Edward L. Spencer, M.D., Q.M.E.

DIPLOMATE OF THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
QUALIFIED MEDICAL EVALUATOR

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PANEL QUALIFIED MEDICAL EVALUATOR'S SUPPLEMENTAL REPORT IN THE SPECIALTY OF PSYCHIATRY, WITH PSYCHIATRIC TESTING

March 11, 2021

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Re:	**Sandra Seeram**
Employer:	**JP Morgan Chase**
Dates of Injury:	**Chronic trauma, 5/17/18 - 1/24/20;** **Chronic trauma, 11/16/18 - 5/2/19**
WCAB No.:	**ADJ12217188; ADJ12217216**
Panel No.:	**7332701**
Claim No.:	**189103909**
Date of Evaluation:	**August 5, 2020**
Place of Evaluation:	**879 W. 190th St., Ste 400, Gardena, CA 90248**

Billed under procedure code ML-106, time spent includes:

- **Review of medical records. 22.5 hours**
- **Preparation, writing, and editing of this report. 8 hours**

The total time spent was 30.5 hours.

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Dear Parties:

This supplemental report has been prepared pursuant to your correspondence dated January 13, 2021, in which you requested a discussion of interrogatories and additional records.

The supplemental report cover letter contains a number of interrogatories mainly related to more detailed analysis of my initial findings of 70% causation due to sales performance expectations, 20% due to a history of bank robberies, and 10% due to nonindustrial stressors such as marital conflict.

In this case, the applicant gave an account of long-term emotional difficulties arising in the context of stressful circumstances and a limited ability to cope with stressful circumstances. Though the case was filed as a chronic injury beginning in November 2018 through May 2019, by which point the applicant had been on medical leave, the allegations about stress and reports of symptoms made by the applicant covered a longer period. I felt that she had experienced a work-related exacerbation of a pre-existing emotional condition resulting in an increase in impairment.

In reviewing my report I recognize that this may be a confusing formulation so I will re-analyze the case de novo in this supplemental report and offer more detailed opinions about causation and apportionment. I will discuss the definition of the injury, the causes of the initial injury, the medical documentation of the progression of her condition from initial injury to final disability, the specific definition of that disability, and set out the causes of her disability.

A. Definition of the injury

I will begin by trying to define the injury more clearly.

The cover letter raised the issue of a stress claim in 2012, which I was not aware of based on the applicant's report to me, and there were no records about this claim. I was aware that she had been on short term disability at intervals, but my understanding was that the illness for which she required short term disability was chronic neck pain.

In any case, the first evidence of a psychiatric diagnosis was in September 2017 when the applicant attracted a diagnosis of adjustment disorder with anxiety. Though the claim involves a six-month period from November 2018 through May 2019, the applicant was diagnosed prior to that time and was continuously emotionally symptomatic after that diagnosis and up to the date of her evaluation.

On September 14, 2017, the applicant presented to Dr. Christine Dao as a walk-in, reporting "work stress" making hand numbness, neck pain, and frontal headache worse. This evaluation led within relatively short order to a referral by her PM&R specialist Dr. Chung to Kaiser's integrated pain management program. She saw psychologist Dr. Coyle and LCSW Kawase for intake evaluations into that program in December 2017. These intake evaluations were the first formal mental health evaluations that I found in all the records.

The symptoms documented at the mental health evaluations in December 2017 were vaguely described and intermingled with descriptions of stressors but included chronic neck pain, and somatic symptoms. DSM-5 symptoms on 12/20/2017 included depressed mood, sad mood,

irritable mood, decreased interest or pleasure, decreased sleep, and decreased concentration. She also had anxiety in the form of excessive worry. She was noted to have no coping skills. A DSM-5 diagnosis of major depressive disorder was made. The impression was of depressive symptoms due to multiple stressors, predominantly work.

Although the various diagnoses entered into the chart have varied, and at different points included major depression, adjustment disorder, unspecified depression, and generalized anxiety disorder, the common theme is a mixed picture of anxiety and depressive symptoms arising in the context of a high level of stress. Therefore, I believe that for the sake of this discussion reducing all these diagnostic labels to the heading of a mixed adjustment disorder is accurate and will simplify the discussion.

B. Cause of the injury

According to DSM-IV-TR, on page 679, adjustment disorders, a type of stress-related condition, are defined as expression of pathological psychological responses to stressors occurring within three months of the stressor.

Therefore, it is reasonable to consider a three-month lookback period to analyze stressors leading to an adjustment disorder.

This three-month lookback period would exclude the contribution of the applicant's relationship to Diana Nielsen from 2009 to 2012 given the DSM-IV-TR operational definition of an adjustment disorder.

In DSM-IV-TR, extreme stressors involving actual or threatened exposure to death or serious injury may, at any future point, be associated with post-traumatic stress disorder symptoms but a difficult supervisory relationship from five years prior would not realistically impact the presentation of an adjustment disorder.

Also in DSM-IV-TR, on page 355, a comparison is drawn between major depressive episodes in response to psychosocial stressors, and adjustment disorders. The difference has to do with the intensity of symptoms. No other methods for assessing the time course of stressors related to depressive disorders as opposed to adjustment disorders are set forth in DSM-IV-TR.

It is expectable that documentation from a clinician will reflect the most clinically salient issues discussed and focused on by the patient and the clinician, and LCSW Kawase's December 2017 assessment focuses on work stressors. However, we may also reasonably include chronic, persisting stressors for which there is evidence in the causation analysis.

The applicant related her stress as of December 2017 to the condition of living in Florida while her family had permanently relocated to California. The travelling back and forth between California and Florida was identified as stressful.

From October 2015 through March 2018, the applicant worked as a branch manager in Florida. The stressors related to that position included commuting as being part of the job requirements.

She did not clearly provide a history of work stressors related to her duties at the Florida branch other than commuting, which would be a stressful work circumstance. No clear problems in Florida with supervisors or sales performance expectations were noted by the applicant or are in the records.

However, work circumstances requiring frequent heavy commuting in an individual with a tendency to experience work stress and with poor coping skills would likely contribute to the onset of emotional symptoms. Therefore, an industrial stressor of commuting is identified as a causal factor.

There were also prior work stressors related to the applicant's account of being involved in numerous bank robberies between 1995 and 2009. She brought this up in her interview with me and complained about it in other settings. She felt that it was a chronic generator of tension and worry, which would contribute to an adjustment disorder because the chronic tension would be ongoing into the future. There was no evidence that she met criteria for post-traumatic stress disorder at any point. Therefore, I assess that the applicant's reported exposure to numerous bank robberies between 1995 and 2009 in the course of her work would be a causal factor in her adjustment disorder because of the ongoing tension associated with working in the bank setting.

It did not appear that her flying from Florida to California was an integral part of her job duties in Florida. Rather, it was a consequence of her working in Florida when she wanted to be living and working in California, with her family. Therefore, a nonindustrial stressor of frequent flying to California and separation from her family is assessed as a causal factor.

There was also the stressor of the applicant's expressed concern about her marriage as evidenced by a reported remote history of infidelity on the husband's part and the June 24, 2016 note of Dr. Hom describing a counseling session with the husband regarding the husband's drinking.

However, there was no follow up and no other indication that this particular issue came up again prior to September 2017. Therefore, I assess that while the specific anxiety the applicant had about her husband's behavior may have remained in the background, there is insufficient clinical evidence to define it specifically as a causal factor in the cause of the adjustment disorder.

There were also stressors related to her family of origin, specifically her living with her parents in Florida, whom she found unsupportive. As she was living with them and exposed to this unsupportive environment, family of origin stressors is assessed as a causal factor.

Other nonindustrial stressors reasonably likely to be active during the three-month period prior to her first diagnosis of an adjustment disorder, namely, June through September 2017, included chronic anxiety about her health. This anxiety was clinically significant in that it was a frequent focus of clinical attention and was out of proportion to objective diagnostic findings. Although there were no clinical contacts at Southern California Kaiser after March 16, 2017 until September 1, 2017, she had a long history of a high level of somatic anxiety, somatic preoccupation, worries about her health, reassurance seeking, cosmetic concerns, and did attract various diagnoses over the years. It was also evident on review of the records that she had a number of complaints that did not correlate to objective findings and that for the neurological complaints in particular no

diagnosis could be made. This pattern appeared to be long-standing. Health concerns would therefore be assessed as a causal factor for her adjustment disorder.

The approximate percentages of causation are set out in Table 1 along with reasons for the

Table 1. Causes of Injury

Cause of injury	Interpretation	Percentage	Reason
Commuting by car for work at Florida branch	Industrial	15%	Occurring on work days only, frequency undefined, dates undefined
History of bank robberies from 1995-2009	Industrial	5%	Remote, no diagnosis of PTSD, chronic exposure at bank branches leading to increased anxiety pressure and vulnerability to adjustment disorder
Family of origin stressor	Non-industrial	20%	Living with parents who were chronically unsupportive
Family of generation stressor: Separated from them	Nonindustrial	25%	Missing husband and children, significance of primary relationship: mentioned in records.
Stress of flying between Florida and California	Nonindustrial	5%	Flying occurred only once every 6-8 weeks
Marital strain	Nonindustrial	0%	Did not come to clinical attention after June 2016
Chronic health anxiety and somatic preoccupation	Nonindustrial	10%	Chart history of frequent somatic concerns out of proportion to diagnostic findings.
Emotional reaction to chronic orthopedic pain in various parts of the body	Industrial relatedness deferred to orthopedic QME	20%	Documentation of frequent medical contacts and concern about orthopedic pain

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C. Progression from initial injury to final disability

Having established the cause of the mixed adjustment disorder that was initially diagnosed in September 2017, we now need to look at its severity and its progression from the onset to the permanent and stationary date of May 20, 2020. I still believe that date best reflects when her condition reached permanent and stationary status for the purposes of impairment rating, as by that point she had completed a course of treatment and the treatment records indicated she had stabilized.

It does not appear that she became clinically asymptomatic at any point after September 2017; she continued to complain of stress and mixed physical and emotional symptoms. Therefore I think it is reasonable to conceptualize that her condition was "in motion" as opposed to stationary until May 20, 2020 and, as an adjustment disorder, would be subject to worsening in the context of continued or increased stress, and potential improvement in the context of decreasing stress.

There was no GAF score provided in the December 2017 Kaiser records; only symptoms were listed and nonspecific connections to difficulty working were made. So, it is difficult to quantify worsening. From December 2017 through November 2018, after her initial diagnosis and prior to the start date of her claim, the records indicated continued symptoms, and essentially no significant improvement. She required time off work due to chronic neck pain from November 29, 2017 through January 5, 2018, then worked in Florida from 1/8/18 through 2/9/18, then returned for California for vacation, returning to Florida on February 27, 2018 with subsequent worsening of symptoms as documented in the March 16, 2018 email she sent to Dr. Chung. She went off work on March 16, 2018 for several months because of worsening neck pain in the context of stressors.

Although she complained of worsening pain and dysfunction, the overall stressor pattern was the same. She was still in Florida, and commuting. She would feel better when off work and on vacation, which reflected temporary improvements in the stressor pattern noted above, and then her condition worsened when she returned to Florida which was associated with a recurrence of most of the stressors.

She then had a psychiatric evaluation on April 11, 2018 with Dr. Marsee while she was off work which resulted in a diagnosis of generalized anxiety disorder in the context of chronic worry, somatic symptoms worse under stress. Family history of anxiety in her brother was noted. The overall impression was of generalized anxiety and a possible somatic symptom disorder, analogous to DSM-IV-TR somatization disorder. Continued physical medicine care was recommended and continuing Cymbalta.

She returned to work on May 16, 2018 in Los Angeles. Her move back to Los Angeles resolved some of the original causal stressors and led to new stressors including a Los Angeles commute. My understanding is that she initially worked at a location "near the Beverly Center" until late 2018 when she was transferred to a location "near the Grove." She had complaints about her commute exacerbating her pain which had been attributed more so to commuting to the Grove location, but these locations are not far from one another, relative to the applicant's home in Torrance. So, I would assess that her Los Angeles commute to both branch locations was a stressor that might contribute the maintenance and exacerbation of her adjustment disorder.

