ERIC E. GOFNUNG CHIROPRACTIC CORP.

QME OF THE STATE OF CALIFORNIA

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

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

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

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

On 10 day of December 2021, I served the within concerning:

Patient's Name: Doran, Daniel

SIF Case: SIF8760713

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

[ ] MPN Request
[ ] Notice of Treating Physician
[ ] Medical Report _____
[ ] Itemized – (Billing) / HFCA
[ ] QME Appointment Notification
[ ] Designation Of Primary Treating Physician
[ ] Initial Comprehensive Report
[ ] Re-Evaluation Report / Progress Report (PR-2)
[ ] Doctor's First Report
[x] Subsequent Injury Benefits Trust Fund Medical Evaluator's ML 201
[ ] RFA
[ ] Permanent & Stationary
[ ] Review of Records
[ ] Authorization Request for Evaluation/Treatment

List all parties to whom documents were mailed to:

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

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

I declare under penalty and perjury under the laws of the State of California, that the foregoing is true and correct, and that this Declaration was executed at Los Angeles, California on 10 day of December 2021.

Ilse Ponce

ERIC E. GOFNUNG CHIROPRACTIC CORP.

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6221 Wilshire Boulevard, Suite 604 / Los Angeles, California 90048 / Tel. (323) 933-2444 / Fax (323) 933-2909

October 25, 2021

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

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

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

SUBSEQUENT INJURY BENEFITS TRUST FUND MEDICAL EVALUATOR'S ML-201-95 REPORT

Time Spent Face to face:	**1 hour 45 minutes**
Time Spent on Report Preparation	**00 minutes**

Dear Gentlepersons:

The above-named patient was seen for an Subsequent Injury Benefits Trust Fund Medical Evaluation for determining eligibility, pursuant to California Labor Code 4751 on October 25, 2021, in my office located at 6221 Wilshire Boulevard, Suite 604, Los Angeles, CA 90048. The information contained in this report is derived from a review of the available medical records, as well as the oral history as presented by the patient.

The evaluation is not intended to ascertain the applicant's current function as it relates to the above captioned industrial injury, but rather determine whether pre-existing disability in combination with impairments arising from the subsequent industrial injury meet the requirements that would qualify the injured worker for SIBTF benefits. The Subsequent Injury Benefits Trust Fund (SIBTF) liability deals with pre-existing impairment and/or pre-existing disability. In other words, disability which was present prior to the industrial injury noted above.

In essence, we are looking into the past in order to determine to what extent the injured worker was disabled, at some time prior to the settled industrial injury noted above. In this report, we will discuss whether or not the injured worker had an industrial injury and whether or not there was an evidentiary basis to determine pre-existing permanent disability. Finally, we will determine whether or not the applicant preliminarily meets the initial criteria for SIBTF eligibility of 35% permanent disability, or 5% permanent disability to an opposite corresponding member, and whether or not he/she will likely incur a total disability in excess of 70%, subject to additional medical evaluations in various medical specialties.

A request was made by Workers Defenders Law Group for me to evaluate Mr. Daniel Doran, to determine his qualification for the Subsequent Injury Benefits Trust Fund. This evaluation is being performed to address the applicant's pre-existing disability to various body parts, as well as outline additional impairment and disability arising from the specific injury on July 11, 2021 to his right hand/wrist, which are the subsequent industrial injuries. I have been authorized to evaluate the industrial injuries and any pre-existing problems. I have been advised to order further evaluations as necessary from other specialists.

This report is billed under ML-201-95 pursuant to California Code of Regulations 9793(h), and 9795(b)(c).

Explanation of Charges: (ML201-95)

The report is being billed as ML-201, a comprehensive medical legal evaluation. This is either the Initial evaluation or a re-evaluation by a physician which occurs after eighteen months of the date on which a prior comprehensive medical-legal evaluation was performed by the same physician. Additional billing is included as MLPRR record review. The following modifiers are also included:

- MLPRR record review was performed on the 1651 pages received. Declaration and attestation was received for the same number of pages. 200 pages were included in the fee for ML201, 1451 pages were billed at $3/page as required by CR 9795, for a total of $4353
- Billed as follows:
    - ML201 = $2015
    - 1451 Units of MLPRR X $3 $4353
    - Total = $6358

Upon meeting Mr. Daniel Doran, I introduced myself and discussed with him my role as an evaluator in this SIBTF matter. He expressed no objection to proceeding with the evaluation.

Initial SIBTF Summary:

1. Did the worker have industrial injury?

Yes, on July 11, 2012.

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

Yes.

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

Yes.

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

Yes, the patient had preexisting disability as related to his eyes as per Dr. Kamkar. Additionally this patient has fibromyalgia and Parkinson's. I defer to Rhuematologist and Neurologist on the issue of extremities as related to the aforementioned conditions and affect on extremities.

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

This patient has fibromyalgia and Parkinson's. I defer to Rhuematologist and Neurologist on the issue of extremities as related to the aforementioned conditions and affect on extremities.

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

Unknown.

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

Yes.

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

I defer this to vocational rehabilitation expert; however, it does not appear this patient is able to return to any gainful employment and in that case he would be considered 100% disabled.

9. Additional records reviewed?

Yes.

10. Evaluation or diagnostics needed?

Rheumatology and others recommended by SIF evaluator Dr. Gupta.

JOB DESCRIPTION (SUBSEQUENT INJURY) :

Mr. Daniel Doran was employed by Benedict and Benedict Plumbing as a plumber/pipefitter at the time of the injury. He began working for this employer in 2009. He worked full time.

Job activities included driving a company truck, installing and repairing pipes, valves, fittings, drainage systems, and fixtures in commercial and residential structures, responding to, diagnosing, and resolving plumbing emergencies, performing routine inspections of plumbing and drainage systems, light construction, carpentry, painting, plastering, flooring ceiling, and electrical work as required, and often installing water heaters.

The physical requirements consisted of walking, standing, flexing, twisting, and side-bending and extending the neck, bending and twisting at the waist, squatting, climbing, crawling, and kneeling.

The patient is a right-hand dominant male, and he would use the bilateral upper extremities repetitively for simple grasping, power grasping, fine manipulation, pushing and pulling, reaching at shoulder level, reaching above shoulder level, and reaching below shoulder level.

The patient was required to lift and carry objects while at work. The patient was required to lift and carry objects weighing up to 100 pounds.

The patient worked eight hours per day and five to seven days a week. His work hours varied. There were no lunch breaks or rest breaks. The job involved working 75% indoors and 25% outdoors.

The last day the patient worked for Benedict and Benedict Plumbing as a construction worker/plumber was on July 12, 2012, at the time of the injury.

There was no concurrent employment at the time of the injury. The patient denies working for any new employer.

Prior Work History:

Regarding prior employment, the patient worked for Dr. Drain in Mammoth Lakes, California as a plumber for approximately two years. He worked full-time. His job duties included driving a company truck, installing and repairing pipes, valves, fittings, drainage systems, and fixtures in commercial and residential structures, responding to, diagnosing, and resolving plumbing emergencies, performing routine inspections of plumbing and drainage systems, light

construction, carpentry, painting, plastering, flooring ceiling, and electrical work as required, and often installing water heaters.

Prior, the patient worked for DD Plumbing, his own business, for approximately five years. He worked full-time. His job duties included driving a truck, installing and repairing pipes, valves, fittings, drainage systems, and fixtures in commercial and residential structures, responding to, diagnosing, and resolving plumbing emergencies, performing routine inspections of plumbing and drainage systems, light construction, carpentry, painting, plastering, flooring ceiling, and electrical work as required, and often installing water heaters.

HISTORY OF SUBSEQUENT INJURIES AND TREATMENT ACCORDING TO PATIENT:

SPECIFIC INJURY: 07/11/2012

The patient states that while working at his usual and customary occupation as a journeymen plumber/pipefitter for Benedict and Benedict Plumbing, he sustained a work-related injury to his head, neck and right hand. The patient explains that he was opening a wall to make plumbing connections when the plaster above him gave way, causing a section of the Lathe and plaster to fall. As the section came down, he recalls he was sitting on the floor in a deep squat position. Instinctively, he put out his right hand to protect himself. The piece of the wall hit his right hand and wrist, and right thumb, and head. He experienced immediate pain in his right wrist and hand, and head/neck. He washed and taped the right thumb and notified his employer of the injury. On July 12, 2021, the patient worked with pain and finished the job.

On July 13, 2012, the pain progressively worsened, and he sought medical care at Huntington Memorial Hospital in Pasadena. He was evaluated, and x-rays of his right hand/thumb were taken. He was diagnosed with fractures in his right hand thumb. His right hand was placed in a thumb spica splint. Pain medication was prescribed. He was placed on TTD.

On July 17, 2012, the patient was referred to Dr. George Tang, an orthopedic specialist, for evaluation. He was diagnosed with a fracture in his right thumb.

On July 24, 2012, the patient returned to Dr. Tang for a follow-up appointment. X-rays showed good alignment of the fracture. He was continued on cast treatment. He remained on TTD.

On September 4, 2012, he followed up with Dr. Tang, and the cast was removed.

In October of 2012, the patient completed 12 sessions of physical therapy.

In January of 2013, the patient was referred to Dr. Mohsen, a neurologist, for evaluation.

In February of 2013, his attorney referred him to Dr. Haronian for evaluation.

Subsequently, he developed anxiety and depression, which he attributed to this industrial injury.

In March of 2013, he returned for a follow-up with Dr. Haronian. Mr. Doran was prescribed medication. He was also started on medication for insomnia, depression, and pain. He has been diagnosed with tendonitis/bursitis and hand contusion right extremity.

In April of 2013, the patient was referred to Dr. Kohan, a pain management specialist, for evaluation. The patient complains of persistent pain in his right wrist, hand, and thumb. He continued to complain of anxiety, stress, and depression due to chronic pain and disability status.

In May of 2013, the patient came under the care of Dr. Hinze for depression, anxiety, and sleep disorder.

In 2013, the patient was referred for an MRI scan of his right wrist.

In June of 2013, the patient was referred for a three-phase bone scan.

On October 16, 2013, the patient underwent a ganglion injection in the cervical spine by Dr. Kohan to treat CRSD sequela of the right wrist injury.

The patient continued to follow up with Dr. Kohan and Dr. Hinze through 2014.

On May 14, 2014, the patient underwent a spinal cord stimulator leed to his cervical spine by Dr. Kohan.

On August 27, 2014, the patient underwent a spinal cord stimulator implantation surgery by Dr. Kohan.

In June 2015, the patient was referred for a PQME evaluation with Dr. Aval at West Coast Orthopedics, Inc.

In June 2016, the patient was referred for a PQME evaluation with Dr. Daphna Slonim, a psychiatrist.

In 2016, the patient underwent a neck injection.

In 2016, he came under Dr. Gary Baker, M.D., at Advanced Pain Specialists. Medication was prescribed. He last saw Dr. Baker in 2000. He continued treating with Dr. Baker through the present.

The patent reports he developed increasing neck pain following development of his chronic regional pain syndrome due to right wrist and thumb injury with significant subsequent pain in the right upper extremity and loss of sensation for which he underwent spinal cord stimulator implant in his cervical spine. The patient reports that due to favoring his right hand post injury, he was stressing his right shoulder during activities and developed progressively worsening pain at the right shoulder with decreased ranges of motion.

CURRENT COMPLAINTS:

Cervical spine/Right Shoulder:

Pain is intermittent to frequent and slight to moderate with numbness of entire right upper extremity.

Right Hand/Wrist:

The pain is severe, and the symptoms occur constantly, in the right wrist, hand, and fingers at times becoming a sharp pain. The pain radiates into the right elbow. The pain is aggravated with gripping, grasping, torquing motions, flexion, and extension of the wrist/hand, pinching, fine finger manipulation, driving, repetitive use of the right upper extremity pushing, pulling, and lifting, and carrying greater than 2-3 pounds. He has cramping, weakness, and loss of grip strength in hand and wrist and has dropped objects as a result. There is tingling in the hands and fingers. He has difficulty sleeping and awakens with numbness, tingling and pain, and discomfort. His pain level varies throughout the day depending on activities. The patient reports this injury was labor disabling.

Note: The patient has significant problems using his right upper extremity.

Neck, Mid and Lower Back – Preexisting to SIBTF injury of 7/11/2012:

Pain is slight to moderate and intermittent to frequent.

Note: The patient reports he developed neck and back pain due the years of working as a plumber and working in awkward positions. He also reports that fibromyalgia contributes to his back pain. The patient reports his neck pain was intermittent and slight prior to 7.11.12 work injury. Patient reports his condition was labor disabling prior to is 7.11.2012 injury as related to back greater than neck with difficulty working in bent over positions for prolonged periods and he had to rest more often.

Psyche:

The patient has continuous episodes of anxiety, stress, and depression due to chronic pain and disability status. He denies suicidal ideation.

The patient has difficulty sleeping, often obtaining a few hours of sleep at a time. He feels fatigued through the day and finds himself lacking concentration and memory at times. He worries about his medical condition and the future.

The patient's condition has worsened due to continued work, lack of medical treatment, and activities of daily living.

Sleep:

The patient reports insomnia.

PAST MEDICAL HISTORY:

Illnesses:

The patient has a history of high blood pressure since about 2000 and diabetes since about 2003. He was diagnosed with Fibromyalgia in about 2007. The patient has a history of gout as well. Patient has a history of Parkinsons.

Injuries:

The patient had a prior work-related injury to his tailbone 1980's when he fell.

The patient reports a non-work-related injury in 1980 when he was assaulted and hit in the head with loss of consciousness as he believes.

The patient denied any new injuries.

Allergies:

The patient denied any known allergies.

Medications:

1. Metformin, taking for diabetes, since 2004.
2. Insulin-NovoLog, taking for diabetes, since October of 2019
3. Insulin- Lantus, taking for diabetes since October of 2019
4. Lisinopril, taking for high blood pressure, for several years.
5. Gabapentin, taking for nerve pain from the accident since 2012.
6. Elavil, taking for depression with pain since 2012.

Surgeries:

On May 14, 2014, the patient underwent implantation of a spinal cord stimulator by Dr. Kohan.

On August 27, 2014, the patient underwent implantation of a spinal cord stimulator by Dr. Kohan.

Hospitalization:

In October of 2019, the patient was hospitalized due to a diabetic coma for four days. He was hospitalized for about six days and sent to a rehabilitation home for 25 days.

Prior to the Subsequent Injury of specific, dated July 11, 2012, the patient was asymptomatic and without any disability or impairment as related to the right wrist, hand, insomnia, and psyche.

REVIEW OF SYSTEMS:

GENERAL:	Denies fever, malaise, or night sweats. The patient reports weight loss.
HEENT:	Denies headache or blurred vision. The patient reports headaches, blurred vision, and nasal congestion.
CARDIAC:	Denies chest pain, orthopnea, or palpitations. The patient reports hypertension.
PULMONARY:	Denies shortness of wheezing, hemoptysis, or productive cough. The patient reports shortness of breath.
GASTROINTESTINAL:	Denies hepatitis, ascites, abdominal pain, or jaundice. The patient reports diverticulitis.
NEUROLOGIC:	Denies migraine headaches, numbness, tingling, cramping, dementia, cerebral palsy, Alzheimer's disease, epilepsy, stroke, paralysis, or TIA. The patient reports Parkinson's disease. He was diagnosed five years ago.
MUSCULOSKELETAL:	See Current complaints/past medical history.
HEMATOLOGIC:	Denies easy bleeding or bruising.
ENDOCRINE:	Denies polyuria or polydipsia. The patient reports diabetes that is labor disabling due to fluctuating levels.
GENITOURINARY:	Denies hesitancy, urgency or frequency, nocturia, or bladder and/or bowel incontinence.

PSYCH: The patient reports depression, anxiety, stress, and lack of sleep due to injury. This condition is labor disabling due to a lack of focus.

ACTIVITIES OF DAILY LIVING:

Reference for ADL values:

Communication: As a result of the industrially related injury, the patient states: No difficulty with writing, typing, seeing, hearing, and speaking, 4/5.

Hand Activities: As a result of the industrially related injury, the patient states: Difficulty with grasping or gripping, lifting, and manipulating small items with a rating of 4/5.

Travel: As a result of the industrially related injury, the patient states: Difficulty with r driving a car and a restful night sleep pattern, with a rating of 4/5.

FAMILY HISTORY:

Mother is deceased and passed away from an infection and had a history of hypertension and a stroke.

Father is deceased and passed away from a stroke and had a history of hypertension.

The patient has two brothers. One brother his history is unknown. One brother has a heart condition. His sister passed away from a stroke.

There is no known history of colon cancer, prostate cancer, breast cancer.

SOCIAL HISTORY:

The patient is widowed, and he has no children.

The patient has completed high school and some college courses.

The patient consumes no alcohol and does smoke one-half of cigarettes per day.

Formerly, he golfed once a week, skied, hunted, and fished. Currently, he is unable to participate in these activities.

The patient walks his dog for exercise every day.

The patient does not participate in any sports activities.

Physical Evaluation (October 25, 2021) – Positive Findings:

General Appearance:

The patient is a 55-year-old male, right-hand dominant, who appeared reported age, and was well-developed, well-nourished, and well-proportioned. He was alert, cooperative and somewhat confused.

Note: The patient has a Parkinsonian tremor at upper and lower extremities. Please note, the patient had a difficult time standing for any substantial period of time as well as with bending forwards and backwards due to balance issues, which complicated his examination. The patient had to be assisted during times of his evaluation when he was standing to prevent him from falling.

Vital Signs:

Pulse:	100
Blood Pressure:	First attempt 160/130, second attempt 180/162
Height:	6'0"
Weight:	140

Cervical Spine:

Tenderness is noted over the bilateral paravertebral and upper trapezius musculature. Tenderness and hypomobility from C2 to C7 vertebral regions.

Bilateral shoulder depression tests were positive, right greater than left.

Cervical spine ranges of motion were decreased and painful. Please see attached formal study with dual electronic inclinometers.

Shoulders & Upper Arms:

Left Shoulder:

Deformity, dislocation, edema, swelling, erythema, surgical scars and lacerations are not present upon visual examination of the shoulders. The shoulders are held in a nonantalgic position.

Tenderness and spasm are not present over the supraspinatus musculature, infraspinatus musculature, teres (minor/major) musculature, subscapularis musculature, periscapular musculature and deltoid musculature on the left. There is no tenderness over the subacromial bursa and subdeltoid bursa on the left. The acromioclavicular joint, glenohumeral joint and

clavicle are not tender on the left. The triceps and biceps brachii muscles are without tenderness and spasm on the left and appear intact and without evidence of rupture.

Apprehension, Dugas, Hawkins and Impingement Sign orthopedic tests are negative on the left.

Right Shoulder:

Tenderness of the supraspinatus with myospasming and tenderness over the subacromial and subdeltoid bursa and acromioclavicular joint.

Right Impingement test was positive.

Ranges of motion of the left shoulder were within normal limits. **Right shoulder ranges of motion were decreased with pain in all ranges of motion.**

Shoulder Ranges Of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	180	180	**150**
Extension	50	50	**40**
Abduction	180	180	**130**
Adduction	50	50	**40**
Internal Rotation	90	90	**65**
External Rotation	90	90	**75**

Elbows & Forearms:

Deformity, dislocation, edema, swelling, erythema, scars and lacerations are not present upon visual examination of the elbow bilaterally.

Tenderness is not present over the lateral epicondyle, medial epicondyle and cubital tunnel bilaterally. Tenderness is not present over the flexor muscle group and extensor muscle group of the forearm bilaterally.

Valgus and Varus Stress Tests are negative. Cozens' (resisted wrist extension) and Golfers' (resisted wrist flexion) tests are negative bilaterally.

Tinel's sign at the right elbow and left elbow is negative.

Ranges of motion for the right and left elbows were accomplished without pain and spasm and were as follows:

Elbow Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual

Flexion	140	140	140
Extension	0	0	0
Supination	80	80	80
Pronation	80	80	80

Wrists & Hands:

Left Wrist:

Deformity, dislocation, amputation, edema, swelling, erythema, scars, and lacerations are not present upon visual examination of the wrists and hands.

Tenderness is not present over the volar and dorsal crease of the wrist on the left. Tenderness is not present over the carpal tunnel and carpals on the left. There is no tenderness over the distal ulna and radius on the left. There is no tenderness noted over the anatomical snuff box and triangular fibrocartilage complex on the left. There is no mechanical block noted during ranges of motion of the wrist. There is no tenderness over the thenar hand musculature, hypothenar hand musculature and intrinsic hand musculature on the left.

Tinel's sign, Finkelstein's test, Phalen's test and reverse Phalen's test are negative on the left.

Right Wrist:

Examination revealed tenderness over the right anatomic snuff box and thenar region.

Right Tinel's and Finkelstein's test is positive.

Ranges of motion of the left wrist were normal without pain**. Right wrist ranges of motion were decreased and painful.**

Wrist Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	60	60	**50**
Extension	60	60	**50**
Ulnar Deviation	30	30	**10**
Radial Deviation	20	20	**25**

Left Hand:

Finger ranges of motion were performed without pain. Triggering of the digits and mechanical block is not present. Tenderness is not present at the digits. Thumb abduction is 90 degrees on the left. Thumb adduction reaches the head of the 5th metacarpal on the left.

Right Hand:

Examination revealed tenderness over the right thumb at carpometacarpal joint.

Bilateral hands digital ranges of motion were grossly within normal limits.

Grip Strength Testing:

Grip strength testing was performed utilizing the Jamar Dynamometer at the third notch, measured in kilograms, on 3 attempts and produced the following results:

Left: 30/32/32
Right: 0/0/0

Motor Testing of the Cervical Spine and Upper Extremities:

Deltoid *(C5)*, Biceps *(C5)*, Triceps *(C7)*, Wrist Extensor *(C6)*, Wrist Flexor *(C7)*, Finger Flexor *(C8)* and Finger Abduction *(T1)* motor testing is normal and 5/5 bilaterally **with the exception of right shoulder 20% strength deficit of flexion, abduction, internal and external rotation of that shoulder and right wrist flexion as well as finger flexion 4/5.**

Deep Tendon Reflex Testing of the Cervical Spine and Upper Extremities:

Biceps *(C5, C6)*, Brachioradial *(C5, C6)* and Triceps *(C6, C7)* deep tendon reflexes are 3/2 bilaterally

Sensory Testing:

C5 *(deltoid)*, C6 *(lateral forearm, thumb & index finger)*, C7 *(middle finger)*, C8 *(little finger & medial forearm)*, and T1 *(medial arm)* dermatomes are intact bilaterally as tested with a Whartenberg's pinwheel **with the exception of generalized hypoesthesia in the entire right upper extremity.**

Upper Extremity Measurements in Centimeters		
Measurements	Left	Right
Biceps	**30**	**28.5**
Forearms	**19**	**18.5**

Thoracic Spine:

Examination revealed tenderness over the bilateral paravertebral musculature with tenderness and hypomobility from T1 to T6 vertebral regions.

