetic dystrophy of upper limb. 3) Reflex sympathetic dystrophy of lower limb. 4) Hand contusion. 5) Wrist tend/burs. 6) Finger fx. Plan: Pt will f/u with Dr. Kohan at this time. TTD. Requested 12 PT for C/S and BUE on an industrial basis.

06/02/15 - P&S Comprehensive Psychological Eval by Health Hinze, Psy.D. DOI: 07/11/12. Pt was seen for an initial psychological evaluation. He was Dx'd with depressive disorder, NOS; anxiety disorder; NOS; sleep disorder due to pain insomnia type; and male erectile disorder. Pt was started on a trial of CBT. At that time pt was taking Lexapro 10 mg. A psychiatric consultation was also recommended. Pt returned and maintained active participation in tx. On 02/04/14, a psychological surgical clearance evaluation was conducted as the pt was pending a SCS trial. He underwent that trial in May 2014. The trial was successful and so he underwent permanent placement on 08/27/14. Pt reports that his PTP was changed to Dr. Kohan. Pt remains off work though apparently he was given a work restriction that he can RTW so long as he does not use his R hand. Mental Status: Pt presented appearing his stated age. Pt presented with appropriate grooming and hygiene. He ambulated without the use of a physical aid. Pt returns today appearing dysphoric and depressed. He has a tendency to become tangential initially responding to a question and then trailing off into other concerns most notably regarding his ortho condition, his pain, and the changes that have occurred with his life post-injury. Mood today is described as frustrated due to a recent termination of state disability benefits. Pt related to the evaluator as candid and cooperative. He approached the evaluation process as open and responsive. He was alert. Speech was a normal rate of responding and volume. Eye contact was normal. Pt showed no problems with expression. He spoke fluently in English and without the use of an interpreter. Pt demonstrated intact memory with no apparent difficultly recalling personal events. Pt was oriented

to person, place, time, and situation. Pt's responses were coherent and easy to understand. Pt's concentration and attention was adequate. Pt showed normal thought content. There was no presence of' hallucinations or delusions. Judgment and insight were good. Pt's intellectual ability was roughly average. Pt expressed no suicidal or homicidal ideation. There is no apparent risk to self or others. Pt did not appear impulsive. Rapport was sufficiently established. Psychological Testing: Beck. Anxiety Inventory (BAI): 35 – Severe level of subjective anxiety. Deck Depression Inventory (BDI): 46 - Severe level of subjective depression. Pain Appraisal Inventory (PAI): PAI has been found to have good internal consistency (Chronbach's alpha: Threat Subscale = 86; Challenge = 81). Interpretation: The high score on threat/loss suggests pt may view any pain stimulus as a signal of danger and leading to avoidance. Exercise and other behavioral assignments may be viewed as having high potential for causing reinjury or triggering a pain episode. Pt may judge that pain has robbed him of all pleasurable aspects of life. Pain Calasirophizing Scale (PCS): 30. Interpretation: The results are non-significant and suggest an adequate adjustment to chronic pain, decreased perceived disability, decreased occupational impairment, less emotional distress, and decreased medication use and use of healthcare services. Coping Strategies Questionnaire Revised (CSQ-R): Interpretation: Results place pt in the low responder subgroup indicating pt scored low on all measures. Pain Patient Profile (P-3): Validity Index: 11. Interpretation: The Depression Scale: Above-Average (55-71): Pts with scores above the average pain pt score on the depression scale usually experience chronic fatigue, sadness, listlessness, and appetite and sleep disturbances associated with pain. Pt may have given tip hope and may lack the motivation required for participating in a tx program. (A psychological evaluation is strongly recommended for these patients). The Anxiety Scale: Above-Average (56-71): Pts with scores above the average pt score on the Anxiety scale typically experienced significant agitation, generalized fear and apprehension, and inner turmoil. Temper and impulse control may be affected, and he may feel an increasing loss of control as a result of the complexity, scope, and magnitude of their pain. When Anxiety scores are considerably higher than average, psychological symptoms are likely to seriously interfere with physical tx. The Somatization Scale: Above-Average (56-69): An above-average score on the Somatization scale suggests that pt is troubled by physical problems, pain and health-related issues that are having a negative effect on life. Pain and suffering may occupy a disproportionate amount of pt's attention and concentration, causing pt to be easily distracted. As scores a rise on the Somatization scale, the likelihood increases that pt has an obsessional level of somatic concentration that is likely to interfere with tx participation and rehabilitation efforts. Conceptualization: Pt returns today appealing dysphoric and depressed. He has a tendency to become tangential initially responding to a question and then trailing off into other concerns most notably regarding his ortho condition, his pain, and the changes that have occurred with his life post-injury. Mood today is described as frustrated due to a recent termination of state disability benefits. Pt returns today indicating that the SCS has led to approximately 50% improvement in pain management; however, there is a trade-off. He reports that over time he has needed to increase the level of stimulation. When he moves there is an electrical buzzing sensation that he experiences all the way down to his toes and as well as his UE. He describes this as a very uncomfortable pain as though he is being shocked. However, if he does not increase the stimulation there is increased pain to RUE. Over time pt reports that overusing the L hand has led to pain that at time is even worse than the R hand. Recently, he was given a work restriction, but he is unable to find work noting that his career is 30 years in plumbing, which requires the use of both hands. He has also

reached a point where he is struggling to use his L hand due to overuse. Apparently, his state disability benefit ended a couple of months before they became exhausted. The reason for this is unclear at this time. However, as a result there has been even further financial hardships placed on him. He is living with his girlfriend of 7 years. She purchased a trailer and he is responsible for paying for the rental space. He has been unable to pay that now for quite some time and this does lead to financial hardships and tension between him and his girlfriend. On most days, pt has minimal activities other than doing very light chores around the home. He points out that he can at least dust with his L hand. He may watch some television. He goes outside for fresh air and takes his dog for a walk with his girlfriend. Last year; pt reports that he reconnected with one of his siblings. He and his brother now have ongoing communication. Pt describes his mood as fluctuating throughout the day. He goes through episodes of depression because of his ongoing life changes and struggles to meet the financial obligations each month. He is limited into how much he can help around the home. At times he feels that he is becoming dependent upon his girlfriend. She must remind him of tasks to be completed because he has become so forgetful. She writes things down on a list for him. Pt reports that there has been a gradual worsening of his anxiety. Out of the blue he experiences rapid head rate, SOB, and trembling. These symptoms last 10-20 minutes and come out of the blue. During these times he feels that his senses become amplified and he becomes more sensitive to light and sounds. There are times that he is afraid that he will "drop dead." He does not avoid anything because the attacks come out of the blue and so he does not associate them with any environment. Pt reports that he feels like his situations is only worsening. He commented, "Every day is more discouraging." He has been without health insurance now for a year. He is diabetic and is medication-dependent .He has a 2-month supply remaining and then does not know how he will have access to further care. Neurovegetative complaints are described by pt. Pt has deficits of sleep onset and maintenance primarily due to pain. He often goes to bed around 1 o'clock in the morning. He first dozes off in his recliner. Once he lies down to sleep he has to turn off his SCS because movement causes electric shocks to go through his body. He trade-off then is that there is increased pan to RUE, which wakes him in the middle of the night. He wakes feeling lethargic, but avoids taking naps during the day. Pt reports continued ED, which was present at the initial evaluation. With the ongoing stress there is also general loss of his libidinal drive. He c/o ongoing problems and forgetfulness. He points out that if he is not focused on something right away the thought will be lost. This becomes discouraging as his girlfriend has to remind him of things and give him lists to complete. Pt c/o a low appetite. He has to force himself to eat, but is discouraged by the fact that he has a "beer belly" even though he does not drink. Pt is smoking approximately 1 pack of cigarettes per day. He uses this as a coping strategy. Unfortunately, this causes further financial drain. Pt patient reports that his attitude has seen some improvement through psychotherapy He feels mostly stable in this regard. When he becomes irritable or upset dealing with the stress from these injuries he goes out for fresh air and goes for a walk and tries not to dwell on the circumstances. He acknowledges that the greater concerns are his depression and the anxiety symptoms that appear to be increasing with time. Pt has now concluded his trial of psychotherapy. He remains on a dose of 50 mg of Elavil. He is pending a panel QME in orthopedics; however, there are no other procedures pending that this examiner is aware of. He has been left with residual psychiatric impairment secondary to this work injury. There are continued anxiety symptoms as well as depression as a result of his physical limitations and pain. He is discouraged by the continued pains that are developing especially now