The most prominent event noted by the applicant during the May 2018 – March 2019 work period was the issue of the market director, Ms. Kathy Ware, behaving towards her in the manner I documented in my initial report. The applicant stated she felt excessively criticized and subjected to unreasonable sales pressure and performance expectation, she was not given pay increases, she had too many responsibilities. I do not have any new information about these allegations. Certainly, it was not the first time she had problems related to supervisor conflicts; the general complaint pattern of an individual working in a position in which they feel overly criticized by a supervisor is very common in my experience and I have no particular insight into whether this was a position whose demands exceeded the applicant's innate capabilities, or whether she was, in fact, expected to do more work than any reasonable employee could accomplish, or whether she was a victim of personal malice on the part of Ms. Ware. I have no opinion on whether the applicant's belief that Ms. Ware had "a lot of openings under her" (implying that others frequently left her supervision) is consistent with her belief that the applicant was singled out by Ms. Ware. Certainly they could be consistent. There is mention of the applicant's personnel file indicating good reviews but the only personnel documents I found in the file were some payroll records from Great Western Bank from the remote past that are not relevant. Really the accuracy of the applicant's account of these events would have to be determined by the Trier of Fact.

Based on my experience evaluating injured workers, the complaint pattern involving Ms. Weir could on its own be sufficient to cause a previously emotionally healthy person to develop an adjustment disorder. In this case it is one factor out of many.

There was also a progression of her orthopedic pain and her somatic symptoms. For example, in August 2018 she reported to Dr. Chung that she had worsening pain in the context of pulling and lifting heavy bags of currency. She remained symptomatic in October 2018.

Relevant non-industrial stressors after her return to California were limited to a mention of some familial anxieties related to the status of her effort at filing for temporary disability related to the Florida branch. Her application was not successful and she resumed work. There was no other clear indication of familial stressors.

All of these new stressors increased her level of emotional dysfunction such that in January 2019 she had an ER visit for left-sided weakness and swelling. There was a notation of work stress and insomnia. There were no acute issues identified or obvious objective findings. According to Dr. Hom on 1/30/2019, the driver of the ER visit was acute stress due to a difficult commute.

Based on this information, I would assess that worsening in her orthopedic pain over the preceding months, and the emotional stressors experienced by the applicant as related to Ms. Ware contributed to a worsening of her adjustment disorder. It is reasonable that the work stressors, and orthopedic symptoms led to this exacerbation requiring an emergency room visit.

The left-sided weakness and swelling was most likely a psychosomatic symptom and manifestation of stress, there being no objective findings to better account for the symptoms.

Regarding her somatic preoccupation, her anxieties about her own health continued to be a focus of clinical attention as well. The most notable occasion of this was her expressed concern about an "aggressive spinal hemangioma" in a March 2019 to Dr. Hom; the applicant had been reading her

own records but no information supporting this in the records was found. She became concerned about the benign enlargement of a lymph node as well.

Other work stressors were not identified in the records until PA Jabeen noted on 2/22/2019, "severe work-related stress... her current supervisors were not fair with her... increased workload and unreasonable expectations." She then went off work as of 3/15/2019 because of continuing left side numbness and pain. On 3/25/19, PA Jabeen noted that she had much less stress since going off work and was applying for disability.

This pattern of events indicates that there was an exacerbation of her adjustment disorder such that she had an emergency room visit in January and her symptoms had improved by March 25, 2019 after she stopped working.

After going off work, the applicant continued to have mental health symptoms and was never asymptomatic. She had additional mental health evaluations and re-enrolled in the integrated pain management program. Looking at the follow up notes, it appeared that the applicant ruminated frequently about the way she had been treated at work, and did not feel that she could return to work.

She was referred to Dr. Girma for a psychiatric evaluation on September 13, 2019. Unfortunately, Dr. Girma's intake note describes essentially historical symptoms and does not really provide a clear distinction between her symptoms that had their onset in 2017 in the context of what Dr. Girma described or understood as supervisory problems in Florida (but as discussed above were related to the conflicts between her living in Florida and her family's living in California, among other problems), and symptoms that she was presently experiencing. She described to Dr. Girma a wide variety of subjective emotional and psychosomatic symptoms, a family psychiatric history of anxiety, a "strained" relationship with her family of generation because of "financial stress in the home due to patient being on disability" all resulting in a diagnosis of generalized anxiety disorder and an unspecified depressive disorder with a treatment plan including individual and group psychotherapy, and an increase in dose of Cymbalta from 60 to 90 mg.

I believe this is most consistent with a continued mixed adjustment disorder being perpetuated by a mixture of chronic background stressors and new acute stressors.

There was no clear period after September 2017 during which she was psychiatrically asymptomatic. Her diagnostic labels changed but I do not believe that it is meaningful to think about the changes in the labels separately from the underlying symptom pattern, which was of anxiety and depression in the context of numerous stressors.

Approximately simultaneously, she was seen by Dr. Curtis and prescribed a combination of Wellbutrin, buspirone, and Ambien. However, she stated in her evaluation with me that she continued to take Cymbalta rather than this combination of medications. My understanding based on our discussion was that she did not take the prescribed combination of medications from Dr. Curtis but rather continued the Cymbalta prescribed privately. She also received psychotherapy for a while until the Center closed because of Covid-19.

Because of her continued anxiety about returning to work, she was treated in the Work Health Intensive Outpatient Program at Kaiser beginning in February 2020, received individual and group therapy, and continued medications, until she completed that program in May 2020 and reached permanent and stationary status. Her participation in the work health IOP was marked by resistance to the idea of returning to work; it appeared that the expectation of the program was that she return to work following completion of the program but she was invested in the idea of being too ill to work.

As to the other hypotheses about causation suggested in the cover letter, I do not think the following factors contributed to the onset or maintenance of her condition:

1. Family history of anxiety or depressive disorder. The reason is that in my experience heritable conditions will typically first appear when an individual is in younger adulthood. In this case, the first documented onset of symptoms consistent with a diagnosis was in 2017. It would be excessively speculative to decide that, around the same time the applicant was subjected to significant stress, she also had the first appearance of a heritable condition.

2. Personality traits/overreaction. The applicant has the trait of somatic preoccupation and hypochondriacal anxieties; this is a trait associated certain personality disorders and personality trait dysfunction. I have accounted for her somatic anxieties and somatic preoccupation in the causation discussion. At the same time, I believe it is also accurate to say that a psychiatric injury or illness can be, and often is, caused by an interaction between certain personality traits and external, non-personality factors. The personality traits may previously have been adaptive or maladaptive, and impairing or nonimpairing. In my view the evidence of presence of maladaptive personality traits is compelling in this case as grounds for apportionment to prior impairment. I will discuss below that her personality traits appeared to be maladaptive and the basis for some level of impairment prior to the onset of her Axis I condition in late 2017.

3. Medication use or polypharmacy. A number of hypotheses around medication-related symptoms were advanced in the cover letter. The issue of the combination of buspirone and Cymbalta leading to serotonin syndrome was raised. Serotonin syndrome would be a rapidly occurring, serious clinical syndrome associated with significant, overt illness in the form of significant vital sign abnormalities, neuromuscular symptoms, and altered mental status. It is also relatively rare. None of these findings were documented at any point; the applicant certainly had a number of clinical contacts with medical staff during the treatment period. More significantly, she denied taking the medications prescribed by Dr. Curtis and my impression was she remained on Cymbalta alone. Based on the review of the records and my interview with this applicant, I found no indication that she had serotonin syndrome. Otherwise, the use of antidepressant monotherapy is common and the doses of Cymbalta used were within the labelled range. It is not recommended in the FDA labelling that Cymbalta exceed 120 mg per day.

4. Alcohol use. The medical records consistently indicated that the applicant used alcohol rarely. The history she gave me was of one or two glasses of wine per week. With Cymbalta monotherapy, we generally do not recommend the use of alcohol with antidepressants but

the clinical reality is that the combination of intermittent low level or social alcohol use and antidepressants is relatively benign. A more serious issue would be if there was a history of chronic, heavy alcohol use, clearly escalating over time with associated symptoms of the DSM-IV-TR syndromes of alcohol abuse or alcohol dependence. These were not present.

D. Definition of disability

The medical records and the applicant's presentation support a level of pre-existing impairment. I previously discussed this opinion in my report on page 23 noting that the record supported a decrease in her GAF from approximately 65 as of December 2017 (at the time of the onset of her symptoms) to 55 as of the August 2020 evaluation.

Her pre-injury impairment can be described along the lines of the categories given in the AMA Guides. The medical records support that she had ongoing difficulties with the chronic stressors in her life predating her injury; she was anxious often and tended to experience somatization reactions manifesting in the records as paresthesias and hypochondriacal anxieties. The tendency to somatize her symptoms can be considered a manifestation of impairment in adaptation to stressful circumstances in that somatization is considered a maladaptive or primitive defense mechanism. These behavioral symptoms as documented in the medical records correspond to mild to moderate impairments in the specific functions of "experiences exacerbation of signs and symptoms of mental disorder" and "decompensates and has difficulty maintaining performance of ... tasks."

There was also evidence of mild impairment in the Memory, Concentration, Persistence, and Pace functions, specifically, "maintaining regular attendance" as evidenced by her requiring time off work for various somatic, psychosomatic, and possibly psychiatric reasons (related to the allegation of 2012 stress leave, about which I do not have any particular information) and "completing a normal workday without interruptions from psychologically based symptoms."

Despite these impairments, she appeared to be functioning at a level compatible with most regular work, despite symptoms arising out of her chronic stress as of the time of the onset of her diagnosable adjustment disorder in late 2017, consistent with relatively mild symptoms existing at that time.

I assessed her level of disability as of May 20, 2020 in my initial report. I had previously offered permanent impairment ratings consistent with a moderate level of overall permanent mental impairment, with moderate impairment specifically noted in areas related to memory, concentration, persistence, and pace, as well as her adaptation to stressful circumstances.

I believe these ratings as given and elaborated in my discussion on permanent disability are still appropriate as are the factors of disability though I would also add that there was also evidence in the intensive outpatient treatment records of the emergence of previously undetected personality trait dysfunction. These personality-based symptoms may emerge under stress and tend to impair an individual's adaptation to stress.

Specifically, this personality trait dysfunction was in evidence on 4/24/20 when it was documented by LCSW Shortt that the patient had interpersonal difficulties after perceiving criticism from

family members, but on reflection was able to think about handling the situation difficulty. This type of psychotherapeutic record entry is suggestive of clinically recognizable patterns of interpersonal instability and rejection sensitivity that can influence interpersonal judgement.

Also of note is a 5/24/20 email from the applicant to LCSW Shortt in which the applicant's raised a number of concerns in a disjointed and vague manner associated with pseudoneurological dissociative type symptoms: "I completely blanked out sitting in kitchen," as well as some indicators of interpersonal splitting. Specifically, the applicant described the psychiatric evaluation she received at Kaiser Permanente, as well as her industrial treatment in a devalued way (minimzing the depth of the psychiatric evaluation; describing industrial treatment as "some worker's comp program" whereas in her description of it to me she stated it was helpful) and invited the therapist to take a concordant position in support of her psychological splitting efforts.

This approach is in contrast to more adaptive and effective behaviors, such as expressing more specific concerns in a less polarized manner, making a realistic assessment of the reality factors at hand, and potentially making better use of the therapist's capacity to help.

This common clinical scenario is consistent with dysfunctional personality patterns that may emerge under stress as well.

E. Causes of disability.

Between the end of 2017 and May 20, 2020 when she completed treatment and became permanent and stationary, she developed worsening impairments corresponding to a decrease in GAF from 65 to 55. I believe that the cause of the decrease in her GAF and increase in her impairment was her continued exposure to various stressors associated with the persistence of her adjustment disorder. Some of the stressors present in late 2017 had resolved and were no longer relevant to the causes of her disability, such that apportionment is not strictly along the lines of causation but can be described separately

Table 2. Causes of disability.

Cause of disability	Interpretation	Percentage	Reason
Persisting chronic health anxiety	Nonindustrial	5%	Continued somatic preoccupation documented in medical records
Emotional reaction to persisting orthopedic pain/neck pain	Industrial relatedness deferred to orthopedic opinion.	15%	Continued complaints of pain in neck, hands, various body parts separate from somatic preoccupation, though these complaints appeared relatively

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Cause of disability	Interpretation	Percentage	Reason
Family financial stressors due to lack of work by applicant in September 2019	Nonindustrial	5%	Documentation of Dr. Girma indicating this stressor, though limited effect given applicant's receipt of private disability insurance benefits and adequacy of husband's work income to support family expenses as described in Social History of my initial report
Anxiety, decreased confidence, and pessimistic expectations related to perceived harassment by Ms. Ware and sales pressure beginning in the fall of 2018	Industrial (deferred to Trier-of-Fact on whether this anxiety results from an actual event of employment vs a perceived event)	60%	Clear temporal relation between the onset of this complaint and significant worsening of symptoms leading to ER visits and inability to continue working.
Emergence of previously subclinical personality trait dysfunction	Nonindustrial	10%	Emerged in spring 2020 intensive outpatient treatment, no evidence of this specific impairing factors in records prior
History of exposure to bank robberies from 1995-2009	Industrial	5%	Increased apprehensiveness about returning to work, reactivity to bank environment. Limited contribution because of remoteness of stressor and lack of evidence of PTSD.

