Babak Kamkar, OD

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April 27, 2021

Subsequent Injuries Benefits Trust Fund
SIBTF Sacramento
1750 Howe Avenue, Suite 370
Sacramento, CA 95825-3367

Natalia Foley, Esq.
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8018 E Santa Ana Canyon, Suite 100-215
Anaheim Hills, CA 92808

RE:	**DORAN, DANIEL**
Social Security:	XXX-XX-1885
DOB:	06/04/1966
Date of Injury:	07/11/2012
SIF Claim #:	SIF8760713
WCAB Case No.:	ADJ8760713

COMPREHENSIVE MEDICAL-LEGAL EVALUATION SUBSEQUENT INJURY BENEFITS TRUST FUND

To Whom It May Concern:

As requested, Mr. Daniel Doran, was evaluated at my Glendale office located at 1104 East Colorado Street in Glendale, California 91205, for a Subsequent Injuries Benefits Trust Fund Ophthalmological Evaluation on April 27, 2021.

I have received a cover letter dated February 18, 2021 from Natalia Foley, Esq., requesting a medical-legal report regarding the Ophthalmic aspects of Mr. Doran's case. The letter requests a report covering causation of complaints, apportionment, permanent disability, labor disablement, and any additive factors to the industrial injuries with the ending date: 07/11/2012 related to my specialty.

I had the opportunity to perform an evaluation for Mr. Daniel Doran in my Glendale office on April 27, 2021. The appointment began at 10:15 a.m. and concluded at 12:45 p.m. Diagnostic tests performed in my office included retinal photography and visual fields. Arrowhead Evaluation

Services, located in Redlands, CA, helped facilitate this evaluation. This report will focus on the ocular and visual condition of the examinee.

Per the Official Medical-Legal Fee Schedule effective April 1, 2021, this evaluation qualifies for billing as ML-201, Comprehensive Medical Legal Evaluation.

Moreover, the evaluation qualifies for medical record review, MLPRR, a total of 1,631 pages of medical records were reviewed. The evaluation included a detailed history taking 50 minutes in time, involving multiple body parts, comprehensive dilated eye examination including evaluation of visual fields, panoramic fundus photography, extensive medical records review, and the preparation and editing of the report. Causation and apportionment are discussed. I Babak Kamkar, OD, QME, verify under penalty of perjury, that I personally reviewed 1,631 pages of records received from the parties involved in this matter.

The appointment began with the explanation that the purpose of the visit was solely to evaluate and report on his case. He understood this purpose and had no questions. The following report contains my professional opinion and conclusions concerning this case.

PRE-EXISTING DISABILITY AND INDUSTRIAL DISABILITY

Mr. Doran reported memory problems. He stated that he can recall information from the past easier, than from the past 3-4 years.

Mr. Doran's current ocular complaints included 1) ocular pain, 2) reduced vision, 3) light sensitivity and glare.

1) Mr. Doran complains of sharp pain in his eyes associated with temporal headaches that usually start early in the morning when he wakes up. He also reported eye irritation, itching, and feeling of sand in his eyes, which frequently cause blurry vision. He recalled having eye irritations prior to his industrial injury, specifically after Liquid Drano was accidentally splashed into his eyes in about 2011.

2) He reported experiencing intermittent blurry vision as well as double vision associated with high level of blood sugar since 2005. He said that if his glucose level were not high, then his visual symptoms would be less severe. He has been using over-the-counter reading glasses. He reported, however, the glasses were not always helpful.

3) Mr. Doran reported sun sensitivity, as well as glare at night that started in the last few years. He has difficulty driving around sunset and sunrise.

He stated that his first glasses were prescribed in 1990's for driving. His last glasses, that were prescribed in 2020, were broken in December 2020, and he has been using over-the-counter reading glasses since that time.

HISTORY OF INJURY

Mr. Doran was employed at Benedict and Benedict Plumbing, as a construction worker and plumber. On July 11, 2012, in the afternoon, while working in an old building, he was cutting in the ceiling, and a piece of heavy portion of the ceiling wall fell on him. He covered his head with his hands trying to protect his head and face. He felt a pop and pain in his right hand. His right wrist, thumb, and fingers were injured. He stated that he might have been unconscious for some time, but he was not certain. His head and hands were in blood. He cleaned himself and continued to work but went home early that day.

He reported the accident to the realtor that day but was not referred for help. He returned to work the next day, but had difficulty performing his job due to the wrist pain and was provided an assistant to help him. His wrist pain persisted, and he had difficulty performing his duties. He went to the Huntington Memorial Hospital in Pasadena 2 days after the accident. In the hospital he was examined, an x-ray was performed, and he was diagnosed with right hand trauma with non-displaced fracture of the right thumb with possible first metacarpal fracture. A cast was applied. He was in the cast for about 6 weeks. He was referred to an orthopedic surgeon, but surgery was not done.

Reportedly, he started experiencing pain in his left hand which, he believes, is due to overusing it. An MRI was done, and he was diagnosed with right hand median chronic pain syndrome, and left-hand strain secondary to overcompensation. He underwent multiple physical therapy sessions but continued experiencing pain in his right hand. Reportedly, a spinal cord stimulator was permanently implanted in 2014 due to the constant pain, but he continued experiencing pain in his right hand which radiated to his right forearm, accompanied with burning sensation and tingling on his right hand, forearm, and wrist.

He developed stress, anxiety, and depression due to the constant pain, and inability to work. He believed that he developed Parkinson disease and shaking in his extremities because of that accident.

HISTORY OF OTHER INJURIES

He stated that while working for Benedict and Benedict Plumbing, a piece of metal went into his eye. He went to the doctor who removed it. He did not recall which eye was injured or the date of that injury, but it was probably in the 1980s.

He reported that while working in construction, Liquid Drano accidentally splashed to his shoulder and eyes. He said that the incident happened probably in 2011. He said that he washed his eyes with water and went to urgent care. He was prescribed eye ointment and other eye medications. His left eye was covered by a patch for a few days. Despite receiving medical care, he was still not able to see well with his left eye for at least a week. He recalls he was experiencing eye pain for a long time after the accident.

Mr. Doran reported 2 cutting accidents with his hand. One of them was in 1980's while working for himself, and the other one was probably in 1990's while working for the other construction company.

He did not report any car accident other than in March 2020. He stated that he was the driver, and he did not notice the other car because of rain, and accidentally hit the other car. He did not receive any injuries at that time.

JOB HISTORY AND DESCRIPTION

Mr. Doran had difficulty remembering some events of his life.

He reported that he has not worked since July 12, 2012.

From 2008 to 2012 he worked for Benedict and Benedict Plumbing as a construction worker and plumber.

From 1990 to 2008 he moved to different states including Nevada, Indiana, and other states and worked in construction and plumbing companies as a construction worker and plumber.

From about 1980 to 1990, he worked for Benedict and Benedict as a worker.

Prior to that he worked for Fire Sprinkler as a worker.

MEDICAL HISTORY

Mr. Doran reported history of Parkinson's disease since about 2011. He stated that he is experiencing tremors and memory problems for the past 5-6 years.

He reported history of diabetes since 2005. He started using insulin since October 2019, when he was admitted to the hospital with diabetic coma that lasted for 5 days. He stayed in the hospital for one month. He reported that the last time he was checked for a complete blood test, his Hb A1c was 14. He reported his fasting glucose level was 288 the day before this evaluation, and on average it is about 230. He said it never drops below 150.

He reported stress, anxiety, and depression, due to the continuing pain and inability to work.

He reported double mastectomy due to breast cancer in 2005.

FAMILY HISTORY

He reported family history of cataract in his father. He also reported history of arthritis, cancer, diabetes, and high blood pressure in both of his parents.

SOCIAL HISTORY

Mr. Doran is widowed for the past 5 years. He has one child from a prior marriage, and 2 stepchildren.

He smokes 1 pack of cigarettes per day for the past 40 years. He uses alcohol socially but denies use of recreational drugs.

He is currently homeless, and has difficulty receiving medical care. He is bothered by inability to receive and keep his insulin.

RECORD REVIEW

Please see the section at the end of this report.

PRESENT MEDICATIONS

Mr. Doran reported taking the following medications:

Insulin for diabetes
Neurontin for nerve damage
Singulair for asthma
Lisinopril for hypertension

ALLERGIES

Mr. Doran did not report any allergies to medications.

PHYSICAL EXAMINATION

Examination revealed a 6-foot-tall white male, who appeared his stated age of 54.

Uncorrected Vision Far (20 feet):

Rt Eye	20/40
Lt. Eye	20/40
Both eyes	20/30

Uncorrected Vision Near (16 inches):

Rt Eye	RS 160
Lt Eye	RS 160
Both eyes	RS 100

Corrected vision: Mr. Doran had brought in a pair of OTC glasses for reading with the power +2.75.

Visual acuity with these glasses at near (16 inches):

Rt Eye	RS 30
Lt Eye	RS 30
Both eyes	RS 30

Cover-uncover test showed no tropia.

Extraocular muscles were smooth and unrestricted.

Confrontation fields were full in all directions.

Near point of convergence was 15 cm.

Refractive findings were as follows:

OD	+0.50 -0.50 x 110	20/30
OS	+1.25 -1.25 x 085	20/25
OU	20/20	

Near add +2.00 OU

External exam: There was dermatochalasis in both eyes, more pronounced in the right eye. The upper eyelid margin in the right eye bifurcated the pupil in primary position. The tear breakup time was reduced to about 10 seconds in each eye. He was experiencing halos when examining his eyes with light.

By slit lamp biomicroscopy, conjunctiva was clear in both eyes. The cornea showed 1+ inferior superficial punctate keratitis in both eyes. The irides were flat and green color in both eyes. The crystalline lens showed peripheral cortical spokes cataract in both eyes. The anterior chamber was deep and quiet in both eyes. The angles were open in both eyes.

Pupils in both eyes were 5 mm in dim lighting and 3 mm in bright lighting with brisk direct and consensual reflexes. Using the APD Tester™ device, there was no afferent pupillary defect.

Intraocular pressures (IOP) were measured by Goldmann Applanation Tonometry. Right eye measured as 21 mmHg and the left eye measured as 25 mmHg at 12:25 p.m.

The patient was dilated with standard dilating drops of 1% tropicamide and 2.5% phenylephrine in both eyes. Fundus exam was performed through dilated pupils.

The vitreous humor was clear in both eyes.

There was 2+ tortuous retinal vasculature with A/V crossing defects in both eyes. There were no retinal hemorrhages, exudates, or cotton-wool spots in either eye.