to LUE which is his only useful hand. He does not know what career opportunities he has available to him as he has worked his entire life in the plumbing industry. Further psychological services should be afforded to this person as he continues to cope with this chronic condition. Dx: Axis I: Anxiety disorder, NOS. Depressive disorder. NOS. Axis II: No Dx. Axis III: Deferred to appropriate medical specialist. Axis IV: Psychosocial And Environmental Problems: Financial hardship, ongoing need for medical attention and chronic pain. Axis V: GAF: 60 (time of evaluation). Causation/Apportionment: This examiner opines that the work related accident is consistent with the psychological findings in today's examination of occupational problems. His psychological injuries are directly related to the injuries sustained in the work environment, this claim is compensable as the psychological injury occurred in connection with a physical injury. This examiner has not found any evidence to suggest the presence of a pre-existing psychological disorder. The events of the employment were the predominate cause (>51%) of emotional psychological injury. Based on the results of this evaluation, this examiner has determined that approximately >51% of the permanent impairment was caused by the direct result of the injury arising out of and occurring in the course of employment. There is no basis to apportion to a nonindustrial factor. There is some slight tension in the home in regards to a grown daughter of his girlfriends that is living there; however, this is not contributory to the permanent psychological disability. In consideration of this it is determined that 100% of the permanent psychological disability is apportioned to the 07/11/12 injury and resulting pain and physical limitations. Levels of Mental Impairment: Impairment Level: 1) ADL: Moderate to marked. 2) Social Functioning: Mild. 3) Memory, Concentration, Persistence, and Pace: Moderate. 4) Deterioration or Decompensation in Complex or Work lift Settings: Mild. AMA Impairment Rating: Pt has reached MMI on a psychological basis as of the date of this report. Pt's psychological WPI rating based on the GAF is 15%. Work Restrictions/Abilities: Any duties that would exacerbate his injury and increase his pain level would likely cause a corresponding worsening of his psychological symptoms and increase risk for relapse. As such any work restrictions outlined by the PTP should be adhered to. Pt is recommended to avoid taking on high pressure positions or those requiring strict adherence to production quotas. Pt is recommended to avoid taking on night shift positions as this may further disrupt his sleep cycle. Patient Work Function Impairment: 1) Ability to comprehend and follow instructions: Level of Impairment: Slight to moderate. 2) Ability to perform simple and repetitive tasks: Level of Impairment: Slight. 3) Ability to maintain a work pace appropriate to a given work load: Level of Impairment: Moderate. 4) Ability to perform complex or varied tasks: Level of Impairment: Moderate. 5) Ability to relate to other people beyond giving arid receiving instructions: Level of Impairment: Slight to moderate. 6) The ability to influence people: Level of Impairment: Slight. 7) Ability to make generalizations, evaluations or decisions without immediate supervision: Level of impairment: Slight. 8) Ability to accept and carry out responsibility for direction, control and planning: Level of Impairment: Slight to moderate. Future Psychological/Recommendation: Pt is recommended for 24 future CBT and relaxation training sessions to be set aside and used intermittently to maintain stability as pt confronts this chronic condition. Pt should have access to psychiatric consultations for medication management, Further evaluations and diagnostic studies should be available to assess his process in tx.

06/30/15 - PQME by Soheil M. Aval, MD at West Coast Orthopedics, Inc. DOI: 07/11/12. Employed by Benedict & Benedict Plumbing Company as a Plumber since 03/2009. Pt was cutting into a wall, which was made of floating cement, being very heavy, at which time an upper portion of the wall fell down upon him. He placed R hand over his head to protect head, at which time the wall struck R hand. Pt reported injury to employer, but was not referred for treatment. He went home early. The following day, he returned to work and was provided a helper to assist him. The following day, pt sought treatment at Huntington Memorial Hospital, was examined and x-rays revealed fracture. A soft brace was dispensed. R thumb was cleansed as he had sustained a laceration. A few days later, he was referred to Huntington Orthopedics a hard cast was applied, he wore until late 09/2012. Cast was replaced with a removable hard cast, he used for the next month or two. He participated in approximately 12 sessions of PT for R hand but felt increased pain. He was referred for an EMG/NCV of RUE, result unknown. Pt retained the services of an attorney in 01/2013, was referred to Dr. Kohan, he examined and had x-ray in addition to dispensing meds. In 2014, a ganglion injection was provided to neck for pain relief for R hand with no benefit noted. Pt states he underwent an MRI scan with dye of R hand in 2014, results unknown. In 2014, pt began to suffer pain to L hand and arm, he feels is due to overcompensation. In 05/2014, he underwent a trial of a spinal cord stimulator to his back with benefit and as such, in 08/2014, the spinal cord stimulator was permanently implanted in back. He states that the stimulator does mask the sharp burning pains in addition to the pins and needles sensations to hands and arms. Due to this injury, pt states he developed stress, anxiety, and depression due to his pain and inability to work. He has received group counseling for approximately 2 years with some benefit noted. Pt continues to treat with Dr. Kohan. Denies seeing any other physicians to date and has not sustained any new or further injuries. Pt had undergone an MR arthrogram of R hand in addition to an EMG/NCV of R hand. Work Loss Hx: Following the DOI, pt worked for one day and has not resumed work activities. Currently, he does not feel capable of working regular duties or modified duties. PMH: Other Industrial Injuries: In 2010, while working for the same employer, pt was underneath a sink and acid splashed into eyes and sustaining injury to eyes. He remained off work for about 5 days, receiving treatment with an ophthalmologist, included eye drops and provision of an eye patch. He states he fully recovered. Major Illnesses: Diabetes. Current Meds: Metformin, Neurontin, Elavil and Norco. Currently, pt relates constant pain to R wrist, hand and thumb, radiates to R forearm with burning sensation in addition to pins and needles to R hand, wrist and forearm, with sharp pain to the back of hand. Also notes N/T to R hand and all fingers. Pain increases with usage of R hand, carrying, lifting and writing. Symptoms are relieved with use of stimulator, meds and rest. Pain does awaken him from asleep. L wrist and hand pain is intermittent and localized with N/T to L hand and fingers. Pt relates difficulty sleeping in addition to anxiety and depression. He also describes stomach upset, difficulty with sleeping and difficulty with sexual functions. Pt reports difficulty performing ADLs. Family Hx: Father and mother deceased due to stroke. One brother with diabetes. Social Hx: Smokes 1 pack of cigarettes/day. Widower. X-ray of B/L hands reveals normal quality of bone. No acute fracture or dislocations. There is no significant osteopenia. Joint spaces are grossly preserved. Dx: 1) R hand trauma with reported non-displaced fracture of R thumb with possible first metacarpal fracture per initial medical records. 2) Subsequent R hand sympathetically mediated pain, most consistent with chronic regional pain syndrome. 3. Mild R carpal tunnel syndrome, per electrodiagnostic evaluation of 01/15/13. 4. Mild L hand strain, secondary to overcompensation. Disability Status:

Pt has reached MMI. Causation: Industrial injury. Apportionment: 100% due to injury of 07/11/12. Impairment Rating: R Wrist 25% WPI. Work Restrictions: Precluded from activities of repetitive or forceful gripping, fine manipulation, torqueing, and heavy lifting with RUE. LUE does not require work restrictions. Return to Work: Permanent work restrictions are indicated. Should pt's employer be unable to accommodate these restrictions, pt would be unable to return to his prior occupation. Future Medical Care: Pt should be allowed future medical care which might include orthopedic consultations at times of flare-ups with a regimen of PT and/or acupuncture. Updated diagnostic studies should be allowed. Pt should remain under the care of Dr. Kohan, pain management specialist, for provision of various injections and monitoring, adjusting and dispensation of medications. The spinal cord stimulator should be monitored.

03/17/16-10/24/17 - Casualty Claim Form.

06/21/16 - Psychological Testing. Hamilton Anxiety Rating Scale: Anxious/Mood (3): Worries anticipated of the worst and irritability. Tension (3): Feeling of tension, fatigability, trembling, feeling of restlessness and inability to relax. Fear (2): Of being left alone, of traffic and of crowd. Insomnia (3) Difficulty in falling asleep, unsatisfying sleep and fatigue on waking, nightmares. Intellectual (cognitive) (3): Difficulty in concentration, poor memory. Depressed mood (3): Loss of interest, lack of pleasure in hobbies, depression. Somatic (3), Cardiovascular symptoms (1), respiratory symptoms (2) GI symptoms (3), GU symptoms (3), autonomic symptoms (2) and Somatic muscular (2). Total score: 33. Epworth Sleepiness Scale: 2. TOMM Score Sheet: Total correct of Trial 1: 36. Total correct of Trail 2: 44. Total correct of retention trial: 47.