The decrease in GAF from 65 to 55 corresponds to a change in the level of WPI from 8 to 23. Therefore, in my opinion, the increase in WPI from 8 to 23 is accounted for by the stressors and factors listed above which all should be subject to the findings of the Trier of Fact as to their industrial relatedness.

F. Credibility of applicant

I indicate that I felt the applicant was credible despite MMPI-2 results indicating significant to extreme exaggeration of subjective complaints.

There are really two areas of credibility that we have to consider. The first is the credibility of her symptoms and reported functional difficulties, and the second is the credibility of her account of difficulties at work.

Regarding the credibility of her symptoms, she presented on open-ended questioning a psychiatrically reasonable account of symptoms consistent with a person who is quite anxious, dysphoric, pessimistic, and has an impairment in her ability to cope with stress. The MMPI-2 does attempt to assess the validity of reported somatic symptoms and an individual who reports a wide variety of somatic symptoms including pseudoneurological symptoms may be assessed by the instrument as exaggerating or reporting noncredible symptoms. She may be presenting some medically unlikely symptoms as a manifestation of emotional distress; this was addressed and identified by both Dr. Marsee in his April 2018 evaluation in which he considered a diagnosis of somatic symptom disorder, and the orthopedic evaluation submitted of Dr. Halbrecht from December 2020 in which a diagnosis of conversion disorder was offered as an explanation for pseudoneurological findings. Certainly, failure to identify somatization as a process contributing to her overall high level of pain and physical distress may lead to misdirected treatment efforts.

The issue of symptom exaggeration may need to be considered when decisions are made about deployment of orthopedic treatment or work restrictions. However, if the question is, "is the applicant a fundamentally psychiatrically well individual presenting noncredible emotional symptoms," the answer to that question is no. The applicant appears emotionally unwell despite treatment, and has clear evidence of long standing psychiatric and personality-related emotional impairments.

The MMPI-2 results really should be used to orient the treating clinician to the applicant's pattern of somatization due to emotional dysfunction so that the psychiatric nature of her difficulties is appreciated and appropriate treatment offered.

As to the credibility of her account of her treatment by Ms. Ware, my view is that I do not have sufficient factual information about the work situation to assess the work circumstances. Although some personnel files were submitted, they were from much earlier in the applicant's career and did not cover the period in question.

However, I think the most realistic scenario is that essentially the applicant is a person with a history of limited ability to cope with stress, who had significant prior chronic stressors, who experiences many routine life difficulties as being at the outer limits of her ability to handle, and experienced a significant additive stress in her interactions with Ms. Ware. Whether those interactions were harassing, or were realistic, normative attempts to manage the applicant's work performance is not something I can decide based on the information available; really it is outside of medical expertise.

She is describing, in general terms, a scenario of an employee being assigned sales goals and specific performance expectations, who finds that they do not have sufficient internal or external resources to meet those goals no matter how much effort they put forth, and who then experiences disappointment in their failure to achieve the goals and anxiety about the realistic job-related consequences of underperformance, particularly when the supervisor then exerts pressure upon the individual. In my experience, this pattern is common in evaluations for psychiatric injuries and

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does seem to contribute significantly to the development and maintenance of clinically significant symptoms.

In fact, her complaints as expressed in the intensive outpatient program records support that the specific work problems were less about harassment and more about her sense of herself as an incapable failure, with references made to her medical difficulties, pain, and perceived lack of ability work. The records did not contain further specific references to fears about the behavior of Ms. Ware.

G. Conclusion

I have attempted to identify, on detailed re-review of the previous medical records and new information submitted, the specific point at which the applicant developed a psychiatric disorder, the causes of that disorder, the nature of her impairment at that time, the circumstances of her clinical worsening, her final level of impairment, and the stressors and injurious factors giving rise to that final impairment. It does appear that the onset of her injury was prior to the claimed CT period, with there being worsening during the CT period and after, owing to the contribution of a mixture of old and new industrial and nonindustrial factors, and that worsening led to an increase in her impairment and the final impairment rating.

SPECIAL COMMENTARY

The above responses and opinions are based on reasonable medical probabilities, as viewed from the perspective of available documentation and information submitted to this evaluator, including the applicant's direct anamnesis.

Thank you for the opportunity to serve as the Panel Qualified Medical Evaluator, in the specialty of psychiatry, for this most interesting case and condition.

LC 139.1 DECLARATION

Pursuant to AB 1300, LC Sec. 5703, I have not violated Labor Code section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Dated this 11th day of March, 2021, at Los Angeles County, California.

Sincerely,

Edward L. Spencer, M.D., Q.M.E.
Diplomate of the American Board of Psychiatry and Neurology

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APPENDIX A: MEDICAL RECORDS REVIEWED

REVIEW OF FILE

Approximately 1,743 pages of records have been received and reviewed by the undersigned. Documents within the records that are not considered of medical importance to this practitioner may not be included in the summary though they have been reviewed in their entirety.

NON-MEDICAL RECORDS:

Request for Supplemental QME Report, signed by Shantev Mirzakhanyan, Dietz, Gilmor & Chazen, dated January 13, 2021.

The examiner continued to serve as the psychiatric Panel QME in this matter. He initially evaluated the applicant on August 5, 2020, and was deposed on November 23, 2020. However, the deposition was not completed, and he agreed to address Defendant's questions in a supplemental report. He was to review Defendant's interrogatory, all enclosed records for his reference, and prepare a supplemental report of his findings as discussed at his November 23 deposition.

Defendant's Interrogatory: The defendants requested that he review the enclosed materials and address the following interrogatories directly related to the material provided for review:

Predominate Causation: In his report dated August 28, 2020, he stated that "It would be most realistic to conceptualize the applicant's case as a stress-related exacerbation of a pre-existing stress-related condition"; and opined that her stress-related condition prior to the cumulative trauma claim was caused 70% by sales performance expectations; 20% by bank robberies on multiple occasions between 1995 and 2009; and 10% by non-industrial, familial stressors related to frequent moving and marital conflict. (Report page 21.)

• Did you consider the following work-related issues described by the applicant to support your preliminary finding in favor of industrial causation?

If applicable, what percentage of her industrial psychiatric injury was caused by the following? For example....

• You opined that the causes of her stress-related condition prior to the cumulative trauma claim was 70% due to occupational stressors related to sales performance expectations prior to November 2018. With that in mind, did you consider her sales performance expectations after November 2018 in your causation analysis? What percentage of applicant's psychiatric injury do you attribute to her sales performance expectations before and after November 2018, given the following?

○ After she moved back to California in May of 2018, she was transferred to an understaffed branch, was overworked, and was unable to meet sales goals. She also reported that she was

overwhelmed and performed everyone else's job duties, working 10 hours per day. (Hamlin Psyche Center. Report dated October 28, 2019.)

○ On January of 2019, she was transferred to the Fairfax branch., which she claimed that she had been underperforming before her arrival, and which she claimed, she was able to increase the performance "before too Jong." During her time at the Fairfax branch, she had no time for lunch. (Hamlin Psyche Center, Report dated October 28, 2019.)

• What percentage of applicant's psychiatric injury do you attribute to her relationship with Diana Nielsen given the following?

○ She told you that from 2009 to 2012, she was working at the Hawthorne branch and her manager there, Diana Nielsen, "made her life so difficult". The applicant considered Ms. Nielsen's actions to be excessive singling her out among the other managers and having unrealistic performance expectations. (Your Report dated August 28, 2020, page 6.)

• What percentage of applicant's psychiatric injury do you attribute to her relationship with Kathy Ware given the following?

○ She told you that her supervisor, Kathy Ware, "turned on her" in the fall of 2018. Specifically, during meetings of the branch managers, Ms. Ware single her out and picked on her. Her performance would be scrutinized in a way that she felt was more severe than the level applied to the other managers. Ms. Ware would call out the applicant frequently, accuse her of being unprepared, and express disappointments about her performance as a branch manager. (Your Report dated August 28, 2020. page 5.)

○ She also told Kaiser that "I think it started a few years ago, last March I got a new boss, seemed very nice but then all the yelling and screaming, and then I started having all this pain, and the harping and visits, and then the pain got so bad I couldn't move. I stopped working in March of 2019." (Kaiser Records, Report dated February 11, 2020, page 4451.)

• What percentage of applicant's psychiatric injury do you .attribute to her involvement in bank robberies given the following?

○ She told you that over the course of her employment with JP Morgan Chase Bank, she was involved in at least 9 bank Robbers, and specifically recalled a robbery in 1993 in the Venice branch and a robbery in 2009 at the Hawthorne branch. (Your Report dated August 28, 2020. page 6.)

○ She also told Hamlin Psyche Center that she experienced bank robberies, while at JP Morgan Chase Bank in 1989, 1993, 2003, and 2007. (Hamlin Psyche Center, Report dated October 28, 2019.)

○ On May 20, 2020, she wanted a "program that will prepare her for bank robberies (career in banking)." (Kaiser Records, Report dated May 20, 2020, page 5486.)

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• What percentage of applicant's psychiatric injury do you attribute to her commute, while she worked in Florida given the following?

○ From September 1, 2017 to approximately March 23, 2018, she had been floating to different bank branches in southern Florida, driving 17 miles/50 minutes in both directions. (Kaiser Records, Report dated March 23, 2018, page 1984.)

• What percentage of applicant's psychiatric injury do you attribute to her commute, while she worked in California given the following?

○ She complained that in 2019, she was transferred to a new branch, and was unable to get to her children as a result of the long commute. (Hamlin Psyche Center, Report dated October 28, 2019.)

○ She reported to Kaiser that she transferred on January 14, 2019 and had to drive 3 hours total. (Kaiser Records, Report dated January 30, 2019, page 2569.)

○ On February 14, 2019, she attributed numbness in her hands to driving over 1 hour; "to having to drive longer distance because her work relocated her further away." (Kaiser Records, Report dated February 14, 2019, page 2646.)

○ On April 11, 2019, she treated for back pain, complaining that her chronic back pain was triggered by work stress, and that "Driving worsens pain too." (Kaiser Records, Report dated April 11, 2019, page 3057.)

○ On July 29, 2019, she reported that she had to "'drive all the way out to Fairfax, and the commute was aggravating her pain." (Kaiser Records, Report dated July 29, 2019, page 3405.)

• What percentage of applicant's psychiatric injury do you attribute to her multiple relocations between California and Florida given the following?

○ A Kaiser report notes, "A lot of stress- has new home." (Kaiser Records, Report dated October 19, 2010, page 0167.)

○ She reported to you that from January 2002 through September 2007 and October 2015 through March 2018, she relocated to Florida. (Your Report dated August 28, 2020, page 6.) However, her personnel file documents that she was employed by Great Western (a predecessor to JP Morgan Chase) starting 1988 and worked in Florida from 1988 to 1992. She then relocated to California, and worked in California from 1992 to 1995. She then relocated to Florida, and worked in Florida from 1995 to 1997. She then relocated to California, and worked in California from 1998 to 2002. (See personnel records, Employee Change Notices.)

• What percentage of applicant's psychiatric injury do you attribute to her stress from flying to/from California and Florida due to the following?

○ On November 29, 2017, she reported that "She is a bank Manager for Chase, and has a lot of stress. They are having her travel to Florida a lot, where she has to float around to different

branches." (Kaiser Records, Report dated November 29, 2017, page 1649.) Please note that at this time, her family was living in Torrance, California. (Kaiser Records, Report dated November 29, 2017, page 1663.)

○ On February 22, 2018, she complained that "has stress with work - driving all over the place; flying back to Florida tonight." (Kaiser Records, Report dated February 22, 2018, page 1914.) Please note that at this time, her family was living in Torrance, California. (Kaiser Records, Report dated February 22, 2018, page 1923.)

○ On April 25, 2018, she complained that she did "a lot of flying because she wants to stay here in southern California." (Kaiser Records, Report dated April 25, 2018, page 2222.) Please note that at this time, her family was living in Torrance, California. (Kaiser Records, Report dated April 23, 2018, page 2214.)

Non-Industrial Stressors: Did you consider the following non-industrial factors when rendering your final conclusions on causation of her psychiatric disability? For example,

• Did you consider the fact that for two and a half years she lived in Florida away from her family living in California?

○ The applicant's medical records document that she lived apart from her family. As noted above and throughout the Kaiser records referenced, she worked for Chase in Florida from October 2015 to March 2018. However, during this time period, her family was living in Torrance, California. (Kaiser Records, Report dated December 3, 2015, page 1293; Report dated April 23, 2018, page 2214.)