The macula of both eyes appeared homogenous and avascular. The optic nerves appeared with sharp borders. The cup-to-disc ratios were estimated as 0.3 in both eyes. No retinal tears or holes were detected in the peripheral retina of both eyes.

DIAGNOSTIC STUDIES:

The following are Diagnostic Studies performed as part of this evaluation.

1. Fundus Photography, CPT Code: 92250

Associated ICD-10 code: H35.033

- Fundus photography was performed by Optos instrument. This technology allows detailed panoramic 200-degree views of the retina. Wide field red-green and auto- fluorescent images of the right retina were obtained. Diabetic and hypertensive retinopathy was documented in both eyes.

2. Visual Fields, CPT code: 92083 and 92082

Associated ICD-10 code: H40.011

- Visual Field Study was performed using a threshold 24-2 and a supra-threshold kinetic strategy from non-seeing to seeing along 16 meridians for each eye. These methods were used to quantify defects in the visual fields in accordance with the disability rating system of the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. The results are plotted in the figures below. The kinetic visual field plots for Mr. Doran were interpreted as glaucoma suspect and superior visual field in the right eye and general restriction in the left eye. The reliability for both eyes was good.

Figure 1 Left Eye Kinetic Visual Field

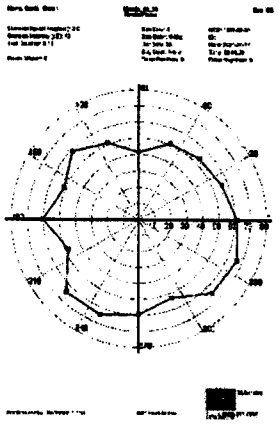


Figure 2 Right Eye Kinetic Visual Field

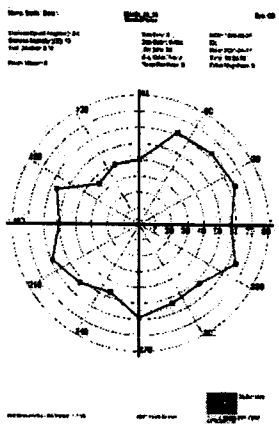


Figure 3 Left Eye Threshold 24-2 Visual Field

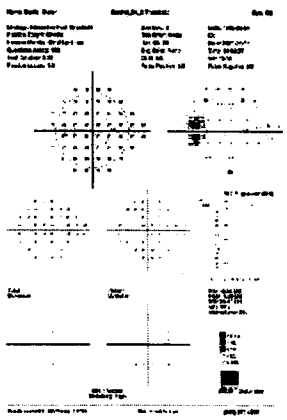
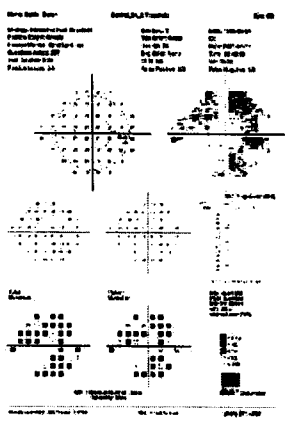


Figure 4 Right Eye Threshold 24-2 Visual Field



The impairment related to field restrictions in this case are considered in the Impairment section further in this report.

DIAGNOSES

1. Dry eye syndrome, pre-existing, ICD-10 code: H04.123
2. Subjective visual disturbances, pre-existing, ICD-10 code: H53.1
3. Glare sensitivity, ICD-10 code: H53.71
4. Glaucoma suspect, right eye, ICD-10 code: H40.011
5. Hypertensive retinopathy, bilateral, ICD-10 code: H35.033
6. Regular astigmatism, bilateral, natural, ICD-10 code: H52.13

7. Presbyopia, natural, ICD-10 code: H52.4

DISCUSSION

The focus of this evaluation and report is to identify any current ocular conditions, their likely causation and how they are labor-disabling, and those prior to the industrial injury, their causation and how they were labor-disabling. In addition, work preclusions also must be identified.

In my evaluation of Mr. Doran, I found that he has several subjective ocular and visual complaints that began prior to the subsequent industrial injury. I also found clinical signs that support his complaints. While several of his ocular diagnoses are labor-disabling, not every diagnosis is labor-disabling. For example, astigmatism and presbyopia are correctable with eyeglasses and are not considered labor-disabling.

A. Ocular irritations, dry eye syndrome

In my evaluation of Mr. Doran, I found that he has moderate to severe dry eye syndrome. He exhibited superficial punctate keratitis (SPK) in the inferior portion of his cornea in both eyes. SPK is an eye disorder characterized by the death of small groups of cells on the surface of the cornea. It may be caused by exposure to environmental elements, autoimmune conditions, side effect of medications, or anatomical anomalies. The eyes become irritated, watery, and sensitive to light, and vision may be affected.

Mr. Doran has had symptoms of painful ocular irritations at least since 2011 and believes exposure to chemicals at his work has probably increased his dry eye condition. He had an injury when Liquid Drano was splashed on his eyes. In addition to SPK he exhibits reduced tear-break-up time that support the diagnosis of dry eye syndrome.

Dry eye syndrome is labor disabling. It limits a person in working in front of a computer screen for extended periods, in dusty or windy environments, in jobs with differing humidity conditions such as kitchens or laundry facilities. There are many other examples where dry eye syndrome causes work preclusions. Work preclusions for this case is discussed further in this report.

The AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, considers dry eye syndrome as bodily pain and allows up to a maximum of 3% disability rating. In this case, I believe, currently and **pre-existing** to the subsequent industrial injury there has been **2%** disability from dry eye syndrome. This opinion is justified because of the level of the symptoms and ocular signs observed and my over 30 years of clinical experience.

B. Light and glare sensitivity

As stated, Mr. Doran also complains of glare and light sensitivity. He recalls having these symptoms for the past few years. He reported avoiding driving at nights. He denied having these symptoms prior to the industrial injury. His evaluation showed superficial punctate keratitis, cortical cataracts, and diabetic retinopathy, which are correlated to glare and light sensitivity.

Glare and light sensitivity, in this case, are not pre-existing. They are not considered part of the SIBTF pre-existing labor-disabling factors. From a Worker's Compensation viewpoint, these factors are considered for discussions regarding work preclusions.

The AMA Guides allows for individual adjustment for conditions such as photophobia and glare sensitivity. It allows up to the maximum of 15% for individual adjustment. Specifically, on page 297, it states:

> "Although visual acuity loss and visual field loss represent significant aspects of visual impairment, they are not the only factors that can lead to a loss of functional vision. This edition of the Guides does not provide detailed scales for other functions, such as: ...Glare sensitivity (veiling glare), delayed glare recovery, photophobia (light sensitivity), and reduced or delayed light and dark adaptation... Binocularity, stereopsis, suppression, and diplopia.
>
> If significant factors remain that affect functional vision and that are not accounted for through visual acuity or visual field loss, a further adjustment of the impairment rating of the visual system may be in order. The need for the adjustment, however, must be well documented. The adjustment should be limited to an increase in the impairment rating of the visual system (reduction of the FVS) by, at most, 15 points."

In the precedence case of Michele Tousley vs. Dept of Interior, State of Utah, the individual adjustment for glare and decrease in contrast sensitivity was determined as 15%. With the severity of his symptoms in mind, I see reasonable medical justification of allowing **10.0%** individual adjustment for Mr. Doran. This opinion is based on the level of his symptoms, the clinical findings, on my clinical experience of over 30 years, and the above-mentioned case. There is no pre-existing disability from glare and light sensitivity.

C. Blurry vision

Mr. Doran had complaints of blurry and double vision since 2005. He was diagnosed with diabetes in 2005 and has had several episodes of extremely high blood sugar which cause vision changes. In 2019 he was admitted to the hospital with diabetic coma that lasted about five days. About six months ago, his Hb A1c was 14. He has had difficulty in obtaining insulin since he is currently homeless.

The examination showed best-corrected visual acuity level of 20/ 30 in the right eye, 20/25 in the left eye, and 20/20 binocularly. This mild reduction in visual acuity is likely related to the SPK of his corneas and cortical cataract. He likely had double vision and large swings in refraction due to extremely high blood sugar.

Reduced visual acuity is labor disabling. The AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, has detailed instructions on calculating visual impairment. In the Guides, visual acuity of 20/30 is assigned a Visual Acuity Score (VAS) of 90 (Visual Acuity Impairment Rating of 10%), visual acuity of 20/25 is assigned a Visual Acuity Score (VAS) of 95 (Visual Acuity Impairment Rating of 5%), and visual acuity of 20/20 is assigned a Visual Acuity Score (VAS) of 100 (Visual Acuity Impairment Rating of 0%).

Using Table 12-3 of AMA Guides, on Page 284, the current Functional Acuity Score (FAS) is calculated as follows:

VASOU	:	100 x 3 = 300
VASOD	:	90 x 1 = 90
VASOS	:	95 x 1 = 95

ADD OU, OD, and OS = 485

Divide by 5 = 97 This is Functional Acuity Score (FAS)

Acuity related Impairment Rating is **3.0%** (calculated as 100 – FAS).

There are also limitations in his peripheral vision. Kinetic visual field and threshold 24-2 tests showed restrictions in the peripheral vision in both eyes. The superior field defects in the right eye are likely related to the droopy eyelid secondary to dermatochalasis combined with early glaucomatous visual field defect (i.e., Bjerrum scotoma).

The AMA Guides, 5th Edition, has specific instructions on how to score the visual fields, starting on page 287. The guidelines dictate plotting the fields in 10 meridians, 2 in each upper quadrant and 3 in each lower quadrant. The following meridians were used to divide the 360-degree field: 25°, 65°, 115°,155°, 195°, 225°, 255°, 285°, 315°, and 345°. The visual fields in this case are plotted and the missed points in each meridian are calculated as follows.

Right Eye

25° Meridian → 10 points are seen = 10
65° Meridian → 8 points are seen = 8
115° Meridian → 8 points are seen = 8
155° Meridian → 9 points are seen = 9
195° Meridian → 9 points are seen = 9
225° Meridian → 9 points are seen = 9
255° Meridian → 8 points are seen = 8
285° Meridian → 9 points are seen = 9
315° Meridian → 9 points are seen = 9
345° Meridian → 10 points are seen = 10

Adding all the values, the visual field score for right eye (VFS_{OD}) is 89.

Left Eye

25° Meridian → 9 points are seen = 9
65° Meridian → 9 points are seen = 9
115° Meridian → 9 points are seen = 9
155° Meridian → 9 points are seen = 9
195° Meridian → 8 points are seen = 8
225° Meridian → 10 points are seen = 10
255° Meridian → 10 points are seen = 10
285° Meridian → 9 points are seen = 9
315° Meridian → 10 points are seen = 10
345° Meridian → 10 points are seen = 10

Adding all the values, the visual field score for left eye (VFS_{OS}) is 93.