Ranges of motion of the thoracic spine were decreased and painful. Please see attached formal study with dual electronic inclinometers.

Lumbar Spine:

Spinal cord implant was noted subdermally in the low back region at both sides.

Tenderness was noted over the bilateral paravertebral musculature as well as right sciatic notch with tenderness and hypomobility present over L1 to L5 vertebral regions.

Milgram's test was unable to be performed due to pain.

Straight Leg Raising Test (supine) was positive bilaterally for back pain.

Right: 70 degrees.
Left: 60 degrees.

Lumbar spine ranges of motion were decreased and painful. Please see attached study performed with dual electronic inclinometers.

Hips & Thighs:

Deformity, dislocation, edema, swelling, erythema, scars and lacerations are not present upon visual examination of the hips and thighs.

Tenderness and spasm is not present over the greater trochanteric region, hip bursa, hip abductor, hip adductor, quadriceps, biceps femoris musculature and femoroacetabular joint bilaterally.

Patrick Fabere test and Hibb's test are negative bilaterally.

Hip ranges of motion were performed without pain and spasm.

Hip Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	120	120	120
Extension	30	30	30
Abduction	45	45	45
Adduction	30	30	30
External rotation	45	45	45
Internal rotation	45	45	45

Knees & Lower Legs:

Multiple wounds were noted at the bilateral lower legs due to bug bites and diabetes as per patient, otherwise normal exam.

Tenderness is not present over the quadriceps tendon, patella, infrapatellar tendon, tibial tuberosity, medial joint line, lateral joint line and popliteal fossa bilaterally. Palpation of the lower leg muscles/regions was unremarkable for tenderness at the gastrocnemius, tibialis anterior *(dorsiflexion & inversion)* and peroneal musculature *(lateral ankle-eversion)* bilaterally.

McMurray's test, Varus Stress test, anterior drawer test and posterior drawer test are negative.

Range of motion of the knees was without pain, spasm, weakness, crepitus or instability bilaterally.

The patient was able to squat without knee pain or weakness.

Knee Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	135	135	135
Extension	0	0	0

Ankles & Feet:

Examination of ankles and feet did not demonstrate gross deformity, dislocation, amputation, edema, swelling, erythema, scars, lacerations, hallux valgus and hammertoes. The foot arch height is normal and without pes planus and pes cavus.

Tenderness is not present of digits 1 through 5, including metatarsals, cuneiforms, navicular, cuboid, talus and calcaneus. Tenderness is not present at the distal tibia, distal fibula, talonavicular joint, anterior talofibular ligament and deltoid ligament. There is no medial ankle instability or lateral ankle instability bilaterally. The Achilles tendon is intact. Tenderness is not present over the tarsal tunnel, sinus tarsi and tibialis posterior tendons *(medial ankle-plantarflexion & inversion*) bilaterally.

Anterior drawer test, posterior drawer test and Tinel's sign are negative bilaterally. The dorsalis pedis pulses are present and equal bilaterally.

Ankle ranges of motion were performed without pain, spasm, weakness, crepitus or instability bilaterally.

Ankle Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Metatarsophalangeal joint (MPJ) Extension	60	60	60
MPJ Flexion	20	20	20
Ankle Dorsiflexion	20	20	20
Ankle Plantar Flexion	50	50	50
Inversion (Subtalar joint)	35	35	35
Eversion (Subtalar joint)	15	15	15

Motor, Gait & Coordination Testing of The Lumbar Spine and Lower Extremities:

Ankle Dorsiflexion *(L4)*, Great Toe Extension *(L5)*, Ankle Plantar Flexion *(L5/S1)*, Knee Extension *(L3, L4)*, Knee Flexion, Hip Abductor and Hip Adductor motor testing was normal and 5/5.

Squatting could not be performed due to balance issues.

Heel and toe walking could not be performed due to balance issues.

The patient's gait was antalgic with a Parkinsonian-like gait.

Deep Tendon Reflex Testing of The Lumbar Spine and Lower Extremities:

Ankle *(Achilles-S1)* and Knee *(Patellar Reflex-L4)* deep tendon reflexes are normal and 2/2.

Sensory Testing:

L3 *(anterior thigh)*, L4 *(medial leg, inner foot)*, L5 *(lateral leg and midfoot)* and S1 *(posterior leg and outer foot)* dermatomes are intact bilaterally upon testing with a pinwheel **with the exception of hypoesthesia in the right L5-S1 dermatomal innervation.**

Girth & Leg Length (Anterior Superior Iliac Spine to Medial Malleoli) measurements were taken of the lower extremities, as follows in centimeters:

Lower Extremity Measurements Circumferentially & Leg Length in Centimeters		
Measurements (in cm)	Left	Right
Thigh - 10 cm above patella with knee extended	**40**	**39.5**
Calf - at the thickest point	**20.5**	**21**
Leg Length - Anterior Superior Iliac Spine To Medial Malleolus	**100**	**100**

REVIEW OF RECORDS:

See Addendum #1

Diagnostic Impressions:

1. Cervical spine myofasciitis, M79.1.
2. Cervical facet-induced versus discogenic pain, M53.82.
3. Cervical spine/right upper extremity chronic regional pain syndrome, G90.5.
4. Thoracic spine myofasciitis, M79.1
5. Thoracic facet-induced versus discogenic pain, M54.6.
6. Lumbar spine myofasciitis, M79.1.
7. Lumbar facet-induced versus discogenic pain, M47.816.
8. Right shoulder tenosynovitis/bursitis, M65.811.
9. Right shoulder impingement syndrome, rule out, M75.41.
10. Right thumb status post fracture, S62.501A.
11. Right carpal tunnel syndrome, G56. 01.
12. Fibromyalgia, M79.7.
13. Hypertension, I10.
14. Anxiety and depression, F41.9, F34.1.

See record reviewed from other SIF evaluators.

SUMMARY, CONCLUSIONS & RECOMMENDATIONS:

Diagnostic Studies recommended to further evaluate nature and extent of injury, none is recommended at this time.

Specialty Medical Evaluations recommended to further evaluate nature and extent of injury:

Rheumatology for further workup of fibromylagia.

AMA Impairment , 5th Edition Analysis, Causation, Pre and Post Subsequent Injury Apportionment, Maximum Medical Improvement, Work Restrictions and Discussions:

A. Causation (Pre-Existing and Not Aggravated): As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation of thoracic and lumbar is secondary to pre-existing conditions/injuries that were not aggravated due to subsequent injury of 07/11/2012 as discussed within this report and summarized in the "discussion section." I reserve the right to change my opinions should additional medical records come forward.

B. Causation (Pre-Existing and Aggravated): As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation of cervical spine is secondary to pre-existing conditions/injuries that were aggravated due to subsequent injury of 07/11/2012 as discussed within this report and summarized in the "discussion section." I reserve the right to change my opinions should additional medical records come forward.

C. **Causation (Subsequent Injury):** As per currently available medical records and history as per the patient, it is within reasonable medical probability that causation of right wrist, hand and upper extremity including shoulder is secondary to the subsequent injury dated 07/11/2012 as discussed within this report and summarized in the "discussion section." I reserve the right to change my opinions should additional medical records come forward.

Permanent & Stationary Status:

A) **Preexisting the subsequent work injury:** It is within reasonable medical probability this patient's preexisting condition**(s) as related to** cervical, thoracic and lumbar spine reached maximum medical improvement/permanent and stationary status prior to the time of the subsequent injury dated 07/11/2012. It is within reasonable medical probability the patient's condition was **labor disabling prior to subsequent injury with a permanent partial disability as the pre-existing condition(s)/injury(ies) affected the patient's ability to work in a demonstrative way that included working in awkward positions, bending, kneeling, stooping and crouching as well as in awkward positions of the cervical spine with prolonged posturing.**

B) **Following the subsequent Work Injury:** It is within a reasonable medical probability this patient has reached maximum medical improvement **as related to** right upper extremity and is permanent and stationary following the subsequent injury dated 07/11/2012. It is within reasonable medical probability that the patient's subsequent injury is compensable and labor disabling with a permanent partial disability.

AMA IMPAIRMENT & APPORTIONMENT ANALYSIS

1. Spine: Cervical, Thoracic, Lumbar.
2. Upper Extremities**:** Right Shoulder, Right Wrist/hand.

Spine:

A. Cervical Spine:

1. Patient qualifies for DRE category III, 18% whole person impairment by referring Table 15-5 on page 392 due to asymmetric loss range of motion, signs of radiculopathy such as pain and sensory loss in dermatomal distribution, loss of muscle strength and unilateral atrophy.

Pre-existing Cervical - I apportion 10%, which equates to 2% whole person impairment.
Subsequent Injury Cervical – I apportion 90% which equate to 16% whole person impairment.

B. Thoracic Spine: Patient qualifying for DRE category II, by referring table 15-4 on page 389 due to asymmetric loss of range of motion, 5% whole person impairment.
Pre-existing - I apportion 10**0% for thoracic spine**.
Subsequent Injury – I apportion 0% to subsequent injury.

C. Lumbar spine: Patient qualifies for DRE category II, 5% whole person impairment by referring table 15-3 on page 384 due to asymmetric loss of range of motion.

Pre-existing - I apportion 100%.
Subsequent Injury –0%.

UPPER EXTREMITY:

A. Right Shoulder muscle function deficit impairment is 11% upper extremity impairment by referencing table 16-35 on page 510 due to 20% strength deficit of flexion abduction, internal and external rotation of the shoulder or 7% whole person impairment by referencing table 16.3 on page 439.

Pre-existing - I apportion **0%** for right shoulder.
Subsequent Injury – I apportion 100% to subsequent injury.

Note: Please note, the patient developed right shoulder issues secondary to right wrist injury and developing CRPS.

B. **Right Wrist/hand** dominant upper extremity impairment is 25% whole person impairment by referring tables 13-22 on page 343 and patient qualifying for class III due to being able to use involved extremity but having difficulty with self-care.

Pre-existing - I apportion **0%** for right wrist/hand.
Subsequent Injury – I apportion 100%.

Final Apportionment Analysis:

A. **Total Whole Person Impairment Apportioned to Pre-Existing is 82% by combining the undersigned's 12% whole person impairments due to preexisting neck and back conditions with 58% neurological impairment by Dr. Lawrence Richman due to movement disorder with 30% internal whole person impairment by Dr. Samir Gupta due to diabetes, asthma, hypertension and Parkinson's with 24% psych impairment by Dr. Nung Fung due to depression and anxiety with 7.33% ophthalmology whole person impairment by Dr. Babak Kamkar due to ocular impairment.**

B. **Total Whole Person Impairment Apportioned to Subsequent Injury is 58% by combining the undersigned's 41% whole person impairment due to cervical spine and right upper extremity impairment with 25% psychological impairment by Dr. Nung Fung due to psych, sleep and sexual impairment with 4% internal impairment by Dr. Samir Gupta due to hypertension.**

C. **Total Whole Person Impairment that I am unable to establish apportionment for is 19.66% whole person impairment for Ocular as per by Dr. Babak Kamkar, it is unknown if this is natural progression of patient's preexisting ocular issues, and I defer this to Dr. Kamkar to further explain.**

Permanent Work Restrictions Currently:

Cervical Spine: No lifting over 10 pounds. No prolonged posturing with head and neck. No repeated turning of the head from side-to-side.

Thoracic and Lumbar Spine: No lifting over 10 pounds. No repeated bending or twisting.

Right Shoulder: No work with right arm at or above shoulder height. No lifting, pushing or pulling with right arm over 5 pounds.

Right Wrists and Hand: No repeated or forceful grasping, torqueing, pulling and pushing with right hand. No lifting, pushing or pulling over 5 pounds with right hand.

Subjective Factors of Disability:

The subjective factors of disability consist of:

1. Cervical spine/right shoulder pain, intermittent to frequent and slight to moderate with numbness of the entire right upper extremity.

2. Right wrist/hand pain.

3. Mid and lower back pain, slight to moderate and intermittent to frequent.

Objective Factors of Disability:

With regards to cervical spine, the objective factors of disability consist of:

1. Palpatory tenderness.
2. Decreased and painful ranges of motion.
3. Abnormal orthopedic testing.

With regards to thoracic spine, the objective factors of disability consist of:

1. Palpatory tenderness.
2. Decreased and painful ranges of motion.
3. Abnormal orthopedic testing.

With regards to lumbar spine, the objective factors of disability consist of:

1. Palpatory tenderness.
2. Decreased and painful ranges of motion.
3. Abnormal orthopedic testing.

With regards to right shoulder, the objective factors of disability consist of:

1. Palpatory tenderness.
2. Decreased and painful ranges of motion.
3. Decreased muscle function of the right shoulder.

With regards to right wrist and hand, the objective factors of disability consist of:

1. Palpatory tenderness.
2. Decreased grip strength.
3. Abnormal neurological examination findings.

Vocational Rehabilitation Benefits:

In my opinion the patient is a qualified injured worker, as they can no longer work as plumber; however, the issue is broader in the sense that it does not appear this patient is able to return to any gainful employment and in that case he would be considered 100% disabled.

CONCLUSIONS:

I have reviewed Labor Code 4751 and there appears to be adequate evidence to conclude, with reasonable medical probability, that Mr. Daniel Doran meets initial SIBTF criteria.

1. There does appear to be adequate evidence to conclude with reasonable medical certainty that Mr. Daniel Doran had previous partial disability as per the work restrictions outlined by the undersigned.

2. The combined effect of the preexisting impairment and the impairment due to the subsequent injury is likely to result in a permanent disability equal to, or greater than, 70%.

3. The permanent disability resulting from the subsequent injury, when considered alone and without regard to or adjustment for the occupation or age of the employee, exceeds the 35% threshold for Labor Code 4751.

REASONS FOR OPINIONS:

1. The consistency of the mechanism of injury with the patient's complaints and the consistency of the patient's description of injuries in relation to the submitted medical records.

2. Review of available medical records.

3. Perceived credibility of Mr. Daniel Doran and his internally consistent statements and physical action.

4. My experience in treating similar patients and injuries over the past 20 years.

LC 4751 Compensation for specified additions to permanent partial disabilities

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

occupation or age of the employee is equal to 5 percent or more of total, or (b) the permanent disability resulting from the subsequent injury, when considered alone and without regard to or adjustment for the occupation or the age of the employee, is equal to 35 percent or more of total.

DISCLOSURE STATEMENT

I derived the above opinions from the oral history as related by the patient, revealed by the available medical records, diagnostic testing, credibility of the patient, examination findings and my clinical experience. This evaluation was carried out at 6221 Wilshire Boulevard, Suite 604, Los Angeles, California 90048. I prepared this report, including any and all impressions and conclusions described in the discussion.

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628 (b)): I declare that the history was taken by Irma Chavira and I personally reviewed the history with the patient (essentially the history was taken twice), I performed the physical examination, reviewed the document and reached a conclusion. The names and qualifications of each person who performed any services in connection with the report are Dr. Mayya Kravchenko, D.C., who assisted with assembly of components of this report which was transcribed by Acu Trans Solution, LLC, and I proofread and edited the final draft prior to signing the report in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph (5) of subdivision (j) of Section 139.2.

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628 (j)): "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 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 compliance with recent Workers' Compensation legislation (Labor Code Section 5703 under AB 1300): "I have not violated Labor Code Section 139.3 and the contents of this report are true and correct to the best of my knowledge. This statement is made under penalty of perjury and is consistent with WCAB Rule 10978."

The undersigned further declares that the charges for this patient are in excess of the RVS and the OMFS codes due to high office and staff costs incurred to treat this patient, that the charges are the same for all patients of this office, and that they are reasonable and necessary in the circumstances. Additionally, a medical practice providing treatment to injured workers experiences extraordinary expenses in the form of mandated paperwork and collection expenses, including the necessity of appearances before the Workers' Compensation Appeals Board. This office does not accept the Official Medical Fee Schedule as prima facie evidence to support the reasonableness of charges. I am a board-certified Doctor of Chiropractic, a state-appointed Qualified Medical Evaluator, a Certified Industrial Injury Evaluator and certified in manipulation under anesthesia. Based on the level of services provided and overhead expenses for services contained within my geographical area, I bill in accordance with the provisions set forth in Labor Code Section 5307.1.

NOTE: The carrier/employer is requested to immediately comply with 8 CCR Section 9784 by overnight delivery service to minimize duplication of testing/treatment. This office considers "all medical information relating to the claim" to include all information that either has, will, or could reasonably be provided to a medical practitioner for elicitation of medical or medical-legal opinion as to the extent and compensability of injury,

including any issues regarding AOE/COE - to include, but not be limited to, all treating, evaluation, and testing reports, notes, documents, all sub rosa films, tapes, videos, reports; employer-level investigation documentation including statements of individuals; prior injury documentation; etc. This is a continuing and ongoing request to immediately comply with 8 CCR Section 9784 by overnight delivery service should such information become available at any time in the future. Obviously, time is of the essence in providing evaluation and treatment. Delay in providing information can only result in an unnecessary increase of treatment and testing costs to the employer. I will assume the accuracy of any self-report of the examinee's employment activities, until and unless a formal Job Analysis or Description is provided. Should there be any concern as to the accuracy of the said employment information, please provide a Job Analysis/Description as soon as possible.

I request to be added to the Address List for Service of all Notices of Conferences, Mandatory Settlement Conferences and Hearings before the Workers' Compensation Appeals Board. I am advising the Workers' Compensation Appeals Board that I may not appear at hearings or Mandatory settlement Conferences for the case in chief. Therefore, in accordance with Procedures set forth in Policy and Procedural Manuel Index No. 6.610, effective February 1, 1995, I request that defendants, with full authority to resolve my lien, telephone my office and ask to speak with me.

The above report is for medicolegal assessment and is not to be construed as a report on a complete physical examination for general health purposes. Only those symptoms which I believe have been involved in the injury, or might relate to the injury, have been assessed. Regarding the general health of the patient, the patient has been advised to continue under the care of and/or to get a physical examination for general purposes with a personal physician.

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

Sincerely,

Eric E. Gofnung, D.C.
Manipulation Under Anesthesia Certified
State Appointed Qualified Medical Evaluator
Certified Industrial Injury Evaluator

Signed this 10 day of December, 2021, in Los Angeles, California.

ADDENDUM 1 - REVIEW OF RECORDS

REVIEW OF RECORDS:

Pursuant to Cal Code Regs., Title 8, § 9793(n) the parties attested to sending 1827 pages , however only 1651 pages were provided for my review, these have been received and reviewed by myself in preparation of this report.

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

2. September 02, 2021, Attestation from Applicant Attorney Natalia Foley, Esq. attesting to 1827 pages being sent to Dr. Gofnung for his upcoming appointment on October 11, 2021.

3. October 25, 2021, Cover Letter for SIBTF Evaluation In Chiropractic Specialty (Date of Appointment – 10/25/21), from Natalia Foley, Esq (Workers' Defender's Law Group) to Eric Gofnung, DC: In this letter Ms. Foley indicated that Dr. Gofnung had been selected to act in the capacity of SIBTF Medical Evaluator in regard to the applicant's Subsequent Injury Benefit Trust Fund Claim in chiropractic specialty. He was specifically asked to provide a medical legal evaluation in his area of expertise as a chiropractic doctor. He was also provided with the medical records in this case for his review.

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

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

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

   c) Please cover in your report the following topics:

      - Subjective complaints
      - Objective factors or findings
      - Current diagnosis

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

d) Please answer within the scope of your specialty:

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

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

4. **Unidentified date of report**, Description of Employee's Job Duties: Job Description: The patient began employment with Benedict & Benedict Plumbing, as Plumber. His job included all types of commercial and residential plumbing/repairing. He worked 8 hours per day. His job duties included constant (6-8 hours) standing, repetitive use of right hand; frequent (3-6 hours) walking, standing, bending at neck and waist level, squatting, climbing, kneeling, crawling, twisting neck and waist, simple/power grasping & fine manipulation with both hands, pushing and pulling with both hands, reaching above and below both shoulder levels, lifting of 0-50 pounds and carrying of 0-100 pounds; as well as occasional (up to 3 hours) sitting, and occasional lifting of 50-100 pounds. His Job duties also included driving cars, trucks, forklifts and other equipment; working around equipment and machinery; walking on uneven grounds; exposure to excessive noise;

exposure to extremes in temperature, humidity and wetness; exposure to dust, gas, fumes or chemicals; working at heights; operation of foot controls or repetitive foot movement; use of special visual or auditory protective equipment; and working with bio-hazards such as bloodborne pathogens, sewage and hospital waste.

5. January 11, 2011, Office Visit, William White, MD, HealthCare Partners Medical Group: Reason for Consultation: New patient visit. HPI: The patient stated that he had a history of diabetes mellitus, which he felt was controlled with diet. He reported losing weight and had problems when he was taking medication for blood sugar control. He recently had an episode of acute gout and was taking Allopurinol 300 mg one daily. ROS: He stated that he had blurry vision that he felt was probably related to his diabetes. His sugars were high. Frequent urination was also reported that he attributed to his increased water intake. PE: Ht: 69 inch. Wt: 180 lbs. Body Mass Index: 26.6. GU: A wart noted on skin of the penis. Noted tight sphincter with evidence of hemorrhoids. Assessment/Plan: 1) Normal examination: Labs were ordered. Schedule EKG in 3 weeks. Referred to Valley GI for colonoscopy due to family history of colon cancer in fifties. 2) Diabetes mellitus, which was well-controlled; check current Hgb A1c. 3) Gout, which was improving; control risk factors. 4) Genital warts, which was failing to change as expected: Schedule removal in 3 weeks with Dr. White.

6. February 02, 2011, Followup Office Visit, William White, MD, HealthCare Partners Medical Group: Reason for Visit: Followup on tests; joints ache all over; wart on penis. Current Medications: Allopurinol 300 mg, Accu-Chek Aviva Strip, Accu-Chek Multiclix Lancets Miscellaneous, Accu-Check Aviva Kit. Vital Signs: BP: 140/86. Wt: 183 lbs. Body Mass Index: 26.4. PE: Penis: Skin of penis had a 1 cm x 1.5 cm wart. Assessment: 1) Diabetes mellitus, which was well-controlled; check current HgbA1c. 2) Gout, which was improving; control risk factors. 3) Genital warts, which was failing to change as expected; wart on skin of penis; biopsied and removed same day. Prescribed Cephalexin 500 mg.