○ On December 14, 2017, she complained that her stress was mostly related to living in Florida for work, while her husband and children were living in California. She had been trying to obtain a transfer from Florida to California for 2 years. She visited with her family every 6 to 8 weeks. (Kaiser Records, Report dated December 14, 2017, page 1808.)

○ On December 20, 2017, she reported that "She had been moving back and forth between Florida and California, but they decided to move to California permanently 2 years ago." She described her staying in Florida as being "stuck in Florida." (Kaiser Records, Report dated December 20, 2017, page 1819.)

• With the above in mind, what percentage of applicant's psychiatric injury was caused by her time away from her family while working in Florida?

• Did you take the following marital problems when considering causation of her psychiatric injury? For example,

○ She reported to you that "There have been no recent problems with infidelity. She estimates that the last time infidelity was a problem was 2004." She also reported talking to her doctors about her marital problems, including her husband's drinking; and that her husband was frustrated when she lost her income. (Your Report page 8.)

○ On June 24, 2016, she had a telephone visit with her doctor, discussing her "concern about her husband's drinking", and unresolved concerns about history of cheating and trust. (Kaiser Records, Report dated June 24, 2016, page 1412.)

○ In your report, you attributed 10% of applicant's stress-related condition prior to the CT claim to non-industrial, family stressors, in part because the infidelity was "remote." (Your Report page 21.) Although she estimated that the last time her husband was unfaithful was in 2004, the medical records indicate that over a decade later, she still had "unresolved issues" related to the infidelity.

• With the above in mind, did you consider applicant's discussion with her doctors as recent as 2016 about her husband's infidelity, as well as her report to you that she was concerned about her husband's drinking and his frustration over her loss of income when assessing causation of her psychiatric injury?

• What percentage of her psychiatric injury, if any, was caused by her marital problems?

• In your causation analysis, did you consider any of family issues found in the enclosed medical records? For example,

○ On December 20, 2017, she stated that she felt "overwhelmed by taking care of her elderly parents as well. She felt that her parents and siblings had been distancing themselves from her regardless of her efforts to support them, which also distressed her." She also reported that her father was probably suffering from depression, and that she "feels disconnected from his parents whom she lives with. She feels that her parents are controlling. She feels distanced from her sister and brother." (Kaiser Records, Report dated December 20, 2017, pages 1819, 1821.)

She described her parents as "very strict and not emotionally open or expressive." (Kaiser Records, Report dated April 11, 2018, page 2173.)

○ On October 7, 2019, she told Dr. Windman that mother had issues with verbal abuse, while her father had alcoholism issues. She also reported that her father had health issues including a history of multiple strokes, and this was specifically noted as a non-industrial source of stress. (Hamlin Psyche Center, Report dated October 28, 2019.)

○ On February 18, 2020, she emailed her therapist stating "Due to my father's health condition, I will not be able to attend the following classes Feb 20, 21, 25, 27 & 28, 2020. I will be able to attend March 03, 2020 and going forward." (Kaiser Records, Report dated February 18, 2020, page 4641.)

○ On March 4, 2020, she discussed "how she grew up with her father being very angry, mom critical, and not feeling supported." (Kaiser Records, Report dated March 4, 2020, page 4663.)

○ On April 10, 2020, she disclosed "'getting upset with family members yesterday." (Kaiser Records, Report dated April 10, 2020, page 5128.)

○ On April 22, 2020, she disclosed "disclosed having a difficult day yesterday where after perceiving criticism from family members she became angry and yelled at them all." (Kaiser Records, Report dated April 22, 2020, page 5267.)

• With the above in mind, what percentage of applicant's psychiatric injury do you attribute to her family issues?

• Did you consider serious medical conditions involving immediate members of her family in your causation analysis? For example,

○ She reported to you that her brother and sister have received mental health treatment for anxiety disorders: and that a distant relative has a history of completed suicide. She also denied a history of hospitalization in the family (Your Report, page 9.)

○ Her medical records document a family history of breast cancer, diabetes, hypertension, and CVD. (Kaiser Records, Report dated March 1, 2011, page 0269.)

○ Her medical records document a family history of strokes, hypertension, hyperlipidemia, diabetes, overweight, breast cancer, autoimmune disorder, and alopecia. (Kaiser Records, Report dated November 2, 2012, page 0842; July 15, 2014, page 1042.)

• With the above in mind, what percentage of applicant's psychiatric injury do you attribute to medical issues involving her family?

• Did you consider applicant's personal medical history when considering causation of her psychiatric injury? For example,

○ On August 14, 2009, she requested an appointment with an OB/GYN because she was concerned that she might have cancer, as her mother and sister were diagnosed with problems. (Kaiser Records, Report dated August 14, 2009, page 0088.)

○ Her medical records document a history of hypothyroidism since 2010. (Kaiser Records, Report dated February 27, 2013, page 0895.)

○ On October 24, 2011, she requested a test for polycystic ovary syndrome. During the last 3 months, her menstrual cycle had been lasting for 3 weeks and her menstrual cycles was every 20 days. (Kaiser Records, Report dated October 24, 2011, page 0548.)

○ Her medical records document a history of prominence of the left jugulodigastric lymph node since 2015. (Kaiser Records, Report dated April 10, 2018, page 2127.)

○ On September 4, 2015, she was diagnosed with eczema, keratosis pilaris, and alopecia. (Kaiser Records, Report dated September 4, 2015, page 1108.)

○ In March of 2019, she was concerned about hemangiomas. (Kaiser Records, Report dated March 17, 2019, page 2899.)

○ On April 27, 2019, she was diagnosed with diverticulitis. (Kaiser Records, Report dated April 27, 2019, page 3170.)

• With the above in mind, what percentage of applicant's psychiatric injury do you attribute to her concerns involving her medical issues?

• In your causation analysis, did you consider any personality traits for exaggerating her symptoms and/or overreacting to situations? For example,

○ The applicant's medical records document a history of hypochondria and/or exaggeration of symptoms. She reported that she "'does not have any coping skills." (Kaiser Records. Report dated December 20, 2017, page 1820.)

○ She reported that she had always been a worrier, usually about finances and the future (was quite shy as a child) and she has a history of muscle tension and other somatic complaints when she was under a lot of stress. She also had insomnia, irritability, and restlessness when anxious and stressed. (Kaiser Records, Report dated April 11, 2018, page 2172.)

○ Her medical records document that she "'seemed noticeably agitated and defensive when return to work date was brought up." (Kaiser Records, Report dated May 20, 2020, page 5486.)

• With the above in mind, what percentage of applicant's psychiatric injury do you attribute to her personality traits and/or reaction to situations?

• In your causation analysis, did you consider any financial stress as a source for her psychiatric injury? For example,

○ On October 11, 2019, she reported that her application for Social Security was denied, that her family had become strained because of financial stress, and that she had sleep problems. (Kaiser Records. Report dated October 11, 2019, page 3895.)

○ Her medical records document frustration with the denial of her long-term disability and short-term disability, finances, and work. (Kaiser Records. Report dated May 27, 2020, page 5533.)

• With the above in mind, what percentage of applicant's psychiatric injury do you attribute to concerns regarding her financial stress?

• In your causation analysis, did you consider applicant's long history of medication usage as a source of her psychiatric injury? For example,

○ On September 13, 2019, she was being prescribed Cymbalta. (Kaiser Records, Report dated September 13, 2019, page 3829.) On October 7, 2019, she was prescribed Wellbutrin 100 mg, BuSpar 10 mg, and Ambien 0.5 mg. (Hamlin Psyche Center, RFA dated October 7, 2019.) Does combining Ambien with BuSpar may increase side effects such as dizziness, drowsiness,

confusion, and difficulty concentrating? Did you find these among the applicant's complaints even prior to being prescribed these drugs in combination?

Isn't it true that when combining BuSpar with Cymbalta, there is an increased risk of a rare but serious condition called the serotonin syndrome, which may include symptoms such as confusion, hallucination, seizure, extreme changes in blood pressure, increased heart rate, fever, excessive sweating, shivering or shaking, blurred vision, muscle spasm or stiffness, tremor, incoordination, stomach cramp, nausea, vomiting, and diarrhea? The applicant has complained about some or all of these symptoms, correct?

○ The applicant reported to you that she drinks wine twice per week. (Your Report page 9.) Isn't it true that Cymbalta, Wellbutrin, BuSpar, and Ambien are all known to interact badly with alcohol? The applicant reported increased alcohol consumption due to her emotional stressors, correct? Among the effects of combining alcohol with these drugs are seizures, hallucinations, delusions, paranoia, mood and behavioral changes, depression, suicidal thoughts, anxiety, panic attacks, dizziness, drowsiness, difficulty concentrating, impairment in thinking and judgment, and liver damage, correct? The applicant has complained about some or all of these symptoms, correct?

The FDA generally recommends concurrent usage of no more than three psychotropic agents at a time, correct? The applicant's medication list following the initial evaluation with Dr. Windman includes four such agents, correct?

• With the above in mind, what percentage of applicant's psychiatric injury do you attribute to her medication usage and/or drug interactions?

• In your causation analysis, did you consider her prior psychiatric disability claims as a direct result of her pending symptoms as opposed to industrial causation from events of employment that took place in 2019? For example,

○ On December 20, 2017, she reported that her "depressive symptoms started getting worse since June 2017 due to increased troubles at work. She was experiencing severe somatic symptoms at work and decided to take a short-term disability and leave work." (Kaiser Records, Report dated December 20, 2017, page 1819.) On May 4, 2018, she reported that she was in the process of an appeal for her short-term disability. (Kaiser Records. Report dated May 4, 2018, page 2326.) On November 14, 2019, her short-term disability was denied. (Kaiser Records, Report dated November 14, 2019. page 4092.)

○ On November 26, 2019, she reported that she was on long-term disability for her psychiatric injury. (Kaiser Records, Report dated November 26, 2019. Page 4152.)

○ On December 11, 2019, she reported she would be on long-term disability for two years. (Kaiser Records. Report dated December 11, 2019, page 4217.)

○ The applicant told Dr. Windman that she filed a stress case in 2012, and never recovered from it. (Hamlin Psyche Center, Report dated October 28, 2019.)

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○ She reported that her depressive symptoms started in 2012 due to her boss, who was "threatening and demanding." She developed medical conditions, including severe headache, which made it difficult for her to function at work. (Kaiser Records, Report dated December 20, 2017, page 1819.)

○ She presented with neck and joint pain since 2012 that started gradually due to work-related stress and increased workload. (Kaiser Records, Report dated June 18, 2019, page 3293.)

○ On July 31, 2019, she reported that her symptoms had been "gradually worsening with the increasing stress and workload she does." Her pain had been worsening since 2012. She believed her pain was from "repetitive movements at work, loading the ATM – heavy machines pushing/pulling." (Kaiser Records, Report dated July 31, 2019, pages 3452-53.)

• Were you aware of any prior psychiatric disability claims filed by the applicant?

• Did the applicant report any prior periods of leave of absence from work due to psychiatric injury and/or need for psych treatment?

• With the above in mind, since the applicant has filed prior claims for psychiatric disability as early as 2012, and she has consistently treated for her psychiatric condition since then, are her pending psych symptoms a direct result from an old injury as opposed to a separate and distinct injury occurring in 2019? Please explain why or why not.

• If you do not find evidence of a separate and distinct psychiatric injury in 2019, what percentage of applicant's current psychiatric injury do you attribute to her prior psychiatric claims and need for treatment?

Apportionment: In the examiner's report dated August 28, 2020, her stated that "Apportionment to prior impairment was supported by the record." (Report page 25.) In the even that She continued to find that the predominance threshold for psychiatric injury was met, She was to address the following interrogatories regarding apportionment:

• Since you initially opined that applicant sustained an aggravation of a preexisting psychiatric condition, what percentage of her current disability is attributed to her preexisting condition?

• Do you find apportionment appropriate to the following non-industrial factors? Please explain why or why not. If so, what percentage do you attribute to each factor considered?

○ Distance/Travel caused by family in CA and working in Florida.

○ Discussion of her husband's infidelity with her doctors as recent as 2016.

○ Concerns reported to you about her husband's drinking and his frustration over her loss of income.

○ Family issues as discussed above.

○ Family medical history as discussed above.

○ Concerns of her medical history as discussed above.

○ Personality traits as discussed above.

○ Financial stressors discussed above.

○ Medication Usage and/or drug interactions as discussed above.