06/21/16 - MMPI-2 Test by Alex B. Caldwell, Ph.D. at Caldwell Report. Test Taking Attitude: Attention and Comprehension: His score on the Variable Response Inconsistency scale (VRIN) was unelevated his item responses were self- consistent throughout the inventory. This suggests that he was clearly able to read and comprehend the test items, that he was attentive in considering his responses, and that he consistently matched the item numbers in the booklet to the corresponding numbers on the answer sheet. He does not appear to have had any difficulties in understanding the content or responding to the format of the inventory. Attitude and Approach: He was very guarded, denying and self-favorable in has approach to the inventory. The clinical scale elevations he obtained may be suppressed and incomplete and the pattern somewhat distorted. Considering just scales L, F, and K, the interpretive statements are probably accurate, but they may understate the severity of his problems and his level of disturbance. He made a considerable number of atypical and rarely given responses to the items occurring in the last half of the inventory (scale F-back). This was in contrast to tie relative absence p atypical responses to the earlier MMPI-2 items (scale F). Socio-cultural Influences vs. Conscious Distortion: Pt showed a moderate level of conscious defensiveness, responding 'too positively" to many of the MMPI-2 items. In contrast, his score on the scale (Ss) measuring his currently attained, recently experienced, or self-perceived socioeconomic status was below average. He appears to be someone of less than average socioeconomic status identification who deliberately tried to make a favorable and controlled presentation in responding to the MMPI-2. Some of his clinical scales are apt to be significantly under-elevated. His elevation on the L scale, like his elevation on K, reflects considerable guardedness and denial, a conscious avoidance of admitting any faults or improper

actions that might be held against him. The elevation on L should not be interpreted as reflecting more than a mild amount of ingrained properness or characterological self-control. These scores strongly suggest the possibility that he had to take the MMPI-2 against his will. Symptoms and Personality Characteristics: The current level of his day-to-day coping and immediate practical self-sufficiency tests he severely disorganized in many areas. He is also prone to frustration with his place in life, but he would have serious difficulties in facing- this. He tests as mildly shy socially, His overall balance of masculine and feminine interests is within the normal range for his age and education. Diagnostic Impression: Dx of conversion, pain, and hypochondriacal disorders and of psychophysiologic disorders are the most common with this pattern. Some of these pts were seen as having depressive disorders with a strong somatic emphasis. However, the clinical and diagnostic picture appears more mixed and severe than usual. It should be re-emphasized that his generally guarded and self- favorable responding together with his understatement of his problems and his idealized self-presentation make his profile more ambiguous than most. Tx Consideration: Family consultation can be quite beneficial to evaluate the secondary gains and to arrange to minimize them. Stresses should be minimized. MMPI-2 Critical Items: Pt is easily awakened by noise, lacking self-confidence, feels useless at time, most nights does not go to sleep without thoughts or ideas bothering, memory does not seems to be all right, afraid of losing his mind, has difficulty in starting to do things, most of time, he wish he were dead, seems hopeless, has had very peculiar and strange experiences, peculiar odors come out of pt at times, often feels as if things were not real, often had to take orders from someone who did not know as much as he did, worried about sex, has had blank spells in which his activities were interrupted and pt did not know what was going on around him, enjoyed using marijuana and home life is not pleasant. Self-Rating Scale: 41.

07/18/16 - Psychiatric QME Rpt by Daphna Slonim, MD. DOE: 06/21/16. DOI: 07/11/12. Pt cut through a wall with a saw. A chunk of the wall came down from above and struck him on R wrist and hand. He had an open wound on R thumb. He cleaned it himself and taped it. He was in pain and he left to go home as it was the end of his shift. Pt reported the injury to the owner. He could not sleep because of pain. The next day they gave him a helper to finish the job. On Friday, 07/13/12, Pt drove himself to ER. X-ray was taken and he was told he had a fx on R thumb. They splinted it and taped it. Pt went to see and ortho surgeon who put a cast on it. He then had PT and EMG. It hurt terribly. So he decided to get an attorney and was referred to the office of Dr. Haronian and Dr. Kohan. Dr. Kohan Dx'd RSD because of severe persistent burning pain in R forearm. D Kohan gave him an injection in neck, which did not help. In August 2014 Dr Kohan installed a SCS. Dr. Kohan release pt from under his care in September 2015 and stopped his SDI without even notifying him. Pt saw a psychologist Dr. Hinze. He only received group therapy. He did not receive any individual psychotherapy. He felt it was informative but did not help much. Pt was released by Dr. Hinze around May 2015. Around the same time he saw QME orthopedist Dr. Aval. Pt reported that he was never referred for psychiatric evaluation nor received any psychotropic medications, other than Elavil. Pt reported that when the SCS turns high it takes the burning pain in R forearm from 10/10 to 5-6/10. But he also has a buzz in his knees, ankles, and hips. The stimulator was placed on 8/28/14. Since the work accident, pt has a jerky tremor of LUE and LLE. He was told by one of the PA s at Dr. Kohan s office that could be the side effects of Neurontin. He takes 800 mg 4 times per day and when the dose was cut down, the pain increased.

Dr. Baker, his pain management doctor, also prescribed Elavil 50 mg in evening. Dr. Bao Thai treats him for diabetes. Metformin 100 mg. He also gets Glipizide 5 mg as well as low dose of med for high BP. BP and diabetes has been under control. WC pain TTD check for 2 years. Pt was getting money from State Disability until August 2015. When Dr. Kohan cut him off, he got welfare and food stamps. Pt was then again put on SDI by Dr. Baker. Pt applied for social security in January 2015 and it was denied. Pt lives with his girlfriend of 8 years. She has been supporting him. She has been on social security disability as well as her late husband's social security. Because of financial problems, he had to sell most of his belongings including his truck. He has been living in constant fear that his girlfriend would kick him out. Pt has a burning pain in R forearm up to his elbow, 6/10; with the stimulator, going up to 10/10 when he turns off. Pain in L wrist 9/10; with stimulator 5/10. Pain in anal area constantly 5-10/10. Pain in both knees 5-9/10. C/o HA 7-8/10. Pt is impotent since shortly after the accident. Pt has shaking/twitches in L leg and hand. L side of mouth seems to be paralyzed. Pt has pressure in chest. Sometimes he has it when he takes a shower with rapid heartbeats. Throat is very dry and it makes him feel he is choking. Also has difficulty swallowing because of it. Has abdominal pain with nausea. Has constant ringing in ears. Feels physically weak. Pt is extremely constipated and has to take stool softeners. Current Emotional Complaints: Pt feels sad all the time. He used to cry but now cannot cry even though he wants to. He feels discouraged about the future and feels dissatisfied and bored with everything. Pt feels he is being punished "Maybe my bad karma" he has thoughts about killing himself but would not do it. Pt lost a big part of his self confidence He feels disgusted with himself because he is unable to work and cannot even walk his dog. He blames himself for dropping things. He blames himself for getting injured. He should have had a helper. He feels he looks ugly. Pt cannot shave any longer, and cannot afford a shave. He is bald, not like his father and brothers. Pt had problems making decisions. He does not trust his judgment He lets his girlfriend make all decisions. Pt has no energy and motivation. He feels like a spent nickel. His entire body is sore. He gets tired from doing almost anything. He has to push himself very hard to do anything. He reads the newspapers. He listens to the Dodger games on radio. Pt cannot even tie a fishing hook to go fishing. Pt has no appetite. He does not eat until supper, He has to force himself to eat. He lost all of his interest in sex. He is impotent. Pt has lost most of his interest in other people. He talks with a couple of neighbors. Before the injury, he used to socialize about 6-10 hours per week with friends going out to dinner or going fishing. Pt goes to bed around 1:00 a m. It takes 1-2 hours to fall asleep. He wakes up 1-2 times per night to go to the bathroom. It takes a while to fall asleep again. He wakes up around 7 30 a m. In the last few weeks, he has nightmares, but he does not recall them. He feels very fatigued, but he can no fall asleep with the stimulator being on. Pt feels worried about his physical condition. He worries about finances and about his girlfriend kicking him out. He feels tense restless and nervous and is unable to relax. He feels shaky, irritable and impatient but he keeps it all inside. He does not lose his temper. He feels afraid of traffic and of crowds. He tries to avoid driving the freeways. He gets anxious in a store where there are a lot of people. Pt has problems with his short term, memory. His concentration is not as good as it used to be. Sometimes when he reads, his mind wanders. He then needs to re-read the same thing over again. Personal Hx: Pt was born in Pasadena on 06/04/66. His father died in 1998 at age 77 from a stroke and complication of diabetes. He worked for an insurance group. He was strict and an alcoholic and was not available emotionally. He traveled a lot but was a good provider. His mother died in 2007 at age 81 from strokes and sepsis She was a housewife and a "good mother." Pt is the youngest of