7. March 23, 2011, Followup Office Visit, William White, MD, HealthCare Partners Medical Group: Chief Complaints: Multiple aches and pains; concerns regarding back pain; blood sugars had been elevated. Interim History: The patient stated that he has had pain in his arm and forearm bilaterally. He stated that he was having pains in his left low back. His fasting blood sugars were noted to be of 180-190 range. This was not consistent with his last hemoglobin A1c, which was 6.4. He was not taking any diabetic medications. Current Medications: Allopurinol 300 mg, Indomethacin 25 mg, Accu-Chek Aviva Kit, Accu-Chek Aviva Strip, Accu-Check Multiclix Lancets Miscellaneous. Vital Signs: Wt: 182 lbs. Body Mass Index: 26.7. PE: Complained of bilateral upper extremity and back pain. Assessment/Plan: 1) Diabetes mellitus, which was failing to change as expected; he stated that his Finger stick reading were of 180 range. Last Glyco January 04, 2011 = 6.4. 2) Gout, which was improving. 3) Backache, which was mildly exacerbated; probably muscle strain; control risk factors.

8. July 22, 2011, X-Ray of Thoracic Spine, Warren W. Lam, MD: Impression: Normal thoracic spine.

9. July 22, 2011, X-Ray of Cervical Spine, Warren W. Lam, MD: Impression: There is some mild degenerative changes noted involving C3-4 and C5-6. There are no fractures, subluxations or bony erosions. The prevertebral soft tissues are normal.

10. July 22, 2011, Followup Office Visit, William White, MD, HealthCare Partners Medical Group: Chief Complaint: Pains in upper back. Interim History: The patient stated that he was always tired. He complained of pain in his upper back. His fasting blood sugars were in 130 to 140 range with occasional 170. His last hemoglobin A1c was 6.4 (in January 2011). Current Medications: Remained unchanged. Vital Signs: Wt: 182 lbs. Body Mass Index: 26.7. PE: Neck: He had good flexion and could touch his chin 1 inch from chin to chest, left and right lateral motion of the neck, 45-50 degrees. There was mild tenderness over C7 vertebrae. Assessment: 1) Hypercholesterolemia, which was failing to change as expected; elevated LDL consider statin therapy. 2) Diabetes mellitus, which was well-controlled; he stated that his Finger stick readings were of 180 range. Last Glyco Jan 04, 2011 = 6.4. 3) Gout, which was improving; control risk factors. 4) Backache, which was mildly exacerbated; probable muscle strain; Control Risk Factors. Prescribed naproxen 375 mg.

11. September 23, 2011, Followup Office Visit, William White, MD, HealthCare Partners Medical Group: Chief Complaints: Fatigue, night sweats, left flank pain. Interim History: The patient stated that he went to Uta fishing for vacation and after that he had problems with fatigue. He stated that he had frequent urination at night and has had left **mid** pain and flank pain. His previous white blood counts were noted at 12000 and 11000 range. He was working as a plumber. He had not lost any time from work. He was smoking about a pack for 20+ years and has had cough at times. Father had colon carcinoma in his fifties. The patient had been advised to have colonoscopy but this had not been performed yet. Physical Exam: Wt: 176 lbs. Abdomen: Left lower quadrant slight tenderness with percussion over the left kidney area was noted. Assessment/Plan: 1) Increased urinary frequency, which was failing to change as expected. Plan urinalysis. 2) Cigarette smoking, which was failing to change as expected; less than one pack a day over 20 years. Advised to stop. 3) Chronic fatigue syndrome, which was failing to change as expected. Labs were ordered. Fatigue-malaise-left flank pain: Consider left kidney infection. Consider diverticulitis/consider lung infection. Other orders: Chest x-ray/colonoscopy. He was to call in 5 days regarding test results.

12. September 23, 2011, X-Ray of Chest, Babak A. Yaghmai, MD: Impression: Normal chest.

13. September 30, 2011, Message, William White, MD, HealthCare Partners Medical Group: Left a message to patient indicating that he had elevated WBC count. Also, informed that A1c was noted be at 6.1. Advised him to call back and do additional testing regarding his fatigue.

14. October 10, 2011, Ultrasound of Abdomen, Byron M. Sotomayor, MD: Impression: 1) There is no evidence of gallstone or biliary dilation. No focal hepatic mass is shown. The liver appears within normal limits in size and morphology. 2) The pancreatic body, spleen, and bilateral kidneys appear within normal limits.

15. October 10, 2011, Renal/Bladder Ultrasound, Byron M. Sotomayor, MD: Impression: Unremarkable renal ultrasound. There is no evidence of renal calculi, hydronephrosis, or renal solid mass lesion.

16. October 21, 2011, Followup Office Visit, William White, MD, HealthCare Partners Medical Group: Chief Complaints: Lower left abdominal pain, elevated WBC count, frequency of urination, malaise and fatigue of undetermined cause. Assessment: 1) Abdominal tenderness. 2) Chronic fatigue syndrome. Plan: Prescribed Cipro 500 mg and Metronidazole 500 mg. Labs were ordered. Colonoscopy was ordered.

17. October 25, 2011, Gastroenterology Followup Note, Samuel Mourani, MD: Chief Complaint: The patient was referred because of abdominal pain and family history of colon cancer. Impression: 1) Left lower quadrant abdominal pain. Symptoms could be related to mild diverticulitis. Colon malignancy should be excluded. 2) Family history of colon cancer. His father was diagnosed with colon cancer in his fifties. Recommendations: Continue antibiotics; would be scheduled for colonoscopy next week.

18. November 04, 2011, Colonoscopy Report, Samuel Mourani, MD: Impression: 1) Polyp in the proximal ascending colon. 2) Diverticulitis of the descending colon. 3) Grade 2 internal hemorrhoids. Recommendations: 1) High fiber diet and fiber supplement. 2) Dicyclomine Hydrochloride 20 mg. 3) Followup with this examiner in Arcadia office within 2-3 weeks. 4) Colonoscopy in 3 years.

19. November 10, 2011, Gastroenterology Followup Note, Samuel Mourani, MD: Interim History: The patient came in followup. Colonoscopy done six weeks prior showed a polyp in the proximal ascending colon, which was removed. He was noted to be have diverticulosis and internal hemorrhoids. He further reported that apparently, he woke up early in the morning previous day with severe cramps and had been having significant problem with loose stools, tenesmus, and frequency. He also noticed some blood in the stool. Physical Examination: There was left-sided periumbilical abdominal tenderness. Impression: 1) Adenomatous colon polyp and family history of colon cancer. 2) Diverticulosis coli. 3) Diarrhea, tenesmus, and blood in the stool were likely related to Clostridium difficile colitis. She had received ciprofloxacin recently and this examiner suspected that the patient's presentation was most consistent with Clostridium difficile colitis. Diverticulitis should be kept in mind as a cause of this presentation but this examiner suspected that this was less likely. Recommendations: She was started on metronidazole 250 mg and he was asked to start taking probiotics. He was advised to

take metronidazole for two weeks. Stool ordered for Clostridium difficile toxin. He was asked to call after he did the stool test to discuss results and to update on progress.

20. December 01, 2011, Gastroenterology Followup Note, Samuel Mourani, MD: Interim History: The patient was in followup. He was now reporting intermittent symptoms of abdominal pain occasionally in the periumbilical area and occasionally in the left side of the abdomen with some radiation to the back. There were also some reports of bloating and constipation. He tried Bentyl, which tend to help his symptoms but was causing lethargy. PE: Abdomen: Noted periumbilical left-sided tenderness. Impression: Symptoms were likely related to irritable bowel syndrome. Recommendations: He was reassured. Suggested to take Trazodone 50 mg nightly. Routine labs and a CT scan of the abdomen and pelvis were ordered. Advised to followup in three weeks.

21. January 05, 2012, Gastroenterology Followup Note, Samuel Mourani, MD: Interim History: The patient continued to report left lower quadrant abdominal pain. The pain was intermittent without clear relieving or exacerbating factors. He also reported mild constipation. He tried Trazodone, but that was causing lethargies, so he was not compliant with it. He mentioned that Bentyl offered some help. PE: Weight: 182 lbs. There was left lower quadrant abdominal tenderness. Recent CT scan showed mild diverticulosis without obvious diverticulitis. Laboratory data continued to show mild leukocytosis. Impression: Persistent complaint of left lower quadrant abdominal pain associated with mild leukocytosis, although he had no obvious diverticulitis on CT scan. The possibility of mild diverticulitis could not be completely excluded. Recommendations: Suggested a course of Augmentin 875 mg twice a day for 10 days and also probiotics. This examiner asked the patient to have a CBC done towards the end of the treatment and then followup in two weeks. His decrease in white count would be monitored with above treatment. If leukocytosis persist despite above treatment, then further evaluation with hematological consultation would be required.

22. January 19, 2012, Gastroenterology Followup Note, Samuel Mourani, MD: Interim History: The patient was seen in followup. He was given Augmentin after his last visit and he was asked to repeat his CBC, which continued to show leukocytosis. He mentioned that his abdominal pain was slightly better, but he still had some lower abdominal discomfort and constipation for which he was using Bentyl with some improvement. PE: Wt: 184 lbs. Abdomen: Left lower quadrant abdominal tenderness was noted. Impression: 1) Lower abdominal pain, likely functional and related to irritable bowel syndrome. He had diverticulosis, but there was no evidence of diverticulitis on colonoscopy or CT scan. 2) Persistent leukocytosis without response to antibiotics. Suspicion of bone marrow pathology should be excluded. Recommendations: Advised him to continue Bentyl. Suggested fiber supplements on a regular basis. He was referred to see Dr. Polonsky for further evaluation of his mild leukocytosis. Advised him to followup in 6-8 weeks.

23. February 07, 2012, Initial Hematology Consultation, Monty B. Polonsky, MD: HPI: The patient with a recent history of leukocytosis. He reported that it was discovered in

September when he was being seen because he wasn't feeling well and was weak like a "wet noodle," but besides that, no other specific complaints were reported. He reported that his appetite had decreased a bit but not hugely. He had been trying to eat more healthfully. He had lost 15 pounds over the last four months, primarily from change in diet and not eating quite so much, **which change he had attributed to his girlfriend**. His energy level was moderately decreased as noted above, and this was his main complaint. He did have some sweats when his gout was active and his diabetes was out of control but nothing severe. PMH: Gout, diabetes mellitus, sweats when sugars were out of control. In 2006, he underwent bilateral mastectomies. Reviewing the pathology from Methodist Hospital revealed that it was not actually mastectomies but bilateral breast tissue was removed, presumably from gynecomastia, which was becoming irritating and painful, especially while he was working. PE: Wt: 179 lbs. Impression: The patient with mild leukocytosis but normal differential. He did have a history of gout and diabetes mellitus. Gout might be present at a chronic low level causing mild stimulation of his white cells, causing them to be mildly elevated. In addition, patients with diabetes mellitus, frequently had chronic infections at a subacute level and this might be causing mildly elevated white blood cell count. This examiner had asked that the patient stop his prednisone soon, wait at least one week, get some labs done, and return back in one week later. These labs were to include CMP, CBC, BCR-ABL qualitatively, iron studies including ferritin, JAK2, reticulocyte count, ESR, C-reactive protein, and vitamin B12 folic acid levels. Depending on these results, further evaluation would be considered. At this point, it appeared to be a benign process but again, this examiner would await labs for further interpretation.

24. <u>February 14, 2012, Followup Office Visit, Seetha Lath, MD, HealthCare Partners Medical Group:</u> HPI: The patient was seen for an urgent visit because his blood sugar level was 450. He had chronic gout and was on allopurinol 300 mg with good control. 2 weeks prior, he had developed pain in his knee and left foot. His PCP advised him to take 5 mg prednisone for one week. He had diabetes mellitus controlled with diet alone. His last glycohemoglobin was 6.1. His blood sugar had been gradually increasing. 5 days prior, it was 230, went up to 300 for 2 days and over 400 next 2 days. His friend alerted him that he might develop a diabetic coma and that he should see the physician ASAP. He stated that his eyes were blurry same day. Current Medications: Allopurinol 300 mg, Accu-Chek Avia in Vitro Strip, Accu-Chek Multiclix Lancets Miscellaneous, Accu-Chek Aviva KIT, Carisoprodol 350 mg, Ciprofloxacin Hcl, Metronidazole 500 mg, Naproxen 375 mg, Colcrys 0.6 mg, Prednisone 5 mg. Vitals: BP: 122/78. Wt: 178 lbs. Body Mass Index: 26.3. Random Blood Sugar: 558 mg. Urinalysis showed increased sugar levels. Assessment: Diabetes mellitus, which was severely exacerbated; blood sugar of 558 mg possibly secondary to prednisone intake. Plan: Discontinue prednisone. He was thirsty and drank 3 glasses of water after which he felt better. Continue Allopurinol. He was advised to go to urgent care clinic in Pasadena now.

25. <u>July 13, 2012, Emergency Department Report, James D. Luna, MD</u>: DOI: 07/11/2012. History of Present Injury: The patient presented with a left thumb injury that occurred 2 days prior while opening up a piece of wall for re-plumbing purpose, and the wall fell

onto his left thumb, hitting on the top of it, resulting in a laceration on the side of the nail and ecchymosis of the nail itself and also pain at the first metacarpophalangeal joint. He tried to work but found the pain was too much, and he presented for evaluation. PMH: Gout and diabetes. Physical Examination: Extremities: The left thumb had minor laceration on the ulnar aspect of the nail. There was also a subungual hematoma, although it was small and did not appear to be drainable. The entire area was tender to palpation because of these injuries. There was also pain at the distal metacarpophalangeal joint. Diagnosis: Left thumb torus type fracture at the metacarpophalangeal joint, subungual hematoma and minimal distal thumb laceration. Treatment Plan: He would be placed in a thumb spica splint. X-ray of the right thumb was performed and reviewed. Work Status: He would be taken off work for a week.

26. July 13, 2012, X-ray of Right Thumb, Warren W. Lam, MD: Impression: 1) No fracture, dislocation or destructive bony change. 2) No arthritic change noted. 3) Some mild soft tissues swelling around the thumb was noted in the hypothenar eminence. 4) No radiopaque foreign body.

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

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

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

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

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

32. September 04, 2012, Primary Treating Physician's Progress Report (PR-2) – Periodic Report, George Tang, MD: Interim History: The patient presented here for follow-up visit of his right thumb fracture. He had some discomfort without the cast in that thumb area. Assessment and Plan: First metacarpal fracture, **right**: He was done quite well. He was recommended to have a thumb spica orthosis to transition him out of the cast area to wear nothing. Also recommended to have physical therapy. Work Status: He remained on total disability until October 31, 2012.

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

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

35. November 08, 2012, Primary Treating Physician's Progress Report (PR2) – Periodic Report, George Tang, MD: Interim History: The patient presented for follow-up visit of his right thumb fracture. He still had a bit of limited range of motion throughout the hand and thumb area. He had a bit of pain in the hand and thumb area. Physical Examination: Right Hand: The hand was colder than the contralateral side. Right Wrist: He had pain with the range of motion and wrist flexion and extension. His wrist flexion had improved considerably. He was able to flex down to roughly about 35 degrees with the wrist extension. He had quite a bit of pain when extending to about 20 degrees. Thumb: Range of motion was somewhat limited secondary to the pain as well. He was stable to touch the small finger, but with the small finger extending into the thumb instead of the thumb going to the small finger. He had generalized pain throughout. Assessments: 1)

First metacarpal fracture, **right**. 2) Reflex sympathetic dystrophy. Plan: 1) Neurologist recommended an EMG to the right upper extremity. 2) Given some enteric-coated Naprosyn as an antiinflammatory medication; Prilosec to prevent upset stomach; Medrox as an antiinflammatory cream to use as necessary to decrease the symptoms around the thumb itself. Work Status: Remain on total disability until December 31, 2012.

36. December 20, 2012, Primary Treating Physician's Progress Report (PR2) – Periodic Report, George Tang, MD: Interim History: The patient presented for follow-up visit of his right thumb. He saw the neurologist and the neurologist recommended an EMG to the right upper extremity. He complained of some numbness on the thumb area, in the palmar aspect of the thumb region. His range of motion was still decreased in the right thumb area. He had finished his physical therapy. The therapy had been helpful in terms of getting range of motion of his fingers and his wrist area. He had quite a bit of symptoms of pain in that right thumb region. Physical Examination: Sensation was decreased in the thumb area. Range of motion was decreased compared to the other side. Assessments: 1) First metacarpal fracture, **right**. 2) Reflex sympathetic dystrophy. Plan: 1) Neurologist recommended an EMG to the right upper extremity. 2) Given some enteric-coated Naprosyn as an antiinflammatory medication; Prilosec to prevent upset stomach; Medrox as an antiinflammatory cream to use as necessary to decrease the symptoms around the thumb itself. Work Status: Remain on total disability until February 28, 2013.

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

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

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

40. January 31, 2013, Primary Treating Physician's Progress Report (PR2) – Periodic Report, George Tang, MD: Interim History: The patient presented for a follow up visit of his right hand and wrist area. His hand was still painful and had an EMG done on January

15, 2013, which showed mild carpal tunnel syndrome. Physical Status: Pain throughout the whole right arm. Diagnoses: 1) First metacarpal fracture, **right**. 2) Possible reflex sympathetic dystrophy. Plan: He would start the physical therapy. Given some enteric-coated Naprosyn as an antiinflammatory medication; Prilosec to prevent stomach upset; Medrox as an antiinflammatory cream to use as necessary to decrease the symptoms around the thumb itself and Gabapentin as a medication to treat his possible reflex sympathetic dystrophy condition. Work Status: He was temporarily totally disabled from any work until approximately March 30, 2013.

41. February 18, 2013, Initial Comprehensive Evaluation and Request for Authorization of a Primary Treating Physician/Doctor's First Report of Occupational Injury or Illness, Edwin Haronian, MD: DOI: 07/11/2012. Job Description: The patient began employment with Benedict & Benedict Plumbing in February 2010, as Plumber. He worked 6-12 hours per day, five days per week, and worked on call "a couple of days a week". His duties at the time of injury entailed: Travelling to different job sites, loading and unloading material and tools from and onto a truck, carrying these to his immediate work site, repairing/removing/replacing toilets, sinks, bathtubs, and working on new water line and gas pipes. He was required to make holes on the ground and break walls. He utilized various hand-held and power tools. The precise activities required entailed: Prolonged standing and walking as well as continuous fine maneuvering of his hands and fingers, and repetitive bending, stooping, squatting, kneeling, crawling, twisting, turning, forceful pushing and pulling, forceful gripping and grasping, reaching to all levels, torqueing, lifting and carrying up to 100+ pounds, ascending stairs and ladders. History of Injury: Remained unchanged. Current Work status: He remained off work since July 12, 2012. Employment History: He stated that prior to working for Benedict & Benedict plumbing, he was self-employed as a Plumber. He had worked as plumber for close to 30 years. Present Complaints: 1) Right wrist/hand and thumb: He had continuously complained of aching in his right wrist, hand and thumb; at times becoming sharp, shooting and throbbing pain. His pain was radiating to his forearm. He had episodes of numbness and tingling and he complained of cramping and weakness in the right hand.

    He was losing muscle tone in the right and thumb. His pain increased with gripping, grasping, and repetitive hand and finger movements. He had difficulty sleeping and was awakening with pain and discomfort. His pain level was varying throughout the day depending on activities. Pain medication provided him temporary pain relief. 2) Non orthopedic complaints: Depression/anxiety. Medications: He was taking prescribed medication for diabetes, Motrin 800 mg and Prevacid. Activities of Daily Living: Activities of Daily Living were reviewed. Physical Examination: Wrist & Hand: There was tenderness over the distal radius and the carpus on the right. Phalen and Reverse Phalen testing were positive on the right. Finger: Range of motion was painful over the right thumb without mechanical block. The thumb adduction/abduction was decreased over the right thumb. Review of Medical Records: Reviewed EMG/NCV of right upper extremity dated January 15, 2013. Diagnoses: 1) Right carpal tunnel syndrome status post right thumb fracture, which has healed. 2) Right hand contusion. Plan: 1) Consult for pain management to rule out reflex sympathetic dystrophy (RSD). 2) 4 sessions of

psychotherapy for depression/anxiety. 3) Acupuncture 2 times a week for 3 weeks to right wrist to right hand. Medications: 1) Cream Baclofen. 2) Medrox patch. 3) Prilosec. 4) Relafen. 5) Thumb spica. 6) Ultram. Work Status/Restrictions: No use of the right hand. He should remain on TTD, if the work modifications could not be accompanied by the employer.

42. March 18, 2013, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right wrist and hand following previous fracture. Pain level was 7-8/10. He was awaiting pain management consultation to rule out reflex sympathetic dystrophy. PE: He was visibly uncomfortable. Significantly decreased grip strength was noted on the right side. Mottling and allodynia was noted. Diagnoses: 1) Wrist tendinitis/bursitis, **right**. 2) Hand contusion, **right**. Plan: Recommended to refill therapeutic cream and to start Neurontin, Elavil and Vitamin C. Requests were placed for authorization for MRI of right wrist without contrast, consult with pain management to rule out reflex sympathetic dystrophy, four sessions of psychotherapy, psychological evaluation and acupuncture six times for the right wrist and hand. Advised to continue modified work duties.

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

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

of Daily Living were reviewed. Current Medications: Metformin, Januvia, Baclofen Cream, Medrox Patch, Prilosec, Relafen, Neurontin and Lexapro.

Social History: Widowed. He was a smoker for 30 years and smokes less than a pack of cigarettes per day. ROS: Anxiety, stress and depression. PE: Weight: 170 pounds. Diminished reflexes 1/2 in biceps, triceps and brachioradialis on the right. Decrease motor strength 4-/5 over the right wrist flexor and wrist extensors. Tenderness was noted over the entire elbow joint including the medial and lateral epicondyles on the left and right with swelling noted. There was significant mottling of the right hand with cooler temperature compared with the left hand. There was mild hyperhidrosis on the right. Diagnostic Studies: Reviewed the right upper extremity electrodiagnostic studies dated January 15, 2013. Impression: 1) History of right hand contusion. 2) Sympathetically-mediated neuropathic pain, right upper extremity, possible mild complex regional pain syndrome. Recommendation: Medication regimen that included Neurontin and Elavil to be optimized. Dr. Kohan opined that triple phase bone scan would help with the diagnosis in an objective manner. He added that if no other pathology could be noted over the right wrist requiring surgery, the patient could be recommended to undergo a series of stellate ganglion injection to address his symptomatology. Disability and work status: Deferred to PTP.

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

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

    Diagnoses:

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

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

Axis III: GAF score of 56.

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

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

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

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

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

51. July 09, 2013, Physician's Progress Report (PR2), Heath Hinze, Psy. D: Subjective Complaints: The patient reported to have anger, anxiety, fear, feeling hopeless and inability to gain pleasure in life. Objective Findings: He appeared to be angry, anxious, depressed and hopeless. Diagnoses: 1) Anxiety disorder. 2) Depressive disorder. Treatment Plan: Recommended 4 sessions of cognitive behavioral therapy and relaxing training sessions.

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

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

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

55. August 06, 2013, Physician's Progress Report (PR2), Heath Hinze, Psy. D: Subjective Complaints: The patient reported to have anger, anxiety, fear, feeling hopeless and inability to gain pleasure in life. Objective Findings: He appeared to be angry, anxious,

depressed, fearful and hopeless. Diagnoses: 1) Anxiety disorder. 2) Depressive disorder. Treatment Plan: He was requested for 4 sessions of cognitive behavioral therapy and relaxing training sessions. Work Status: Deferred to PTP.