○ Credibility (subjective vs. objective evidence of harassment):

In his report dated August 28, 2020, he found applicant to be a credible historian. (Report page 18.) In his report, he stated that she "responded to the MMPI-2 items in an extremely exaggerated manner, endorsing a wide variety of rare symptoms and attitudes. These results might stem from a number of factors that include excessive symptom checking, falsely claiming psychological problems, low reading level, a plea for help, or a confused state. Her extreme score on the F(P) scale suggested that her responses were more extreme than people who were hospitalized for severe psychiatric problems." (Report page 12.)

He also stated that "The MMPI-2 profile was notable for indications of excessive responding and over endorsement of items as demonstrated by F scale elevation to 110 and F(p) elevation to 90. The clinical scale elevations related to the endorsed items revealed the highest elevations on scales Sc and D, reflecting bizarre sensory and cognitive experiences and depression. Although the Pa scale was also elevated, the pattern did not reflect the Sc and Pa elevation associated with gross F scale exaggeration that is most likely to reflect deliberate exaggeration. The MMPI-2 profile most likely reflected the significant somatization, health anxieties, depression, and the applicant's hypervigilance to somatic sensations that she described in her interview." (Your Report page 18.)

• With the above test results in mind and following your review of the enclosed materials, do you find evidence in the medical reports that applicant exaggerated her complaints or symptoms? Do you find applicant's narrative to be exaggerated? For example,

○ The applicant alleged that she was singled out and harassed by Kathy Ware; that Ms. Ware questioned why the applicant did certain things; that Ms. Ware yelled at her because her monitor did not have a privacy screen protector; and that Ms. Ware expressed disappointment in her work performance. (Your Report pages 5-8.)

○ The applicant's personnel file reflected that she received good performance reviews, including a rating of Strong for Teamwork and Leadership skills in her 2018 performance review. Do you find her allegations regarding Ms. Ware about her performance to be consistent with the performance reviews documented in her personnel file?

• Do you find evidence of harassment by Ms. Ware in the applicant's medical records from Kaiser?

• The applicant alleged that that there were a lot of openings under Ms. Ware. (Kaiser Records, Report dated February 11, 2020, page 4451). The applicant also claimed that she was singled out by Ms. Ware. Do you find these allegations consistent?

He was to prepare a supplemental report addressing Defendant's interrogatories above and provide his final opinions and conclusions regarding causation, permanent disability, apportionment, need for future medical treatment, and all other issues he deemed appropriate.

Deposition of Sandra Seeram (Volume I), dated June 26, 2020.

The applicant was deposed before and acted as a witness in regard to the case of a branch.

She was not working this time.

She took Topamax, Levothroid, and Cymbalta in the last 24 hours. She denied consuming alcoholic beverages in the last 24 hours.

She had lived at 2692 Cabrillo Avenue, Torrance, California since March 2018. She owned the house and there was no mortgage.

She was born in New York.

She attended college for 2 years and obtained associate's degee at Palm Beach Community College in 1992.

Both of her parents were alive and living in Boca Raton, Florida. She had a younger brother and younger sister. They lived also in Boca Raton, Florida. She denied providing her family a financial support.

She got married with Viti Seeram on May 23, 1992. They had 2 children, a son, aged 23 and a daughter, aged 17. She was living with them.

Before that, she lived at 10832 Tea Olive Lane, Boca Raton, Florida.

She had been involved in bank robberies.

She filed 2 applications of cumulative trauma injury against JP Morgan Chase.

She filed state disability presently for this case. She started receiving from state benefits from March 2019 to October 2019, $1632 every 2 weeks.

She also took Klonopin, Flexeril, and Naproxen.

She denied smoking and using drugs. She consumed alcoholic beverages for 2 to 3 times a month. She consumed 1 cup of coffee a day.

She took vitamin D, vitamin C, vitamin A, Vitamin K, and Biotin. She was currently on medical insurance of Kaiser Permanente.

She got all of her medications and treatments from Kaiser.

Presently, she was trying her best to return to work at Chase and was not finding any other job. She had 3 and half years left for her to retire.

She last worked for Chase on March 15, 2019. She was paid through annual base salary, $75, 200 a year. She received a typical bonus, $23, 000. For a typical year, she would be making close to $100.000.

She worked as a branch manager for Chase. Her direct supervisor was Kathy Ware. Her job duties entailed mainly managing the branch. She was responsible for auditing, fixing problem of a branch, and managing her employees. For 20 years, she managed 9 branches. She was known as "Ms. Fixer."

She sustained a lot of stress because of the workload and environment, while working for Chase. There was a time that Ms. Ware got mad at her of not having the protective screen. There was a time that she took Mobic and called in sick the day before. She tried asking for time off from work, but was denied.

She had a good relationship with her employee and co-workers, while being at Chase.

She received performance review in 2013, meets minus.

Presently, their source of income was from her husband and her last Prudential long-term disability check.

Presently, she paid for acupuncture and spent a lot of time with chiropractor. She ate healthy foods.

Presently, she had tingling in her fingertips and toes. She had numbness in her feet, pain in her knees, stiffness in her neck, headaches, and middle back pain. She had pain in the shoulder areas, hands, and wrists. She described the pain as sharp and stabbing, rated as 7/10. The neck pain was eased when she laid down and through acupuncture.

Topamax helped her to ease her pain and also to prevent the headaches. She started having neck pain when she was at the Hawthorne office in about 2012. Same year also, she went to Kaiser Permanente for treatment.

She was still seeing her Kaiser doctors. She had also seen a Workers' Compensation doctor(s) related to her neck. She had a follow-up with her pain management next week.

Chiropractic and physical therapy had helped her neck issues. She had x-rays and MRI of the neck. She received injection shots for her neck.

Because of the neck and wrist issues, she had tingling in her fingertips that was associated with pain and numbness. Before, she rated this pain as 10, but presently, it was 5-8/10.

She rated the pain in her wrists as 5/10 in the left, and 4-8/10 in right. Her pain in the wrist was worsened at the time she first stopped working, at 9-10/10. She started having this in 2012 and sought treatment at Kaiser. She received physical therapy, acupuncture, chiropractic, and injections for wrists pain. She was also provided brace for wrists, but it made it more swollen and bigger.

The tingling in her toes was associated with numbness and pain. According to her doctor, the toe issues were caused by her neck pain. She rated her toe pain as 10/10 at the time she was working, and presently at 5/10. This issue arose in 2015. She received acupuncture therapy for her toes.

In regard to her knees, this had started in 2015. She rated the pain before as 8/10 and presently as 4/10. She received acupuncture and physical therapy.

The tingling in her feet was associated with numbness and pain, right worse than left. According to her doctor, the feet issues were caused by her neck pain. She rated her feet pain as 8/10 at the time she was working, and presently at 4/10. She received acupuncture, physical therapy and x-rays for her feet. This issue arose in 2015.

In regard to headaches, she rated the pain before as 8/10 and presently 8-9/10. She also took Mobic and Naproxen to ease her headaches. The doctor told her that the causes of her headaches were her neck, stress, and back.

Prior to 2012, she already had back pain. She received acupuncture, physical therapy, chiropractic, x-rays and MRIs to her back. Prior to receiving treatments for her back, she rated the pain as 4-7/10.

She started having shoulder issues in 2015, covered by Dr. Chong. She rated the pain before as 9/10 and presently as 5-7/10. She received acupuncture for shoulder issues. She received thoracic MRI.

In regard to hand and grip issues, her doctor told her neck issues caused it. She received acupuncture for it. She rated her pain as 10/10 before, right was more and 8/10 in right and 6/10 in the left presently.

She was diagnosed with diverticulitis by her personal doctor. The doctor told her that her diverticulitis was caused from stress and lack of eating. She treated it with good diet.

She had depression, emotional outbursts, lack of patience, becoming introverted, kind of giving up on everything, worrying, uncontrollable worry, anxiety, becoming guarded like defensive and

not trusting anyone, irritable, and forgetful. Her emotional symptoms started maybe in summer/fall of 2018.

There was also a time that she was embarrassed in front of everyone.

She was referred to see a psychologist through Kaiser in September 2019. She was seeing somebody for psyche issues through Workers' Compensation. She was still seeing a psychologist or psychiatrist.

Because of Corona Virus, her appointment with Kaiser was through telephone. The last time she had was on Wednesday.

For her, she had improvements with her diverticulitis and mental condition. The primary obstacle for her to return to work was physical and non-physical problems.

Dr. Denise Hom was her primary care physician.

Her psyche problems started when Ms. Ware harassed her. Ms. Ware belittled and yelled at her. Ms. Ware expressed disappointment in her work performance. She felt singled out by Ms. Ware: she was not given the cost of living increase and she was not paid for short-term disability. She only felt the care of Natalia.

Deposition of Sandra Seeram (Volume II), dated July 24, 2020.

The applicant was still seeing Dr. Denise Hom, who had been her primary care physician since 2007. She had also seen Dr. Curtis (outside of Kaiser), and Dr. Iseke at the Wellness Center in Long Beach. She had an upcoming QME appointment. She had a bone scan of her entire body done at Kaiser on July 14th, and she was scheduled to see Dr. Hom on July 28, 2020 to discuss this.

She had been diagnosed with high cholesterol and arthritis.

Since being off work, the applicant noted having a lot of face care now. "I have broken out everywhere," and had gone to multiple dermatology appointments. She also had excruciating pain that she tried to take a lot of vitamins to help with the pain and to try to care for the bones. She was trying to rest more. She did not sleep as much. Her mind "is just wandering," adding she was not the same person. "I think the day just gets away, depressed. I don't know how the day goes."

She had the long-term disability "trying to give me a hard time," sending in paperwork and trying to get social security. She added that JP Morgan Chase never paid her for long-term disability, so a thousand hours of sick time was lost.

She went out once to try to get something. However, she was unable to pick up what she wanted. She was unable to drive a car. She watched TV, but "that did not work." She would eat oatmeal for breakfast, and just heat up whatever was left over for lunch. She took a shower once a day.

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A lot of fighting was going on in their house. She described the relationships as not the same anymore. "It's not COVID-19. I can tell you that." She worried a lot on her part, having a lot of anxiety.

Once a week, everyone went, and then she would be at home. She would take medicines and vitamins morning and night.

In the first volume of her deposition, she mentioned having diverticulitis and some dietary struggles. She had gained about 6 pounds, which was believed was from stress.

She was unable to perform household activities. She could only make some eggs for herself. With regard to grocery shopping, she could do it if "it was under 5 pounds." She went out with her family once in a while, but "it was just too much." She described her face as really bad, and the sun on her face was painful.

She did not feel like socializing. She did text her mother every day. She did not want anyone to see what she looked like right now.

She could drive to a maximum of 15 minutes without her feet getting numb. She only walked around in the house (they lived in a condo).

She never smoked. If she did drink, it would probably be a half glass of wine.

The last time that she took a vacation was in February. She went Florida to see her father, who was ill. Since she stopped working at JP Morgan Chase, she had not left the country.

She testified having pain and aches from her work-related stress. When driving home, she would be numb and had to call for help. There was one incident when she called Kaiser, and was told to call 911. She had to be taken via ambulance away from work. Her son came to get her from Kaiser when she got discharged. When she stopped working, she had to go back to emergency where she was told of having anxiety.

Due to stress, her skin had broken out. She had skin lacerations. She lost half of her hair. She also had stomachaches and dizziness. She was always getting sick, with constant flu and colds. She wanted to do nothing with her husband, with loss of sex drive. She had chest pain which felt like a heart attack.

She experienced stress when sitting on a conference call, being talked down to that she could not think anymore. When sitting in a meeting and being yelled at, her stomach would hurt more. Her memory was affected. She had become very moody. "I am Miss Social," hosting all the parties and people would come to their house. She felt very isolated. She just felt like a failure right now. She had a good career and had lost everything.

She was taking about 10 pills a day. They were serving medications for a "pre heart attack" and for the nerves. She described having bone lacerations. The spacing between her neck was gone. She had bulging between the spine. She was only 51 but she felt like 70 years old.

Whenever she laid down, her mind was not at rest. She would think of everything that was going on. When she finally fell asleep, she would have horrible dreams. This had been going on for the last 2 years. She had racing thoughts about work experiences – how she was treated, and about the ongoing paperwork. She was no longer the driven person that she used to be. She felt humiliated.

When asked about her future, she replied, "I don't have one." She only had 3-1/2 years to retire, now that was not going to happen.

Deposition of Edward Spencer, M.D., dated November 23, 2020.

Miscellaneous, undated.

Miscellaneous reports were received such as employee transfer request, employee change notice, status change preprocessor notes, and memorandum.

MEDICAL RECORDS:

Call Documentation, signed by Sandra Kim, M.D., Kaiser Permanente, dated August 14, 2009.