4 siblings. He has 1 sister and 2 brothers. Since 2007 when his mother died, he has not spoken with his sister and brothers as there were issues with the inheritance. His older brother is an alcoholic. Pt lived with the mother for a few years before her death and was her caregiver. But after the mother's death, they immediately sold the house. He received a lot less money from the inheritance than his other siblings. He reported his childhood as normal and difficult, as he was not doing well in school like his siblings. There are no h/o psychiatric problems in the family. Educational Hx: Pt attended St Francis High School until the 11th grade. He did not graduate. He left home at age 17 and went to work. He took different classes related to plumbing. Military Hx: None. Employment Hx: Pt at age 17 worked for a fire sprinkler company, first in manufacturing and then installing. He worker 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 pt moved to Indiana and worked there as a plumber for 3 companies, names unrecalled until November; 1997, when he came back to California after his father had a stroke. He returned to Indiana but work was very slow, and he returned to California to work. While he was there, his wife committed suicide on 12/03/01. Then he worked as a self-employed plumber and took care of his mother, who had a stroke. After his mother's death, pt moved to live in Bishop, California. He worked for Dr. Drain. He was laid off and was on unemployment. In 2009, he re-started working for Benedict & Benedict. LEGAL Hx: None. Marital Hx: Pt was married in 1993. His wife committed suicide in 2001. She was bipolar. They had no children. He then remarried in 2002. She cheated on him, and they divorced in 2003. In the last 8 years, pt has been in a relationship with Mary. She is 58 and a widow She has been on Social Security Disability for a bad knee and depression caused by her husband's death. Medical Hx: Pt was Dx'd with diabetes 10 years ago. It has been controlled with oral med. High BP was Dx'd in March 2015, and he has been on low dose of meds. Otherwise, he has been healthy. Pt reported he has a "growth in his rectum." It started with a well above the anus. It was Dx'd as a fistula. It started in December 2015. He has been on antibiotics for a few months The surgeon wants to do a colonoscopy first. They are waiting for Medi-Cal to Ok it. It has been painful. He needs to sit on semi-solid surface. Previous Industrial Injuries: None. Previous Psychiatric Hx: None. Current Meds: Neurontin 800mg, Elavil, 50 mg; Metformin 1000 mg, Glipizide 5 mg; meds for BP 5mg. Habits: Cigarettes I pack per day for 35 years. Alcohol: A little wine at dinner for the last 8 years, before he used to drink beer and whiskey. Coffee: 1 cup per day. Pt denied the use of street drugs. The Last time he smoked marijuana was 20 year ago. Clinical Impression: In the mental status examination,, pt was seen as a well-developed balding, bearded, well nourished who appeared to be his stated age. He was casually dressed. He wore a brace on R wrist. His LUE and LLE were shaking constantly. L side of mouth seemed paralyzed. Pt had to change position positions and stand up at times. Pt was somewhat tense and ill at ease throughout the interview but was pleasant, cooperative, and talkative. His affect was appropriate to the amount of tension, depression, and worry that he reported. His mood did reflect his depression and stated anxiousness and concern. He was serious throughout the interview. There was nothing to suggest malingering. Pt was correctly oriented for time, place and person. There did not seem to be any defect noted in his remote memory ability. His immediate recall and short term memory were slightly impaired. His general fund of knowledge appeared to be average range and was judged to be appropriate to his age, education

and work experience. His concentration was impaired. He made 3 mistakes on the serial 7s. He was unable to correctly repeat 4 digits backwards. An essay of pt's thought processes did not real any clinical evidence of loose associations and there were no indications of delusions, hallucinations or ideas of reference. His conceptualization ability appeared to be intact, and his capacity to do abstract thinking was felt to be WNL. Pt did not describe, and it was impossible to elicit any evidence of abnormal features in his basic personality. Pt's insight appeared to be fair. Pt's motivation to get his life stabilized from an emotional, physical, vocational viewpoint appeared to be quite good. His general judgment for events in his culture and lifestyle did not appear to be grossly impaired. Psychological Testing: BDI: 41 severe depression. Hamilton Anxiety Rating scale: 33 – Moderate/severe anxiety. Epworth sleepiness scale: 2 (not sleepy). TOMM: 06/44/47 (not malingering). Dx: Axis I: Major depression, single episode, severe. Anxiety disorder, NOS. Psychological factors affecting medical condition. Insomnia due to orthopedic pain. Insomnia due to axis I Dx. R/o pain disorder with both psychological factors and a medical condition. Axis II Personality Disorders and Specific Developmental Disorders: Immature, histronic, and avoidant personality traits. Axis II: Physical Disorders and Conditions: 1) RSD R wrist and hand. 2) Musculoskeletal complaints. 3) Cardiovascular complaints. 4) GI complaints. 5) HA. 6) High BP by hx controlled with meds. 7) Diabetes, Type II-controlled with meds. 8) Neurological problems. Axis IV: Psychosocial and Environmental Problems, Occupational Problems, Problems with Primary Support Group, Economic Problems. Axis V: Current GAF: 55. This is equivalent to 23% WPI. Disability Status: At no time ever was opt TTD purely from a psychiatric point of view. At this time, his condition is regarded as P&S with moderate psychiatric disability. Causation: Industrial causation is preponderant to all other causes combined in the psychiatric disability of pt. Good faith personnel action was not a substantial factor. However, AOE/COE is a legal and not a medical decision, so this examiner would leave it to the Tire-of-fact. Apportionment: 20% is apportioned to pre-existing and non-industrial factors. 20% is a result of financial worries. 60% is apportioned to the industrial injury of 07/11/12. Recommendations: Recommended to refer to proctologist for consult to r/o industrial causation, neurology consult, polysomnogram. Opinion as to Disability Status: On the basis of present psychiatric study, this examiner believes that pt has been vocationally disabled as a result of work-related accident. Pt reports himself suffering from a combination of physical and emotional disabilities. From psychiatric viewpoint, this examiner believes he has suffered emotional, mental, psychological and personality distresses as a direct result of the industrial injury and continued inability to work at his usual/former occupation. The combination of physical and emotional disabilities have caused him to have difficulties in functioning in his everyday world. This examiner believes that his present disabilities are due in part at least to psychological factors and this examiner opines these psychological factors are the result of the claimed accident. This examiner opines that for WC rating purposes pt's psychological status is P&S and is of a moderate degree of impairment. Objective Factors Of Disability: Being socially withdrawn, impaired sleep, indecisiveness, not functioning hobbies and in the household impaired concentration and memory avoiding driving the freeway. Subjective Factors Of Disability: Pain in UE, pain in anal area depression anxiety, worries, tension, nervousness irritability anhedonia, HA, weakness, fatigue, lack of energy, loss of self confidence, lack of motivation, guilt feeing, difficulty swallowing choking feelings, nightmares suicidal ideation, fear of being left alone/traffic/crowds. Work Restrictions: Pt should avoid stresses at work. Vocational Rehab: This is not indicated from a psychiatric point of view.

Work Function Impairment Form: Slight: Ability to comprehend and follow instructions, ability to maintain a work pace appropriate to a given workload, ability to relate to other people beyond giving and receiving instructions. Very Slight: Ability to perform simple and repetitive tasks. Slight/Moderate: Ability to influence. Moderate: Ability to perform complex or varied tasks, ability to make generalizations, evaluations or decisions without immediate supervision and ability to accept and carry out responsibility for direction control and planning. AMA Disability Rating: 1) Disability to perform ADLs: Slight/moderate impairment. 2) Social Function: Slight/Moderate impairment. 3) Concentration, persistence and pace: Slight impairment. 4) Deterioration or decompensation in complex or work like setting: Moderate impairment. Future Psychiatric Care: Pt would benefit from psychotropic medication and should be under psychiatric care once a month for at least 2 years. No more psychotherapy is indicated at this time. More intensive psychological or psychiatric care should be made available in case of deterioration in the future.

08/12/16 - Utilization Review Rpt at Cid Management. Prospective request for 1 replacement of SCS battery a non-rechargeable IPG. Requested to provide results obtained from the SCS including any changes in pain levels, med usage or functional benefits.