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

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

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

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

60. September 19, 2013, Secondary Treating Physician Pain Management Follow-Up Report, Jonathan Kohan, MD: Interim History: The patient presented with a complaint of a chronic unremitting pain in his right wrist, hand and distal forearm. Pain level was 8/10. He was maintained on Neurontin, Relafen, Elavil and Norco. His pain was suboptimally controlled. Received approval for one right stellate ganglion injection. PE: He was

visibly uncomfortable. Allodynia was noted in his right hand and wrist with colder temperature when compared to opposite extremity. Decreased grip strength was noted. Impressions: 1) Complex regional pain syndrome type 1. 2) Chronic wrist and hand pain on the right side. Recommendation: Refilled medications. Lyrica to be started. Work Status: Deferred.

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

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

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

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

65. November 11, 2013, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient was status post stellate ganglion block on the upper extremity conducted on October 16, 2013. He stated minimal benefit from this intervention provided by the pain management physician, Dr. Kohan. He continued to complain of right hand pain with hypersensitivity and reduced function. He was status post a right thumb fracture with closed treatment only. Physical examination showed hyperesthesia over the whole right upper extremity. He presented wearing a thumb spica splint. He held the limb in unnatural position and was reluctant to utilize the hand. There was significantly decreased range of motion in the hand and wrist. The grip strength was significantly reduced. There was some skin and hair atrophy noted. Diagnoses: 1) Hand contusion. 2) Wrist tendinitis/bursitis. 3) Finger fracture. Plan: He had now failed to

respond to stellate ganglion block. Dr. Haronian opined that the spinal cord stimulation was the next appropriate step. He reported that the patient had significantly reduced function, and he was using opioid pain medication. He opined that the spinal cord stimulator was likely to reduce the patient's pain level and reduce his usage of opioid pain medication, and improve his function. Work Status/Restrictions: No use of the right hand. He should remain on temporary total disability if the work modifications could not be accommodated by the employer. Return to clinic in 6 weeks.

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

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

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

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

70. December 12, 2013, Secondary Treating Physician Pain Management Follow-Up Report and Request for Authorization, Jonathan Kohan, MD: Interim History: The patient presented with a complaint of a chronic pain in his right forearm, wrist and hand. Pain level was 6-7/10. He was diagnosed with complex regional pain syndrome type 1 of the right upper extremity and was being considered for spinal cord stimulator as he failed to improve with other means. PE: He was visibly very uncomfortable. Allodynia was noted on the right distal forearm, hand and wrist. Decreased grip strength was noted. Impression: Complex regional pain syndrome type 1 with right forearm, wrist and hand. Recommendation: Continued to await authorization for psychological consult for

clearance for spinal cord stimulator. Dr. Kohan opined that the patient had failed to improve with a plethora of conservative treatment and remained to be very symptomatic and he was a strong candidate for the recommended treatment. Formal request to be placed for authorization for purchase of right wrist brace. Work Status: Deferred.

71. January 06, 2014, Follow-Up Report of Primary Treating Physician, Edwin Haronian, MD: Interim History: The patient continued to complain of significant pain in the right upper extremity. Diagnoses: 1) Reflex sympathetic dystrophy of lower limb. 2) Anxiety disorder, not otherwise specified. 3) Depressive disorder, not otherwise specified. 4) Male erectile disorder. 5) Sleep disorder due to pain, insomnia type. 6) Hand contusion. 6) Wrist tendinitis/bursitis. 7) Finger fracture. Plan: He was being seen by Dr. Kohan who diagnosed him with reflex sympathetic dystrophy. Dr. Kohan had requested spinal cord stimulator; however, the patient required to be cleared psychologically prior to that procedure.

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

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

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

medications in an abrupt fashion and that he required the medical therapy in order to function. Work Status/Restrictions: Remained unchanged.

75. March 06, 2014, Secondary Physician Progress Report (PR-2), Jonathan Kohan, MD: Subjective Complaints: The patient reported depressed mood. Objective Findings: He appeared depressed and the affect was flat. Treatment Plan: Norco, Neurontin and Levaquin. Work Status: Deferred to PTP.

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

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

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

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

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

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

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

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

84. June 19, 2014, Secondary Treating Physician Pain Management Follow-Up Report and Request for Authorization, Jonathan Kohan, MD: Interim History: The request for permanent placement of his neuromodulation unit had been submitted for review on June 13, 2014. Physical Examination: There were no changes in his left upper extremity

mottling and hyperhidrosis. Impression: 1) Complex regional pain syndrome, right upper extremity type 1. 2) Right wrist tendinosis. Recommendation: Authorization and request would be submitted for his medication regimen of Elavil, Neurontin and Norco. Disability and work status were deferred.

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

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

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

88. August 27, 2014, Operative Report, Jonathan Kohan, MD: Pre and Postoperative Diagnosis: Complex regional pain syndrome. Procedures Performed: 1) Percutaneous implantation of spinal cord stimulation leads x 2, cervical spine. 2) Implantation of pulse

generator. 3) Myelogram. 4) Complex programming. 5) Somatosensory evoked potential.

89. September 04, 2014, Secondary Treating Physician Pain Management Follow-Up Report, Jonathan Kohan, MD: Interim History: The patient was status post percutaneous implantation of spinal cord stimulator. Impressions: 1) History of complex regional pain syndrome. 2) Status post recent spinal cord stimulation implantation, cervical spine. Recommendations: Both incisions were redressed. Recommended to continue Levaquin and soft cervical collar. Disability Status: Total and temporarily disabled for at least three months.

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

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

92. October 16, 2014, Secondary Physician's Progress report (PR-2), Jonathan Kohan, MD: Subjective Complaints: The patient reported to be adjusting with the spinal cord stimulator but was feeling sharp pain in abrupt movements. He reported still struggling with financial strain, which was a constant stressor for him. He reported that he was feeling as if he was devalued as a person by the lack of respect he was receiving from his attorneys and doctors, which had impacted his self-esteem and mental status. He reported feeling angry, anxious, depressed mood, loss of control, hopeless, inability to gain pleasure in life, irritability, isolation from others, loss of appetite, sleep disturbances, struggling with activities of daily living, withdrawing from family and friends, worry

about financial strain, worry about pending deposition, and worry about persistent pain. Objective Findings: He appeared apathetic, dysphoric, euthymic and fatigued. Affect was flat. Diagnoses: 1) Hand contusion. 2) Wrist tendinitis/bursitis. 3) Finger Fracture. 4) Anxiety disorder. Treatment Plan: Same day's evaluation showed Beck Anxiety Score of 43 (severe) and Beck Depression Score of 42 (severe). Prescribed Elavil 50 mg, Neurontin 300 mg and Norco 7.5/325 mg. Work Status: Deferred to PTP.

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

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

95. June 02, 2015, Permanent and Stationary Comprehensive Psychological Evaluation of a Secondary Physician, Heath Hinze, Psy. D: Interim History: The patient was seen for an initial evaluation on May 07, 2017. He was diagnosed with depressive disorder, not otherwise specified; anxiety disorder, not otherwise specified; sleep disorder due to pain

insomnia type; and marked erectile disorder. He was started on a trial of cognitive behavioral therapy. At that time he was on Lexapro. A psychiatric consultation was also recommended. He returned and maintained active participation in treatment. As he was pending a spinal cord stimulator trial, a psychological surgical clearance evaluation was conducted on 02/04/14. He underwent the trial in May 2014 and permanent placement on 08/27/14. He reported that his primary treating physician was changed to Dr. Kohan. He remained off work though apparently he was given a work restriction that he could return to work so long as he did not use his right hand. He apparently had a PQME with Dr. Aval, orthopedist on June 30, 2015. Review of Records: Dr. Hinze reviewed Dr. Kohan's followup report dated May 13, 2015.

Diagnoses:

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

Axis II: No diagnosis.

Axis III: Deferred to appropriate medical specialist.

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

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

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

Causation/Apportionment: Dr. Hinze opined that the events of the employment were the predominate cause (greater than 51%) of this patient's emotional psychological injury. No apportionment was indicated for nonindustrial factors. AMA Impairment Rating:

WPI: 15% (mild impairment that was equivalent to GAF 60). Work Restrictions: Dr. Hinze opined that any duties that would exacerbate the patient's injury and increase his pain level would likely cause a corresponding worsening of his psychological symptoms and increase risk for relapse. As such any work restrictions outlined by the primary treating physician should be adhered to. He was advised to avoid taking on high pressure positions or those requiring strict adherence to production quotas. He was also recommended to avoid taking on night shift positions as that might further disrupt his sleep cycle. Future Psychological Recommendations: Recommended 24 behavioural therapy and relaxation training sessions to be set aside and used intermittently to maintain stability and to confront this chronic condition. He should have access to psychiatric consultations for medication management. Further evaluations and diagnostic studies should be available to assess his progress in treatment.

Patient Work Function Impairment:

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

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

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

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

hyperesthesia to the entire right hand, with decreased sensation, grade 4/5, about the tips of all digits on the right hand. He had grip loss secondary to pain with attempts at grasping. There was abnormal cooler temperature about the right hand. Diagnostic Studies: X-rays of the bilateral hands were performed and reviewed, which did not reveal any acute abnormalities.

Diagnoses: 1) Right hand trauma with reported non-displaced fracture of the right thumb with possible first metacarpal fracture per initial medical records. 2) Subsequent right hand sympathetically mediated pain, most consistent with chronic regional pain syndrome. 3) Mild right carpal tunnel syndrome, per electrodiagnostic evaluation of January 15, 2013. 4) Mild left hand strain, secondary to overcompensation. Discussion: Dr. Aval opined that though the patient had received appropriate treatment for his injury; however, he unfortunately developed chronic regional pain syndrome in the right upper extremity. He was advised to remain under the care of Dr. Kohan for medication and future injections. Dr. Aval did not recommend surgery given the patient's sympathetically mediated pain. According to him, if the patient were to undergo carpal tunnel release surgery, most likely his symptoms would significantly worsen. MMI Status: He had reached MMI status. Causation/Apportionment: Dr. Aval opined that the causation was 100% industrial. Impairment Rating: Right Upper Extremity: 25% WPI. Work Restrictions: He was precluded from activities of repetitive or forceful gripping, fine manipulation, torqueing, and heavy lifting with the right upper extremity based on which permanent work restrictions were indicated. If his employer could not accommodate these restrictions, he would be unable to return to his prior occupation. Future Medical Care: He should be allowed future medical care, which might include orthopedic consultations at times of flare-ups with a regimen of physical therapy and/or acupuncture. Updated diagnostic studies should be allowed and he should remain under the care of Dr. Kohan, for provision of various injections and monitoring, adjusting, and dispensation of medications. The spinal cord stimulator should be monitored as well.

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

could be the side effects of Neurontin. He was taking 800 mg four times per day and when the dose was cut down, the pain would be increasing. Dr. Baker had prescribed him Elavil 50 mg, to be taken in the evening. Other than Dr. Baker, he was only seeing his general practitioner, Dr. Bao Thai, under MediCal. She was treating him for his diabetes and high blood pressure conditions. He was prescribed Metformin 1000 mg, Glipizide 5 mg as well as an unrecalled medication for blood pressure. Both his blood pressure and diabetes had been under control.

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

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

started working for Benedict & Benedict in 2009. PMH: Anal fistula. Current medications: Neurontin, Elavil, Metformin, Glipizide. Review of records: Dr. Slonim reviewed the patient's medical/nonmedical records dated from 07/13/12 to 04/11/16.

Diagnoses:

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

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

Axis III: 1) Reflex sympathetic dysfunction, right wrist and hand. 2) Musculoskeletal complaints. 3) Cardiovascular complaints. 4) Gastrointestinal complaints. 5) Headaches. 6) High blood pressure, by history, controlled with medications. 7) Diabetes, Type II – controlled with medications. 8) Neurological problems.

Axis IV: 1) Occupational problems. 2) Problems with primary support groups. 3) Economic problems.

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

Disability Status: Dr. Slonim opined that the patient's was never temporarily totally disabled purely from a psychiatric point of view. He also opined that the patient's condition could be regarded as permanent and stationary with moderate psychiatric disability. Causation: Dr. Slonim opined that industrial causation was preponderant to all other causes combined in the psychiatric disability of this patient. He indicated that good faith personnel action was not a substantial factor. He added that; however, AOE/COE (Arising Out of Employment/during the Course of Employment) was a legal and not a medical decision, so he would leave it to the Trier of Fact. Nonindustrial Stressors: Anal fistula that was causing pain and discomfort. He also admitted being worried by his financial situation and problems with his girlfriend that were caused by these but also by his impotence, depression, and inability to function. He reported difficult childhood caused by his father's "military style" of being strict and critical and being very disappointed in his failure in school. He reported stress being cheated out of his inheritance by his siblings and not talking with them since his mother's death in 2007. For many years, he was his mother's caregiver after her strokes. He reported his wife, who suffered from bipolar disorder, committed suicide while he was away in 2001. His second wife, who was reportedly a "gold digger," cheated on him and then divorced him a year after they got married. In addition, he had preexisting diabetes. He also had left-sided, neurological symptoms with Parkinson's like movements of the left lower and upper extremities, as well as left sided paralysis of his mouth. He had preexisting personality traits as well.

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

AMA Disability Rating:

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

2) Concentration, persistence and pace - slight impairment.

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

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

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

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

99. <u>September 12, 2016, Pain Medicine Re-Evaluation, Gary L. baker, MD, QME:</u> Interval History: The patient's insomnia secondary to pain was worsening. He was requesting to replace current spinal cord stimulator's IPG/Battery with a non-rechargeable one. He has had ongoing difficulty charging the spinal cord stimulator IPG/Battery due to malposition of the battery and he had limited use of right hand to position charger to overcome malposition. The spinal cord stimulator IPG/Battery appeared to have either moved or was malpositioned initially so that it did not flush with his skin. It was also painful in its current position. The spinal cord stimulator was working well so the leads would not have to be replaced. He also reported night-time aggravation of right upper extremity symptoms as he was not able to protect the arm adequately while sleeping. Splint was received and was helpful with sleep but it was 1 size too small. He was in the process of getting it re-done. Subjective Complaints: 1) Neck pain - the pain was radiating down the bilateral upper extremities. 2) Upper extremity pain: There was constant pain in the right wrist, hand, fingers and thumbs that was radiating to the right forearm. His pain was accompanied by muscle weakness, numbness and tingling. Pain was rated as 8/10 in intensity with medications. Pain was rated 9/10 in intensity without medications. There was intermittent pain in the left wrist and hand with numbness and tingling. His pain was reported as recently worsened. 3) Non-orthopedic complaints: a) Insomnia. b) He reported continuous nausea. c) He also reported moderate constipation. Activities of

Daily Living: Activities of Daily Living were reviewed. Current Medications/Physical Exam/Diagnoses/Work Status: Remained unchanged. Treatment Provided: Spinal cord stimulator system adjusted with Medtronic rep to optimize pain coverage. System was otherwise working well but having continued problem with properly charging the spinal cord stimulator unit.

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

The patient did report an injury in this previous period of employment with this employer. He could not recall the date and did not file a claim. Regarding the previous injury, he stated that the owner at that time, Steve Teitz, sent him to a physician. He could not recall the details except to note that he apparently had a bruised coccyx. He estimated he missed three or four days with this injury but made 100% recovery. He reported that he suffered another injury after he restarted working for the company in approximately 2009. He was working on a drain that actually had acid in it without his knowledge. He cut the pipe, which contained acid in a basement. The acid from the cut pipe splashed in his eye. He was in Arcadia, California at that time. He went to an urgent eye care center through workers' compensation insurance. He missed a few days of work but made a 100% recovery. He stated the next injury, which occurred at work through this employer was the one on 07/11/2012. HPI: Remained unchanged. Interim History: He stated that Dr. Kohan first implanted a temporary spinal cord stimulator in May 2014 and a permanent spinal stimulator on 08/28/2014. Over the last six months or so, with the spinal cord stimulator, his typical pain level was 5/10. He estimated that on treatment with Gabapentin alone without the spinal cord stimulator, the pain levels would typically be at 7 or 8/10. Once he stopped the Gabapentin, the pain level would reach

10/10. Once this spinal cord stimulator was implanted on 08/28/2014, the insurance company did not approve Gabapentin treatment. However, currently he was on Gabapentin and was taking it along with Elavil. He indicated that since the injury on 07/11/2012, he had increased headaches. He stated that he had memory problems as well.

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

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

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

a. **<u>02/04/2014, Psychological Consultation, Heath Hinze, Ph. D</u>: On mental status examination, the patient appears slightly nervous with trembling in the left hand. The patient reported increased pain in the left hand that he relates to overuse. The patient demonstrated intact memory and orientation. Psychological testing was performed showing severe levels of subjective anxiety and depression. The patient had been receiving cognitive behavioral therapy from this office. Conservative care brought no improvement to the symptoms of the physical injury. The patient was hoping for at least a 50% reduction of the pain with the spinal cord stimulator. The**

patient continued to have neurovegetative signs with impaired sleep. Apparently, the Elavil now was described as causing grogginess resulting in the dosage decreased from 50 mg to 40 mg at night. At night, it is difficult for him to sleep because he feels "too wound up." He reported problems in concentration, focus, and memory. It was stated based on available information, the patient does not present with a major mood disorder or anxiety disorder that is sufficiently severe to interfere with the success or failure of the spinal cord stimulator trial. Therefore, he presents as a qualified candidate from a psychological perspective to undergo the recommended spinal cord stimulator trial. Authorization was requested for six treatments of cognitive behavioral therapy.

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

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

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

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

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

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

h. 02/17/2015, Primary Treating Physician's Follow Up Report, Jonathan Kohan, M.D: The patient had continuous right upper extremity pain and burning. It was stated that implantation of the spinal cord stimulator improved the symptoms by 50%. In addition, there was ongoing need for Gabapentin, Norco, and Elavil to

control pain, but side effects were denied. The Elavil improved sleep. He stated that Norco reduced the pain allowing facilitation of activities of daily living. Diagnosis was complex regional pain syndrome type 1 of the right upper extremity. Requests were made to refill Norco, Elavil, and Gabapentin. Work restrictions remained unchanged, which would be temporary total disability. It was noted that the cervical spine and bilateral upper extremities were not considered part of the patient's claim. This was puzzling considering the patient's right hand and wrist were injured and the hand and wrist are obviously part of the upper extremity.

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

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

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

l. **<u>05/13/2015, Pain Management Follow Up Report, Jonathan Kohan, M.D</u>: Stimulator helps about 40% to 50% for the right upper extremity complaints. There is much less sensitivity to touch and the burning pain improved. There is residual pain in the neck and right upper extremity. He was taking Norco 7.5 mg once or twice a day, Gabapentin 800 mg a day, and Elavil 50 mg at night. He denies side effects. On physical examination, there were described mild dysesthesias over the right upper extremity but no allodynia, swelling or hyperhidrosis. Impression was complex regional pain syndrome of the right upper extremity. Medications**

would continue but Neurontin would be decreased to 600 mg twice a day. Psychology treatment should continue.

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

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

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

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

q. <u>10/15/2015, Primary Treating Physician's Initial Comprehensive Orthopedic Evaluation Report, Edward Stokes, M.D</u>: There was an injury noted on 07/11/2012 involving the right hand, sleep and psychiatric. The patient did not recall specific details of the treatment. He attempted to prevent impact of the object from striking the head by putting his hands up. As a result, a piece of the wall broke over the

hand. There was no discussion of an actual head injury here; however, and there were no complaints of headaches. On physical examination, weight was described as 180 pounds. The circumference of the forearm 3 inches below the olecranon process was 21.5 cm on the right and 24.5 cm on the left. He had difficulties holding on to the dynamometer and squeezing it with the right hand. On the right hand, metacarpophalangeal flexion was 50 degrees at the thumb and 80 degrees at digits 2 through 5. Metacarpal extension of the thumb was 30 degrees and 20 degrees at digits 2 through 5. Proximal interphalangeal joint flexion was 70 degrees at the thumb and 100 degrees in digits 2 through 5. Proximal interphalangeal joint extension was 30 degrees at the thumb and 0 degrees in digits 2 through 5. Distal interphalangeal joint flexion was not recorded at the thumb and 70 degrees in digits 2 through 5. Distal interphalangeal joint extension was not recorded at the thumb and 0 degrees in digits 2 through 5. Upper extremity reflexes were normal.

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

r. **<u>02/15/2016, Initial Pain Medicine Evaluation, Gary Baker, M.D</u>: There was the injury described when a piece of a wall struck the right hand when it went over the head to protect the head. There was no discussion of a head injury or headaches here. Current medications were Elavil, glipizide, metformin and Neurontin. On physical examination, there was vertebral tenderness at C5 through C7 of the cervical spine. There was moderately limited cervical spine range of motion due to pain. There was decreased sensitivity to touch along the C5 through C7 dermatomes in the right upper extremity. The range of motion of the hand showed limited extension of the fingers. There was a discussion of shocks to the body with the spinal cord stimulator when in the sitting and/or lying position. It was stated that the permanent spinal cord stimulator was not helping like the temporary trial did. Currently, there is less than 50% pain control. The spinal cord stimulator needs adjustment. Patient was considered temporarily totally disabled. Diagnoses included ongoing type 2 complex regional pain syndrome of the right upper extremity, peripheral neuropathy, diabetes mellitus type 2 with hyperglycemia and right thumb nondisplaced fracture. Additional treatment included a fluoroscopic evaluation of the spinal cord stimulator in the Lakewood office. Amitriptyline 50 mg at night and Neurontin 600 mg q.6 hours as needed for pain were recommended.**

s. **<u>03/15/2016, Procedure Note, Dr. Gary Baker</u>: Diagnosis was right upper extremity complex regional pain syndrome, malfunction of the spinal cord stimulator needed**

to be ruled out. There will be a fluoroscopically-guided evaluation of the spinal cord stimulator. Patient tolerated the procedure well without complications. Plan would be to contact the Medtronic representative to assist in evaluating the cause of the positional shocks and suboptimal pain coverage.

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

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

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

w. **<u>07/18/2016, Pain Medicine Re-Evaluation, Gary Baker, M.D:</u> There was ongoing pain in the neck radiating to both upper extremities as well as right upper extremity pain worsened with activity. Medications were amitriptyline, Neurontin, glipizide, and metformin. The spinal cord stimulator system was adjusted with a Medtronic representative to optimize pain coverage. The system otherwise works well but there is continued problems with properly charging the unit. There was again discussion of currently less than 50% pain control with the spinal cord stimulator**

but this statement appears somewhat confusing. It again stated in the discussion session that the spinal cord stimulator needs adjustment. Treatment would be with right hand and wrist splint as well as refilling Elavil, amitriptyline, and Neurontin.