According to the 5th Edition of the AMA Guidelines, to calculate the visual field score for both eyes, an overlay grid is placed over the combination of the right and left visual fields. This grid contains points at the following radial locations: 1°, 3°, 5°, 7°, 9°, 15°, 25°, 35°, 45°, 55°, and 65°. Each meridian is then assessed to see if the point at that radial position is theoretically seen by the subject. The seeing locations are added together to find the visual field score for both eyes (VFS_{OU}).

25° Meridian → 10 points are seen = 10
65° Meridian → 10 points are seen = 10
115° Meridian → 9 points are seen = 9
155° Meridian → 10 points are seen = 10

195° Meridian → 10 points are seen = 10
225° Meridian → 10 points are seen = 10
255° Meridian → 10 points are seen = 10
285° Meridian → 9 points are seen = 9
315° Meridian → 10 points are seen = 10
345° Meridian → 10 points are seen = 10

Adding all the values, the visual field score for both eyes (VFS_{OU}) is 98.

Subsequently, FFS is calculated as follows:

VFSOU : 98 x 3 = 294
VFSOD : 89 x 1 = 89
VFSOS : 93 x 1 = 93

ADD OU, OD, and OS = 476

Then divide by 5 =95.2 This is Functional Field Score (FFS)

Field Related Impairment Rating for current time and pre-existing to the subsequent industrial injury is 4.8% (calculated as 100 – FFS).

With known FFS and FAS values the FVS is calculated as follows: FVS = (FAS x FFS)/100

FVS thus equals: (97 x 95.2) /100 = 92.34 % Functional Vision Score (FVS)

Therefore, the level of impairment rating based on the visual acuity loss and visual field loss is **7.66%.**

The **pre-existing** level of impairment rating based on the visual acuity loss and visual field loss was likely better than the current level. It is likely that there was no glaucomatous visual field loss since the fields would have been much worse by now if they had begun to deteriorate in 2012. However, dermatochalasis field loss was likely present. The following is the calculation of the pre-existing field loss with more than 51% likelihood, in my opinion.

<u>Right Eye</u>

25° Meridian → 10 points are seen = 10
65° Meridian → 8 points are seen = 8
115° Meridian → 8 points are seen = 8
155° Meridian → 10 points are seen = 10

195° Meridian → 10 points are seen = 10
225° Meridian → 10 points are seen = 10
255° Meridian → 10 points are seen = 10
285° Meridian → 10 points are seen = 10
315° Meridian → 10 points are seen = 10
345° Meridian → 10 points are seen = 10

Adding all the values, the visual field score for right eye (VFS_{OD}) is 96.

Left Eye

25° Meridian → 10 points are seen = 10
65° Meridian → 9 points are seen = 9
115° Meridian → 9 points are seen = 9
155° Meridian → 10 points are seen = 10
195° Meridian → 10 points are seen = 10
225° Meridian → 10 points are seen = 10
255° Meridian → 10 points are seen = 10
285° Meridian → 10 points are seen = 10
315° Meridian → 10 points are seen = 10
345° Meridian → 10 points are seen = 10

Adding all the values, the visual field score for left eye (VFS_{OS}) is 98.

Both eyes (VFS_{OU})

25° Meridian → 10 points are seen = 10
65° Meridian → 9 points are seen = 9
115° Meridian → 9 points are seen = 9
155° Meridian → 10 points are seen = 10
195° Meridian → 10 points are seen = 10
225° Meridian → 10 points are seen = 10
255° Meridian → 10 points are seen = 10
285° Meridian → 10 points are seen = 10
315° Meridian → 10 points are seen = 10
345° Meridian → 10 points are seen = 10

Adding all the values, the visual field score for both eyes (VFS_{OU}) is 98.

Subsequently, FFS is calculated as follows:

VFSOU : 98 x 3 = 294
VFSOD : 96 x 1 = 96
VFSOS : 98 x 1 = 98

ADD OU, OD, and OS = 488

Then divide by 5 =97.6 This is Functional Field Score (FFS)

The visual acuity was likely the same since cortical cataract and superficial punctate keratitis were likely present in 2012 and contributed to this visual acuity loss. Therefore, the pre-existing FAS was 97.

The pre-existing impairment based on visual acuity and visual field loss are is calculates as:

FVS = (FAS x FFS)/100

FVS thus equals: (97 x 97.6) /100 = 94.67 % Functional Vision Score (FVS)

Therefore, the **pre-existing** level of impairment rating based on the visual acuity loss and visual field loss was likely **5.33%**.

Having considered all aspects of the visual impairment in this case, we can combine them to achieve a total visual impairment rating. The current level of visual impairment in this case does not match the level present prior to the industrial injury.

Current: 2.0% (dry eye) + 10.0% (photophobia and glare sensitivity) + 7.66% (visual acuity and visual fields impairment) = **19.66%**.

Pre-existing: 2.0% (dry eye) + 0% (photophobia and glare sensitivity) + 5.33% (visual acuity and visual fields impairment) = **7.33%**.

Table 12-10, The Classification of Impairment of the Visual System (expanded) of AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, is shown on page 298 of the Guides. With the pre-existing impairment rating of 7.33%, the table categorizes Claimant's visual impairment as Class 1, in the range of 0 –9%. From an ocular standpoint, Whole Person Impairment Rating (WPI), with an estimate of overall Activities of Daily Living ability loss, was also 7.33%.

This value is additive to all other impairments of the body since there is no overlap in the function of the eyes with respect to other body parts. The visual impairments in this case are labor disabling.

MAXIMUM MEDICAL IMPROVEMENT

From an ocular disability standpoint, it is my opinion that the examinee's current ocular condition has reached maximum medical improvement. The factors of pre-existing disability were permanent and stationary prior to the date of subsequent industry injury in this case.

Going forward, with a new diagnosis of glaucoma suspect, Mr. Doran is advised to have a comprehensive eye examination and a glaucoma work-up evaluation. He will likely gradually lose more of his peripheral vision if he does not get appropriate glaucoma treatment.

SUBJECTIVE FACTORS

Subjective factors of examinee's ocular conditions include ocular irritations, photophobia, glare sensitivity, and blurry vision.

OBJECTIVE FACTORS

Diagnostic objective findings in this case were:

1) Dry eye syndrome
2) Photophobia
3) Glare sensitivity
4) Glaucoma suspect
5) Dermatochalasis
6) Reduced visual acuity

CAUSATION:

Natural causes have likely produced the ocular factors in this case.

APPORTIONMENT:

The industrial injury in this case did not cause any visual impairment.

The level of pre-existing ocular impairment, however, does not match the current level. The detailed discussion above enumerates the proportion of disability present prior to the subsequent industrial injury of 7/11/2012.

WORK PRECLUSIONS

Mr. Doran suffers from dry eye syndrome. Work preclusions include any job that increases dry eyes, such as working in windy environments, working long hours in front of a computer screen, working in air-conditioned rooms, or working with aerosolized chemicals.

He also suffers from sensitivity to light and glare. Work preclusions include working outdoors under the sun and working under bright artificial lights, such as stadiums and concert halls. Due to his disabling glare at night, any occupation that involves driving at night can be hazardous to him and others. Examples include delivery services, bus and transportation jobs, emergency vehicle jobs, police or security jobs, ride sharing jobs, chauffeur, etc. These work preclusions existed prior to his industrial injury, limiting his ability to compete in the workplace.

His superior visual field is restricted. Any position that depends on his ability to see or detect poor contrast objects in his superior visual field would be precluded. An example is air-traffic controller.

FUTURE MEDICAL TREATMENT

Mr. Doran needs a comprehensive eye examination and a glaucoma work-up examination. He needs to control his blood pressure and blood sugar better.

REASONS FOR OPINIONS

1. Review of available medical records.
2. Physical examination findings, which support the examinee's condition.
3. Correlation of the examinee's oral history compared to the records.
4. Credibility of the examinee.
5. Clinical experience and research.

Thank you for the opportunity to evaluate Mr. Doran. Please contact me if I can be of further assistance.

COMPLIANCE DISCLOSURE STATEMENT

I certify that I took the complete history from the patient, conducted the examination, reviewed all available medical records, and composed and drafted the conclusions of this report. If others have performed any services in connection to this report, outside of clerical preparation, their names and qualifications are noted herein. Partial compilation and excerpting of the medical records were completed by trained staff at Arrowhead Evaluation Services, Inc. In combination with the examination, the excerpts and records were reviewed to define the relevant medical issues. The conclusions and opinions within this report are solely mine. 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 it to be true. In accordance with Labor Code Section 5703(a) (2), there has not been a violation of Labor Code Section 139.3, and the contents of the report are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Pursuant to 8 Cal. Code Regs. Section 49.2-49.9, I have complied with the requirement for face-to-face time with the patient in this evaluation. If necessary, I have discussed apportionment in the body of this report. If I have assigned disability caused by factors other than the industrial injury, that level of disability constitutes the apportionment. The ratio of nonindustrial disability, if any, to all described disability represents my best medical judgment of the percentage of disability caused by the industrial injury and the percentage of disability caused by other factors, as defined in Labor Code Section 4663 and 4664.

Date of Report: April 27, 2021. Date of Signing of Report: June 8th, 2021, in Orange County, California

Babak Kamkar, OD, QME

Babak Kamkar, OD, QME
Optometry

MEDICAL RECORDS REVIEW

Job Description: *Employed for Benedict & Benedict Plumbing as a Journeyman (Plumber). Essential Duties include: All types of plumbing repairs, commercial and residential.*
Physical Demands: *Occasionally (Up to 3 hours): Sitting and lifting above 76 lbs. Frequently (3-6 hours): Walking, standing, bending at neck and waist, squatting, climbing, kneeling, crawling, twisting at neck and waist, simple grasping with B/L hands, power grasping with B/L hands, fine manipulation with B/L hands, pushing and pulling with B/L hands, reaching above and below shoulder level, carrying from 0-100+ lbs. Constantly (6-8+ hours): Standing, hand use, repetitive use of hand. Heaviest item required to carry is water heater and distance to be carried varies. Job required driving cars, trucks, forklifts and other equipments, working around equipment and machinery, walking on uneven ground, exposure to excessive noise, exposure to extreme 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. Job requires use of both hands and both legs through the course of daily job routine.*

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

WC Claim Form, dated 01/17/13 w/DOI: 07/11/12. R hand, wrist, sleep problems and depression.

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

WC Claim Form, dated 07/20/12 w/DOI: 07/11/12. Injury to R hand due to falling of rock wall.