08/15/16 - Pain Medicine Re-Eval by Gary L. Baker, MD. Pt c/o neck pain. Pain radiates down the BUE. UE pain. Pain in R wrist, hand, fingers, and thumb and radiates to R forearm. Pain occurs constantly. Pain is burning, electricity, sharp and moderate in severity. Pain is accompanied by muscle weakness, N/T. Intermittent pain in L wrist and hand with N/T. Insomnia. Pain is 7/10 with meds, 10/10 without meds. Pain is reported as recently worsened. Pt reports continuous nausea and constipation as moderate. Pt reports ongoing ADL limitations in self care and hygiene, activity, ambulation, hand function, sleep and sex. Interval Hx: Pt completed a fluoroscopic evaluation of SCS on 03/15/16 and reprogramming of the SCS. Insomnia secondary to pain is worsening. Chief concern, now is difficulty charging the SCS IPG/battery due to malposition of battery and pt has limited use of R hand to position charger to overcome malposition. Report also night-time aggravation of RUE as be is not able to protect the arm adequately as he sleeps. Requests splint to protect R wrist/hand for night-time use only. Discussed will avoid daytime use to avoid atrophy or loss of ROM. Current Meds: Amitriptyline HCl 50 mg, Neurontin 800 mg, Glipizide 10 mg and Metformin 2000 mgs. PE: Pt was noted to be alert, oriented and cooperative. Pt was observed to be in moderate distress. Assessments: Insomnia Severity Index: 23 – Severe clinical insomnia. BDI-II: 45 – Severe depression. Dx: 1) Ongoing Type 2 complex regional pain syndrome, RUE. 2) Peripheral neuropathy. 3) S/p SCS implant. 4) DM, type 2 with hyperglycemia –stable. 5) R thumb non-displaced fx; malposition SCS IPG/battery. Tx: SCS system adjusted with Medtronic rep to optimize pain coverage. System otherwise works well hat having continued problem properly charging the SCS unit. Rx: Elavil 50 mg, Gabapentin 800 mg. Plan: Ordered R wrist/hand splint (long with thumb spica (Exos Peston Model). Pt awaits replacement of SCS battery. TTD for 1 month.

08/17/16 - Utilization Review at Cid Management. Prospective request for 1 replacement of SCS battery a non-rechargeable IPG between 07/18/16 and 02/07/17 is conditionally non-certified.

09/12/16 - Pain Medicine Re-Eval by Gary L. Baker, MD. Pain is 8/10 with meds and 9/10 without meds. Pain is reported as recently worsened. Reports continuous nausea and constipation as moderate. Interval Hx: Pt completed a fluoroscopic evaluation of SCS on 03/15/16 and reprogramming of the SCS. Lead position is normal. Insomnia secondary to pain is worsening. Chief concern now request to replace current SCS IPG/Battery with a non-rechargeable one. He has had ongoing difficulty charging the SCS IPG/Battery due to malposition of the battery and pt has limited use of R hand to position charger to overcome malposition. The SCS IPG/Battery appears to have either moved, or was mal-positioned initially so that it does not lie flush with pt's skin. It is also painful in its current position. The SCS otherwise works well so the leads would not have to be replaced. Report also night-time aggravation of sight UE as he is not able to protect the arm adequately as he sleeps. Requested splint to protect R wrist/hand for night-time use only. Discussed will avoid daytime use to avoid atrophy or loss of ROM. Splint was received and is helpful with sleep but it is 1 size too small. He is in the process of getting it re-done. PE: Pt was noted to be alert, oriented and cooperative. Pt was observed to be in moderate distress. ISI: 23 – severe clinical insomnia. BDI-II: 45 severe depression. Dx: 1) Ongoing Type 2 complex regional pain syndrome, RUE. 2) Peripheral neuropathy. 3) S/p SCS implant. 4) DM, type 2 with hyperglycemia –stable. 5) R thumb non-displaced fx; malposition SCS IPG/battery. Tx: SCS system adjusted with Medtronic rep to optimize pain coverage. System otherwise works well hat having continued problem properly charging the SCS unit. Rx: Elavil 50 mg, Gabapentin 800 mg. Plan: Pt awaits replacement of SCS battery. TTD for 1 month.

12/15/16 - Neurological AME by Mark R. Pulera, MD. DOI: 07/11/12. Employed by Benedict & Benedict Plumbing Company as a journeyman plumber in approximately 2009. He would do primarily residential plumbing, but also some commercial plumbing. He would perform plumbing activities such as remodeling a bathroom. Also worked on-call plumbing jobs, may have six or seven jobs a day. Pt 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. Pt could not recall the details except to note that he apparently had a bruised coccyx. Pt estimated he missed 3 or 4 days with this injury but made 100% recovery. Reports he suffered another injury after he restarted working for the company in approximately 2009, it was in 2010 or so. He was working on a drain that actually had acid in it without his knowledge. Pt cut the acid pipe in a basement, acid splashed in his eye. Pt went to an urgent eye care center through WC insurance. He missed a few days of work but made a 100% recovery. He was initially diagnosed with diabetes in approximately 2006 taking Metformin. On DOI, He made an opening in the wall at a ceiling level. Then, he cut a hole in the bottom of the wall near the floor. Next, he sat down on the floor. As he was sitting down, he heard a crack. He looked upward toward the hole in the wall. The room had a 9-foot ceiling the hole he put near the floor, came loose and started to fall. Pt estimated the piece of wall that struck his arm and head weighed an estimated 150 lbs. He actually tried lifting small pieces of the section of wall to estimate the weight. Pt put R hand above his head to protect head from the falling piece of wall. The piece of wall fell onto R hand but also, to a lesser degree, fell on head. He was sitting down when this happened and had no LOC. There were no witnesses to the actual activity. Noted thumb was split open distally including the thumbnail. It was bleeding. C/o severe pain in whole R hand traveled proximally to wrist a few inches, pain at 12/10. He did not have LOC, was dizzy for a few seconds or minutes. There was a small laceration or abrasion with swelling on scalp. It did not

require sutures. HA rated at 10/10 with a little sore. He stopped working, reported injury to employer, helper provided. Pt self-cleaned and dressed the wound on thumb. On 07/12/12, began working with helper, essentially would only direct the helper and perform little physical work himself because of the limited use of R hand. He would perform some limited work with L hand. On 07/13/12, was examined at Huntington Memorial Hospital, x-ray of R thumb revealed fracture. Applied gauze and provided hard splint and advised to see orthopedist within a week or so. He saw Dr. George Tang applied hard case to R thumb, provided meds. States pain meds helped for a few hours at a time. Pt was placed on TTD by Dr. Tang. For the first few weeks after the injury, R thumb and hand pain remained severe at a 12/10. Pt continued to have severe pain in R thumb, hand, and wrist area. Dr. Tang told the pain was due to the traumatic injury. Pt was advised to wear neoprene cast all the time. At some point, the doctor advised him only to wear the neoprene cast at night or when he was performing activities. Pt has PT, noted some redness in R hand area. Had slight swelling in the dorsal area of the metacarpals of R index fingers. Pt noted apparent shrinking or atrophy of probably both arms since the injury. Noted R hand and proximal wrist area appeared cooler to tough than LUE. He noted physicians also felt R hand was cooler than L hand. Constant burning pain in R hand and wrist area. In addition to burning pain, pt C/o soreness type of pain in all 5 digits of R hand and distal forearm and wrist persists. Pt describes the severity of the soreness type of pain as screaming pain which he attributes to the direct trauma to the distal RUE. The screaming pain would feel like he is being struck with an object repeatedly in R hand and wrist area, struck with a ball, pin hammer repeatedly in R wrist and hand area. Perhaps this pain was initially so severe, it was considered screaming pain immediately after the injury per pt. Gradually over time, the screaming pain appeared to reduce somewhat and turned into more of a soreness type of pain. Currently have both the burning type of pain and the soreness type of pain at this time. He noted when he began receiving physical therapy after the cast came off, he would have increased pain when he came in contact with hot paraffin wax. At some point, the physical therapist actively attempted to flex and extend his R wrist, which caused excruciating pain similar to the levels of the day of the injury. It was actually this active flexion and extension of R wrist by the physical therapist that trigged the new burning pain, which developed after the injury. Pt feels the therapist should not have attempted to actively move R wrist. He told the therapist to stop attempting to move R wrist, but she continued to do so. This caused pt's frustration. He essentially became frustrated and anxious and depressed over his persistent symptoms from the injury. Pt was evaluated by Dr. Haronian, he referred to Dr. Kohan pain specialist. Dr. Kohan offered Morphine pump or a spinal cord stimulator. Pt has h/o alcohol, decided he would go with the spinal cord stimulator treatment. Dr. Kohan first implanted a temporary spinal cord stimulator in 05/2014, helped with pain. Notes that temporary spinal cord stimulator would cause a buzzing sensation in both arms, which appeared to lessen his sensation of pain. Therefore, pt agreed to have permanent implantation of the spinal cord stimulator on 08/28/14, states feels like electrocuted. Notes the permanent spinal cord stimulator was implanted between his shoulder blades and a battery pack was implanted in lower back area. Notes his physician uses Medtronic Spinal Cord Stimulator, typically use for pain in spine, but not pain in arms. Reports 10/10 pain before spinal cord stimulator and over the last 6 months or so, with the spinal cord stimulator, typical pain levels are 5/10. He was on Gabapentin, helped little with pain. Apparently, there were issues with getting Gabapentin authorized, helped with pain at 7 or 8/10 and 10/10 pain without meds. States he resumed Gabapentin before spinal cord stimulator was implanted. Pt is currently taking Elavil