On August 14, 2009, the applicant requested an appointment with ob/gyn in TRR for tests including Pap. She was concerned that she might have cancer, as her mother and sister were diagnosed with problems.

It was noted that her mother and sister were told she had polyps in their uterus seen on ultrasound.

Dr. Kim advised that polyps in uterus was not an inherited thing and they were only rarely cancerous. She could be scheduled for a routine gyn appointment.

Office Visit, signed by Michael Acord, M.D., Kaiser Permanente, dated October 19, 2010.

History: The applicant complained of mild to moderate aching and tingling in both hands and forearm for several years. She used hands all day in bank.

Past Medical History: She had a history of mixed hyperlipidemia, menorrhagia, and GERD.

Physical Examination: She was oriented and well developed. She was well nourished and was in no distress. Her mood appeared not anxious. She was not agitated. She did not exhibit a depressed mood. She was not apathetic.

X-ray of the Cervical Spine: Impression: Mild C5-6 DOD with slight decreased disk height without significant osteophytes. Straightening of the cervical lordosis. No significant prevertebral soft tissue swelling. Visualized lung apices were clear. Remaining AP and lateral cervical spine examination was unremarkable.

Diagnoses: 1) Paresthesia of upper limb. 2) Carpal tunnel syndrome.

Plan: She was recommended upper extremity nerve conduction velocities, cervical x-rays, and physical therapy for mobilization and stabilization.

Office Visit, signed by Katrin Massoudian, M.D., Kaiser Permanente, dated March 1, 2011.

History: The applicant presented with Pap smear, physical examination gynecologic, breast examination, and menstrual problem. Her last menstrual period was on February 17, 2011. She had prolonged menstrual cycle (bleeding for 2 weeks). Dr. Kim evaluated her since 2008-2009. She had proliferative endometrium. She felt worse and was currently having some mid-cycle spotting. She had hot flashes at night.

Past Medical History: She had a history of mixed hyperlipidemia, menorrhagia, and GERD.

Family History: She was significant for breast cancer, diabetes, hypertension, and CVD.

Physical Examination: She was alert, well appearing, and in no apparent distress.

Laboratory: TSH was high at 7.93. FSH was

Diagnoses: 1) Menometrorrhagia. 2) Screening for CA, cervix. 3) Screening for CA, breast.

Plan: She was advised trial of OCPs then ablation if that failed. Check laboratory. Screening mammography was recommended.

Office Visit, signed by David Nguyen, M.D., Kaiser Permanente, dated November 2, 2012.

History: The applicant had a carpal tunnel syndrome on October 26, 2012. She had a history of OA cervical spine, carpal tunnel syndrome with bilateral hands, bilateral upper extremity tingling and numbness. She was seen in physical medicine in the past. She had hand numbness. Last evaluation was in 2010 by Dr. Acord for localized neck muscle pain. He had intermittent nocturnal hands numbness and tingling. Work station might not be ergonomically set up.

Current Medication: She was on Zocor 20 mg, Levora-28 0.15-30 mg-mcg, Levothroid 75 mcg, Mobic 7.5 mg, Aristocrat/Kenalog 0.1% top ointment, Protopic 0.03% top ointment, and Atarax 25 mg.

Physical Examination: She was well developed, well nourished, and in no distress. She appeared to not be writhing in pain. She appeared healthy. Affect was normal.

Diagnoses: 1) Carpal tunnel syndrome. 2) Numbness and tingling of skin. 3) Neck pain, musculoskeletal. 4) Arm paresthesia.

Plan: Wrist splint was ordered to use at night during sleep for the next 6 weeks. She was to avoid repetitive prolonged wrists/hands gripping, grasping or forceful grasping. She had trial of over the

counter Vitamin B6. She was to consider nerve conduction study testing. She was to continue with neck stretching program and focus on the posture.

Neurology Consultation, signed by Eileen Bardolph, M.D., Kaiser Permanente, dated February 27, 2013.

Reason for Consult: The applicant was with a history of numbness of mouth/lips and would like neurology evaluation. She had unremarkable laboratory.

Subjective: She had tingling and numbness in the perioral region on and off for the past year. She also had some eyelid twitching left eye on and off. Mouth get numbness fingertips left hand and right hand numb on and off for the past year. Told carpal tunnel syndrome on right. She admitted to more stress at work. She was not walking as much as she used to. She had history of hypothyroidism since 2010 and vitamin D deficiency on supplement.

Outpatient Prescriptions: She was on Multivitamin, Vitamin D3 1,000 unit, Zocor 20 mg, Levora-28 0.15-30 mg-mcg, Levothroid 75 mcg, Aristocrat/Kenalog 0.1% top ointment, and Protopic 0.03% top ointment.

Mental Status Examination: She was alert and oriented to person, place, time, and situation. She had intact memory for details of medical history. Attention and concentration were intact. Speech was clear and fluent. Affect was appropriate.

Impression: 1) Paresthesia. 2) Vitamin D deficiency. 3) Review of medication.

Plan: She was to increase walking daily. Multivitamins and Vitamin D3 1,000 unit were ordered.

Office Visit, signed by Moris Rabanipour, M.D., Kaiser Permanente, dated February 27, 2013.

History: The applicant presented for health maintenance examination without PAP.

Physical Examination: She was in no acute distress.

Bilateral Screening Mammogram, March 20, 2013: Impression: Benign. There was no mammographic evidence of malignancy. Return to annual mammogram screening schedule was recommended.

Assessment: 1) Health checkup, adult. 2) Hypothyroidism. 3) Hyperlipidemia mixed. 4) Screening for CA, breast.

Plan: X-ray mammogram screening bilateral, TSH, creatinine, electrolyte panel, and vitamin D were ordered. Routine advice given on healthy diet and exercise. She was to return in 1 year for annual examination. Routine laboratory was ordered. She was recommended self-breast examination and limited alcohol intake no more than 2 drinks daily. Sun protections and sunscreen

use was advised. She was to continue with simvastatin, low fat and low cholesterol diet. Recheck TSH.

Office Visit, signed by Katrin Massoudian, M.D., Kaiser Permanente, dated July 5, 2014.

Subjective: The applicant's last menstrual period was on June 25, 2014. She presented for Pap smear. Periods improved on Levora started in 2012 for menorrhagia. She was thinking about weaning or trying low dose pills. Low dose pill tried in 2011, but she had prolonged spotting.

Assessment: 1) Screening for cervical cancer. 2) Routine gynecology examination including cervical PAP. 3) Screening for HPV. 4) Oral contraceptive pull surveillance.

Plan: Gynecology cytology, HPV cotest, and Microgestin 1-20 mg-mcg were ordered.

Office Visit, signed by Denise Hom, M.D., Kaiser Permanente, dated September 4, 2015.

Subjective: The applicant presented for history of chronic neck pain/problems, back and shoulder pain; trying walking; and drive to work better. She had a history of right thumb/wrist pain for years. She had intermittent pain, worse with typing, writing a lot, improved with thyroid treatment, exercise, and follow up with PMR.

Physical Examination: She was well developed, well nourished, and was in no distress. Non-toxic appearance. Affect was normal.

Laboratory: TSH was high at 4.52. TPO AB was high at 61.3. HGBA1c% was high at 5.8. Cholesterol was high at 239. Triglycerides was high at 150. LDL was high at 147.

Assessment: 1) Cervical spondylosis. 2) Right carpal tunnel syndrome. 3) Paresthesia of upper limb. 4) Hyperlipidemia mixed. 5) Hypothyroidism. 6) Vitamin D deficiency. 7) Numbness and tingling of skin. 8) GERD. 9) Contraceptive management menorrhagia. 10) Eczema. 11) Congenital keratosis pilaris. 12) Alopecia. 13) Foot callus.

Plan: She was recommended for laboratory, physical medicine, Cyclobenzaprine 10 mg, dermatology, and podiatry. She was to continue wristband, Levothroid 72 mcg, calcium + vitamin D with meals, and Pepcid. She was to follow up in 3-6 months.

Patient Message, signed by Denise Hom, M.D., Kaiser Permanente, dated December 3, 2015.

The applicant would like to request laboratory work to check her cholesterol, thyroid, and vitamin D levels plus any additional blood test to follow up from last visit.

Telephone Appointment Visit, signed by Denise Hom, M.D., Kaiser Permanente, dated June 24, 2016.

The applicant was concerned about husband's drinking. She had unresolved concerns about history of cheating/trust in past when her son was 1 year old. Her husband did nothing. She was

leaving back for Florida Sunday. She was trying to look at "big picture", while his husband sees day to day activities.

Assessment: Problem in marital or partner relationship counseling.

Plan: She was advised to follow up with psych/therapy for counseling.

Office Visit, signed by Helen Chung, M.D., Kaiser Permanente, dated November 29, 2017.

History: The applicant presented with neck pain. She was last seen on December 17, 2015. She had history of pre-diabetes mellitus, hypothyroid, GERD, vitamin D deficiency, bilateral carpal tunnel syndrome. Dr. Nguyen saw her for bilateral carpal tunnel syndrome. Dr. Acord also previously saw her for neck pain. Dr. Chung last saw her in 2015. She had neck pain radiated to arms with numbness and tingling. She had pain associated with headaches. She had pain worse with work. She was a bank manager for Chase, and had a lot of stress. They were having her travel to Florida a lot, where she had to float around to different branches.

Medication: She was on Microgestin 1 mg-20 mg (21)/75 mg, Aventyl/Pamelor 10 mg, Vitamin D3 1,000 unit, Mobic 15 mg, Mevacor 20 mg, retina 0.01% top gel, and Levothyroxine 88 mcg.

Physical Examination: She was oriented to person, place, and time. Non-toxic appearance. She was in no distress. Her mood appeared anxious.

Diagnoses: 1) Cervical myofascial pain syndrome. 2) Cervical disc degeneration. 3) Chronic neck pain.

Plan: Referral to physical medicine external, Cymbalta 20 mg, Robaxin 500 mg, and Ketorolac injection 30 mg were ordered. She may resume Meloxicam. She was to continue home exercise program. She was referred to ACP trial to help stabilize chronic pain condition.

Integrated Pain Management Program Initial Consultation Note, signed by Emily Woyshner, P.A., Kaiser Permanente, dated December 14, 2017.

History of Present Illness: The applicant had neck pain that started in 2012, on and off. She had persistent neck pain as of June 2017. She also had chronic headaches. She worked as a bank teller. Her posture was constantly with cervical spine in flexion. She had mild DDD of cervical spine and central stenosis. She had constant pain, daily even off work for 2 weeks, and no improvement. She had aching, cramping, sharp, shooting, throbbing, and tingling. She had pain aggravating with sitting for a long time, lifting, standing, and climbing. She had pain relieved with medications, bed rest, heat, massage, and physical therapy. She had headaches started in June. She had headaches every day. She had pain mostly on the top of her head, sometimes forehead and behind eyes. She had constant shooting. She wakes up at 2 am almost every night with headaches until she take Motrin and Advil. She had constant headaches. She had pain worse with movement. She had occasional nausea. Prior to June, she would get a headaches a few times a week. She would usually take Motrin. She was most recently taking Naproxen for her headaches, but was told to stop since November.

Medication: She was on Cymbalta 20 mg, Robaxin 500 mg, Microgestin 1 mg-20 mg (21)/75 mg, Vitamin D3 1,000 unit, Mobic 15 mg, Mevacor 20 mg, retina 0.01% top gel, Levothyroxine 88 mcg. and Ketorolac injection 30 mg.

Allergies: She was allergic with penicillin's.

Physical Examination: She was alert and was in no acute distress.

Assessment: 1) Chronic daily headaches. 2) Chronic neck pain. 3) Right shoulder joint pain. 4) Cervical spondylosis. 5) Right carpal tunnel syndrome. 6) Hypothyroidism due to thyroiditis. 7) Migraine. 8) Analgesic overuse headache.

Plan: She was referred to physical therapy/occupational therapy, Topamax 25 mg, and Lidoderm 5% top patch. She was to continue Duloxetine 40 mg. She was advised to limit Acetaminophen use and not exceed more than 3,000 mg a day. She was to follow up in 4 weeks.

Telephone Appointment Visit, signed by Virginia Coyle, Psy.D., Kaiser Permanente, dated December 15, 2017.

Reason for Referral: The applicant had chronic neck pain and a lot of emotional stress/work stress.