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

On mental status examination, the patient appeared to have some degree of underlying frustration, anxiety, and/or depression regarding his injury. His Mini-Mental State exam score was 26/28. Speech appeared mildly hypophonic and he complained of a softer voice for at least the last few months. On cranial nerve exam, there might be subtle mild masked facies present with decreased eye blink. There was mild-to-moderate atrophy of the right thenar and hypothenar eminences of the right hand. There were multiple, intermittent, spontaneous, jerky, involuntary movements involving predominantly the left upper extremity, but also other body parts such as the head, trunk, and bilateral lower extremities. The abnormal involuntary movements also involved the right upper extremity to a lesser degree. The involuntary movements had elements of Parkinson's disease like tremor, but also elements of the rapid movements of chorea and the slower movements of athetosis. The movements occurred at rest and were slightly worsened with movement including fine finger movement and finger-nose-finger testing. It appeared that the movements persisted with gait and probably interfered with gait. He noted that when he turned off the stimulator; those movements occurred perhaps 50% less than with the stimulator on. The right thumb was slightly flexed with essentially minimal volitional movement with severely restricted passive range of motion. The fingers, hand, and wrist on the right could be actively moved throughout approximately 50% of normal range of motion in all planes with pain except for flexion of distal interphalangeal joint, proximal interphalangeal joint and metacarpal phalangeal joint flexion of digits 2, 3, 4, and 5. He could not oppose the right thumb to the right fifth digit.

The gait was slightly wide based. While walking, there was minimal decreased arm swing worse on the right compared to the left. Attempting to walk on the toes hurt the stimulator site. Heel walking gait was also uncomfortable. Tandem gait was minimally unsteady. The patient noted that he has had this gait problem at least since the stimulator was implanted. There was decreased sensation to light touch and pinprick in a patchy non-dermatomal or peripheral nerve distribution below the right elbow, worse in the whole right hand and particularly worse in the entire right thumb. The sensory impairment involved the palmar and dorsal aspect of the entire right hand and all five digits to a mild degree in a patchy distribution. Two-point discrimination was impaired in the right thumb, second digit, and fifth digit at approximately 10 mm. Diagnoses: 1) Traumatic injury to the distal right upper extremity on 07/11/2012, industrial. 2) Chronic regional pain syndrome type 1/reflex sympathetic dystrophy of the right upper extremity, industrial. 3) Potential movement disorder caused by the spinal cord stimulator implantation, industrial. 4) Underlying mild Parkinson's disease, nonindustrial. 5) Multifactorial sleep disorder, with industrial component. 6) No neurologic injury or impairment or disability for impaired memory. 7) Mild closed head injury on 07/11/2012 without permanent neurologic impairment for headache or impaired memory. 8) No definite right or left "evidence of carpal tunnel syndrome" due to the injury on 07/11/2012. Causation: The mechanism of injury in this case was a traumatic injury including essentially laceration and fracture of the right thumb on 07/11/2012.

For the reasons discussed in this report this injury resulted in chronic regional pain syndrome type 1/reflex sympathetic dystrophy of the right upper extremity on an industrial basis. Next, there was the multifactorial movement disorder. First, there was likely a component of movement disorder due to the spinal cord stimulator implantation based on available data, which Dr. Pulera considered to be industrial. Then, there was a movement disorder due to underlying mild Parkinson's disease, which was considered being completely nonindustrial. In addition, there was a multifactorial sleep disorder with components such as pain including reflex sympathetic dystrophy, which were also indicated as industrial by this examiner. Psychiatric QME, Dr. Slonim had indicated that there were industrial psychiatric diagnoses, which were had industrial causation as well. Dr. Pulera opined that there was at least an industrial component of the sleep disorder due to pain and psychiatric conditions. He explained that it remained to be determined if there was any underlying obstructive sleep apnea that could be aggravated by industrial medication use such as Gabapentin or Elavil and/or potential industrial weight gain. On 07/11/12, there was a mild closed head injury but this did not result in any temporary or permanent disability, or permanent neurological impairment for symptoms including headache or depression. Dr. Pulera further opined that there was no neurologic cause of complaints of persistent headaches except for potential use of spinal cord stimulator and memory loss in this case. He added that the subject industrial injury did not cause or aggravate the patient’s right and left carpal tunnel syndrome. Impairment: a) There was 5% impairment for sleep with the caveats discussed. b) 0% neurologic impairment for mental status. c) 53% whole person impairment for the right upper extremity.

d) 5% neurologic impairment for gait in the lower extremities due to the spinal cord stimulator; 5% neurologic impairment for the bilateral upper extremities due to the spinal cord stimulator. Combining both there was 10% total impairment of the extremities due to the spinal cord stimulator. f) There was 1% impairment due to impaired eye blinking and masked facies secondary to Parkinson's disease; 2% impairment for hypophonia due to Parkinson's disease; 5% neurologic impairment of the bilateral lower extremities due to Parkinson's disease; 1% neurologic impairment of the bilateral upper extremity due to Parkinson's disease. 9% total neurologic impairment was indicated due to Parkinson's disease. Total WPI: Dr. Pulera estimated that there was 60% total neurological impairment on an industrial basis and there was 9% nonindustrial impairment due to mild underlying Parkinson's disease. Disability: The patient would be considered temporarily totally disabled neurologically from the date of injury of 07/11/2012 to the date of this examination of 11/17/2016. He was considered as neurologically permanent and stationary at this point. Regarding sleep disorder, beginning the day of injury 07/11/2012 there would be temporary partial disability with the following restrictions and limitations: No driving or operating dangerous machinery, tools, or equipment while drowsy. As of 11/17/2016, Dr. Pulera opined that the sleep disorder would be permanent and stationary given the caveat that the parties might desire additional sleep related medical workup. He indicated that the above restrictions and limitations for sleep would now be the same as permanent partial disability. If the above neurological restrictions and limitations could not be honored then, he would be a qualified injured worker who could not return to his usual and customary occupation as a plumber. Apportionment: Dr. Pulera estimated that there was 100% industrial apportionment for the right upper extremity chronic regional pain syndrome/reflex sympathetic dystrophy impairment/disability due to the industrial injury of 07/11/2012.

He also estimated that there was 100% nonindustrial apportionment for the impairment/disability related to Parkinson's disease. There was 25% total nonindustrial apportionment for the sleep related impairment/disability. He added that he would award 35% industrial apportionment for the pain associated with the chronic regional pain syndrome/reflex sympathetic dystrophy of the right upper extremity in case **Pena vs. Alvarado Hospital** was relevant, and 40% to apportionment to other industrial factors, which would give a total 75% industrial apportionment for the sleep related impairment/disability. Future Medical Care: Commenting further on orthopedic future medical care were deferred to the orthopedic QME, Dr. Soheil Aval. Dr. Pulera opined that the psychiatric treatment recommended by psychiatric QME, Dr. Slonim could address the psychological factors affecting pain and sleep. He also opined that ultimately such treatment could potentially alter his opinions as well. Regarding the right upper extremity chronic regional pain syndrome/reflex sympathetic dystrophy, lifelong treatment was indicated including lifelong access to a neurologist. Regarding involuntary movements due to the spinal cord stimulator, Dr. Pulera would strongly recommend follow up with a physician experienced in the management of spinal cord stimulators. He opined that any complications with respect to spinal cord stimulator should definitively be ruled out. For the mild closed head injury on 07/11/2012, for completeness sake, Dr. Pulera recommended that a brain MRI scan without contrast should be performed to rule

out traumatic brain injury. Furthermore, recommended that lifelong access to physician knowledgeable on sleep disorders should be allowed regarding the sleep concerns. He recommended that if the parties so desire, a polysomnogram and multiple sleep latency tests should be performed. He added that the patient's mild underlying Parkinson's disease should be addressed by a neurologist on a nonindustrial basis.

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

PE: He had a wrist brace in place and a noticeable left upper extremity resting tremor. His BP was 130/80. The breath sounds were slightly decreased bilaterally. The bowel sounds were somewhat hyperactive. The range of motion of the right wrist was decreased due to pain. There was decreased grip strength of the right hand. A surgical scar from a spinal cord stimulator was noted. An obvious left upper extremity resting tremor was noted. Review of records: Dr. Lineback reviewed the patient's medical/nonmedical records dated from 07/13/12 to 11/11/16. Diagnoses: 1) Sleep disorder (insomnia). 2) Chronic constipation. 3) Adult onset diabetes mellitus. 4) Hypertension. 5) Resting tremor. 6) Shortness of breath. 7) Anal fistula. 8) Right hand pain. 9) Reflex sympathetic dystrophy. 10) Status post spinal cord stimulator implantation. 11) Status post crush injury, right hand. 12) Complex regional pain syndrome. 13) Positive family history of hypertension. 14) Erectile dysfunction. Disability Status: Reached permanent and stationary status. Discussion/Causation: Discussed with the patient that his diabetes was diagnosed prior to the time of his employment with Benedict Plumbing Company. Dr. Lineback opined that diabetes represented a pre-existing condition and should be treated on a nonindustrial basis. With regard to his erectile dysfunction, the patient to be referred to a urologist for further comment regarding the it's etiology. With respect to the sleep disorder, there was no evidence in the medical records that he had any prior history of a sleep disorder before his 2012 industrial injury. Dr. Lineback opined that the chronic pain could be a major source of insomnia and it was medically probable that the patient's right upper extremity

symptoms resulting from his crush injury to his right hand in 2012 was the proximate cause of his sleep disorder.

He added that the patient's insomnia should be considered job related and should be treated on an industrial basis. With regard to hypertension, he opined that it was a direct result of the chronic pain resulting from the patient's industrial injury to his right hand and his hypertension should be considered job related and should be treated on an industrial basis. Regarding shortness of breath, Dr. Lineback opined that it was more likely related to chronic obstructive lung disease secondary to the patient's cigarette smoking. He further opined that the patient's respiratory symptoms should be considered nonindustrial and should be treated on a nonindustrial basis. Regarding anal fistula, this examiner described that the patient's constipation due to chronic pain treatment with narcotic analgesic the use of which was necessitated by the crush injury might have caused his anal fistula. These issues should also be considered job related and should be treated on an industrial basis. Impairment Rating: Sleep disorders: 3% WPI. Hypertension: 5% WPI. Anal fistula and constipation: 7% WPI. Apportionment: 100% of the patient's disability with respect to his sleep disorder should be apportioned to industrial factors as there was no evidence of any nonindustrial factors playing a role in his insomnia. 25% of his disability with respect to his hypertension should be apportioned to his nonindustrial family history. The remaining 75% of his disability with respect to his hypertension should be apportioned to industrial factors. 100% of his disability with respect to anal fistula and his constipation should be apportioned to industrial factors as well.

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

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

4) Dr. Aval also mentioned that the patient had moderate to severe difficulty with preparing meals. 5) Dr. Aval reported the patient had increased symptomatology and difficulty with activities of heavy lifting. 6) Dr. Aval noted the patient was unable to lift or carry even a gallon of milk. 7) Dr. Aval noted the patient had moderate symptomatology and difficulty with bending and twisting his neck, bending and twisting his back, lifting his arms overhead, typing and writing. 8) Dr. Aval stated the patient was unable to push or pull. 9) Dr. Aval indicated the patient had moderate to severe difficulty with kneeling, squatting, crawling, climbing. 10) Dr. Slonim noted the patient being socially withdrawn, impaired sleep, indecisiveness, not functioning in hobbies and in the household, impaired concentration and memory, avoiding driving the freeway. Analysis of Occupations: The analysis of the patient employment history demonstrated that he had occupationally performed in skilled work of medium physical requirements. Transferable skills analysis: He had very few if any transferable skills. Work context elements and temperaments considered physical and environmental work context elements: Sitting reduced to 2, Standing reduced to 2, Walking/Running reduced to 2, Making repetitive motions reduced to 2, Hazardous conditions reduced to 2, Hazardous equipment reduced to 2, Hazardous situation reduced to 2, Cramped awkward reduced to 2, Bending/twisting of the body reduced to 2, Kneeling crouching reduced to 2, Climbing ladders reduced to 2, High places reduced to 2, Keeping regaining balance reduced to 2.9, Directing others reduced to 1, Repetitive moves reduced to 0.9, Influence people reduced to 1, Variety of duties reduced to 1, Expressing feelings reduced to 1, Alone working

reduced to 1, Stress tolerance reduced to 0.9, Under instruction reduced to 1, People dealing with reduced to 1, and Judgments making reduced to l.

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

She commented that a worker with multiple body parts or organ systems that were "injured "or have an" impairment" assigned to them were greater disadvantage of "real world" work because of the synergistic effect of one injured body part on the other. She further explained that this problem was also compounded by the effects of medication and the injuries themselves on what was called "pace" and "persistence," which is the ability of a person to maintain sufficient attention and focus to complete a given task in a reasonable amount of time, which was necessary to be productive and maintain employment. She opined that when a vocational expert considers these matters together, the sum would be always greater than the additional parts. She added that in the "real world" the patient with his multiple impairments would be unable to sustain productive and competitive gainful employment and therefore, he was unable to compete within the open labor market and did not have any future earning capacity. She was asked as a vocational expert to determine if the patient was able to return to work in the current labor market. After careful review and consideration of his physical and emotional work limitations, dosage of medications that he was currently taking and its side effects, and his transferable skills, determined by McCroskey and Volcano 16.0 it was Ms. Wilson's professional opinion that based on his industrial related impairment and his industrial

physical limitations that were provided in the medical reports of Agreed Medical Examiner Dr. James F. Lineback, Qualified Medical Examiner Soheil M. Aval, and Qualified Medical Examiner, Dr. Daphna Slonim, the patient was not amenable to vocational rehabilitation. He was not able to sustain gainful employment and therefore, was not able to compete in the open labor market and as result of his industrial related impairments provided by considering his pre injury capacity and abilities, he had at present no consistent and stable future earning capacity.

103. November 06, 2017, Pain Medicine Re-Evaluation Note, Gary L. Baker, MD: DOI: 07/11/12. Chief Complaints: 1) Neck pain: The pain was radiating down the bilateral upper extremities. The pain was radiating bilaterally to the hands. 2) Low back pain: The pain was radiating down the right lower extremity. 3) Insomnia. Interim History: The patient's pain was reported as recently worsened. He rated 6/10 pain with medications and 10/10 without medications. In addition, he reported continuous nausea and moderate constipation. ADLs: ADLs were reviewed. PE: Neck: Spinal vertebral tenderness was noted in the cervical spine C5-7 region. The ROM of the cervical spine was moderately limited due to pain. Pain was significantly increased with flexion, extension, and bilateral rotation. Sensory exam showed decreased sensitivity to touch along the C5-7 dermatome in the right upper extremity. Right upper extremity: Noted limited extension of fingers. Grip strength testing was unable to perform. Diagnoses: 1) Ongoing Type 2 CRPS (complex regional pain syndrome), right upper extremity. 2) Peripheral neuropathy. 3) Status post spinal cord stimulator (SCS) implant. 4) Diabetes mellitus type 2 with hyperglycemia – stable. 5) Right thumb non-displaced fracture. 6) Malposition SCS IPG/battery. Plan: 1) Colorectal surgery consultation for evaluation and treatment of anal fistula as per AME. 2) Neurology consultation for evaluation of erectile dysfunction as per AME. 3) Followup in three months.

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

11) Some burning type pain when handling or feeling repetitively with right upper extremity. 12) Some difficulty with fine dexterity with the right upper extremity. 13) Some difficulties with pain in his hip. 14) Some difficulties with climbing stairs/steps. 15) Inability to climb ladders or balance. 16) Noticeable limp. 17) Increase in pain with cold. 18) Vision restriction. In addition, the patient experienced tremors and reported that he was diagnosed with Parkinson's disease in November of 2016. Employability: He was medically precluded from returning to his usual & customary occupation as a Plumber. His vocational education, apprenticeship, in-plant training, on-the-job training, and essential experience gained on other jobs was over 2 years and up to 4 years and was considered as skilled work. Furthermore, he reported education and vocational training level consistent with the general educational development of his usual & customary occupation. His vocationally relevant transferable skills consist of primarily of structural fabricating-installing-repairing. In addition, his vocationally relevant work history also involved performing attaining precise set limits, tolerances, and standards; performing a variety of duties; making judgments and decisions; precision working; compiling, and taking instructions. Work restrictions: From a neurological standpoint (Per AME Mark R. Pulera, M.D.-AME Report of 12/15/2016): Only occasional simple grasping and coarse manipulation should be allowed but no forceful gripping, fine manipulation, torqueing, or heavy activity with the right upper extremity. No walking on uneven ground, crouching or kneeling, crawling or climbing. No driving or operating dangerous machinery, tools, or equipment while drowsy. From an orthopedic standpoint - (Per Soheil M. Aval, M.D., and QME Orthopedic Examination Report of 07/18/2016): He was precluded from activities of repetitive or forceful gripping, fine manipulation, torqueing, and heavy lifting with the right upper extremity. The left upper extremity did not require work restrictions.

From a psych standpoint (Per Daphna Slonim, M.D. Psychiatric QME Report of 07/18/2016): He should avoid stresses at work. In addition, Dr. Slonim indicated the following Factors of Disability with regards to work functions: 1) Ability to comprehend and follow instructions: Slight. 2) Ability to perform simple and repetitive tasks: Very slight. 3) Ability to maintain a work pace appropriate to a given work load: Slight. 4) Ability to perform complex or varied tasks: Moderate. 5) Ability to relate to others beyond giving and receiving instructions: Slight. 6) Ability to influence people: Slight/Moderate. 7) Ability to make decisions, evaluations, judgments or generalizations without immediate supervision: Moderate. 8) Ability to accept and carry out responsibility for direction, control, and planning: Moderate. Review of records: Mr. Calderon reviewed the medical records of the patient dated 08/14/2017, 12/15/2016 and 07/18/2016. Discussion/Opinion: In reference to the opinions outlined in the LeBoeuf Analysis by Laura Wilson, MBA dated 07/10/2017; Mr. Calderon respectfully disagreed with the patient’s vocational expert's opinion that he might no longer have the ability to return to work in the open labor market when only considering his industrial injuries and residual medical work restrictions while excluding the non-industrial medical conditions documented in the medical file (i.e. non-industrial Parkinson's disease, non-industrial diabetes II, and the 25 % of apportioned sleep disorder to non-industrial factors) as well as his non-industrial and/or impermissible factors such as limited education (11th grade)

and training (limited to plumbing training). However, when considering his industrially related orthopedic, neurological, and psychiatric conditions and above noted work restrictions and while excluding the non-industrial and/or impermissible factors as outlined above, it was concluded that he was not precluded from all work and/or from being able to participate in vocational rehabilitation in the form of vocational training and/or employment services.

Mr. Calderon pointed out that under LeBoeuf v. Worker' Comp. Appeals Bd. (1983) 34 Cal.3d 234, it must be demonstrated that the patient was not employable in the open labor market, including a determination that he was no longer able to be retrained for any suitable gainful employment. This would then be considered in any determination of a permanent disability rating. Mr. Calderon further explained that, as noted in "Ogilvie 1112", the most widely accepted view of its holding, which appeared to be most frequently applied by the WCAB, was to limit its application to cases where the employee's diminished future earnings were directly attributable to the employee's work-related injury, and not due to nonindustrial factors. Mr. Calderon opined that this application of LeBoeuf applies more closely to an employer's responsibility under sections 3208 and 3600 to "compensate only for such disability or need for treatment as is occupationally related" (Livitsanos v. Superior Court, supra, 2 Cal. 4th at p. 753) "Employers must compensate injured workers only for that portion of their permanent disability attributable to a current industrial injury, not for that portion attributable to previous injuries or to nonindustrial factors. Other factors excluded in this evaluation include impermissible factors such as general economic conditions or an employee's lack of education (Ogilvie 111- 2011). Mr. Calderon added that based on the above noted parameters and the industrially related orthopedic, neurological, and psych work restrictions and/or limitations; the following occupations were identified as medically appropriate occupations and with lower Specific Vocational Preparation (SVP) to that of the patient’s usual and customary occupation (SVP = 7) and therefore feasible for direct job placement with a short period of on-the-job training. In addition, said occupations were found to be available in sufficient numbers in his geographical area of residence.

The residual light and sedentary occupations identified within the above-mentioned parameters that would not require more than occasional simple grasping and coarse manipulation; nor walking on uneven ground, crouching or kneeling, crawling or climbing; nor driving or operating dangerous machinery, tools, or equipment; are as follows: a) Customer service – Consumer relation clerk. 2) Information clerk. 3) Rental clerk. 4) Usher. Empirical Evidence and Employment Data: At the time of the injuries of 2012 the patient was working as a Commercial and Residential Plumber and earned approximately $25.00 per hour or $52,000.00 annually (40 hour work week). He was declared neurologically permanent and stationary in 2016, and in the event he had continued to perform his usual and customary occupation as a Plumber (i.e. absent the work-related injuries) by all reasonable assessment his wages would have increased in accordance with his longevity/seniority and entitlement to annual increases. Vocational Opinion/Conclusions: Mr. Calderon opined that based on the reports of the patient’s doctors, he retained an ability to return to work in the open labor market in the above

exampled selective sedentary and light occupations when solely considering his industrially related orthopedic, neurological, and psychiatric medical work restrictions and while excluding his non-industrial medical conditions such as his ' diagnosed Parkinson's disease, and type 2 diabetes. He further opined that absent the medically indicated non-industrial medical conditions as documented in the medical file, the patient retained an ability to compete, or be retrained for suitable gainful employment.

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

106. August 25, 2020, SIBTF – Forensic Vocational Analysis and Report, Madonna R. Garcia, MRC, VRTWC: Subsequent Injuries Benefit Trust Fund Vocational Opinion: Ms. Garcia had been requested by Attorney Natalia Foley to perform a forensic vocational analysis and report addressing this patient's ability to compete in the open labor market based upon his subsequent industrial injury as well as his pre-existing illnesses and injuries that had created labor disabling conditions that would diminish the patient's ability to compete in the open market. Due to Covid-19, assessments and reports were delayed. Introductory Comments: Ms. Garcia was requested to address his ability to compete in the open labor market based upon his subsequent industrial injury as well as his pre-existing illnesses and injuries that had created labor disabling conditions that would diminish the patient's ability to compete in the open market. Ms. Garcia's assignment included a face to face interview with this patient, a review of his occupational history, medical history and records, physician assessment of his medical conditions and labor disablement and appointment involving percentage of disability apportioned to the subsequent injury, and pre-existing injuries and illnesses, vocational assessments, transferable skills, the labor market analysis and whether het was amenable to vocational rehabilitation. A thorough evaluation was conducted of him through vocational testing, research through the OASYS system, the Employment Development Department (EDD), the Dictionary of Occupational titles, the Social Security Administration (SSA), the Occupational Employment Quarterly (OEQ), and pertinent case law to determine his pre-injury labor disablement, as well as the post-injury labor market access and ability to compete in the open labor market. She explained to him her position as an Applicant Vocational Expert and informed him that she would not be providing ongoing vocational counseling. She informed him that the information derived during the evaluation would not be considered confidential and that her findings and opinions would be summarized in a report that would be provided to his attorneys and the Subsequent Injuries Benefits Trust Fund.