Application for Adjudication of Claim, dated 01/17/13 w/DOI: 07/11/12. Wall collapsed. Hand, psych, unclassified, sleep dysfunction. Employed by Benedict & Benedict Plumbing as a Plumber.

07/13/12 - ED Report by James Luna, MD at Huntington Hospital. Pt with L thumb injury that occurred 2 days ago while opening up a piece of wall for re-plumbing purposes and the wall fell onto his L thumb, hitting on top of it, resulting in laceration on the side of the nail and ecchymosis of the nail itself and also pain at the first MCP joint. He tried to work yesterday but found the pain was too much. ED Course: Ordered and performed x-ray of R thumb. Placed in thumb spica splint. Administered Tetanus injection. Dx: L thumb torus type fx at the MCP joint, subungual hematoma and minimal distal thumb laceration. Rx: Vicodin and Norco. Plan: Referred to ortho. Discharged home in stable condition.

07/13/12 - X-ray of R Thumb interpreted by Warren Lam, MD at Huntington Hospital.

Findings/Impression: No fx or 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 foreign body.

07/17/12 - PTP's Initial Orthopedic Evaluation (PR-1) by George Tang, MD at Huntington Orthopedic Surgical Medical Group. DOI: 07/11/12. Pt was working where a structure came down and hit both his hands and thumb area. He had immediate pain and swelling to R thumb that is slightly better; however, it is still very symptomatic there. Dx: R thumb first metacarpal fx. Plan: Recommended thumb spica cast. TTD.

07/20/12 - Employee's Report of Injury. DOI: 07/12/12. Pt was struck on hand by falling section of rock wall. Injured R hand.

07/20/12 - Report of Employee's Present Work Status. Pt unable to work until 09/30/12.

07/24/12 - PR-2 by George Tang, MD. Pt was doing well until roughly about a few days ago, he had more pain in that thumb area. He has been more compliant and taking care of his cast. Dx remains unchanged. Plan: Continue cast. TTD.

08/14/12 - PR-2 by George Tang, MD. Pt is earlier than scheduled because the cast is getting soft around the palm area and that he is having more pain in his R thumb area for the past week or so. He is here for a change of his cast. Dx remains unchanged. Rx: Naprosyn, Prilosec. Plan: Thumb spica cast was removed and a new one was placed. TTD.

09/04/12 - PR-2 by George Tang, MD. Pt's cast was removed today. He is having some discomfort without cast in that thumb area. Dx remains unchanged. Rx: Medrox cream. Plan: Recommended a thumb spica orthosis. Recommended PT. Continue enteric-coated Naprosyn and Prilosec. TTD.

09/28/12 - 10/03/12 (2 Visits). PT Notes at U.S. Healthworks. Pt completed 2 sessions of PT for R thumb. Continue with POC.

10/04/12 - PR-2 by George Tang, MD. Pt has some stiffness in R thumb secondary to being in the cast for a while. He has some swelling and some slight tenderness in thumb area. Dx remains unchanged. Plan: Continue PT. Given enteric-coated Naprosyn and Prilosec and Medrox cream. TTD.

10/08/12 – 11/02/12 (8 Visits). PT Notes at U.S. Healthworks. Pt completed 8 sesssions of PT for R thumb. Pt reports increased pain with yesterday's treatment. Pt with increased guarding today during manual therapy. Continue with POC.

11/08/12 - PR-2 by George Tang, MD. Pt sees an improvement with wrist flexion, however still has quite a bit of limited ROM throughout the hand and thumb area. He is having a quite a bit of pain in hand and thumb area. Dx: 1) First metacarpal fx, healed. 2) Reflex sympathetic dystrophy possibility. Plan: Referred to neuro. Continue PT. Given enteric-coated Naprosyn and Prilosec and Medrox cream. TTD.

11/08/12 - Letter of Correspondence at U.S. Healthworks. Pt has been seen for PT post R thumb fx. To date, pt has completed 10 of 12 prescribed PT visits. His progress has been slow thus far with treatments. ROM of his R wrist and thumb continues to be limited and he continues to c/o moderate to severe pain levels. Given the slower progress with his ROM, the opinion of Dr. George is asked for a dyna splint for his R wrist to assist his ROM.

11/08/12 - 11/12/12 (2 Visits). PT Notes at U.S. Healthworks. Pt completed 2 sessions of PT for R thumb. Pt c/o pain in R wrist and thumb up to 8/10. Pt is making slow progress with PT. ROM gradually improving. Pt demonstrates slight improvement in grip and strength.

12/20/12 - PR-2 by George Tang, MD. Pt does c/o some numbness on thumb area, in the palmar aspect of the thumb region. His ROM is still decreased in R thumb area. He has finished his PT, which has been helpful in terms of getting ROM to his fingers and his wrist area. He still has quite a bit of symptoms of pain in R thumb region. Dx: 1) First metacarpal fx. 2) Reflex sympathetic dystrophy. Plan: Recommended EMG of RUE in agreement with neurologist. Given meds. TTD.

01/02/13 - Neurological Eval by Mohsen Ali, MD at Foothills Neurological Medical Group. DOE: 12/17/12. Pt sustained R thumb fx which resulted from a work injury. His pain began since his injury for which he had PT with no improvement. Pt was admitted to having N/T sensation around his wrist and root of his thumb. He also admitted to having weakness of his R grip. PMH: Diabetes mellitus and hypercholesterolemia. PSH: Mastectomy. Dx: 1) Possible CTS. 2) Possible reflexive pathetic dystrophy. Plan: Recommended EMG of R arm.

01/15/13 - EMG/NCV of RUE interpreted by Pouya Lavian, MD.
Impression: Mild R CTS. 1) Standard median conductions across the R wrist as well as special studies to detect early CTS demonstrated median slowing across the R wrist in a pattern indicative of mild R CTS. The median sensory potential was preserved in amplitude and there was no R thenar denervation. 2) EMG of RUE demonstrated no acute or chronic denervation. 3) There was no evidence of R pronator teres syndrome, ulnar neuropathy at the wrist or elbow, radial neuropathy, brachial plexopathy or cervical radiculopathy.

01/31/13 - PR-2 by George Tang, MD. Pt's hand is still very painful and pt is unable to use it effectively. Dx: Possible reflex sympathetic dystrophy. Rx: Gabapentin. Plan: Recommended to start PT. Given enteric-coated Naprosyn, Prilosec and Medrox cream.TTD.

02/18/13 - Dr's 1st Rpt by Edwin Haronian, MD. DOI: 07/11/12. Pt 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 R wrist and hand. He experienced immediate pain to his R wrist and hand and suffered an open wound to his R thumb. He washed it and put tape on it. He reported the injury to his supervisor and went home in pain. He had a restless night and returned to work the next day. He completed his shift in pain. After a couple of days, he was provided with a helper and soon after referred for medical care. CC: C/o continuous aching in R wrist, hand and thumb, at times becoming sharp, shooting and throbbing pain. His pain travels to his 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 activities and finger movements. He has difficulty sleeping and awakens with pain and discomfort. His pain level varies throughout the day depending on activities. Pain meds provides him temporary pain relief. PMH: Diabetes. Dx: 1) R CTS s/p R thumb fx which has healed. 2) R hand contusion. Rx: Baclofen cream, Medrox patch, Prilosec, Relafen and Ultram ER. Plan: Requested MRI of R wrist and hand. Requested referral to pain management consult with Dr. Kohan. Requested psychotherapy and psychological eval. Requested acupuncture. Recommended thumb spica. Modified duty with no use of R hand. Pt to remain on TTD if the work modifications cannot be accommodated by the employer. The timing conditions that were industrially caused have stabilized and reached MMI. Final WPI: 11% (LUE combined WPI is 2% and RUE combined WPI is 9%).

03/18/13 – PR-2 by Edwin Haronian, MD. Pt c/o chronic unremitting pain in wrist and hand on R side following previous fx. His pain level is 7-8/10. Tolerates meds, however, does not report significant amount of improvement. Rx: Neurontin. Trial of Elavil and Vitamin C. Dx: 1) Wrist tendinitis/bursitis. 2) Hand contusion. Plan: Refilled therapeutic cream. Continue modified duty.

04/01/13 – PR-2 by Edwin Haronian, MD. Pt still c/o pain. Also c/o numbness. Neurontin makes him spacey. Pt did not like Elavil. Pt does have some evidence of some depression. At this time, pt is still guarding his R hand. There is an increased suspicion for reflux sympathetic dystrophy. Some redness in hand and the above may be early complex regional pain syndrome. Dx remains unchanged. Rx: Lexapro. Plan: Wean off Neurontin. Stop Elavil. Requested a triple phase bone scan.

04/11/13 - Secondary Physician Pain Management Initial Report by Jonathan Kohan, MD. DOI: 07/11/12. Pt 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 his R wrist and R thumb. He experienced immediate pain at the R wrist and hand. He sustained a laceration to R thumb. He cleaned his laceration and bandaged his thumb. He notified his employer, however, no immediate medical treatment was provided. He went home in pain and 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. CC: Pt experiences ongoing pain at R hand/thumb. N/T that extends to forearm and radiates to hand and fingers. Difficulty bending with thumb. Notes grip weakness and has difficulty with

holding objects and with fine motor coordination. Wrist pain increases with movements. Pain level becomes worse throughout the day depending on activities. Difficulty sleeping and awakens with pain and discomfort. Pain level at hand, wrist and thumb is 8/10. Continuous episodes of anxiety, stress and depression due to chronic pain and disability status. 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. ROS: No problem with eyes, ear or throat. No blurred vision or tinnitus. PE: No jaundice or icterus. Dx: 1) Hx of R hand contusion. 2) Sympathetically-mediated neuropathic pain, RUE, possible mild CRPS. Plan: Recommended a series of stellate ganglion injection.

04/29/13 – PR-2 by Edwin Haronian, MD. Pt continues to c/o significant pain in R wrist and hand with weakness. Dx: Finger fx. Plan: Refilled meds. Continue modified duty.

05/07/13 - Initial Comprehensive Psychological Consult and Rpt by Heath Hinze, PsyD at Hinze Psychological Services. DOI: 07/11/12. Pt 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 the R wrist and hand. Immediate pain to his R wrist and hand and suffered an open wound to R thumb. He washed it and put tape on it. He reported the injury to his supervisor and went home in pain. He had a restless night and returned to work the next day. He completed his shift in pain. After a couple of days, he was provided with a helper and soon after referred for medical care. CC: C/o continuous aching in his R wrist, hand and thumb, at times becoming sharp, shooting and throbbing pain. 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. Dx: Axis I: 1) Depressive disorder, not otherwise specified. 2) Anxiety disorder, not otherwise specified. 3) Sleep disorder due to pain, insomnia type. 4) Male erectile disorder. 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. Plan: Recommended to start psychotherapy. Recommended psychiatric consult. Causation: Psychological injury described is the result of the work injury.