Chief Complaint/Presenting Problem/Course of Illness: She was married, currently working a Chase Bank Branch Manage, and reporting chronic neck pain. She reported recognition that emotional and work-related stress aggravated her pain. Her stress was mostly related to living in Florida for work while her husband and children were living in California. She had been trying to obtain a transfer from Florida to California for 2 years. She visits with her family every 6 to 8 weeks. Moreover, her current position requires extensive traveling by car to different locations, and that the job itself was very stressful. Recently her pain and exhaustion became significantly worsened, and resulting in a need to request medical leave. She was currently in California and plans on remaining here until the end of her medical leave. She had a desire to learn how to better manage her stress and chronic pain.

Interventions: Discussed the Integrated Pain Management Program explaining that it was developed to assist her develop better skills in managing their chronic pain and to learn Mind-Body techniques taught by the Clinical Psychologist and Physical Therapist. Encouraged her to participate in 8 weeks of Group/Classes in addition to individual sessions with Clinical Psychologist, Physical Therapist and a Pain MD/PA.

Assessment: Chronic pain and related limitations. She presented with significant emotional distress related to psychosocial stressors that was most likely further aggravating her pain. She would benefit from consultation with Psychiatry Department in addition to participation in IPMP. She was scheduled for intake with Psychiatry next week.

Treatment Recommendations: She was to consider attending CBTR classes if she was still on leave during the course. She was to follow-up with Psychiatry Department and with IPMP

medication management provider. She had appointment with Emily Woyshner, P.A. on January 15, 2020. She also had appointment with Helen Chung, M.D. on January 16, 2020.

Outpatient Initial Adult Diagnostic Evaluation, signed by Sayaka Kawase, Ph.D., Kaiser Permanente, dated December 20, 2017.

Presenting Problem: The applicant was seeking services today due to depressive symptoms related to multiple stressors. Her depressive symptoms started in 2012 due to her boss who was "threatening and demanding." She developed medical conditions, including severe headache, which made it difficult for her to function at work. She had been moving back and forth between Florida and California, but they decided to move to California permanently 2 years ago. Her husband and 2 children moved to CA first, but she was stuck in Florida since she had not been able to find a job to transfer within Chase. This had caused some marital issues. She had been feeling overwhelmed by taking care of her elderly parents as well. She felt that her parents and siblings had been distancing themselves from her regardless of her efforts to support them, which also distresses her. Her depressive symptoms started getting worse since June 2017 due to increased troubles at work. She was experiencing severe somatic symptoms at work and decided to take a short-term disability and leave work. She was also prescribed with Cymbalta, which had been helping her tremendously. Her progress was reflected on today's TPI scores. Her condition was a lot worse 3 weeks ago.

DSM 5 Symptoms Evaluation: Behavioral Health Impairment (BHI) Severity Score: 19. Behavioral Health Impairment (BHI) Severity Range: Low. She had depression mood, sadness, irritable mood, decreased interest or pleasure, decreased sleep and decreased concentration. She had excessive worry or anxiety and difficulty controlling the worry.

Psychiatric History: She believed that her depression started around 2012.

Relevant Family History: Her father was probably suffering from depression.

Social History: She felt disconnected from his parents whom she lived with. She felt that her parents were controlling. She felt distanced from her sister and brother. She reported that her marriage was getting better and she had strong relationships with her children.

Medications: She was on Topamax 25 mg, Lidoderm 5% top patch, Cymbalta 20 mg, Robaxin 500 mg, Microgestin 1 mg-20 mcg(21)/75 mg (7), Aventyl/Pamelor 10 mg, Vitamin D3 1,000 unit, Mobic 15 mg, Mevacor 20 mg, Retin-a 0.01% top gel, Levothyroxine 88 mcg, and Ketorolac injection 30 mg.

Mental Status Examination: She was in no acute distress and well-groomed age appropriate dress. Behavior was normal and cooperative. She was alert, clear, oriented to person, place, time, situation, and memory intact to immediate, recent and remote recall, concentration normal. She had appropriate eye contact. Speech was normal. Mood was sustained emotional state. Affect was normal range, appropriate, and mood congruent. Thought process was coherent, relevant, and logical. Impulse control was unimpaired. Judgement was unimpaired. Insight was good and fair.

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DSM-5 Diagnosis: Major depression disorder, recurrent, mild to moderate.

Diagnostic Impression: She appeared to be struggling with depressive symptoms due to multiple stressors, but primary work stress. She might benefit from the recommendations.

Treatment Recommendation and Plan: She was advised to schedule psychiatric medical evaluation prior to leaving department or to call for an appointment. She was recommended group therapy/classes scheduled for intake on December 26.

Telephone Appointment Visit, signed by Denise Hom, M.D., Kaiser Permanente, dated February 22, 2018.

Reason for TAV: Neck pain.

Phone Visit Documentation: The applicant with history of chronic neck pain with numbness/tingling of hands and bilateral carpal tunnel syndrome had stress with work. She was driving all over the place. She was flying back to Florida tonight.

Laboratory: Cholesterol was high at 200. LDL was high at 110.

Assessment: 1) Cervical spondylosis. 2) Mixed hyperlipidemia.

Plan: Laboratory was ordered. She was to follow up with PMR, pain management, and psych.

Office Visit, signed by Denise Hom, M.D., Kaiser Permanente, dated March 23, 2018.

History: The applicant presented with neck, shoulder, and back pain. She also had tingling in feet.

Subjective: She was out of work since last Friday for 1 week due to neck pain. She had pain all the time from the neck up; also with upper back pain; feels pulling on head – like coming down. She had bilateral hand edema since after January 8, 2018. She had been floating to different back branches in Florida since September 1, 2017. She was driving 17 miles/50 minutes both directions. She was on leave November 29 to January 5, 2018 with accommodations for 2 weeks. She was called back to work on January 3, 2018 and worked January 8, 2018. She had vacation from February 9 to February 27, 2018 in CA. She had things got worse from February 27 to March 15, 2018 in Florida. She had hot showers and acupuncture helpful. She had history of chronic neck pain/problems, back and shoulder pain; trying walking; status post MRI; flu with PMR; and had stress. She had history of low back pain. She had bilateral feet tingling; driving a lot; feels like left lower extremity twitching/moving. She had history of TPO and hypothyroidism. She had no problems with Levothroid 88mcg and considering synthroid. She had history of hyperlipidemia. She was not eating well and no exercise. She had history of prediabetes and minimal diet/exercise.

Physical Examination: She was well developed, well nourished, and was in no distress. Non-toxic appearance. She was alert. Affect was normal.

Assessment: 1) Cervical spondylosis. 2) Cervical myofascial pain syndrome. 3) Numbness and tingling of skin – bilateral feet. 4) Back pain. 5) Acute stress disorder. 6) Hyperlipidemia mixed. 7) Hypothyroidism due to thyroiditis. 8) Prediabetes. 9) Left lower quadrant abdominal pain. 10) Vitamin D deficiency. 11) Right carpal tunnel syndrome. 12) Paresthesia of upper limb. 13) Numbness and tingling of skin. 14) GERD. 15) Contraceptive management menorrhagia. 16) Eczema. 17) Hyperpigmentation of skin. 18) Congenital keratosis pilaris. 19) Alopecia. 20) Foot callus.

Plan: She was recommended referral to physical medicine, laboratory, and Retin-a 0.01% top gel. She was to continue Lovastatin 20 mg, Levothroid 88 mcg, calcium + vitamin D, wristband, and Pepcid. She was to follow up with PMR, dermatology, and podiatry. She was to follow up in 3-6 months.

Office Visit, signed by Helen Chung, M.D., Kaiser Permanente, dated April 10, 2018.

History of Present Illness: The applicant had chronic neck pain that radiated to arms with numbness/tingling. Her pain was worse with work. She was a bank manager for Chase. She also had chronic numbness and tingling in bilateral feet especially toes. She had occasional low back pain. Her pain was worse with standing.

Medications: She was on Guaifenesin 10-100 mg/5 mL, Mobic 15 mg, Topamax 25 mg, Cymbalta 20 mg, Lidoderm 5% top patch, Robaxin 500 mg, Microgestin 1mg- 20 mcg (21)/75 mg, Vitamin D3 1,000 unit, Mevacor 20 mg, Retin-a 0.01% top gel, and Levothyroxine 88 mcg.

Allergies: She was allergic to penicillin class and Tessalon.

Physical Examination: She was oriented to person, place, and time. She was in no distress. She was alert. She displayed facial asymmetry. A sensory deficit (bilateral toes) was present. Positive intermittent Hoffman's. Affect was normal.

MRI of the Cervical and Lumbar Spine, April 24, 2018: Impression: Mild degenerative changes in the cervical spine producing mild narrowing of the central spinal canal at C5-C6 and C6-7. Findings slightly progressed since the prior examination. Mild degenerative changes in the lumbar spine without significant narrowing of the central spinal canal and neural foramina. Mild nonspecific prominence of the left jugulodigastric lymph node unchanged since September 27, 2015, most likely benign findings.

Laboratory: Albumin was low at 3.35. Protein electrophoresis result was abnormal.

Diagnoses: 1) Numbness and tingling of skin. 2) Chronic neck pain. 3) Cervical myofascial pain syndrome. 4) Cervical disc degeneration. 5) Bilateral carpal tunnel syndrome.

Plan: MRI of cervical and lumbar spine, protein electrophoresis, immunofixation electrophoresis, referral allergy, and Alprazolam 0.25 mg. She was to continue Meloxicam, Methocarbamol, Cymbalta, and Topamax. She was to increase Cymbalta to 40 mg. She was to continue home exercise program. She was to follow up with IPMP full program and psych for

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stress/anxiety/depression. She had DMI/FMLA. She was to return for NCS bilateral lower extremity. She was requesting test for Demerol injection.

Office Visit, signed by Kevin Marsee, M.D., Kaiser Permanente, dated April 11, 2018.

Chief Complaint: Anxiety.

History: The applicant had intake in December with Sayaka, and was referred to work health program, but did not attend screening appointment. She had depressive symptoms related to multiple stressors. Her depressive symptoms started in 2012 due to her boss who was "threatening and demanding." She developed medical conditions, including severe headache, which made it difficult for her to function at work. She had been moving back and forth between Florida and California, but they decided to move to California permanently 2 years ago. Her husband and 2 children moved to CA first, but she got stuck in Florida since she had not been able to find a job to transfer within Chase. This had caused some marital issues. She had been feeling overwhelmed by taking care of her elderly parents as well. She felt that her parents and siblings had been distancing themselves from her regardless of her efforts to support them, which also distresses her. Her depressive symptoms started getting worse since June 2017 due to increased troubles at work. She was experiencing severe somatic symptoms at work and decided to take a short-term disability and leave work. She was also prescribed with Cymbalta, which had been helping her tremendously. Her progress was reflected on today's TPI scores. Her condition was a lot worse 3 weeks ago. Long history of somatic/physical symptoms (e.g. headaches, myofascial pain, various joint pains), followed by physical medicine for at least a few years, seen once by neurology in 2013 and determined to have unspecified parasthesias. She had always been a worrier, usually about finances and the future (was also quite shy as a child), and had a history of muscle tension and other somatic complaints when she was under a lot of stress. She also had insomnia, irritability, restlessness when anxious and stressed. The somatic symptoms were most distressing for her, and were what have limited her ability to work recently. She had recently made the connection between stress/anxiety and her physical discomfort. Extensive review of symptoms did not reveal any evidence of a history of psychosis, mania, or PTSD.

Prior Psychotropic Medication Trials: She was on Duloxetine 40 mg, started late 2017 and helping with anxiety and mood symptoms; Topamax started late 2017, had been helpful in preventing migraines; Tried nortriptyline 10 mg in September 2017 and really didn't like it, felt "frozen" mentally; and Amitriptyline 10 mg also in September did not tolerate.

Family Psych: Brother had anxiety.

Social: She grew up in New York, and moved to Florida with her family when she was 20. She did not have much to say about her childhood, but admits that her parents were very strict and not emotionally open or expressive. She had been married for over 25 years, and the marriage was good now, but had been rocky in the past. She had a 20 years old son and 14 years old daughter. She has worked for Chase for 29 years, currently as a branch manager, but had a lot of trouble transferring from her position in Florida back to southern California. Her husband works for the City as a supervisor.

Medications: She was taking Topamax 25 mg, Cymbalta 20 mg, Microgestin 1mg- 20-mcg (21)/75 mg, Mevacor 20 mg, Levothyroxine 88 mcg, and Ketorolac injection 30 mg.

Mental Status Examination: She had appropriate grooming. She was normal and cooperative. Motor was normal and no tremor. Eye contact was appropriate. Mood was "stressed". Affect was appropriate and euthymic. Speech was normal rate and volume. Thought process was coherent, relevant, and logical. Insight was adequate, although only recently had made the connection between her level of stress/anxiety and somatic symptoms. Cognition was alert and oriented.