Current Symptoms: 1) Emotional dysfunction such as frustration, anxiety, or depression. 2) Sleep complaints. 3) Headache. 4) Two types of pain in the right thumb, hand, wrist, and proximal forearm. 5) New onset abnormal involuntary movements of unknown etiology with complaints of decreased speech volume. 6) Memory complaints. 7) A buzzing sensation in the body after spinal cord stimulator implantation. 8) Mild unsteady

gait. Current Medications: Gabapentin, Elavil, Lisinopril - blood pressure medication, Metformin, Glipizide, allergy medication. Current Sources of Income: She indicated that he did meet his monthly expenditures. His monthly expenditures included his mortgage, utilities expenses. Current Work Status: He was not currently employed. ADLs: ADLs were reviewed. Effects of Medication on Full Time Employment: The patient was taking prescription medication as indicated above that were severely limiting his ability to function in a full-time work setting. Medication usage could limit an employer from fully considering him from full time gainful employment. He was taking Gabapentin, which was an anti-epileptic drug, also called an anticonvulsant. It affects chemicals and nerves in the body that are involved in the cause of seizures and some types of pain. Commonly reported side effects of gabapentin included: ataxia, dizziness, drowsiness, fatigue, fever, nystagmus disorder, sedated state, and viral infection. Other side effects included: blurred vision, diplopia, peripheral edema, tremor, amblyopia, irritability, and xerostomia. He was also taking Elavil (amitriptyline), which was a tricyclic antidepressant with sedative effects. Amitriptyline affects certain chemical messengers or neurotransmitters that communicate between brain cells and help regulate mood. Elavil is a prescription medicine used to treat symptoms of depression. The possible side effect signs of Elavil included drowsiness, dizziness, dry mouth, blurred vision, constipation, weight gain, or trouble urinating. He was also taking Metformin, which was an oral diabetes medicine that was helping in controlling blood sugar levels. Metformin was used together with diet and exercise to improve blood sugar control in adults with type 2 diabetes mellitus. Metformin was sometimes used together with insulin or other medications, but it was not for treating type 1 diabetes. Commonly reported side effects of metformin included: lactic acidosis, diarrhea, nausea, nausea and vomiting, vomiting, and flatulence. Other side effects included: asthenia, and decreased vitamin b12 serum concentrate.

He was also taking Glipizide, which was an oral diabetes medicine that would help control blood sugar levels by helping the pancreas to produce insulin. Glipizide was used together with diet and exercise to improve blood sugar control in adults with type 2 diabetes mellitus. Side effects of this medication included anxiety, blurred vision, burning, crawling, itching, numbness, prickling, "pins and needles", or tingling feelings, chills, cold sweats, coma, confusion, cool, pale skin, depression, difficulty with moving, dizziness, fainting, fast heartbeat, headache, increased hunger, joint pain, leg cramp, muscle aching or cramping muscle pain or stiffness, nausea, nervousness, nightmares, pain in the joints, problems in urination or increase in the amount of urine, seizures, shakiness, slurred speech, sweating, swollen joints, and unusual tiredness or weakness. He was also taking Lisinopril, which was a blood pressure medication an ACE (angiotensin converting enzyme) inhibitor. Lisinopril was used to treat high blood pressure (hypertension) in adults and children who were at least 6 years old. Lisinopril was also used to treat congestive heart failure in adults, or to improve survival after a heart attack. Commonly reported side effects of lisinopril included: dizziness, hypotension, hyperkalemia, increased blood urea nitrogen, and increased serum creatinine. Other side effects included: headache. He was also taking allergy medication. Thus, all these medication side effects would severely limit his

employability as he would be unable to operate machinery or be unable to safely drive a motor vehicle for long distances as employment. Medical History: He described a fall for the same employer approximately in the late 1980s with a bruised coccyx. The company sent him to a physician. He might have been off work for three to four days and made a 100% recovery. After 2009, he 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. He denied having any previous or subsequent specific injuries in his life including closed head injuries, workers' compensation injuries, or motor vehicle injuries, right finger, hand, wrist, forearm, or arm injuries.

Review of Records: Ms. Garcia reviewed the patient's medical/nonmedical records dated from 06/30/2015 to 12/15/2016. Diagnoses: 1) Sleep disorder (insomnia). 2) Chronic constipation. 3) Adult onset diabetes mellitus. 4) Hypertension. 5) Resting tremor. 6) Shortness of breath. 7) Anal fistula. 8) Right hand pain. 9) Reflex sympathetic dystrophy. 10) Status post spinal cord stimulator implantation. 11) Status post injury, right hand. 12) Complex regional pain syndrome. 13) Positive family history of hypertension. 14) Erectile dysfunction. Opinions and Conclusions: Considering the synergistic effect of the patient's functional limitations, while also considering his pre-existing non-industrial and industrial injuries, combined with his industrial injury, this examiner believed the patient incurred a one hundred percent (100%) loss of labor market access. This determination was an accurate representation of his level of disability. In this case, the vocational evidence comes in contrast to the usual application of the schedule for rating permanent disabilities. The schedule should not apply in this case as the actual effect of the industrial injury and the pre-existing problems leads to a total loss of earnings and total permanent disability. To the extent a mechanical application of the schedule might lead to a different result, the actual facts of this case contradicts the application. Ms. Garcia opined that this patient qualified as one hundred percent (100%) totally vocationally permanently disabled. She had determined that the patient was not amenable to any form of vocational rehabilitation. His functional limitations combined with the intensity, duration, and nature of his chronic and disabling pain would preclude his pre-injury skills and academic accomplishments. Ms. Garcia did not believe that this patient was amenable to any form of vocational rehabilitation and thus had sustained a total loss in his capacity to meet any occupational demands (AMA Guides). This had resulted in him experiencing a total loss of labor market access (*Leboeuf*), and a total loss of future earning capacity (2005 PDRS) irrespective of any "Impermissible factors".

107. <u>April 27, 2021, Comprehensive Medical-Legal Evaluation Subsequent Injury Benefits Trust Fund (Ophthalmology), Babak Kamkar, OD</u>: DOI: 07/11/2012. Pre-existing Disability and Industrial Disability: The patient reported memory problems. He stated that he could recall information from the past easier than from the past 3-4 years. Current Ocular Complaints: 1) Ocular pain: He complained 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 was frequently causing 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) Reduced vision: He reported experiencing intermittent blurry vision as well as double vision associated with high level of blood sugar since 2005. He stated that if his glucose level were not high, then his visual symptoms would be less severe. He had been using over-the-counter reading glasses. He reported; however, that the glasses were not always helpful. 3) Light sensitivity and glare: He reported sun sensitivity, as well as glare at night that started in the last few years. He had 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 had been using over-the-counter reading glasses since that time.

History of Orthopedic Injury - July 11, 2012: Remained unchanged. 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 also reported that while working in construction, Liquid Drano accidentally splashed to his shoulder and eyes. He stated 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 recalled that he was experiencing eye pain for a long time after the accident. He 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. Present Medications: He reported taking the following medications: Insulin for diabetes, Neurontin for nerve damage, Singulair for asthma Lisinopril for hypertension. Review of Records: Dr. Kamkar reviewed the patient's medical/nonmedical/miscellaneous records dated from 07/03/2012 to 12/04/2017.

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

1. Fundus Photography revealed. Diabetic and hypertensive retinopathy was documented in both eyes.

2. Visual Fields Study revealed: The kinetic visual field plots for him 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.

Diagnoses: 1) Dry eye syndrome, pre-existing. 2) Subjective visual disturbances, pre-existing. 3) Glare sensitivity. 4) Glaucoma suspect, right eye. 5) Hypertensive retinopathy, bilateral. 6) Regular astigmatism, bilateral natural. 7) Presbyopia, natural. MMI Status: From an ocular disability standpoint, this examiner opined that the patient’s current ocular condition had reached MMI status. The factors of pre-existing disability

were permanent and stationary prior to the date of subsequent industrial injury in this case. Going forward, with a new diagnosis of glaucoma suspect, this patient was advised to have a comprehensive eye examination and glaucoma work-up evaluation. He would likely gradually lose more of his peripheral vision if he did not get appropriate glaucoma treatment. Discussion: The focus of this evaluation and report was to identify any current ocular conditions, their likely causation and how they were 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. Dr. Kamkar indicated that in his evaluation of this patient, he found that the patient had several subjective ocular and visual complaints that began prior to the subsequent industrial injury. He also found clinical signs that support the patient's complaints. While several of his ocular diagnoses were labor-disabling, not every diagnosis was labor-disabling. For example, astigmatism and presbyopia were correctable with eyeglasses and are not considered labor-disabling.

a) Ocular irritations, dry eye syndrome: This examiner added, he found that the patient had moderate to severe dry eye syndrome. He exhibited superficial punctate keratitis (SPK) in the inferior portion of his cornea in both eyes. SPK was an eye disorder characterized by the death of small groups of cells on the surface of the cornea. It might be caused by exposure to environmental elements, autoimmune conditions, side effect of medications, or anatomical anomalies. The eyes would become irritated, watery, and sensitive to light, and vision might be affected. He has had symptoms of painful ocular irritations at least since 2011 and believed exposure to chemicals at his work had probably increased his dry eye condition. He had an injury when Liquid Drano was splashed on his eyes. In addition to SPK, he exhibited reduced tear-break-up time that support the diagnosis of dry eye syndrome. Dry eye syndrome was labor disabling. It would limit 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 were many other examples where dry eye syndrome causes work preclusions. Work preclusions for this case would be discussing 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, Dr. Kamkar believed, currently and pre-existing to the subsequent industrial injury there had been 2% disability from dry eye syndrome. This opinion was justified because of the level of the symptoms and ocular signs observed and his over 30 years of clinical experience.

b) Light and glare sensitivity: As stated, the patient also complained of glare and light sensitivity. He recalled 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 were correlated to glare and light sensitivity. Glare and light sensitivity, in this case, were not pre-existing. They were not considered part of the SIBTF pre-existing labor-disabling factors. From a Worker's Compensation viewpoint, these factors were considered for discussions regarding work preclusions. The AMA Guides allows for individual adjustment for conditions such as

photophobia and glare sensitivity. It would allow up to the maximum of 15% for individual adjustment. Dr. Kamkar explained that 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, this examiner see reasonable medical justification of allowing 10.0% individual adjustment for this patient. There was no pre-existing disability from glare and light sensitivity.

c) Blurry vision: The patient 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 was causing vision changes. In 2019 he was admitted to the hospital with diabetic coma that lasted about five days. About six months prior, his HbA1c was 14. He has had difficulty in obtaining insulin since he was currently homeless. Same day's 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 was 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.

Impairment Rating (bilateral eyes): Pre-existing: 2% (dry eye) + 0% (photophobia and glare sensitivity) + 5.33% (visual acuity and visual fields impairment) = 7.33%. Current: 2% (dry eye) + 10% (photophobia and glare sensitivity) + 7.66% (visual acuity and visual fields impairment) = 19.66%. Subjective Factors of Disability: Subjective factors of the patient's ocular conditions included ocular irritations, photophobia, glare sensitivity, and blurry vision. Objective Factors of Disability: 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: This examiner opined that the natural causes had 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, did not match the current level. Work preclusions: He was suffering from dry eye syndrome. Work preclusions included 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 was also suffering from sensitivity to light and glare. Work preclusions included 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 involving driving at night could be hazardous to him and others. Examples included 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 was 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 Care: He needed a comprehensive eye examination and a glaucoma work-up examination. He needed his blood pressure and blood sugar better.

108. May 03, 2021, Comprehensive Independent Medical-Legal Evaluation Subsequent Injury Benefits Trust Fund (Internal Medicine), Sameer Gupta, MD: DOI: 07/11/2012.

Initial SIBTF Summary:

1. Did the worker have industrial injury?

Yes. The applicant suffered a specific injury on 07/11/2012.

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

Since the injury was a musculoskeletal injury, this would be deferred to a musculoskeletal specialist to comment on.

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

Yes. See the impairment section below.

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

Not from an internal medicine perspective. Deferred to the other specialists.

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

Not from an internal medicine perspective. Deferred to the musculoskeletal specialist.

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

Unknown at this time, would wait until all specialty evaluation was complete and reviewed.

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

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

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

Unknown at this time, would wait until all specialty evaluation was complete and reviewed.

9. Additional records reviewed?

Yes.

10. Evaluation or diagnostics needed?

Yes.

Identifying Data: The patient reported sustaining injury to the right hand and forearm while working as a plumber for Benedict & Benedict Plumbing. General Medical/Psychiatric/Prior Injury History: At the age of 16, he was kicked out of his parents' home and developed depression and anxiety. After his father passed away, he sought treatment. Initially, he was evaluated by Dr. Cortez who treated him with Prozac. He then came under the care of Dr. Stewart Bell, a psychologist. He was treated with medication and received counseling for about two years. In the early 1980s, he was removing a cast iron tub from an upstairs restroom at work, when one of his feet fell through the flooring approximately three feet and landed in a seated position. He developed immediate pain in his tailbone. He was assisted onto his feet by a co-worker. He was referred to an urgent care facility in Pasadena, where he was examined, x-rays might have been taken, and medication might have been prescribed, and taken off work for a few days. He recalled being provided with restrictions of no bending or heavy lifting. He did not recall what his job duties were with the restrictions. He did not recall receiving additional treatment for this injury and was subsequently released to work. In about the 1980s, he was assaulted by two individuals, struck in the head with an object, and lost consciousness. He awoke about two days later at Garfield Hospital in Montebello. He was discharged about three days later. He did not recall receiving additional treatment for this incident. In the 1990s, he developed difficulty breathing and had a fever, which he attributed to having a pneumonia on two occasions. He did not recall where he received treatment, but antibiotics were prescribed. He was evaluated by a pulmonologist, underwent a pulmonary test, and underwent breathing treatments. He did not recall receiving further treatment for his symptoms.

In about 2001, he had gone out with a co-worker for a drink for his birthday and his first wife was upset. When he came home, he found her unconscious from drinking and she went into a coma. Thereafter, he developed insomnia. He sought medical treatment (physician not recalled) and was prescribed Ambien. His insomnia complaints gradually subsided. In the early 2000s, he developed hypertension, which he attributed to being in an unhealthy relationship. He sought treatment (physician name not recalled) and was prescribed with medication. He subsequently sought treatment by Dr. Louis, who treated him with hypertension medication. He had been evaluated by several physicians whose names, he did not recall who treated him with hypertension medication. Approximately 20 years prior, he developed lower back pain, which he attributed to the lifting activities he performed at work. He did not recall being evaluated or treated. In about 2011, his right hand began to shake. He was evaluated by Dr. Tang who referred him to a

neurologist (name not recalled). He was examined and diagnosed with Parkinson's disease; however, no treatment was provided. In about 2011 or 2012, he was in a crawl space on his side or in a seated position, when a customer poured a chemical solution that splashed into an eye. He felt a burning sensation in his eye and began irrigating it with water. He reported the injury to his supervisor and was referred to an urgent care facility in Arcadia. He was examined, his eye was flushed, eye drops were prescribed, provided with an eye patch, and taken off work (duration not recalled). He was then referred to an eye specialist (name not recalled). He was examined, his eye was dilated, and remained off work for a few days. He did not recall receiving any other treatment for his eye. History of Present Illness: He reported that on July 11, 2012, he was involved in a work-related accident. He was waiting for a couple of copper lines to come through the wall when a piece of cement fell (weighing about 130 pounds). He placed his right upper extremity over his head and was struck in the right hand and back of his head. He lost consciousness for a few seconds.

He felt immediate pain and swelling in the right hand, first finger, wrist, and forearm, as well as pain in the back of his head. He cleaned the wounds on his right upper extremity with water. He reported the injury to his supervisor and completed his shift in pain. The following day, he sought medical treatment at Huntington Hospital Emergency Room. He was examined, x-rays were taken, and was released later that day. He was referred to an orthopedic surgeon (name not recalled) in Pasadena. He was examined, x-rays were taken, a soft cast was applied from his right thumb to the forearm, and taken off work. He received about 13 sessions of physical therapy and noted some relief from the hot wax therapy. He underwent a scan with contrast of his right upper arm and an EMG/NCS of the right upper extremity; however, he did not recall the results. He retained legal counsel and was referred to Dr. Haronian, an orthopedic surgeon. He was examined; the prior studies were reviewed, his right upper extremity was placed in a brace, and referred for physical therapy (duration not recalled). In 2014, he underwent surgery for placement of a bone stimulator on the left side of his lower back and the wires extending to his neck area on an outpatient basis and noted some relief. Sometime in 2016, he was referred for an Agreed Medical Evaluation with Dr. Pulera, a neurologist. He was examined and was diagnosed with Parkinson's disease. He was seen on a one-time basis. He was referred to Dr. Lineback, an internal medicine physician. Again, he was examined and seen on a one-time basis. He then came under the care of Dr. Baker for pain management. He was prescribed medication for pain, and also recommendation was made for the replacement of the bone stimulator battery. If the procedure was authorized, he would elect to have the battery replaced. He continued under Dr. Baker’s care. In October 2019, he admitted into Pomona Valley Hospital for a diabetic coma. Upon waking up, he noted blurred vision.

He was treated with medication for five days and transferred to a convalescent hospital, where he was treated with medication. His vision gradually returned. He was released about 25 days after the incident. He came under the care of a primary physician, Dr. Tang. He was examined, medication was prescribed for his diabetes, and a glucose monitor was provided. He related that he became homeless in June 2019 and had been

living out of his vehicle. Then he came under the care of Dr. Louis at Santa Rosa Health. He was examined and medication for his diabetes was prescribed. Secondary to Dr. Louis no longer treating Medi-Cal patients, he recurrently sought treatment at Sutter Emergency Room and was prescribed with medication for diabetes. He sought treatment at Tri City Mental Health, where he was prescribed with insulin. He continued under their care. He was presently not working and had not worked since July 12, 2012. Present Complaints: 1) Diabetes: He complained of excessive thirst, fatigue, and blurred vision. He was recurrently feeling dehydrated and had developed pain in his kidneys. 2) Parkinson's disease/Neurological issues: He complained of recurrent shaking in his hands. He also noted memory loss and difficulty concentrating. 3) Hypertension: He complained of recurrent headaches and lightheadedness. 4) Psyche: He complained of recurrent depression and anxiety. 5) Right forearm: He complained of recurrent pain in the right forearm. He noted swelling in the right forearm. Weakness was noted in the right upper extremity. The symptoms were aggravated with gripping, grasping, lifting, and carrying. 6) Right hand: He complained of continuous pain and some swelling in his right hand. He had no numbness or tingling in his right upper extremity but weakness was noted in the right upper extremity and was recurrently dropping objects. The pain was aggravated with gripping, grasping, lifting, and carrying. 7) Tailbone: He had recurrent non-daily pain in the tailbone. Prolonged sitting aggravated his pain. ADLs: ADLs were reviewed.

Occupational History: The patient began employment with Benedict & Benedict Plumbing in 2009. He last worked on July 11, 2012. Employers: 1) Benedict & Benedict journeyman plumber): 2009 - July 11, 2012. 2) Dr. Drain journeyman plumber): About two years. 3) Unemployed for six and one-half years to provide care for his mother. 4) Benedict & Benedict (helper): About 1985 to 1991. Medical Illnesses: He was diabetic and had Parkinson's disease. He noted a longstanding history of left hip pain. This was progressed over the years, and had gone to the worse point, creating a lot of pain. He also had the mild underlying Parkinson's disease (nonindustrial). He also reported several concussions over the years. He reported closed head injury trauma. He recollected a car accident at around age 15 that created loss of consciousness and concussion. He also recollected being in a fight with loss of consciousness and waking up in the hospital. He reported several other close head injuries over the years as well. He reported that the memory issues associated with these had been quite problematic. He also had sleep issues and possible obstructive sleep apnea for many years. Other relevant included - history of diabetes, hypertension (on lisinopril), asthma (for many years - currently well controlled on montelukast daily and albuterol inhaler as needed), and multiple musculoskeletal issues over the years. Current Medications: 1) Lantus insulin 22 units once at night, onset 2012 for diabetes. 2) Insulin 1 unit as needed (name not recalled), onset 2019 for diabetes. 3) Neurontin (dose not recalled) two to three times per day, onset about 2012 for nerve pain in right hand. 4) Elavil 50 mg one tablet per night, onset 2012 for pain. 5) Montelukast 10 one tablet once per day, onset about 13 years prior for breathing and lung problems. 6) Lisinopril 20 mg one tablet daily onset about 20 years prior for hypertension. 7) Atorvastatin (dose not recalled) one tablet, onset not recalled for high cholesterol and discontinued shortly

thereafter secondary to side effects of feeling sluggish and legs feeling heavy. 8) Celebrex as needed for pain. 9) Albuterol inhaler 2 puffs about once every two weeks for the asthma.

Review of Systems: General: He had noted some loss of appetite. He had lost 60 pounds with the last one to one and half years. Skin: Reported dry skin, itchiness, and hair loss. Head: Reported headache, poor hearing, poor vision and watery eyes, ringing in the ears. Cardiovascular: Reported waking up at night with shortness of breath, swelling of his ankles and feet. Genitourinary: Reported frequent urination at night and recurrent incontinence. Musculoskeletal: Reported muscle and back pain. Abdominal: Reported trouble swallowing and constipation. Neurologic: Reported weakness and numbness in his arms and legs, poor memory, depression, and anxiety. Reported poor sleep patterns or daytime sleepiness. Physical Examination: Ht: 6 ft. Wt: 135 lbs. BP: 163/75. Extremities: Positive pulses bilaterally. Neurologic Examination: Tremor on the right hand and feet. Gait appeared slow, but otherwise normal. Review of Records: Dr. Gupta reviewed the patient's medical/nonmedical/miscellaneous records dated from 07/13/2012 to 12/04/2017. Diagnoses Associated with the Subsequent Industrial Injury: 1) Right upper extremity crush injury on 07/11/2012, subsequent industrial injury in nature, defer to the QME musculoskeletal specialist for further evaluation. 2) Complex regional pain syndrome from right upper extremity injury, subsequent industrial injury in nature, defer to the QME musculoskeletal specialist for further evaluation. 3) History of hypertension, on antihypertensive, mostly industrial per previous report, with 75 percent apportioned to industrial injury (75% of the 5% whole person impairment assigned to this condition). Not further evaluated and concur with this assessment. Diagnoses Associated with Pre-existing Conditions: 1) Longstanding history of left hip pain. This is progressed over the years. He has gone to the point worse creating a lot of pain. Possible preexisting nonindustrial labor disabling injury the need to be evaluated by QME specialist in the field of musculoskeletal injuries.