along with Gabapentin, appears to help pain to some degree. States receiving payments from EDD, but these stopped on 09/01/15. States EDD stopped making payments on that date due to information provided in Dr. Kohan's notes. In approximately 02/2015, Dr. Baker adjusted spinal cord stimulator and continued spinal cord stimulator. X-rays showed the stimulator was in adequate position. However, the surface of the battery implanted in the dorsal L/S area was not flush with the skin which made it difficult to charge. Dr. Baker continued the Gabapentin as well. Notes Dr. Baker wants to implant a new permanent battery pack that would last 3 or 4 years. So it would not have to be charged every 2 weeks like the current battery pack. The current battery pack is difficult to charge because its surface is not flush with the skin. C/o HA at 10/10 as a result of the section of wall striking him in the head. Pt did note that as a plumber he has probably suffered multiple mild closed head injuries due to his job duties such as banging his head into objects attempting to move around in closed areas. He never sought medical treatment or reported any prior closed head injuries to his employer. Before the injury on 07/11/12, pt did have some HAs, which he attributed to sinus problems. He would take OTC medication sometimes for HAs, but could not recall details. Before this injury, he could not estimate how frequent or severe that he would get HAs. Indicates since the injury he has increased HAs, he now may get one HA every one or two weeks, rated as 7.5/10. Typically, HA would be in the back of the head and in B/L temple areas with a squeezing sensation. Pt feels these HAs are due to sinus difficulty. He may take Tylenol approximately once a month or so for HAs. It is difficult for him to assess whether or not the HA will impair his activity. Because of hand injury, he generally does not engage in substantial activities since the injury. Therefore, he cannot assess whether or not HAs impaired his activities. Pt could not say yes or no whether or not he felt emotional stress increased HA. Also has new c/o impaired memory since approximately 2014. Since that time, he has been taking medication such as Neurontin or Elavil which could affect the memory. However, pt is unsure of the timing of his medication use compared to the timing of his memory problems. Pt does note the onset of involuntary movements at least with his LUE. He notes that his girlfriend Mary notices involuntary movements. Pt was not sure of the time of onset of these involuntary movements. He is unsure if these involuntary movements started before or after implantation of the spinal cord stimulator. He does note that it appears these involuntary movements are worse with the spinal cord stimulator. Pt is unsure if these involuntary movements are related to his employment as a plumber. Pt has reported these involuntary movements to his private physician, Dr. Bo Bahthoi. He states that Dr. Bahthoi treats him for diabetes, but feels these involuntary movements are work related. Therefore, she will not address a work-related condition. Does note hoarseness or perhaps softening of the voice over at least the last few months. He does note some level of frustration, anxiety, and/or depression as a result of this injury. He has seen a mental health provider through this injury. Apparently either the mental health provider or another provider has prescribed Elavil for the diagnosis of pain at 50 mg a day. Pt feels the Elavil may be helping his psychological state. After the injury, he has had emotional outbursts which appeared improved on Elavil. C/o sleep difficulty after the injury. He actually feels the sleep difficulty began after the implantation of the spinal cord stimulatory on approximately 08/28/14. The stimulator causes essentially the constant buzzing which may mask a drowsy feeling. Pt states he essentially takes no more naps since the spinal cord stimulator was implanted. Rarely snore, but is unsure when snoring started in his life. Pt note he has 10-15 lbs weight gain since the day of the injury. Notes mild gait instability since at least the time that the spinal cord stimulator was implanted on 08/28/14. Current symptoms:

Emotional dysfunction such as frustration, anxiety, or depression. Sleep complaints. HA. Two types of pain in R thumb, hand, wrist, and proximal forearm. New onset abnormal involuntary movements of unknown etiology with c/o decreased speech volume. Memory complaints. A buzzing sensation in the body after spinal cord stimulator implantation. Mild unsteady gait. Reports difficulty performing ADLs. He does have memory and sleep related complaints, in particular after the spinal cord stimulator was implanted. Current Meds: Gabapentin, Elavil, BP meds, Metformin, Glipizide, allergy meds and taking no NSAIDs currently for pain. Social Hx: Smoking tobacco for 35 years at approximately 1 ppd. Stopped alcohol 8 years ago. Denied illicit drug use. PE: Well-developed, well-nourished. MSE: appeared to have some degree of underlying frustration, anxiety, and/or depression regarding his injury. His Mini Mental Status Examination Score was 26/28. Alert and oriented. Speech appeared mildly hypophonic and c/o softer voice for at least the last few months. Dx: 1) Traumatic injury to the distal RUE on 07/11/12, industrial. 2) Chronic Regional Pain Syndrome Type I/Reflex Sympathetic Dystrophy of RUE, industrial. 3) Potential movement disorder caused by the spinal cord stimulator implantation, industrial. 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 07/11/12 without permanent neurologic impairment for headache or impaired memory. 8) No definite right or L "evidence of carpal tunnel syndrome" due to the injury on 07/11/12. Causation: Industrial injury of 07/11/12. Impairment Rating: Sleep impairment: 5% WPI. Neurologic impairment: 0% WPI. RUE impairment: 53% WPI. 1% impairment due to impaired eye blinking and masked facies secondary to Parkinson's disease. 2% impairment for hypophonia due to Parkinson's disease. BLE due to Parkinson's disease: 5% WPI. Total neurologic impairment due to Parkinson's disease: 9%. Headaches: 0%. 60% total neurological impairment on an industrial basis. There is 9% nonindustrial impairment due to mild underlying Parkinson's disease. Disability Status: Pt would be considered TTD neurologically from DOI: 07/11/12 to 11/17/16. Pt is neurologically P&S. Only occasional simple grasping and coarse manipulation should be allowed, but not forceful gripping fine manipulation, torqueing heavy activity with RUE. 2016. In the absence of further manipulation of spinal cord stimulator, the intermittent persistent involuntary movements involving the whole body would result in the following permanent partial disability; no walking on uneven ground, crouching or kneeling, crawling or climbing. Regarding sleep disorder, 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 11/17/16, restrictions and limitations for sleep would now be permanent partial disability. If the neurological restrictions and limitations cannot be honored then pt be QIW, who could not return to his usual and customary occupation as a plumber. Apportionment: 0% pre/post-injury non-industrial apportionment and there is a total of 0% nonindustrial apportionment for the CRPS/RSD impairment/disability. There is 100% industrial apportionment for RUE CRPS/RSD impairment/disability due to the industrial injury of 07/11/12. The closed head injury would add 100% industrial apportionment during the work exposure on 07/12/12 and 0% non-industrial apportionment. There is 0% nonindustrial apportionment for the impairment/disability related to the involuntary movements caused by the spinal cord stimulator. There is 100% industrial apportionment for the impairment/disability due to the abnormal movements and aberrant sensations caused by the spinal cord stimulator. There would be 100% nonindustrial preexisting factors of apportionment and 0% post-injury factors of apportionment.