05/09/13 – PR-2 by Jonathan Kohan, MD. C/o chronic unremitting pain in his R hand with N/T. His pain levels is 7/10. Pain is suboptimally controlled with meds. Dx: 1) Wrist bursitis. 2) R/o complex regional pain syndrome, type 1. Rx: Trial of Elavil and Vitamin C. Neurontin. Plan: Requested wrist support.

05/31/13 – PR-2 by Edwin Haronian, MD. C/o chronic unremitting pain in R hand and wrist with N/T. Pain at 6/10. His sleep and depression have improved after start of Elavil. He also has less N/T and burning after Neurontin. Rx: Lyrica. Plan: Adjusted Neurontin. Continue modified duty.

06/11/13 – CBT Session Note by Heath Hinze, PsyD. Pt with anger, anxiety, fear, feeling hopeless, inability to gain pleasure in life. Dx: 1) Anxiety disorder, not otherwise specified. 2) Depressive disorder, not otherwise specified. Plan: Requested CBT and relaxation training sessions.

06/12/13 - Radiology Consultation Report of Nuclear Medicine Three Phase Bone Scan with Vascular Flow, Immediate and Delayed Static Images of both Distal Ulnae and Radii, both wrists and both hands Interpreted by Bharath Kumar, MD at San Gabriel Valley Diagnostic Center. Positive Findings: There is a suggestion of hyperemia in the L hand and wrist secondary to L antecubital injection. There is a suggestion of diffusely increased activity 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 fx. There is evidence of increased activity in the 1st R metacarpophalangeal joint. Post traumatic arthropathy would be one of the concerns. Impression: 1) Increased activity in the 1st R metacarpophalangeal joint. Radiographic correlation is recommended. 2) Increased activity in R wrist with focal evidence of increased activity in R trapezium and scaphoid.

07/09/13 - CBT Session Note by Heath Hinze, PsyD. Anger, anxiety, fear, feeling hopeless, inability to gain pleasure in life. Dx remains unchanged.

07/11/13 – PR-2 by Jonathan Kohan, MD. C/o chronic unremitting pain in R hand and wrist with N/T. Dx remains unchanged. Plan: Refilled meds. Increase Elavil.

07/22/13 – PR-2 by Edwin Haronian, MD. C/o persistent pain in R wrist and hand and forearm. Dx remains unchanged. Rx: Trial of Norco. Plan: Recommended to taper down Elavil. Requested purchase of R wrist support. The one pt was provided before did not fit him well. Continue modified duty.

07/25/13 – PR-2 by Jonathan Kohan, MD. C/o chronic pain in his RUE, 6/10. His neuropathic pain has improved after the doubling dose of Neurontin. His sleeping patterns and depression have improved after the initiation of Elavil overall. Dx: Chronic wrist and hand pain. Plan: Increased Neurontin.

08/06/13 - CBT Session Note by Heath Hinze, PsyD. Anger, anxiety, fear, feeling hopeless, inability to gain pleasure in life. Dx remains unchanged.

08/19/13 – PR-2 by Edwin Haronian, MD. C/o chronic pain in R hand and wrist. Pain is burning with radiation to the tips of his fingers. Pt is responding well to Elavil which improves and controls insomnia and neuropathic pain. Dx remains unchanged. Plan: Refilled Elavil and Norco. Continue modified duty.

08/22/13 – PR-2 by Jonathan Kohan, MD. C/o chronic unremitting pain in RUE including wrist and hand, 6/10. Dx: Chronic wrist and hand pain on R side. Plan: Requested stellate ganglion injection on R side.

09/10/13 - CBT session Note by Heath Hinze, PsyD. Anger, anxiety, fear, feeling hopeless, inability to gain pleasure in life. Pt chose not to speak. Pt has missed previous session and was slow to worn up to group. Continue CBT.

09/16/13 – PR-2 by Edwin Haronian, MD. C/o chronic unremitting pain in RUE including wrist and hand, 6/10. Dx remains unchanged. Plan: Refilled Elavil.

09/17/13 – CBT Session Note. Pt did not speak. Pt attends regularly and appears to benefit by listening to others concern/stories. Continue CBT.

09/19/13 – PR-2 by Jonathan Kohan, MD. C/o chronic unremitting pain in R hand, wrist and distal forearm at 8/10. Pain is sub-optimally controlled with present pharmacological regimen. Dx remains unchanged. Rx: Lyrica. Plan: Refilled meds. Increased Norco. Recommended activities which do not aggravate symptoms can be maintained along with HEP.

10/08/13 – CBT Session Note by Heath Hinze, PsyD. Pt discussed his sense of hopelessness, stating he has reached out for help and no one has been there to help him. 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 is having panic attack, feeling that some were intense, reports feeling severity. Felt dizzy. Thought he was going to have a heart attack. Pt's symptoms appear to fall in decreased criteria for panic disorder. Continue CBT.

10/14/13 – PR-2 by Edwin Haronian, MD. C/o chronic unremitting pain in R hand and wrist. Diagnosed with complex regional pain syndrome type 1. Dx remains unchanged. Plan: Recommended activities which do not aggravate symptoms can be maintained.

10/16/13 – Procedure Note by Jonathan Kohan, MD at Osteon Surgery Center. Pre/Post-Op Dx: Complex regional pain syndrome, RUE. Procedure Performed: 1) Stellate ganglion injection on R. 2) Gangliogram. 3) Injection of Marcaine. 4) Fluoroscopy.

10/17/13 – PR-2 by Jonathan Kohan, MD. C/o chronic unremitting pain in L forearm, wrist and hands on R side at 7/10. S/p stellate ganglion injection conducted yesterday. He tolerated procedure well; however, he does not report any significant amount of improvement at this point. Dx: Complex regional pain syndrome type 1 of R forearm wrist and hand. Plan: Refilled Meds. Increased Lyrica. Requesting psychologist to provide psychological clearance to establish realistic expectations.

10/22/13 – 10/29/13 (2 Visits). CBT Session Notes. Pt completed 2 sessions of CBT. Pt discussed ruminations about former boss. Pt examined why his symptoms have increased and his financial situation is fine and that has prompted him to ruminate over bosses' actions. Asked pt if rumination exacerbated pain and he affirmed this, speaking motivations statement that "he should try to distract self" from maladaptive thoughts. Continue CBT.

11/11/13 – PR-2 by Edwin Haronian, MD. S/p stellate ganglion blocks with minimal benefit. Continued c/o R hand pain with hypersensitivity and reduced function. Dx remains unchanged. Plan: Requesting psychological clearance to provide a spinal cord stimulating device. Requested a trial of spinal cord stimulator. Continue modified duty.

11/12/13 – CBT Session Note by Heath Hinze, PsyD. Pt chose to be quite in group. Pt attends regularly but chooses at times to not talk. Continue CBT.

11/14/13 – Secondary Physician Pain Mgmt F/u Report by Jonathan Kohan, MD. C/o chronic unremitting pain in his R hand, wrist and distal forearm, 9/10. The control of neuropathic pain suboptimal with Lyrica. Unable to obtain the clearance from psychologist to series of vicissitudes. Pt was deemed to be a candidate for spinal cord stimulator trial. Dx: 1) R/o complex regional pain syndrome type 1. 2) Chronic wrist and hand pain on the R side. Plan: Refilled meds. Stopped Lyrica, taper Neurontin. Requested psychological consult for clearance for implantation of spinal cord stimulator. Work status and further course of conservative treatment shall be deferred.

11/26/13 - 12/10/13 (3 Visits) CBT Notes by Heath Hinze, PsyD at Hinze Psychological Services. Pt completed 3 sessions of CBT. Pt reports anger, anxiety, inability to gain pleasure in life. Recommended continued CBT and relaxation training sessions.

12/12/13 – Secondary Physician Pain Mgmt F/u Report by Jonathan Kohan, MD. C/o chronic pain in his L arm, wrist and hands on the right side, 6-7/10 with medications. Taking Norco, Neurontin and Elavil. Dx: Complex regional pain syndrome type 1 with the R forearm wrist and hand. Plan: Refilled meds. Requested R wrist brace.

01/06/14 – PTP's F/u Rpt by Edwin Haronian, MD. Continues to c/o significant RUE pain. Seen by Dr. Kohan, diagnosed with reflex sympathetic dystrophy and requested spinal stimulator. Dx: 1) Reflex sympathetic dystrophy lower limb. 2) Anxiety disorder. 3) Depressive disorder. 4) Male erectile disorder. 5) Sleep disorder due to pain, insomnia type. 6) Hand contusion. 7) Wrist tend/burs. 8) Finger fracture. Plan: Scheduled for psych consult.

01/09/14 - Secondary Physician Pain Mgmt F/u Report by Jonathan Kohan, MD. C/o R forearm, wrist and hand pain, 9/10. Pain controlled with meds. Dx remains unchanged. Plan: Increased Norco, Neurontin and tapered Elavil as not tolerating. Continue awaiting psych clearance for spinal cord stimulation trial.

02/06/14 - Secondary Physician Pain Mgmt F/u Rpt by Jonathan Kohan, MD. C/o chronic unremitting R forearm, wrist and hand pain, 8-9/10 with N/T and burning sensation in RUE. Pt cleared by psychologist for spinal cord stimulator trial. Dx remains unchanged. Plan: Requested for spinal cord stimulator trial on an industrial basis.

02/17/14 - PTP's F/u Rpt by Edwin Haronian, MD. Continuing to experience significant symptomatology of chronic regional pain syndrome in RUE. Dx: 1) Hand contusion. 2) Wrist tend/burs. 3) Finger fracture. Pt declined his meds at the pharmacy. Stressed to all parties that pt requires continued and uninterrupted access to his medical therapy. Modified duty with no use his R hand in his workplace.

03/06/14 - STP Pain Management F/u Rpt by Jonathan Kohan, MD. No changes in his symptoms and continues to be treated for diabetes. Remains under the care of psychologist with weekly psychotherapy sessions. Has long standing RUE symptoms of CRPS, not responding to multiple interventions. Reports some increasing level of pain after his most recent medication regimen were delayed. Dx: 1) CRPS type I, RUE. 2) Diabetes. Plan: Requested no further delay in meds. He would like to proceed with neuro stimulation trial.