2) Mild underlying Parkinson's disease nonindustrial. On previous QME report assigned 9 percent not industrial impairment to this. Therefore, the Parkinson's disease is considered to be a pre-existing labor disabling nonindustrial condition that has been assigned a 9 percent impairment. Concur with this assessment. 3) Several concussions over the years. Reports closed head injury trauma. Recollects a car accident at around age 15 that created loss of consciousness and concussion. Recollects also being in a fight with loss of consciousness and waking up in the hospital. Reports several other close head injuries over the years. Previous report from neurology specialist recommended MRIs and even DTI imaging to further evaluate this. 4) Cognitive impairment mild to moderate, likely related to #3, wait for assessment from neuropsychiatrist to better determine next steps. 5) History of diabetes, diabetes was pre-existing to the current injury. Currently on two types of insulin for the diabetes - likely pre-existing, nonindustrial issue. 6) Sleep issues and possible obstructive sleep apnea. Outside of this examiner’s scope - request QME specialist who can evaluate sleep issues to assess for impairment, industrial and non-industrial/pre-existing labor disabling components to this. 7) Pre-existing 20% apportionment of psychiatric issues from Psychiatric QME reported

by Daphna Slonim, MD, therefore this would be pre-existing labor disabling psychiatric issues that would be appropriate to this case. Outside of this examiner's scope, request a specialist in psychiatry to further evaluate and delineate. 8) History of hypertension, on antihypertensive, mostly industrial per previous report, with 25 percent apportioned to pre-existing family history (25 % of the 5% whole person impairment already assigned). Not further evaluated and concur with this assessment. 9) Multiple other musculoskeletal issues, some pre-existing/some industrial in nature, request evaluation from a QME specialist in the field of musculoskeletal issues to better define next steps. 10) Respiratory issues including likely asthma with possible chronic obstructive pulmonary disease given the smoking history, on daily controller treatment in the form of montelukast and as needed bronchodilator treatment, likely pre-existing labor disabling condition.

11) Erectile dysfunction, unclear etiology, outside the scope of this examiner's practice, since 2015, request QME Urologist for evaluating and assessing this condition for industrial and non-industrial factors. Discussion: Based on the same day's consultation, examination and review of available records, it was medically opined that the patient had disability from a subsequent injury as well as significant pre-existing medical impairments and that the disability and labor impairment were greater than that which resulted from the subsequent disabilities alone. Causation: 1) Diabetes: Dr. Gupta opined that the workplace injury in question did not cause or aggravate the patient's diabetes. He noted that the reviewed medical records demonstrated diabetes developing prior to the work place injury and with prior specialist stating that the diabetes was non-industrial in nature. 2) Respiratory issues including asthma: Dr. Gupta also opined that the workplace injury did not cause or aggravate the patient's asthma. He made this opinion based on the subjective history obtained by the patient stating the respiratory problems occurred prior to the workplace injury and aggravated by his non-industrial smoking habit. Also the medical records had revealed assessment from previous specialist stating that the shortness of breath was a non-industrial issue related to the smoking habit. Permanent & Stationary: Diabetes and asthma: He had reached MMI status.

Subjective Factors of Disability: Complaints of excessive thirst, fatigue, and blurred vision. He was recurrently feeling dehydrated and had developed pain in his kidneys. Intermittent shortness of breath, coughing and wheezing. Other subjective factors of disability was deferred to the other recommended specialists. Objective Factors and Findings: On two types of insulin for the diabetes. On montelukast and albuterol for the asthma. Medical records supporting these diagnoses. Other objective factors of disability was deferred to the other recommended specialists. Impairment Ratings: Pre-existing Impairment – a) Diabetes: 10% WPI. b) Asthma: 13% WPI. Pre-exiting Labor Disablement: Both the diabetes and the asthma were labor disabling. For the diabetes, given the need to take two types of insulin, need for frequent bathroom use, and the visual issues and risk for getting into another diabetic coma, this condition was labor disabling. For the asthma, given the need for daily medications, needed to have access to albuterol at all time, and the need to reduce physical exertion in the labor environment;

the asthma and respiratory issues were deemed to be labor disabling. Apportionment: The diabetes was 100%·apportioned to pre-existing non-industrial issues. The respiratory issues of asthma with underlying smoking history was also deemed to be 100% apportioned to pre-existing non industrial issues. Work Restrictions: He was currently not working. Once the total disability was determined, it would be prudent for the patient to undergo an evaluation with a licensed vocational rehabilitation specialist to determine employability. Specialty Referral: QME referral in following specialties: a) In the field of musculoskeletal injuries. b) In the field of neuropsychiatry. c) Sleep specialty. d) Psychiatry. e) Urology.

109. May 17, 2021, Comprehensive Independent Medical-Legal Evaluation Subsequent Injury Benefit Trust Fund (Psychiatry), Nhung Phan, Psy.D.: DOI: July 11, 2012.

Initial SIBTF summary:

1. Did the worker have industrial injury?

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

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

Deferred to orthopedic specialist.

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

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

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

Deferred to orthopedic specialist.

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

Deferred to orthopedic specialist.

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

Unknown at this time.

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

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

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

No.

9. Additional records reviewed?

Yes.

10. Evaluation or diagnostics needed?

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

Complaints Secondary to the Industrial Injury of July 11, 2012.

1. After 2012: Began developing strokes and mini strokes.

2. After 2012: Feeling depressed due to not being able to work, being homeless, and being in constant pain, which was overwhelming sometimes and making him physically sick.

3. 2012-2014: Received counseling for subsequent injury for two years with benefits.

4. 01/15/2013: Diagnosed with mild right carpal tunnel syndrome.

5. 2015: Diagnosed with Parkinson’s disease six year prior.

6. March 2015: Diagnosed with high blood pressure.

7. December 2015: Diagnosed with a fistula for “growth in the rectum”

8. June 2016: Reached MMI.

9. 2016: Third wife died from a heart problem and he began having suicidal ideations.

10. 2018: Sister died from a stroke.

11. 2019: Became homeless for the past two years.

12. 05/15/2021: Beloved dog died and he also felt suicidal.

13. May 2021: 5th anniversary of his third wife's death.

14. May 2021: Currently smoker half a pack of cigarettes per day.

Complaints Secondary to Pre-Existing Injuries or Conditions:

1. Childhood: First experienced emotional difficulties in his life from his dad physically/verbally/emotionally abusing him and hitting him with a leather belt.

2. Age 14: Began smoking one pack of cigarettes per day and ongoing for 40 years.

3. 1980s: Head injury after he was struck in the head while being robbed.

4. 1985: Arrested for drunk driving and spent a couple of hours in jail for a DUI (driving under influence).

5. 1980s-1990s: Married to first wife for 11 years.

6. 1980s: Digestive problems.

7. 1992-1993: Ulcers/stomach pain.

8. 1998: Father died from a stroke.

9. Early 2000: Attended AA mandated by the court and had treatment with a psychiatrist, needing support to cope with his failed marriages.

10. Early 2000s: Vision or hearing issue.

11. Early 2000s: Received psychological counseling after split from second wife.

12. December 2001: First wife committed suicide and died from a gun inflicted wound to her heart.

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

14. Date unknown: Married to second wife for 11 months; she was unfaithful.

15. 2005: Diagnosed with **breast cancer**.

16. 2006: Diagnosed with diabetes.

17. 2006: Married to third wife for ten years.

18. 2007: Mother died from a stroke.

19. Date unknown: Motor vehicle accident resulting in head injury/concussion.

20. Date unknown: Received EDD benefits after laid off from employment, Dr. Drain.

21. Date unknown: History of hypercholesterolemia.

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

Pre-existing Psychiatric Diagnoses:

Axis I: Episode of mental/clinical disorder.

- Physical Abuse of Child.
- Major Depression, Recurrent, Moderate.
- Panic Disorder without Agoraphobia.
- Alcohol Abuse.
- Bereavement.

Axis II: Personality disorder

- No diagnosis.

Axis III: Physical disorders and conditions:

- Status per the review of the medical records above.

Axis IV: Severity of psychosocial stressors: Moderate.

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

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

Axis V: Global Assessment of Functioning (GAF): Current – 54.

Review of Records: Dr. Phan reviewed the patient's medical/nonmedical/miscellaneous records dated from 07/13/2012 to 12/04/2017. Discussion of Pre-Existing Disability Rating: He had experienced symptoms of depression and impairment of his functional abilities. This examiner concluded that the patient had experienced moderate work limiting impairments on a psychological basis prior to the subsequent industrial injury. The following issues contributed to his pre-existing psychological disability: a) He had been experiencing feelings of depression since he was a child regarding his father's abuse. b) He experienced recurring depressive symptoms related to his first wife's death, second wife's infidelity, deaths of his parents, and failed marriages and divorces. c) In 1985, he received a DUI for drunk driving, was incarcerated as a result, and had to attend AA meetings. d) In early 2000, he sought treatment from a psychiatrist to cope with his failed marriages. e) In December 2001, he took a six week leave of absence to work for an NFL player and take care of his first wife's father after her death. Based on this clinical picture and the impact on his functioning, it was this examiner’s opinion that the patient met criteria for Physical Abuse of Child; Major Depression, Recurrent, Moderate; Panic Disorder without Agoraphobia; Alcohol Abuse; and Bereavement. Additionally, his GAF score was 54, which was equivalent to a WPI of 24%. This GAF falls into the 51-60 decile, which was described by the 2004 Permanent Disability Rating Schedule as follows: Moderate symptoms (e.g., flat affect and circumlocutory speech, occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers). It was also this examiner’s opinion that these disorders significantly impacted the patient’s occupational functioning causing pre-existing labor disablement, evidenced by his time off work to grieve over his first wife's death, psychotherapy treatment for his marriages, and incarceration for alcohol abuse and rehab treatment.

His symptoms had reached a plateau and he was able to work for other companies for a brief period before he became industrially injured in spite of his psychological impairment. Thus, these psychological diagnoses were permanent and stationary prior to his subsequent industrial injury of July 11, 2012. Consequently, the following actual psychological work restrictions existed prior to the subsequent injury: Due to his symptoms of depression, he required a flexible work schedule to accommodate his need for weekly psychotherapy sessions and monthly psychiatric consultations. An understanding supervisory to provide feedback to him in a sensitive manner due to his fragile self-esteem. Slow increase in complexity of job duties and tasks given his deficits with concentration, focus, and memory regarding his bereavement. Promoting as much predictability as possible in the employee's daily tasks. Providing clear guidelines and

instructions, possibly in writing related to his vision impairment. Allowing for flexibility with regard to pace of work and timing of breaks. Working as part of a team to decrease his sense of loneliness or isolation. Avoiding excessive work, overtime, and insisting on him taking normal breaks and a lunch. These actual pre-existing restrictions provided evidence of his actual labor disablement that was present prior to his subsequent industrial injury.

Subsequent Injury Psychiatric Diagnoses:

Axis I: Episode of mental/clinical disorder.

- Major Depression, Recurrent, Severe.
- Anxiety Disorder Not Otherwise Specified.
- Panic Disorder without Agoraphobia.
- Pain Disorder Associated with Both Psychological Factors and a General Medical Condition.
- Insomnia Related to Anxious Disorder.
- Other Specified Sexual Dysfunction.
- Bereavement.

Axis II: Personality disorder

No Diagnosis.

Axis III: Physical disorders and conditions

- Status per the review of the medical records above.

Axis IV: Severity of psychosocial stressors: Severe

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

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

Global Assessment of Functioning

Current - 47

Discussion of Subsequent Injury Psychiatric Diagnoses: 1) Major depressive disorder: Taking into consideration the available information, his cluster of symptoms would best be categorized as a mood disorder. According to the DSM 5, the essential features of Major Depressive Disorder (MOD) include a total of nine (9) symptoms, of which an examinee must endorse at least five (5). Additionally, these symptoms must persist for a two-week period and represent a change from their previous level of functioning. Following his injury, he reported the following symptoms: "I feel sad or depressed at this time due to not being able to work, being homeless, and being in constant pain that is overwhelming sometimes, and it makes me physically sick. I have depressed mood most of each day for the past two weeks. I have decreased interest in most activities, including a decreased interest in golfing, making love, fishing, hunting, and engaging in outdoor activities." He added, "I had feelings of worthlessness or low self-esteem. I have felt fatigue or loss of energy. I had problems with thinking, problems concentrating, or difficulty making decisions. I have extreme difficulty, perhaps due to Parkinson's." Also, "I had thoughts of wishing I was dead or of suicide since the subsequent injury related to my wife's and dog's deaths. I have never attempted suicide or made a plan to kill myself. Before the injury, I weighed 225 pounds and now I currently weighs 140 pounds. I had a change in my sleep since the subsequent injury." 2) Anxiety Disorder not Otherwise Specified: Taking into consideration the available information, his cluster of symptoms would best be categorized as an anxiety disorder. According to the DSM 5, the essential features of Generalized Anxiety Disorder (GAD) include a total of six (6) symptoms, of which an examinee must endorse at least three (3). However, he did not meet the full criteria for GAD, therefore, he falls under Anxiety Disorder not Otherwise Specified. Additionally, these symptoms must persist for a 6-month period and represent a change from their previous level of functioning.

Following his injury, he reported the following symptoms: "I have felt anxious and worried since July 2012. I have excessive worry or anxiety. I always worry, all day, every day. I experience feeling restless, anxiety causing fatigue, anxiety causing irritability, anxiety causing problems concentrating, and anxiety causing problems sleeping." 3) Panic Disorder without Agoraphobia: Taking into consideration the available information, his cluster of symptoms would best be categorized as an anxiety disorder. According to the DSM 5, the essential features of Panic Disorder without Agoraphobia include recurrent unexpected panic attacks and an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes. A total of four (4) or more symptoms of the 13, must be met. Additionally, these symptoms must persist for a 6-month period and represent a change from their previous level of functioning. Following his injury, he reported the following symptoms: "I felt as if I had anxiety or panic-type symptoms at this time, the symptoms started a few years ago, usually in the shower and anywhere as well. I have experienced my heart pounding or racing. I have experienced dizziness or lightheadedness. I have experienced discomfort/tightness in my chest. I

have experienced shortness of breath/problems breathing. I have experienced feelings of choking or problems with swallowing. I have experienced nausea or abdominal distress not related to medication. I have experienced chills or hot flushes. I have experienced numbness or tingling in my body not related to physical injury." "I have anxiety and panic-type symptoms every month. I also experienced monthly anxiety or panic-type symptoms before my subsequent injury. I feel unable to travel without a companion. I have recurrent distressing dreams or nightmares of a traumatic event, of monsters or the devil. I have made efforts to avoid thoughts, feelings, or talking about the event (i.e., people, places, objects); trying to escape nightmares. I have experienced an increase in being very watchful about my surroundings. I have to really check the ground to be level."

4) Pain Disorder Associated with both Psychological Factors and a General Medical Condition: Taking into consideration the available information, his cluster of symptoms would best be categorized as a somatic symptom and related disorder. According to the DSM 5, the diagnostic criteria for Pain Disorder Associated with Both Psychological Factors and a General Medical Condition include pain symptoms that cause clinically significant distress or impairment. The psychological or behavioral factors were judged to have an important role in onset, severity, exacerbation, or maintenance of pain symptoms. Following his injury, he reported the following symptoms: "I have the most pain in my hand, despite having physical therapy. Being in pain and homeless make me feel depressed." 5) Insomnia Related to Anxious Disorder: Taking into consideration the available information, his cluster of symptoms would best be categorized as a sleep-wake disorder. According to the DSM 5, the essential features of Insomnia Related to Anxious Disorder included sleeplessness (individual receiving less than 5½ hours of sleep per night on average without medications), fatigue, difficulty falling asleep, and frequently interrupted sleep. These sleep disturbances had been persisting for more than one month. Following his injury, he reported the following symptoms: "Prior to the subsequent injury, it varied on how long it took me to fall asleep. I slept for 6 hours each night, and I woke up a few times at night due to pain. After the subsequent injury in 2012, it still varies on how long it takes me to fall asleep. I currently sleep in my vehicle. I sleep for 6 hours each night and wake up several times at night due to the sound of police, as well as anxiety. Some nights I cannot sleep." 6) Other Specified Sexual Dysfunction: Taking into consideration the available information, his cluster of symptoms would best be categorized as a sexual dysfunction disorder.

According to the DSM 5, the essential features of this category applies to presentations in which symptoms characteristic of a sexual dysfunction cause clinically significant distress in the individual predominate, but did not meet the full criteria for any of the disorders in the sexual dysfunctions diagnostic class. He met this disorder; in which he had a specific reason of pain during intimate relations. Following his injury, he reported the following symptoms: "I would engage in sexual activity if I had a girl. I used to have sex daily, but now only if I find someone. I have pain in my genital, back, and joint areas during sexual activity." 7) Bereavement: Taking into consideration the available information, his cluster of symptoms would best be categorized as an uncomplicated

bereavement disorder. According to the DSM 5, this category could be used when the focus of clinical attention was a normal reaction to the death of a loved one. As part of their reaction to such a loss, some grieving individuals present with symptoms characteristic of a major depressive episode - for example, feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss. Following his injury, he reported the following symptoms: "My wife died five years ago, and I miss her a lot. I'm still very sad over her death. My dog just died this month, and she was the love of my life. I'm grieving over my dog. I just had thoughts of killing myself because of the passing of my dog, but I have no guts to kill myself." Impairment Rating: Thus, after careful consideration of all of the information contained in this report, the patient's GAF score was placed at the level of 47, which would translate to a Whole Person Impairment (WPI) of 36%. Based upon his mild sleep dysfunction, and his Epworth Sleepiness Scale score of 4, the level of his current sleep impairment was equal to a 2% disability rating attributed to the chronic pain and psychological symptoms that arose as a result of his subsequent injury. Based upon his moderate sexual dysfunction of Class 2 impairment, the level of his current sexual impairment was equal to a 13% disability rating attributed to the chronic pain and psychological symptoms that arose as a result of his subsequent injury. It had to be noted that the Sexual Dysfunction Whole Person Impairment should follow along orthopaedic lines, because sexual dysfunction was rooted in his orthopaedic injuries.

Causation of Subsequent Disabilities and Labour Impairment: His disorders and functional limitations had qualified him for a GAF of 47 - which was equivalent to a WPI of 36%. Based upon his chronic sleep dysfunction that arose out of his subsequent injury, the level of his sleep impairment was equal to a 2% disability rating. Based upon his chronic sexual dysfunction that arose out of his subsequent injury, the level of his sexual impairment was equal to a 13% disability rating. Based on his history, his condition was attributable to compensable consequences of orthopaedic issues. Specialty Referral: Referred to neurologist to address issues relative the patient's SIBTF claim and examine the progression of his underlying mild Parkinson's disease that was diagnosed back on 12/15/16 by neurologist, Dr. Pulera. Conclusions: This examiner opined that the patient's subsequent psychiatric injury was predominantly caused by the actual event of employment. He reasoned that, given the longitudinal nature of the patient's emotional difficulties, they were more than a mere "lighting-up" of his previous depressive and chronic pain symptoms typically seen during an exacerbation. Rather, they had been permanent and were more accurately described as an "aggravation." This issue was clearly seen via an examination of the patient's GAF and WPI scores prior to and subsequent to his injuries. His prior GAF score of 54 equates to a WPI of 24%. Following his subsequent injury, his psychiatric condition deteriorated significantly. The increase in depressive and anxiety symptoms resulted in a decrease of his GAF to 47 – which was indicating that his disability increased by 12% to 36%. The subsequent injury disability was representing the predominant cause of his overall disability rating. This examiner reinstated that the patient's pre-existing psychological issues were permanent & stationary prior to the subsequent industrial injury of July 12, 2012. Given the length of time that had expired and the consistency of psychiatric symptoms since their inception.

It was this examiner's opinion that this patient's current psychiatric disability was now permanent and stationary.

His psychiatric injury was labor disabling and required the following work restrictions:

- Part-time schedule with frequent breaks due to his fragile and emotional states (from his depression, anxiety, and Parkinson's disease).

- Flexible schedule to accommodate his need for weekly psychotherapy.

- Flexible schedule to accommodate his sleep disorder.

- No distracting noise as he had been bothered by the police and activities while sleeping in his car.

Due to his cognitive difficulties from his depression, anxiety, and Parkinson's disease, he required the following:

- Accommodation of increased time due to slower pace and persistence.

- Understanding supervisor to break larger tasks into a series of smaller ones.

- Frequent feedback on performance with sensitivity to his struggles.

- Time to reconnect with co-workers given his deteriorated social skills (resulting from his depressive symptoms of social withdrawal).

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

Apportionment between Disability Stemming from Subsequent Injury and Pre-Existing Disabilities: As stated above, he had a pre-existing psychiatric disability that was permanent and stationary, ratable, and work limiting. His rating was as follows: Pre-existing Psychiatric Impairment: A 24% WPI from GAF of 54. Dr. Phan believed that the patient's psychiatric condition was aggravated by the subsequent injury and he subsequently experienced a significant psychiatric deterioration. He also believed that the increase of the patient's psychiatric impairment was not due solely to the subsequent injury as he was currently homeless, struggling with Parkinson's disease, and was grieving over his dog and wife's deaths.

Current Psychiatric Impairment 36% WPI from GAF of 47

The subtraction method was applied	36% WPI minus 24% WPI = 12%. 12% WPI apportioned to the subsequent injury.
Pre-existing Disability	Subsequent Disability
Psychiatric disability – 24%	Psychiatric disability increased by 12% to 36%

It had to be noted that preponderance of psyche impairment only goes to causation of the psyche injury, not causation of the psyche disability. The aforementioned ratings were unmodified and un-combined. His disability from the subsequent and pre-existing was greater than that which resulted from the subsequent alone.

110. May 20, 2021, Initial Comprehensive Independent Medical Neurologic SIBTF Evaluation Report, Lawrence M. Richman, MD:

Initial SIBTF summary:

1. Did the worker have an industrial injury?

Answer - Yes. The applicant was injured in 2012 when he was struck by a plaster well and sustained blunt trauma to the head, right hand and altered sensorium, consistent with a concussion. He developed headaches. He was subsequently diagnosed with Parkinson's Disease. He was unaware of any medical evaluation for tremor prior to the injury date in 2012.

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

Answer - Not known.

3. Did the worker have a pre-existing labor-disabling permanent disability?

Answer - Yes. He had a history of diabetes mellitus. He had a history of fibromyalgia. He had a history of two cerebral concussions in high school from sports, as well as being hit over the head with a blunt object during a fight and being hospitalized for forty-eight hours. He had some form of a movement disorder, which might or might not be neurogenic. In the event that this was neurogenic, it was likely that it had been present for ten years or longer preceding his date of hire.

4. Did the pre-existing disability affect an upper or lower extremity or eye?

Answer - Yes. He had some form of a movement disorder, which might or might not be neurogenic. In the event that this was neurogenic, it was likely that it had been present

for ten years or longer preceding his date of hire. He showed a gait disturbance, which should be further addressed pending review of medical records.