There is 100% nonindustrial apportionment for the impairment/disability related to Parkinson's disease. There is 0% industrial apportionment for the impairment/disability due to Parkinson's disease related to the work exposure on 07/11/12. Regarding apportionment for sleep disorder, pre-existing, non-industrial factors of apportionment include nonindustrial pain, unknown factors and genetic causes of OSA, awarded 25% pre-existing nonindustrial apportionment for the sleep related impairment/disability. There is 0% post-injury nonindustrial apportionment for the sleep impairment/disability. There is 25% total nonindustrial apportionment for the sleep related impairment/disability. Awarded 35% industrial apportionment for the pain associated with the CRPS/RSD of the right upper extremity in case Pena vs. Alvarado Hospital is relevant, and 40% to apportionment to other industrial factors. Awarded 75% industrial apportionment for the sleep related impairment/disability. Future Medical Care: This examiner defers issues of orthopedic future medical care to the ortho QME Dr. Soheil Aval. Regarding RUE CRPS/RSD, lifelong treatment is indicated. Lifelong access to a neurologist should be provided depending on future symptomatology, which was somewhat unpredictable as well as the specific wishes of pt. Visits to a neurologist may occur up to monthly, once a month or so. Recommend f/u with a physician experienced in the management of spinal cord stimulators. Any complications should be ruled out definitively. Certainly, if the spinal cord stimulator physician recommends replacing or revising any component of the spinal cord stimulator and/or battery, this should be allowed. MRI of brain without contrast should be performed to rule out traumatic brain injury. This examiner would anticipate the brain MRI scan would be negative. Once the brain MRI scan would be negative, this would confirm that there would be no future medical care indicated for the closed head injury including for complaints of headache or impaired memory. Regarding sleep, lifelong access to physician knowledgeable on sleep disorders should be allowed. Again if the parties desire a polysomnogram and multiple sleep latency tests, it should be performed. These tests could help rule out OSA, which could be potentially treated with CPAP. CPAP and related durable medical equipment should be provided for if indicated as diagnosed by the sleep specialist physician. Mild underlying Parkinson's disease should be addressed by neurologist on a nonindustrial basis. Recommended spinal cord stimulator be turned off for three months or so if possible in order to assess any remaining aberrant sensory complaints and/or involuntary movements. Prior to any neurological reevaluation, this examiner recommended repeating the BUE electromyogram and nerve conduction studies by a competent electromyographer. Prior to any re-eval, eliminate meds such as Gabapentin, could be contributing to movement disorder for 3 months or so.

12/15/16 - Internal Medicine AME Rpt by James F. Lineback, MD DOI: 07/11/12. Pt is currently widowed and has no children. He does not drink alcohol, though does smoke on a regular basis. Pt was initially noted to have an elevated blood sugar in 2005. Eventually, a dx of diabetes was made and he was subsequently started on oral hypoglycemic therapy. He remains on 2 diabetes meds to this day. Pt was hired in 2009 by Benedict & Benedict Plumbing Company in Pasadena. As a plumber, he was responsible for unclogging and changing pipes. He would work underneath sinks or in crawl spaces of homes or in attics, Occasionally, he would install water heaters. Pt would lift water heaters that occasionally weighed greater than 100 lbs. He worked 8 hours a day, 5-7 days a week between 2009 and the time of his injury in 2012. Pt was working in Pasadena on 07/11/12 using a reciprocating saw to open the floor in order to make plumbing connections. As he was doing so, the plaster that was above him apparently gave way, causing a large section to

fall. Pt elevated his R hand to protect himself from the wall that apparently fell on top of him. He noted the immediate onset of pain in R hand and wrist, though did not lose consciousness. Pt states that he called the company and told them to bring another worker. Pt continued to experience pain, though eventually resumed his regular duties, mostly supervisory work. On 07/13/12 pt's pain was apparently so great that he presented to Huntington Memorial Hospital in Pasadena. He was evaluated and x-rays were taken before his hand was placed in a soft cast. He was also treated with pain meds. Pt was treated with a narcotic analgesic, Norco, and developed chronic constipation in 2014. He continued to require narcotic analgesics for pain control, causing the constipation to persist. Eventually, he developed an anal fistula in 2016 that continues to cause recurrent rectal pain. In November of 2015, pt was noted to have an elevated BP while experiencing severe hand pain. He was started on a single antihypertensive agent at that time and subsequently developed ED. His HTN is currently under good control on a single antihypertensive agent at this time. Pt subsequently developed difficulty sleeping due to insomnia. He currently sleeps 4 hours per night and awakens several times during the night due to pain. He states that sleep latency is generally exceeding 1 hour. He also states the following day he is tired, though he does not sleep during the day. At this time, pt's primary complaint remains his R hand pain. He also continues to experience intermittent constipation and ED. He has also developed a resting tremor in LUE. The working Dx for R hand has been complex regional pain syndrome versus reflex sympathetic dystrophy. Pt had a SCS implanted in August 2014, which partially improved his symptoms. Current Medications: Metformin, Glipizide, Lisinopril, Gabapentin, Elavil. SH: Pt is widowed and has no children. Does not drink alcohol though smokes one-half to one pack of cigarettes per day. Completed high school education and some college courses. FH: Pt's mother died of an infection in her 80s. His father died of a stroke in his 70s. There is a family h/o HTN (both parents). Previous Surgeries: SCS implantation. Allergies: None. Dx: 1) Sleep disorder (insomnia). 2) Chronic constipation. 3) Adult onset DM. 4) HTN. 5) Resting tremor. 6) SOB. 7) Anal fistula. 8) R hand pain. 9) Reflex sympathetic dystrophy. 10) S/p SCS implantation. 11) S/p crush injury, R hand. 12) Complex regional pain syndrome. 13) Positive family h/o HTN. 14) ED. P&S Status: P&S. Restrictions: Pt fits the criteria for Class 1 (3%) impairment of the whole person as per the AMA Guidelines pertaining to sleep disorders. He also fits the criteria for Class 1 (5%) impairment of the whole person as per the AMA Guidelines pertaining to HTN. He now fits the criteria for Class 1 (7%) impairment of the whole person as per the AMA Guidelines pertaining to his anal fistula and constipation. Apportionment: 100% of pt's disability with respect to his sleep disorder should be apportioned to industrial factors. There is no evidence of any nonindustrial factors playing a role in his insomnia. As stated previously, both of pt's parents have a h/o HTN. Therefore, 25% of his disability with respect to HTN should be apportioned to his nonindustrial family hx. The remaining 75% of his disability with respect to his HTN should be apportioned to industrial factors. There is no evidence that pt had any nonindustrial risk factors for anal fistula or constipation. Therefore, 100% of his disability with respect to his anal fistula and his constipation should be apportioned to industrial factors. Work Accommodations/Voucher: This issue would obviously be best addressed by an orthopedist since pt's R hand remains his primary complaint. Future Medical Care: As stated previously, pt's diabetes represents a pre-existing condition and should be treated on a nonindustrial basis. This examiner would also recommend pt be referred to an urologist for further workup of his ED. In addition, this examiner is recommending pt be referred to a neurologist for evaluation of LUE resting tremor to r/o Parkinson's disease. Since it is unclear as

to the etiology of that symptom, that evaluation should be provided on an industrial basis. Pt's sleep disorder will require tx, preferably by either a sleep specialist or a general internist. That tx should be provided on an industrial basis. Similarly, pt should be provided with access to tx by a general internist for tx of his industrially related HTN. Any and all meds for HTN, as well as any further diagnostic testing should be provided on an industrial basis. As stated previously, pt's SOB is most likely related to his nonindustrial smoking habit. Therefore, any further diagnostic testing or tx for his respiratory complaints should proceed on a nonindustrial basis. Pt should be provided with access to tx by a general internist for tx of his constipation and should also be evaluated by a colon-rectal surgeon for his anal fistula. Since it is medically probable that his constipation and his anal fistula is related to his industrial injury, tx for both of those problems should proceed on an industrial basis. If, indeed, pt's anal fistula requires surgical tx, that tx should be provided on an industrial basis. This examiner is recommending pt's constipation be treated with Metoclopramide, as well as a stool softener, such as Metamucil.