03/31/14 - PTP's F/u Rpt by Edwin Haronian, MD. Still complaining of pain. Dx: 1) Reflex sympathetic dystrophy lower limb. 2) Depressive disorder. 3) Male erectile disorder. 4) Sleep disorder due to pain, insomnia type. 5) Hand contusion. 6) Wrist tend/burs. 7) Finger fracture. Plan: Requested to proceed with a spinal cord stimulator. Off work as he has significant difficulty with the use of his R arm.

04/03/14 - STP Pain Management F/u Rpt by Jonathan Kohan, MD. C/o chronic unremitting pain in his R arm with N/T and burning sensation, which precludes him from performing ADL. Receiving treatment for his diabetes. Dx: 1) CRPS type I, RUE. 2) R wrist tendinitis/bursitis. Plan: Requested meds refill and spinal cord stimulator trial on industrial basis as occupational injury precipitated onset of the pt symptoms.

05/01/14 - Secondary Physician Pain Management F/u report by Jonathan Kohan, MD. Symptoms remain unchanged. Scheduled for the spinal cord stimulator trial. Pt was having difficulty obtaining Elavil. Per pt, rational for denial is the fact that Elavil that it is addressing the pt's psychological condition. Pt has been experiencing significant worsening of his conditioning after the Elavil was not provided. Dx remains unchanged. Rx: Levaquin trial. Plan: Refilled meds. TTD x 6 weeks.

05/12/14 - PTP's F/u Rpt by Edwin Haronian, MD. Still complaining of pain. Dx remains unchanged. Plan: F/u to evaluate response to the spinal cord stimulator. Instructed smoking cessation. Off work.

05/14/14 - Operative Report by Jonathan Kohan, MD at Kinetix Surgery Center.
Pre/Post-op Dx: Sympathetically-mediated neuropathic pain, RUE.
Procedures performed: 1) Percutaneous implantation of spinal cord stimulation leads times two, C/S. 2) Myelogram. 3) Complex programming. 4) Fluoroscopy.

05/19/14 - STP Pain Mgmt F/u Rpt by Jonathan Kohan, MD. Pt reports > 70% improvement of his UE symptoms after undergoing neuromodulation. Reports 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. Dx: 1) CRPS. 2) Success with neuromodulation trial. Plan: Requested permanent placement of the SCS unit. Previously cleared from a psychological stand point. Requested Elavil. Refilled meds.

06/19/14 - Secondary Physician Pain Mgmt F/u Rpt by Jonathan Kohan, MD. Has significant improvement after undergoing the trial. Using meds to address his current complaints which is providing partial improvement. Request for permanent placement of his neuromodulation unit has been submitted for review on 06/13/14. Dx: 1) CRPS, RUE, type I. 2) R wrist tendinosis. Plan: Requested medication regimen without changes, including Elavil, Neurontin and Norco.

06/23/14 - PTP's F/u Rpt by Edwin Haronian, MD. Pt returns with continued significant R hand and RUE pain with numbness, weakness, and a "pins and needles" sensation. C/o temperature and color changes of RUE. Pt is s/p R thumb fracture with resultant CRPS. Underwent a spinal cord stimulator trial with fairly significant improvement in his pain and ROM. Pt developed L wrist pain with decreased ROM, weakness, and numbness as a compensatory consequence of favoring his RUE. Wearing a thumb Spica brace for the R hand. Dx: 1) Hand contusion. 2) Wrist tend/burs. 3) Finger fracture. 4) Reflex sympathetic dystrophy of upper limb. Plan: Continue meds. TTD.

07/17/14 - STP Pain Mgmt F/u Rpt by Jonathan Kohan, MD. No changes in his complaints in his UE, more severe on the right side. Currently he is relying on his medication to address his complaints, but is eager to proceed with a spinal cord stimulation implantation which is scheduled for late 08/2014. Experiencing LUE symptoms with weakness and numbness. Plan: Assuming that no interventions made to evaluate his LUE complaints, will be able to cover his complaints with the neuromodulalion that he will be having. Requested Levaquin.

08/04/14 - PTP F/u Rpt by Edwin Haronian, MD. Continues to c/o significant RUE pain. Has been diagnosed with reflex sympathetic dystrophy. Scheduled for permanent placement of the spinal cord stimulator. Dx remains unchanged. TTD.

08/27/14 - Operative Report by Jonathan Kohan, MD at Kinetix Surgery Center.
Pre/Post-op Dx: Complex regional pain syndrome.

Procedures performed: 1) Percutaneous implantation of spinal cord stimulation leads times two, C/S. 2) Implantation of pulse generator. 3) Myelogram. 4) Complex programming. 5) Somatosensory evoked potential.

09/04/14 - STP Pain Mgmt F/u Rpt by Jonathan Kohan, MD. Pt has been using the unit already and reports significant improvement of his neuropathic pain over the RUE, denying any issues with any aberrant sensation, coverage, or charging. Continued Levaquin. Dx: 1) History of CRPS. 2) S/p recent spinal cord stimulation implantation, C/S. Plan: Continue med. TTD.

09/09/14 - Secondary Physician Pain Mgmt F/u Rpt by Jonathan Kohan, MD. Pt has been benefited from permanent replacement of his cervical neural modulation system greatly. His burning pain has resolved with the use of the stimulator Continued with Gabapentin, Norco and Elavil. Dx remains unchanged. Plan: Discontinue antibiotic, refill meds. Reduce Gabapentin, Norco and continue with Elavil.

10/16/14 - STP Pain Mgmt F/u Rpt by Jonathan Kohan, MD. Now recovered from his recent procedure in the form of implantation of his spinal cord stimulation, 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. Has had some symptoms on the LUE, but not as severe, but reports that both are being covered by the stimulator. Dx remains unchanged. Plan: Reprogrammed his unit further and it will be able to give him additional programs which will also over his LUE. Refilled meds. Advised to rely on the use of his stimulator and attempt to take less medication, in particular his Norco.

12/08/14 - PTP F/u Rpt by Edwin Haronian, MD. Scheduled AME in 11/2014 was cancelled. Pt is significantly depressed, anxious, describes insomnia, and is stressed. Was taking Elavil previously, which helped. The spinal cord stimulator has helped to reduce his pain and increase his functional capacity, however, he does continue to be symptomatic. Has difficulty with ADL, sleeping and is awakened due to pain and discomfort. Also describes pain in the LUE due to favoring of RUE, as a compensatory consequence of the original industrial injury. Dx: 1) Mononeuritis. 2) Reflex sympathetic dystrophy of upper limb. 3) Reflex sympathetic dystrophy of lower limb. Plan: Requested to be seen by a psychologist; Elavil and PT for C/S and BUE on industrial basis. F/u with Dr. Kohan. Awaited rescheduling AME. TTD.

06/02/15 - P&S Comprehensive Psychological Eval of a Secondary Physician by Heath Hinze, Psy.D at Hinze Psychological Services. DOI: 07/11/12. Pt was started on a trial of CBT. Pt was taking Lexapro. A psychiatric consultation was also recommended. He returned and maintained active participation in treatment. On 02/04/14, a psychological surgical clearance evaluation was conducted for spinal cord stimulator trial; underwent trial in 05/2014 and had permanent placement on 08/27/14. Remains off work though apparently he was given a work restriction that he can return to work so long as he does not use his R hand. Spinal cord stimulator has led to

approximately 50% improvement in pain; however, there is a trade-off. 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 the 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. He has also reached a point where he is struggling to use his L hand due to overuse. His state disability benefit ended a couple of months before they became exhausted. Dx: Axis I: 1) Anxiety disorder. 2) Depressive disorder. 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. Causation/Apportionment: Events of the employment were the predominate cause (>51%) of emotional psychological injury. 100% of the permanent psychological disability is apportioned to 01/11/12 injury and resulting pain and physical limitations. Impairment Level: ADL: Moderate to marked. Social functioning: Mild. Memory, concentration, persistence, and pace: Moderate. Deterioration or decompensation in complex or work life settings: Mild. Impairment rating: Pt reached MMI on psychological basis. 15% WPI. 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. Recommended to avoid taking on high pressure positions or those requiring strict adherence to production quotas; avoid taking on night shift positions as this further disrupt his sleep cycle. Future Psychological Recommendation: Recommended CBT and relaxation training sessions. Should have access to psychiatric consultations for medication management. Further eval and diagnostic studies should be available.

06/30/15 - Ortho PQME Rpt by Soheil Aval, MD at West Coast Orthopedics. DOI: 07/11/12. 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 his R hand over his head to protect his head, at which time the wall struck his R hand. Reported the injury to his 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 where he was examined, and x-rays were taken of his R hand; sustained a fracture. A soft brace was dispensed. R thumb was cleansed as he had sustained a laceration. Hard cast was applied, which he wore until late 09/2012. This cast was replaced with a removable hard cast, which he used for the next month or two. He participated in 12 PT sessions but felt increased pain. He was referred for an electrodiagnostic evaluation of RUE. Retained attorney services and in 01/2013 was referred to Dr. Kohan. In 2014, a ganglion injection was provided to his neck for pain relief for his R hand with no benefit noted. Underwent an MRI of R hand in 2014. He began to suffer pain to L hand and arm, which he feels is due to overcompensation. In 05/2014, he underwent a trial of a spinal cold stimulator to his back with benefit and as such, in 08/2014, the spinal cord stimulator was permanently implanted in his back. He states that the stimulator does

mask the sharp burning pains in addition to the pins and needles sensations to his hands and arms. Due to this injury, pt states that he developed stress, anxiety, and depression due to his pain and inability to work. Received group counseling with some benefit noted. Continues to treat with Dr. Kohan. CC: Constant pain to the R wrist, hand and thumb, which radiates to the R forearm with a burning sensation in addition to pins and needles sensation to the R hand, wrist and forearm, with sharp pain to the back to the hand. Notes N/T to the R hand and all fingers. Pain does awaken him from sleep. 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. PMH: Industrial Injuries: In 2010, while working for the same employer, pt was underneath a sink and acid splashed into his eyes, sustaining injury to his eyes. He remained off work for about five days, receiving treatment with an ophthalmologist, which included eye drops and provision of an eye patch. He states he fully recovered. Diabetic. X-rays of B/L hands were normal. Dx: 1) R hand trauma with reported non-displaced fracture of the 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 CTS, per electrodiagnostic evaluation of 01/15/13. 4) Mild L hand strain, secondary to overcompensation. Status: Pt reached MMI. Impairment: 25% WPI for R wrist. Work restrictions: Precluded from activities of repetitive or forceful gripping, fine manipulation, torquing, and heavy lifting with the RUE. LUE does not require work restrictions. Should the pt's employer be unable to accommodate these restrictions, he would be unable to return to his prior occupation. Causation: Industrial. Apportionment: 100% of the pt's impairment due to the injury to 07/11/12.