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

Answer - Not known, pending review of medical records.

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

Answer - Not known, pending review of medical records.

7. Is the employee 100% disabled or unemployable from other pre-existing disability and work duties together?

Answer - Not known, pending review of the medical records as to the nature of his movement disorder.

8. Is the employee 100% disabled from the industrial injury?

Answer - Not known.

9. Additional records reviewed?

Answer - The medical records were not reviewed, as they were not available at the time of this evaluation.

10. Are evaluations or diagnostics needed?

Answer - Yes. He might require further metabolic brain imaging pending review of his medical records.

Summary of Surgical and Medical Problems:

1. It was known that this patient sustained a cerebral concussion during his course of employment in 2012 associated with post-traumatic headaches.

2. It was known that he had a history of diabetes, which was longstanding and should be addressed by an internal medical specialist.

3. He showed form of movement disorder, which might represent a true neurogenic disorder or fictitious disorder, which would require review of the medical records.

4. He had a history of two concussions while in high school; one related to sports and the other related to an assault, from which he was rendered unconscious and hospitalized for forty-eight hours.

Chief Complaints: As related to the patient's nonindustrial injury, he had a movement disorder of the upper limbs and an unstable gait. It was unclear that whether this represented a neurogenic movement disorder or a fictitious movement disorder. ADLs: ADLs were reviewed. Neurological Examination: Motor: He showed a coarse tremor in the bilateral upper limbs, right greater than left. Sensory: He showed symmetrical sensation of both upper limbs. It was noteworthy that he showed no increasing tremor with the Jendrassik Maneuver. The medical records would have to be carefully reviewed to determine whether, in fact, he had Parkinson's Disease versus another form of tremor versus a fictitious medical disorder. Deep Tendon Reflexes: All reflexes were 1+ and symmetrical. Coordination: There was impairment of coordination with finger-to-nose testing with both upper limbs. Gait and station: He ambulated with a broad-based and unstable gait. Review of Records: 1636 pages of records were received but review was deferred pending receipt of an attestation and declaration. Clinical Impressions: 1) Movement disorder and gait disturbance, to be further assessed, pending review of medical records. 2) History of a cerebral concussion occurring in 2012, industrial causation. 3) Post-traumatic headaches due to a head injury sustained in 2012, industrial causation. 4) Diabetes mellitus, longstanding and nonindustrial. 5) History of two concussions; one from a high school sports injury and the other from an assault, nonindustrial. Discussion and Recommendations: He presented with a movement disorder the etiology of which was indeterminate. It was important to review his medical records assuming that his movement disorder was related to a true neurogenic process. This examiner opined that this patient qualified for a Class III rating for both upper limbs with 35% on the right and 25% on the left with 100% apportionment to nonindustrial factors. This examiner also opined that in the event that the patient had a true gait disturbance, he would qualify for a Class II rating from Table 13-15 with a 19% whole person impairment apportioned 100% to nonindustrial factors. Thirty-five percent combines with 25% to equal 50%. Fifty percent combines with 19% to equal 58%. His final whole person impairment was 58% assuming that his movement disorder was actually related to an underlying neurogenic disorder.

This report is being served timely pursuant to the QME emergency regulation regarding COVID-19:

ADDENDUM TO FINDING OF EMERGENCY OF THE DEPARTMENT OF INDUSTRIAL RELATIONS DIVISION OF WORKERS' COMPENSATION REGARDING THE CALIFORNIA LABOR CODE:

TITLE 8. CALIFORNIA CODE OF REGULATIONS DIVISION 1. DEPARTMENT OF INDUSTRIAL RELATIONS

CHAPTER 1. DIVISION OF WORKERS' COMPENSATION FORMERLY ARTICLE 7. PRACTICE PARAMETERS.

SECTION 78. QME EMERGENCY REGULATIONS IN RESPONSE TO COVID-19 CURRENTLY ARTICLE 4. EVALUATION PROCEDURES.

SECTION 46.2; (C). QME EMERGENCY REGULATIONS IN RESPONSE TO COVID-19: DURING THE TIME THIS REGULATION IS IN EFFECT, ALL OF THE TIME PERIODS ENUMERATED IN SECTION 38 OF TITLE 8 OF THE CALIFORNIA CODE OF REGULATIONS ARE <u>EXTENDED BY A PERIOD OF 15 DAYS.</u>

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Date

Evaluator

Summary/Discussion

Calibration Certificate

Device ID	Device Type	Date of Examination
19EE89	Muscle Tester	10/25/2021

Last Factory Calibration

Date
5/28/2014

Last Full Calibration

JTECH Recommended Drift Limits	Drift from Factory Calibration	Date & Time
±20%	2.0%	1/20/2021 3:59:10 PM

Last Zero Calibration

JTECH Recommended Drift Limits	Drift from Factory Calibration	Date & Time
±20%	2.0%	1/20/2021 3:59:10 PM

Patient Information

Name: Daniel Duran
Gender: Male
Birth Date: 6/4/1966
Dominant Hand: Right

Primary Insurance

Secondary Insurance

Employer

Referral

Attorney

Care Providers

Range of Motion - Inclinometry

Spine Range of Motion

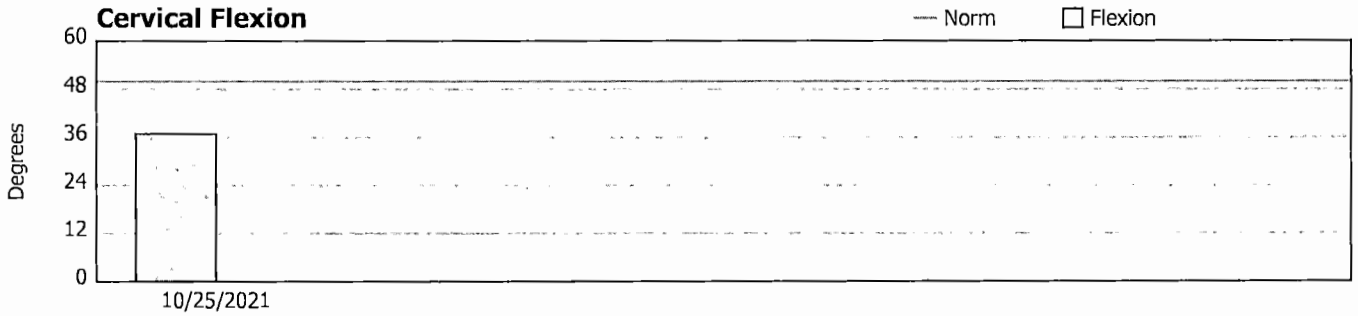
The patient's active range of motion was objectively evaluated with Tracker ROM from JTECH Medical using the dual inclinometry protocols outlined in the AMA Guides to the Evaluation of Permanent Impairment.

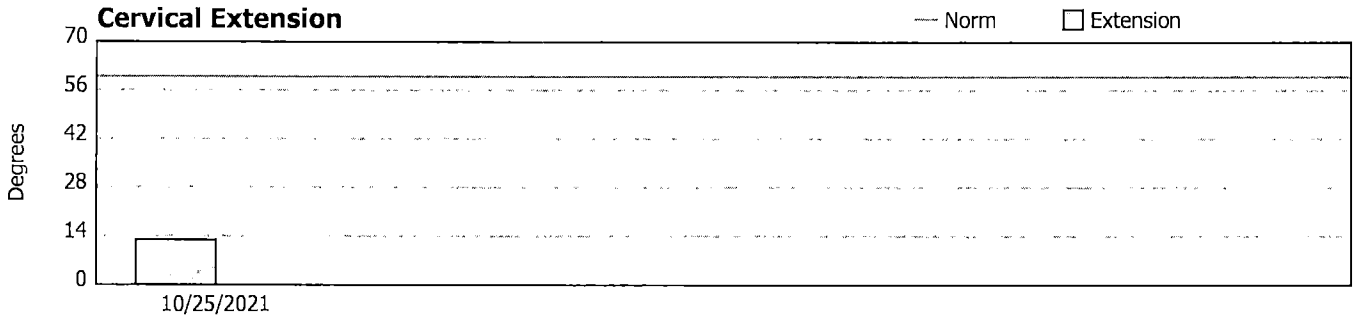
% Norm	Difference	Result	Norm	Cervical ROM
74%	13°	37°	50°	Cervical Flexion
22%	47°	13°	60°	Cervical Extension
60%	18°	27°	45°	Cervical Lateral Left
36%	29°	16°	45°	Cervical Lateral Right

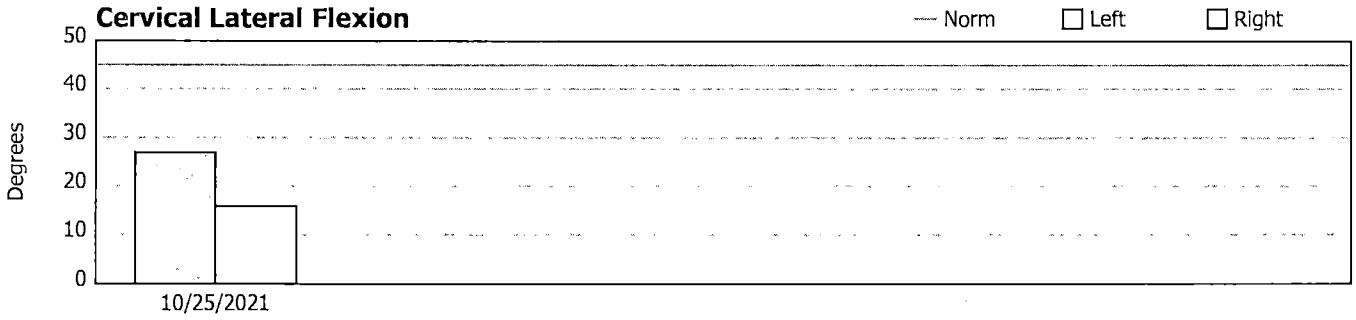
According to the AMA Guides, "An accessory validity test can be performed for lumbosacral flexion and extension... If the straight-leg-raising angle exceeds the sum of sacral flexion and extension angles by more than 15°, the lumbosacral flexion test is invalid. Normally, the straight-leg-raising angle is about the same as the sum of the sacral flexion-extension angle... If invalid, the examiner should either repeat the flexion-extension test or disallow impairment for lumbosacral spine flexion and extension."

Unless otherwise noted, the table(s) above show current test results compared to American Medical Association normative values.

Spine Range of Motion Progress







Custom Spine Range of Motion

The patient's active range of motion was objectively evaluated with Tracker ROM from JTECH Medical using dual inclinometry protocols.

Custom Spine Range of Motion Progress

Extremity Range of Motion

The patient's active range of motion was objectively evaluated with Tracker ROM from JTECH Medical using the single and dual inclinometry protocols outlined in the AMA Guides to the Evaluation of Permanent Impairment.

The table(s) above show current test results compared to American Medical Association normative values.

Extremity Range of Motion Progress

Custom Extremity Range of Motion

The patient's range of motion was objectively evaluated with Tracker ROM from JTECH Medical using single and/or dual inclinometry protocols.

Custom Extremity Range of Motion Progress

Eric E. Gofnung Chiropractic Corp
6221 Wilshire Blvd Suite 604
Los Angeles, CA 90048
United states

Phone (323)933-2444
Fax (323)933-2909

Date

Evaluator

Summary/Discussion

Calibration Certificate

Device ID	Device Type	Date of Examination
19EE89	Muscle Tester	10/25/2021

Last Factory Calibration

Date
5/28/2014

Last Full Calibration

JTECH Recommended Drift Limits	Drift from Factory Calibration	Date & Time
±20%	2.0%	1/20/2021 3:59:10 PM

Last Zero Calibration

JTECH Recommended Drift Limits	Drift from Factory Calibration	Date & Time
±20%	2.0%	1/20/2021 3:59:10 PM

Patient Information

Name: Daniel Duran
Gender: Male
Birth Date: 6/4/1966
Dominant Hand: Right

Primary Insurance

Secondary Insurance

Employer

Referral

Attorney

Care Providers

Range of Motion - Inclinometry

Spine Range of Motion

The patient's active range of motion was objectively evaluated with Tracker ROM from JTECH Medical using the dual inclinometry protocols outlined in the AMA Guides to the Evaluation of Permanent Impairment.

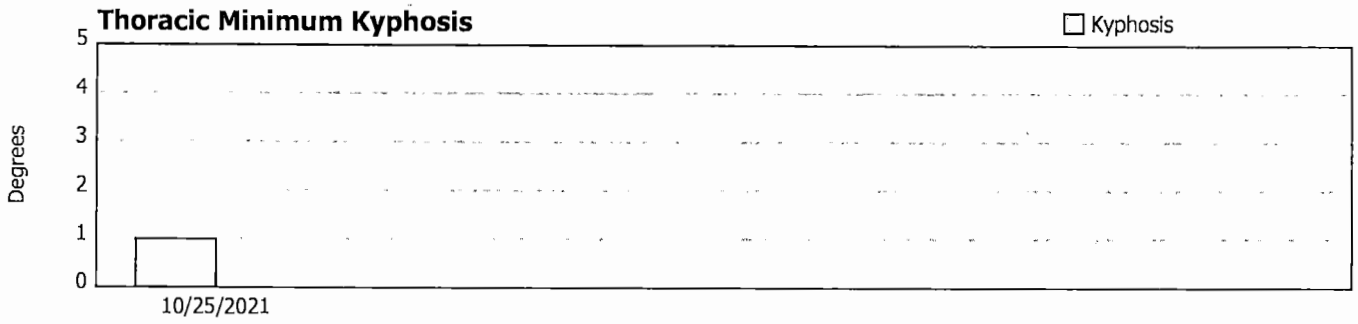
% Norm	Difference	Result	Norm	Thoracic ROM
–	–	1°	–	Thoracic Minimum Kyphosis
42%	26°	19°	45°	Thoracic Flexion
43%	17°	13°	30°	Thoracic Rotation Left
47%	16°	14°	30°	Thoracic Rotation Right

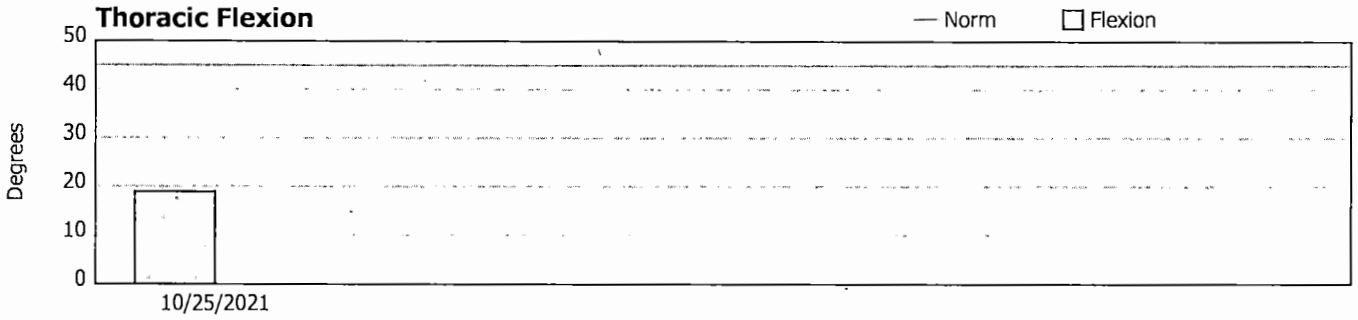
% Norm	Difference	Result	Norm	Lumbar ROM
40%	36°	24°	60°	Lumbar Flexion
68%	8°	17°	25°	Lumbar Extension
44%	14°	11°	25°	Lumbar Lateral Left
48%	13°	12°	25°	Lumbar Lateral Right

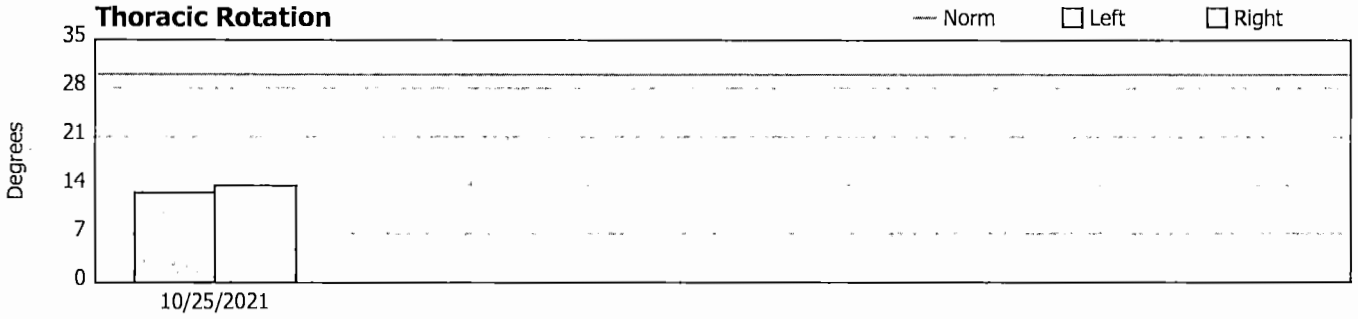
According to the AMA Guides, "An accessory validity test can be performed for lumbosacral flexion and extension... If the straight-leg-raising angle exceeds the sum of sacral flexion and extension angles by more than 15°, the lumbosacral flexion test is invalid. Normally, the straight-leg-raising angle is about the same as the sum of the sacral flexion-extension angle... If invalid, the examiner should either repeat the flexion-extension test or disallow impairment for lumbosacral spine flexion and extension."

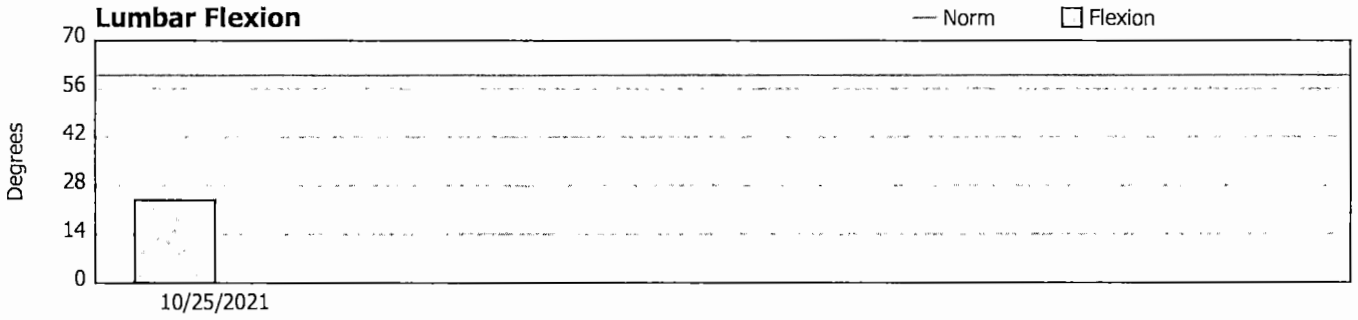
Unless otherwise noted, the table(s) above show current test results compared to American Medical Association normative values.

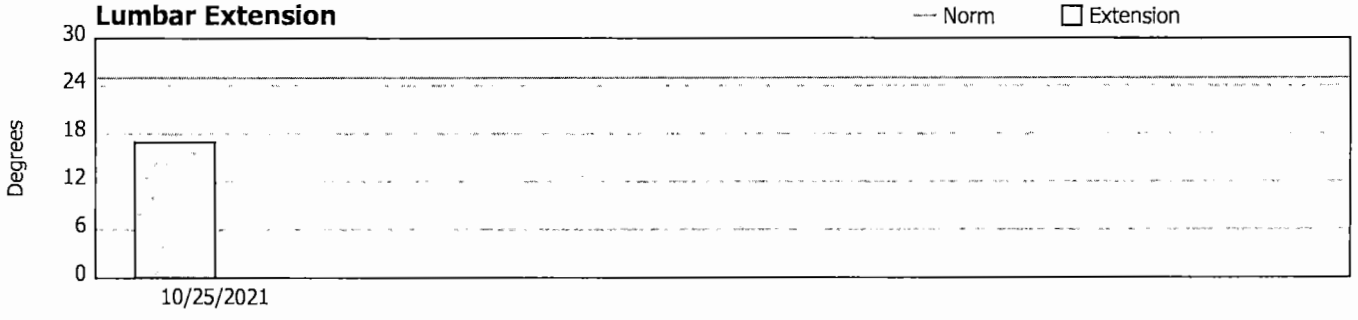
Spine Range of Motion Progress

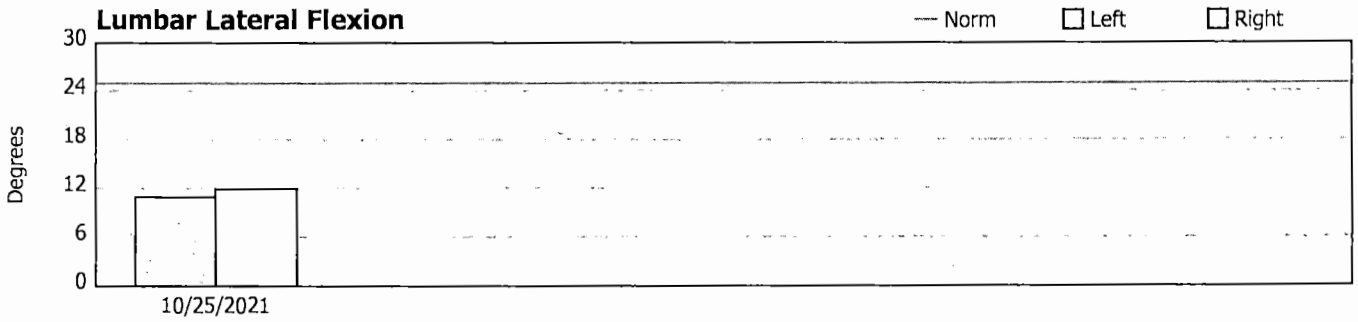

Thoracic Minimum Kyphosis
Kyphosis
Degrees
5
4
3
2
1
0
10/25/2021


Thoracic Flexion
Norm
Flexion
Degrees
50
40
30
20
10
0
10/25/2021


Thoracic Rotation
Norm
Left
Right
Degrees
35
28
21
14
7
0
10/25/2021


Lumbar Flexion
Norm
Flexion
Degrees
70
56
42
28
14
0
10/25/2021


Lumbar Extension
Norm
Extension
Degrees
30
24
18
12
6
0
10/25/2021



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Custom Spine Range of Motion Progress

Extremity Range of Motion

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The table(s) above show current test results compared to American Medical Association normative values.

Extremity Range of Motion Progress

Custom Extremity Range of Motion

The patient's range of motion was objectively evaluated with Tracker ROM from JTECH Medical using single and/or dual inclinometry protocols.

Custom Extremity Range of Motion Progress