07/10/17 - Vocational Eval Rpt by Laura M. Wilson, MBA at Laura M. Wilson & Associates. Pt was employed as a plumber at the time of his industrial injury. During this period, pt 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 Vocatioi'141 Background: Pt was born in Pasadena, California. Pt currently resides in San Dimas. California. Pt graduated from Citrus College taking plumbing courses in 1980. At the time of his industrial injury pt was employed with Benedict and Benedict Plumbing as a plumber for 4 years earning $25.00 per hour. Prior to his employment with Benedict and Benedict Plumbing, pt was employed with Dr. Drain in the city of Mamoth Lakes as a Plumber for 1 ¼ years. Prior to his employment with Dr. Drain, pt was self-employed with Double D Plumbing for 8 years. Prior to his employment with Double D Plumbing, pt was employed as a Pipe Fitter at the age of 17. Since his industrial injury pt has not been employed. On 03/17/17, pt was deemed unemployable by the United States Federal Government and awarded Social Security benefits. Pt is receiving $1,040.00 per month. Medication: Amitriptyline HCL 50 mg, Metformin 1000 mg, Montelukast 10 mg, Gabapentin 800 mg, Lisinopril 10 mg and Glipizide 5 mg. Occupations that were analyzed using McCroskey and Volcano 16.0 Software: Analysis of pt's employment hx demonstrates that pt has the occupationally performed in skilled work of medium physical requirement. The exertional level of job reflects the estimated overall strength weight requirements of a job. Pt's physical demands of his employment require that be able to perform medium is defined by United States Department of Labor as work that requires lifting a maximum 50 lbs occasionally with frequent lifting or carrying object weighing lbs. Transferable Skills Analysis: Pt has very few if any transferable skills. In assessing both pt's physical work limitations and transferable skills, McCroskey Volcano 16.0 software did not identify any occupations that are physically and emotionally appropriate for pt within the open labor market within the Los Angeles geographical area in which pt had any of the transferable skills required for employment within the labor market for him. Injuries Disabilities and Special Problem Considered: Lower back, carpal tunnel, mental, cardiovascular, and chronic pain were check off to reflect pt's industrial related disabilities that are being considered. Work Context Elements and Temperaments Considered Physical and Environmental Work Context Elements: Sifting reduced to 2, standing reduced to 2, walking/running reduced to 2, make repetitive motions reduced to2, 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 need to 0.9, under instruction reduced to 1, people dealing with reduced to 1 and judgments, making reduced to 1. Critical Workers Traits and Temperaments Considered: Strength, lift/carry/push/pull/reach handle feel, repetitive or short cycle work. In pt's, his past employment as a Plumber is a skilled type of work. Consequently, in occupational terms, he does not appear to have been impacted by education, since pt graduated from Citrus College, thus, there is no reason to assume that he would be affected by them in the future. Therefore, pt's industrial related injury and subsequent work limitations are the only and direct cause of his non-amenability to vocational rehabilitation. Apportionment: QME Dr. Soheil M. Aval apportioned 100% of pt's impairment is due to the injury to 07/11/12. Dr. Aval does not see evidence of other contributing factors to his impairment. QME Dr. James F. Lineback indicated 100% of pt's disability with respect to his sleep disorder should be apportioned to industrial factors. There is no evidence of any nonindustrial factors playing a role in his insomnia. According to Dr Lineback both of pt's parents have a h/o HTN. Therefore, per Dr. Lineback 25% of his disability with respect to his hypertension should be apportioned to his nonindustrial family hx, and the remaining 75% of his disability with respect to HTN should be apportioned to industrial factors. Dr. Lineback indicated there is no evidence that pt had any nonindustrial risk factors for anal fistula or constipation. Dr. Lineback commented 100% of pt's disability with respect to his anal fistula and his constipation should be apportioned to industrial factors. QME in Psychology Dr. Daphna Slonim commented 20% is apportioned to pre-existing and non- industrial factors, 20% is a result of financial worries, and 60% is apportioned to the industrial injury of 07/11/12. In this examiner's analysis. This examiner has considered any apportionment raised by AME Dr. James F. Lineback, QME Soheil M. Aval and QME Dr. Daphna Slonim, without consideration of whether it is valid under the law (i.e. as explained in Escobedo) or not. With regard to apportionment, this examiner has considered the opinions of AME Dr. James F. Lineback, QME Soheil M. Aval, and QME Dr. Daphna Slonini and the impairments and the physical and emotional mental industrial functional losses directly caused by the industrial injury that they have discussed. If that non-industrial apportionment is found to be legally valid, then in this examiner's opinion pt has a 100% permanent disability as a direct result of the industrial injury. Conclusion: It is with the above understanding that this report is written to determine the effects of the industrial related impairments on pt and his amenability to vocational rehabilitation, therefore, sustain gainful employment and compete within the Open Labor Market. This examiner was asked as a vocational expert to determine if pt is able to RTW in the current labor market. After careful review and consideration of pt's physical and emotional work limitations, dosage of medications that he is currently taking and its side effects, and his transferable skills, determined by McCroskey and Volcano 16.0 it is my professional opinion that based on his industrial related impairment and his industrial physical limitations that were provided in the medical reports of AME Dr. James F, Lineback, QME Soheil M. Aval, and QME Dr. Daphna Slonim, pt is not amenable to vocational rehabilitation and is not able to sustain gainful employment and therefore, is 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 has at present no consistent and stable future earning capacity.

09/11/17 - Benefits Paid Report.

12/04/17 - Revised Vocational Eval by Alejandro A. Calderon, MA. Vocationally Relevant Employment Background: 2009 – 2012: Employer: Benedict & Benedict: Position: Plumber (Residential/Commercial). Wages: $25.00 per hour Duties: Pt worked as a plumber doing commercial or residential plumbing duties. 2002 – 2009: Employer: Dr. Drain, Mammoth Lakes, CA. Position: Plumber. Duties: Pt worked as a plumber doing commercial or residential plumbing duties. Prior to 2002, pt was self-employed. He had his plumbing company of Double D Plumbing. In the 1990's, he worked as a Plumber in Alabama. He also worked as a Pipefitter with Security Protection back In the 1980's. No other work was reported. Pt indicated the following physical tolerance limitations: Reported difficult ability to stand, walk and sit due to his hip problem, difficult ability to drive due to his hip problem, ability to lift and carry up to 10 lbs with RUE. No restriction with the LEU. Reported ability to push and pull up to 10 lbs with RUE right. No restriction with the LUE other than difficulties resulting from Parkinson's Disease. Reported limited ability to bend and kneel. Reported inability to squat/crouch. Reported limited ability to twist/pivot. Reported very limited to reach above shoulder level. Reported ability to reach at shoulder level. Reported limited ability to reach below shoulder level. Reported some burning type pain when handling or feeling repetitively with right upper extremity. Reported some difficulty with fine dexterity with the RUE. No restriction with the left upper extremity. Reported some difficulties with pain in his hip. Reported some difficulties with climbing stairs/steps. Reported inability to climb ladders or balance. Reported noticeable limp. Reported increase in pain with cold. Reported vision restriction. Pt experiences tremors and reported that he was Dx'd with Parkinson's disease in November of 2016. Employability: Pt is medically precluded from returning to his Usual & Customary Occupation as a Plumber. Discussion/Opinion: In reference to the opinions outlined in the Le Boeuf Analysis by Laura Wilson, MBA dated 07/10/17; this examiner respectfully disagrees with pt's vocational experts opinion that pt may no longer have the ability to RTW in the open labor market when only considering his industrial injuries and residual medical work restrictions while excluding the non-industrial medical conditions documented in the medical file (i.e. Non-industrial Parkinson's Disease, non-industrial Diabetes II, and the 25 % of apportioned sleep disorder to non-industrial factors) as well as Mr. Duran's non-industrial and/or impermissible factors such as limited education (11th grade) and training (limited to Plumbing training). However, when considering only pt's industrially related orthopedic, neurological, and psychiatric conditions and above noted work restrictions and while excluding the non-industrial and/or impermissible factors as outlined above, it is concluded that pt is not precluded from all work and/or from being able to participate in vocational rehabilitation in the form of vocational training and/or employment services. Concluding Opinion And Amenability For Vocational Services: An extensive analysis was completed of pt's employability as it relates to transferable skills, industrially related impairments and restrictions, and the effect that these have on his ability to work, including an analysis under LeBoeuf v. Workers' Comp Appeals Board, with the following findings: Based on the reports of his doctors, pt retains an ability to RTW in the open labor market in 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 Dx'd Parkinson's Disease, and Diabetes II. Absent the medically indicated non-industrial medical conditions as documented in the medical file, pt retains an ability to compete, or be retrained for suitable gainful employment.

NOTE: Remainder of the record includes other patient records.

NP/rpc/sr
03/17/2021

State of California
DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT

AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

Case Name: Doran, Daniel v Benedict & Benedict Plumbing
(employee name) *(claims administrator name, or if none employer)*

Claim No.: SIF8760713 **EAMS or WCAB Case No. (if any):** ADJ8760713

I, RAYLENE TENORIO, declare:
(Print Name)

1. I am over the age of 18 and not a party to this action.
2. My business address is: 1680 PLUM LANE, REDLANDS CA 92374
3. On the date shown below, I served the attached original, or a true and correct copy of the original, comprehensive medical-legal report on each person or firm named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.

B placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.

C placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.

D placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*

E personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: *(For each addressee, enter A – E as appropriate)*	Date Served:	Addressee and Address Shown on Envelope:
A	06/25/21	Subsequent Injures Benefit Trust Fund- SENT ELECTRONICALLY
A	06/25/21	Workers Defenders Law Group 8018 E. Santa Ana Canyon, Ste. 100-215 Anaheim Hills, CA 92808

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: 06/25/2021

Raylene Tenorio RAYLENE TENORIO
(signature of declarant) *(print name)*

QME Form 122
Rev. February 2009