06/21/16 - Psychiatric QME Report by Daphna Slonim, MD. DOI: 07/11/12. DOE: 06/21/16. Pt cut through a wall with a saw. A chunk of the wall came down from above and struck him of the R wrist and hand. He had an open wound on the R thumb. He cleaned it himself and taped it. He was in pain and left to go home, as it was the end of his shift. Reported the injury to the owner. He could not sleep because of the pain. The next day, they gave him helper to finish the job. On Friday, 07/13/12, pt drove himself to ER at Memorial Hospital. X-rays were taken, and he was told he had fracture on his R thumb. They splinted it and taped it. Seen an orthopedic surgeon, who put a cast of it. 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, diagnosed RSD because of severe persistent burning pain in the R forearm. Dr. Kohan gave him an injection in the neck with no help. In 08/2014, Dr. Kohan installed a spinal cord stimulator and was released from his care on 09/2015 and stopped his SDI without notifying him. On 02/2016, pt was referred to Dr. Baker. He saw psychologist Dr. Hinze, received group therapy. He was released by Dr. Hinze around 05/2015, 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 spinal cord stimulator turns high it fakes the during pain in the 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 08/28/14. Singe the work accident, pt has a jerky tremor of LUE and RUE. Dr. Baker, prescribed Elavil. Pt sees general practitioner, Dr. Bao

Thai, who treats him for his diabetes. Both BP and diabetes under control. He applied for Social Security in 01/2015, and it was denied. He appealed it with an attorney and is scheduled for a hearing on 09/2016. CC: Burning pain in R forearm up to his elbow, 6/10 with stimulator, 10/10 when turns it off. Pain in L wrist, 9/10; with stimulator, 5/10. Pain in anal area constantly, 5-10/10. Pain in both knees when moving, 5-9/10. HAs 2-3 x/week, 7-8/10. Pt is impotence since shortly after the accident. Has shaking/twitches in L leg and hand. L side of mouth seems to be paralyzed. Has pressure in the chest lasting 10-15mins. Throat very dry and makes him feel choking, difficulty swallowing. Abdominal pain daily with nausea. Constant ringing in ears. Feels physically weak. Extremely constipated and has to take stool softeners. Feels sad, used to cry, feels discouraged about the future and feels dissatisfied and bored with everything. Feels he is being punished. Has thoughts about killing himself but won't do it. Feels disgusted and blames himself. Feels he looks ugly. Has no energy and feels entire body is sore. No appetite and lost interest in sex. Decreased sleep and has nightmares. Feels very fatigued but cannot fall asleep with the stimulator being on. Feels tense, restless, nervous, unable to relax, shaky, irritable and impatient. Has problem with short term memory and concentration. PMH: Diabetes, high BP, anal fistula. Dx: Axis I: 1) Major depression, single episode, severe. 2) Anxiety disorder NOS. 3) Psychological factors affecting medical condition. 4) Insomnia due to orthopedic pain. 5) Insomnia due to Axis I dx. 6) R/o pain disorder with both psychological factors and a medical condition. Axis II: Personality disorders and specific developmental disorders: Immature, histrionic, and avoidant personality traits. Axis III: Physical Disorders and Conditions: 1) RSD, R wrist and hand. 2) Musculoskeletal complaints. 3) Cardiovascular complaints. 4) GI complaints. 5) HAs. 6) High BP, by history, controlled with meds. 7) Diabetes, Type II-controlled with meds. 8) Neurological problems. Axis IV: Psychological and environmental problems: Occupational problems. Problems with primary support group. Economic problems. Axis V: GAF: 55, equivalent to 23% WPI. Disability status: TTD from psychiatric point of view. Condition regarded as P&S with moderate psychiatric disability. Causation: Industrial causation. Apportionment: 20% to pre-existing and non-industrial factors. 20% of financial worries. 60% to the industrial injury 07/11/12. Objective factors of disability: Being socially withdrawn, impaired sleep, indecisiveness, not functioning in hobbies and in 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, headaches, weakness, fatigue, lack of energy, loss of self confidence, lack of motivation, guilt feelings, difficulty swallowing, choking feelings, nightmares, suicidal ideation, fear of being left alone/traffic/crowds. Work restrictions: Should avoid stresses at work. Vocational rehabilitation: Not indicated from a psychiatric point of view. Future psychiatric care: Recommended referral to proctologist for consultation to r/o industrial causation and to the neurologist. Would benefit from psychotropic medication and should be under psychiatric care. 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. Prospectively requested for 1 replacement of spinal cord stimulator battery, a non-rechargeable IPG. Requested for additional information including results

obtained from the spinal cord stimulator, including any changes in pain levels, medication usage, or functional benefits by UR.

08/15/16 - Pain Medicine Re-evaluation by Gary Baker, MD at Advanced Pain Specialists of Southern California. DOI: 07/11/12. Neck pain, radiating down the BUE. UE pain: Pain is in the R wrist, hand, fingers, thumb and radiates to the right forearm, constant, describes the pain as burning, electricity, sharp and moderate in severity. Pain is accompanied by muscle weakness, N/T. There is intermittent pain in the left wrist and hand with N/T. Insomnia. Pain, 7/10 with meds; 10/10 w/o meds. Pain is reported as recently worsened. C/o continuous nausea and moderate constipation. Pt completed a fluoroscopic evaluation of the spinal cord stimulator on 03/15/16 and reprogramming of the SCS. Insomnia secondary to pain is worsening. Chief concern now is difficulty charging the spinal cord stimulator IPG/battery due to malposition of the battery and pt has limited use of R hand to position charger to overcome malposition. Report also night-time aggravation of RUE as he is not able to protect the arm adequately as he sleeps. Requests splint to protect R wrist/hand 'for night-time use only. Dx: 1) Ongoing Type 2 CRPS, RUE. 2) Peripheral neuropathy. 3) S/p spinal cord stimulator (SCS) implant. 4) Diabetes Mellitus, type 2 with hyperglycemia –stable. 5) Fx R thumb non-displaced fracture. 6) Malposition SCS IPG/battery. Tx: SCS mgmt: SCS system adjusted with medtronic rep to optimize pain coverage. System otherwise works well but having continued problem properly charging the SCS unit. Plan: Continue Elavil and Neurontin. Recommended R wrist/hand splint (long) with thumb spica #1. Discussed will avoid daytime use to avoid atrophy or loss of ROM. Referred to a qualified psychiatrist or psychologist. Awaits replacement of a SCS battery. The battery migrated and is poorly positioned for the charger. TTD for 1 month.

08/17/16 - Utilization Review Rpt by Marvin Pietruszka, MD. Prospective request for 1 replacement of spinal cord stimulator battery a non rechargeable IPG is conditionally non-certified.

09/12/16 - Pain Medicine Re-evaluation by Gary Baker, MD. Pain, 8-10 with meds and 9/10 w/o meds. Insomnia secondary to pain is worsening. Chief concern is 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 RUE 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, received and is helpful with sleep but it is 1 size too small. He is in the process of getting it re-done. Dx remains unchanged. Tx: SCS mgmt: SCS system adjusted with medtronic rep to optimize pain coverage. System otherwise works well but having continued problem properly charging the SCS unit. Continue meds. TTD.

12/15/16 - Neurological AME by Mark Pulera, MD. DOE: 11/17/16. DOI: 07/11/12. Pt was at the job site. 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. It was an old building and the type of wall was described as a lathing wall which typically would involve underlying chicken wire and wood straps covered in plaster or cement. This is apparently a weaker type of wall. Because of its apparent underlying weakness, the middle section of the wall, below the hole he put near the ceiling and above the hole he put near the floor, came loose and started to fall. He was sitting Indian style on the floor and a piece of wall that struck his arm and head weighed an estimated 150 pounds. He actually tried lifting small pieces of the section of wall to estimate the weight. Pt put his R hand above his head to protect his head from the falling piece of wall. The piece of wall fell onto his R hand but also, to a lesser degree, fell on his head. He was sitting down when this happened. There were no witnesses to the actual activity. He stood up and walked out of the room down the stairway. At this point, the handyman of the building saw him. As a result of this injury, pt noted that his thumb was split open distally including the thumbnail. It was bleeding. Immediately after the injury, pt complained of a new severe pain in his whole R hand which traveled proximally to the wrist a few inches. The pain was so severe at the time that not only did the thumb hurt but the whole R hand hurt. The pain was so intense it made him scream. He described a new R hand pain as a 12/10. He states he placed his R hand over his head and the R hand took the blunt of the force from the falling section of the wall. However, piece of the wall also struck him on the top of the head. Pt estimated perhaps a 75- pound piece of wall struck him in the head. He felt it was probably an indirect blow to the head. He was sitting down when this happened. On his scalp, there was a small laceration or abrasion with swelling. Pt immediately developed a new pain in the head, 10/10 no known bleeding. He stopped working, drove himself home using his L hand. He stated that he spoke with his employer immediately after the injury. He self-cleaned and dressed the wound on his thumb. He made a makeshift splint. On 07/13/12, when he got to work, he could no longer take the severe pain in his R hand. He figured due to the severe persistent pain in his R hand something must be seriously wrong with him. He thought maybe he broke his R hand. He went to speak to his employer, threw the work-related keys onto a desk and told he was going to a hospital. He probably drove himself to Huntington Hospital in the company truck, where x-rays revealed fracture in his right thumb, had hard splint for the thumb. He was upset that he had to stop working because of the injury. Dr. Tang, orthopedist, put on a hard case to the R thumb. Continued to have severe R thumb and wrist pain and was put on TTD. 2 months or so after the injury, pt continued to have severe pain in the R thumb, back of the R hand, and a few inches of the proximal wrist. Dr. Tang would say that these pains were due to the traumatic injury. Had neoprene cast for R thumb, have helped the pain to a small degree. Once the hard cast was removed, PT was started for the R thumb and hand, he developed a new severe burning pain, mostly on the dorsal 3- to 4-inch area of the proximal R wrist radiating to all five digits on the right. Noted apparent shrinking or atrophy of probably both of his arms. Dr. Kohan first implanted a temporary spinal cord stimulator in 05/2014. Pt reports that temporary spinal cord stimulator appeared to help the pain. He notes that the temporary spinal cord stimulator would cause a buzzing sensation in both of his arms, which appeared to lessen his sensation of pain. Therefore, he agreed to have permanent implantation of the spinal cord stimulator and had it implanted on 08/24/14. He

notes that his physician uses Medtronics Spinal Cord Stimulator, which is typically used for pain in the spine, but not pain in the arms. He was receiving payments from EDD, but these stopped on 09/01/15. Pt went to Dr. Baker, a pain management specialist on 02/2015, who adjusted the spinal cord stimulator and continued spinal cord stimulator and wants to implant a new permanent battery pack that would last three or four years. CC: Emotional dysfunction such as frustration, anxiety, or depression; sleep complaints, headache, two types of pain in the R thumb, hand, wrist, and proximal forearm, new onset abnormal involuntary movements of unknown etiology with complaints of decreased speech volume, Memory complaints, a buzzing sensation in the body after spinal cord stimulator implantation, mild unsteady gait. Previous injuries: 1) Fall for the same employer approximately in the late 1980s with a bruised coccyx. 2) After 2009, pt was exposed to acid in his eye with the same employer. He received urgent eye care treatment and probably missed a few days of work. He also made 100% recovery. PMH: Diabetes, hypertension, umbilical hernia. PE: Head, eyes ears, nose and throat: The head is normocephalic and atraumatic. There is no CSF otorrhea, or rhinorrhea. There are no battle sign or raccoon's eyes. There is no soft tissue swelling. The scalp is non tender. Cranial nerve VII: There may be subtle mild masked facies present with decreased eye blink. Dx: 1) Traumatic injury to the distal right upper extremity on 07/11/12, industrial. 2) Chronic regional pain syndrome type 1/Reflex symptathetic dystrophy of RUE, industrial. 3) Potential movement disorder caused by the spinal cord stimulator implantation, industrial. 4) Underlying mild Parkinson's disease, nonindustrial. 5) Multifactorial sleep disorder, with industrial component. 6) No neurologic injury or impairment or disability for impaired memory. 7) Mild closed head injury on 07/11/12 without permanent neurologic impairment for headache or impaired memory. 8) No definite R or L "evidence of CTS" due to the injury on 07/11/12. Causation: CRPS type 1/RSD of RUE – industrial. Mild Parkinson's disease - completely nonindustrial. Multifactorial sleep disorder with components such as pain including RSD - industrial. Injury not cause or aggravate R and L CTS. Impairment: 60% total neurological impairment on an industrial basis (including 1% impairment due to impaired eye blinking and masked facies secondary to Parkinson's disease). 9% nonindustrial impairment due to mild underlying Parkinson's disease. Disability: Favored permanent partial disability of the RUE with only occasional simple grasping and coarse manipulation should be allowed, but no forceful gripping, fine manipulation, torquing, or heavy activity with the RUE. In the absence of further manipulation of spinal cord stimulator, the intermittent persistent involuntary movements involving the whole body would result in the permanent partial disability; No walking on uneven ground, crouching or kneeling, crawling or climbing. Regarding sleep disorder, TPD with no driving or operating dangerous machinery, tools, or equipment while drowsy. Sleep disorder would be P&S. If the above neurological restrictions and limitations cannot be honored then pt would be a QIW who could not return to his usual and customary occupation as a plumber. Apportionment: 35% industrial apportionment for the pain associated with the CRPS/RSD of RUE, and 40% to apportionment to other industrial factors. 75% industrial apportionment for the sleep related impairment/disability. Future Medical Care: Deferred issues of orthopedic future medical care to the orthopedic QME, Dr. Soheil Aval. Lifelong access to a neurologist should be provided depending on future symptomatology. Strongly recommend follow-up with a physician

experienced in the management of spinal cord stimulators. Doubted if there is any significant traumatic brain injury and brain MRI scan should be performed to rule out traumatic brain injury. Regarding sleep, lifelong access to physician knowledgeable on sleep disorders should be allowed. If desired, a polysomnogram and multiple sleep latency test, it should be performed to rule out obstructive sleep apnea, which could be potentially treated with CPAP. For the mild underlying Parkinson's disease, this should be addressed by neurologist on a nonindustrial basis. Entire psychiatric condition should be P&S prior to any neurological reevaluation. 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; repeating BUE EMG/NCS prior to neurological reevaluation.

12/15/16 - Internal Medicine AME by James Lineback, MD. DOI: 07/11/12. Employer: Benedict & Benedict Plumbing Co. Pt initially noted to have an elevated blood sugar in 2005, eventually, diagnosed of diabetes and was subsequently started on oral hypoglycemic therapy. He was working, 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 the R hand and wrist, though did not lose consciousness. He called the company and told them to bring another worker. He continued to experienced pain, though eventually resumed his regular duties, mostly supervisory work. On 07/13/12, the pt's pain was apparently so great that he presented to Huntington Memorial Hospital. He was evaluated and x-rays were taken before his hand was placed in a soft cast. He was also treated with pain medications and a narcotic analgesic, and developed chronic constipation in 2014. He continued to require narcotic analgesics for pain control. It caused the constipation to persist and eventually, he developed an anal fistula in 2016 that continues to cause recurrent rectal pain. In 11/2015, he 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 erectile dysfunction. His HTN is currently under good control on a single antihypertensive agent at this time. 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 one hour. He also states the following day he is tired, though he does not sleep during the day. Primary complaint remains his R hand pain. He also continues to experience intermittent constipation and erectile dysfunction. Developed a resting tremor in his LUE. The working diagnosis for his R hand has been CRPS versus RDS. The patient had a spinal cord stimulator implanted in 08/2014, which partially improved his symptoms. PSH: Spinal cord stimulator implantation. Social Hx: Smokes one-half to one pack of cigarettes per day. Family Hx: Mother died of an infection in her 80s. Father died of a stroke in his 70s. Hypertension (both parents). PE: HEENT: The extraocular movements are grossly normal and the pupils are equal and reactive to light, auditory canals are clear. The neck is supple. Dx: 1) Sleep disorder (insomnia). 2) Chronic constipation. 3) Adult onset diabetes mellitus. 4) HTN. 5) Resting tremor. 6) SOB. 7) Anal fistula. 8) R hand pain. 9) Reflex sympathetic dystrophy. 10) S/p spinal cord stimulator implantation. 11) S/p crush injury, R hand.

12) Complex regional pain syndrome. 13) Positive family history of hypertension. 14) Erectile dysfunction. Status: P&S. Discussion: Diabetes represents a pre-existing condition and should be treated on a nonindustrial basis. Erectile dysfunction has apparently been a problem since 2015 and recommended referral to an urologist. Insomnia, HTN, constipation, and his anal fistula should be considered job related and should be treated on an industrial basis. Respiratory symptoms should be considered nonindustrial. Restrictions: Class 1 (3%) WPI pertaining to sleep disorders. Class 1 (5%) WPI pertaining to hypertension. Class 1 (7%) WPI pertaining to his anal fistula and constipation. Apportionment: 100% disability with respect to his sleep disorder, anal fistula and his constipation apportioned to industrial factors. 25% of his disability with respect to his hypertension should be apportioned to his nonindustrial family history and remaining 75% to industrial factors. Future medical care: Recommended referral to an urologist for further workup of his erectile dysfunction and to a neurologist for evaluation of his LUE resting tremor to r/o Parkinson's disease on an industrial basis. Treatment should be provided on an industrial basis for sleep disorder by either a sleep specialist or a general internist and for industrially related hypertension. SOB is most likely related to his nonindustrial smoking habit. Treatment by a general internist for treatment of his constipation and should also be evaluated by a colon-rectal surgeon for his anal fistula on an industrial basis. If, indeed, the anal fistula requires surgical treatment, that treatment should be provided on an industrial basis. Recommended constipation be treated with Metoclopramide, and stool softener, such as Metamucil. Work accomodations/voucher: To be best addressed by an orthopedist since the pt's R hand remains his primary complaint.

07/10/17 - Vocational Eval Report at Laura M. Wilson & Associates. DOI: 07/11/12. Employer: Benedict & Benedict Plumbing. Pt has suffered a loss in his ability to amenability to vocational rehabilitation, sustain gainful employment, and therefore, his ability into compete in the open labor market and to determine the percentage of diminished future earning capacity (wage loss) due to his worker compensation injuries. 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. Pt's physical demands of his employment require that be able to perform Medium is defined by the United States Department of Labor as work that requires lifting a maximum of 50 pounds occasionally with frequent lifting or carrying object weighing pounds, categorized as Medium work. Analysis: Pt's 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, his industrial related injury and subsequent work limitations are the only and direct cause of his non-amenability to vocational rehabilitation. Conclusion: Pt had a steady industrial history, he enjoyed his 4 - year career on how prior to his industrial injury he was independent and enjoyed participating in physical activities such as working, fishing, golfing, and doing woodwork. These are some of the things pt isn't able to do because of his physical limitations caused by his industrial injury. Since his injury, pt has difficulties conducting ADL. He has chronic

pain caused by impairments and he experiences loss of concentration, memory difficulties, low energy levels, sadness, and agitation on a constant basis. In the "Real World" pt with his multiple impairments would be unable to sustain productive and competitive gainful employment and therefore, he is unable to compete with in the open labor market and does not have any future earning capacity. Based on his industrial related impairment and his industrial physical limitations that were provided in the medical reports, 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 preinjury capacity and abilities, he has at present no consistent and stable future earning capacity.

12/04/17 - Revised Vocational Eva Report at Canizalez Associates. DOI: 07/11/12. 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: Based on the reports of his doctors, pt retains an ability to return to work in the open labor market in the below exampled selective Sedentary and Light Occupations when solely considering his industrially related orthopedic, neurological, and psychiatric medical work restrictions and while excluding his nonindustrial medical conditions such as his diagnosed Parkinson's Disease, and Diabetes II. Absent the medically indicated non-industrial medical conditions as documented in the medical file, pt retains an ability to compete, or be retrained for suitable gainful employment. Discussion: When considering only pt's industrially related orthopedic, neurological, and psychiatric conditions and while excluding the non-industrial and/or Impermissible factors, 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. The residual Light and Sedentary occupations identified would not require more than occasional simple grasping and coarse manipulation; nor walking on uneven ground, crouching or kneeling, crawling or climbing; nor driving or operating dangerous machinery, tools, or equipment.

(End of Record Review)

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** *(employee name)* v **Benedict & Benedict Plumbing** *(claims administrator name, or if none employer)*

Claim No.: **SIF8760713**

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

I, **RAYLENE TENORIO** *(Print Name)*, declare:

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	06/22/21	Subsequent Injuries Benefits Trust Fund SIBTF Sacramento 1750 Howe Avenue, Suite 370 Sacramento, CA 95825-3367
A	06/22/21	Natalia Foley, Esq. Workers Defenders Law Group 9018 E Santa Ana Canyon, Suite 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: 06/22/2021

Raylene Tenorio
(signature of declarant)

RAYLENE TENORIO
(print name)