TPI: Behavioral Health Impairment (BHI) Severity Score: 28. Behavioral Health Impairment (BHI) Severity Range: Moderate. Depression – PHQ2 Screen: Positive. Depression – PHQ9 Score: 7. Depression – PHQ2 Severity Range: Mild.

Diagnostic Impression: 1) Generalized anxiety. 2) Rule out somatic symptom disorder.

Additional Assessment: She had a long history of anxiety and somatization symptoms when under a lot of stress. Her somatic symptoms were her primary focus and had been most disabling regarding her work function. She had very dedicated care by physical medicine. She would really benefit from psychotherapy through the IPMP, which she had not been able to commit to yet (although was referred late last year and had a telephone intake with Virginia Coyle, Psy.D.), in large part due to denial of her disability claim late last year. Her mood and anxiety symptoms had improved with Duloxetine. She would be recommended to continue this - maximum dosage was 120 mg.

Treatment Plan: She was to increase Cymbalta as directed by Dr. Chung. She was to avoid use of heavy alcohol and illicit drug, which could interact with medications, worsen psychiatric condition, and have negative social and health consequences. She was to continue to see primary care provider. She was to make a follow-up appointment.

Telephone, signed by Hanna Chung, R.N., Kaiser Permanente, dated April 23, 2018.

The applicant had upcoming appointment in the South Bay Carson Allergy Clinic. If she had ST appointment before MD, she was informed to be off all oral antihistamines at least 5 days before the skin test appointment.

Progress Note, signed by Kaungsett Lin, P.T., Kaiser Permanente, dated April 25, 2018.

Subjective: The applicant worked in Florida on disability FMLA. She had been floating to different bank branches in Florida since September 1, 2017. She had a lot of flying because she wanted to stay here in Southern California. She was going back to work on September 26. She was very motivated to go back to work but she believed she needed to rehab before going back to work because the symptoms were not tolerable. She was unsure what exercises were safe.

History: She complained of history of chronic neck pain for 6 years and flared up in June (after having more stress at work) with upper back pain now and left lower extremity more than right

lower extremity numbness/tingling. She had constant neck and upper back pain, along with intense feeling of pulling on the head. She had right hand edema that was on and off.

Assessment: Neck pain with radiating pain, with signs and symptoms of cervical radiculopathy. She would benefit from continued physical therapy for progression of exercises so she might return to work in September. She was appropriate for physical therapy.

Plan: She was to monitor symptoms for central stenosis. She had thoracic quadruped rotation. She had progress ULTT in sitting position.

Call Documentation, signed by Elias Estrada, M.A., Kaiser Permanente, dated April 25, 2018.

The applicant had MRI of spine, which showed mild age-related changes in the neck and low back spine. There was mild narrowing around nerves in the neck. Spinal cord looks fine. There were no pinched nerves in the low back spine. She was to follow up as scheduled for NCS BLE. MRI also showed nonspecific prominent in left side neck lymph node, felt to be benign.

Call Documentation, signed by Irene Reveles, L.V.N., Kaiser Permanente, dated May 4, 2018.

The applicant was inform that she had a disability claim and need to go to the disability office. She would also need to send message/e-mail via kp.org to Dr. Hom if she had any questions.

Call Documentation, signed by Irene Reveles, L.V.N., Kaiser Permanente, dated May 7, 2018.

The applicant had a telephone appointment with Dr. Hom on May 8, 2017.

Office Visit, signed by Denise Hom, M.D., Kaiser Permanente, dated January 30, 2019.

Subjective: The applicant presented for follow up of left hand numb, chest tight and neck swollen and pushing forward on neck. She was driving for an hour and 10 minutes in traffic. She could barely swallow and took 2 Cymbalta's and 1 ASA. She felt terrible. She had transferred job January 14, but drives 3 hours in total. She had no time for acupuncture and would consider chiropractor. She was out of work since last Friday for 1 week due to neck pain. She had pain all the time from the neck up; also with upper back pain; feels pulling on head – like coming down. She had bilateral hand edema since after January 8, 2018. She had been floating to different back branches in Florida since September 1, 2017. She was driving 17 miles/50 minutes both directions. She was on leave November 29 to January 5, 2018 with accommodations for 2 weeks. She was called back to work on January 3, 2018 and worked January 8, 2018. She had vacation from February 9 to February 27, 2018 in CA. She had things got worse from February 27 to March 15, 2018 in Florida. She had hot showers and acupuncture helpful. She had history of chronic neck pain/problems, back and shoulder pain; trying walking; status post MRI; flu with PMR; and had stress. She had history of low back pain. She had bilateral feet tingling; driving a lot; feels like left lower extremity twitching/moving.

Physical Examination: She was well developed, well nourished, and was in no distress. Non-toxic appearance. She was alert. Affect was normal.

Assessment: 1) Follow up after ED Visit. 2) Cervical spondylosis. 3) Cervical myofascial pain syndrome. 4) Chronic neck pain for more than 3 months. 5) Costochondritis. 6) Numbness and tingling of skin – bilateral feet. 7) Back pain. 8) Acute stress disorder. 9) Right carpal tunnel syndrome. 10) Paresthesia of upper limb. 11) Numbness and tingling of skin. 12) Mixed hyperlipidemia. 13) Hypothyroidism due to thyroiditis. 14) Prediabetes. 15) Upper respiratory infection. 16) Left lower quadrant abdominal pain. 17) Vitamin D deficiency. 18) GERD. 19) Contraceptive management menorrhagia. 20) Eczema. 21) Hyperpigmentation of skin. 22) Congenital keratosis pilaris. 21) Alopecia. 22) Foot callus.

Plan: She was recommended Guaifenesin 10-100 mg/5 mL and Retin-a 0.01% top gel. She was to switch Mobic with Motrin. She was to continue Topamax, Cymbalta, Lidoderm patch, Robaxin, wristband, Lovastatin 20 mg, Levothroid 88 mcg, calcium + vitamin D, Pepcid, and Protopic. She was to follow up with PMR, neurology, ob/gyn, dermatology, and podiatry. She was to follow up in 3-6 months.

Call Documentation, signed by Helen Chung, M.D., Kaiser Permanente, dated January 30, 2019.

The applicant had appointment for back and neck. She was in the ER on Monday and was advised her to follow up with Dr. Chung. She wanted to know if she could have a TAV appointment. ER recommended acupuncture and she was requesting referral. She was also told to ask Dr. Chung if she could go back to work on Monday February 4 since Dr. Hom has her returning to work on Monday.

Office Visit, signed by Helen Chung, M.D., Kaiser Permanente, dated February 14, 2019.

The applicant had numbness in hands while driving for more than an hour. She had chest tight and swelling feeling (went to ED/saw PCP – medically cleared), felt like bones were separating in her hands and pulling sensation, and right leg going numb. She attributed this to having to drive longer distance because her work relocated her further away. She tried wrist splint, but worsened symptoms. She had tremendous job stress. She wanted FMLA for time off for txs and ACP extension.

Medications: She was on Guaifenesin 10-100 mg/5 mL, Mobic 15 mg, Topamax 25 mg, Cymbalta 20 mg, Lidoderm 5% top patch, Robaxin 500 mg, Microgestin 1mg- 20 mcg (21)/75 mg, Vitamin D3 1,000 unit, Mevacor 20 mg, Retin-a 0.01% top gel, and Levothyroxine 88 mcg.

Diagnoses: 1) Chronic pain syndrome. 2) Bilateral carpal tunnel syndrome. 3) Myofascial pain syndrome. 4) Cervical disc degeneration. 5) Lumbar disc degeneration. 6) Anxiety/stress: work stress.

X

Plan: MRI of thoracic spine was pending. She was on Meloxicam, Cymbalta, Methocarbamol, and Topamax. ACP extension. She was to follow up with IPMP full program and psych for stress/anxiety. She was to proceed with allergy referral for corticosteroid testing. She had orthopedic referral for bilateral CTS. Option NEURO referral for paresthesia's. She would consider transitioning to permanent restrictions. She might be provided FMLA, if medically indicated, while she was actively receiving rehab treatments/tests. Once completed, or if she had reached Maximal Medical Improvement, then she was to follow up with PCP for future FMLA if indicated.

Patient Message, signed by Denise Hom, M.D., Kaiser Permanente, dated March 17, 2019.

The applicant had numbness mostly on her left side. She was no longer be driving the hour and half to work each way contacting HR service and JP Morgan Chase nurse since they have approved work modification. She never adhered to it. She asked if she was looking up the correct MRI results.

Office Visit, signed by Helen Chung, M.D., Kaiser Permanente, dated April 11, 2019.

The applicant had ongoing chronic neck pain, and felt like there was chronic swelling in the left supraclavicular region. She had chronic pain triggered by stress at work, from hostile work environment. They were making her like miserable. Driving worsened her pain too. She presented because she wanted DMI extension. She had physical therapy, which did not help. She had ACP that had some helped.

Diagnoses: Chronic pain syndrome.

Plan: She was to continue IPMP including follow up with their psych/MD. She was also to continue ACP. She was to follow up with PCP to monitor left jugulodigastric lymph node.

Colonoscopy Report, signed by Payam Afshar, M.D., Kaiser Permanente, dated April 27, 2019.

Impression: Normal colonoscopy to the cecum and distal terminal ileum. Mild right-sided diverticulosis. Small, non-bleeding internal hemorrhoids.

Pain Management Follow Up Visit, signed by Mobashshera Jabeen, P.A., Kaiser Permanente, dated June 18, 2019.

History of Present Illness: The applicant presented with neck and joints pain since 2012 – started gradually - due to work related stress - increased workload - pain radiating to both upper extremity and lower extremity with numbness, tingling, weakness on and off. She was feeling little better with medication and acupuncture and seeing Pain Psychologist, Dr. Coyle - willing to do Cognitive Behavior Therapy classes. She was still having stress as her work being not accommodative. She had aching, stabbing, sharp, and throbbing pain every day rated as 7-10/10. Symptoms had been progressively worsening. Her pain was aggravated by walking, exercise, standing, sitting, and activity; and alleviated by resting. Physical therapy did not help. Acupuncture had helped pain.

Physical Examination: She was oriented to person, place, and time. She was well developed, well nourished, and in no distress. Mood, memory, affect, and judgement were normal.

Assessment: 1) Cervical myofascial pain syndrome. 2) Cervical disc degeneration. 3) Chronic neck pain more than 3 months. 4) Muscle tightness.

Plan: She was to limit Acetaminophen use and not to exceed more than 3,000 mg. She was to continue Mobic 15 mg, Robaxin 500 mg, Cymbalta 20 mg, and Topamax 100 mg. She was to avoid prolonged use may affect kidney. She was to follow up with physical therapy, cognitive behavior therapy classes, Dr. Coyle, and acupuncture. She was to consider trigger point injection if pain was not managed. She was to follow up in 4 weeks.

Office Visit, signed by Helen Chung, M.D., Kaiser Permanente, dated July 29, 2019.

The applicant was a bank manager, but she was given tasks that she should not be doing as manager, such as handling money/stamping all day long/telebanking, which was aggravating her neck and back pain. Her employer was not honoring the DMI restrictions. They have her drive all the way out to Fairfax, and the commute was aggravating her pain. She had a lot of stress/anxiety related to work as manager; says that some of the other bank managers were also on disability. She had filed for private/SS disability, and work comp. She was seeing work comp on August 21. She was continuing to see IPMP. In interim, she had US neck soft tissue June 3, 2019 that showed Lymph Node with unremarkable appearance.

Medications: She was on Levothyroxine 88 mcg, Topamax 100 mg, Cymbalta 20 mg, Mobic 15 mg, Lidoderm 5% top PTMD patch, and Vitamin D3 1,000 unit.

Diagnoses: 1) Occupational problems or work circumstances. 2) Chronic pain syndrome. 3) Anxiety. 4) Myofascial pain. 5) Cervical disc degeneration. 6) Lumbar spondylosis.

Plan: She was referred to psychiatry. She had work comp evaluation pending in August. She had follow-up with IPMP for chronic pain management. DMI for permanent restrictions was already given.

Physical Therapy Initial Evaluation, signed by Alice Langit-Cole, P.T., Kaiser Permanente, dated July 31, 2019.

History: The applicant was referred to IPMP for neck and shoulder. She was gradually worsening with the increasing stress and workload. She was a bank manager for Chase Bank. She had multiple tasks and some lifting more than 50 pounds.

Chief Complaints: She had neck and shoulder pain worsening since 2012 with increasing workload at work. She had pain aggravated with lifting, reading, driving, and sitting. She had pain eased with stretch, rest, and medication. She had moderate relief with medications. She had cortisone injection for wrist. TP injection for neck muscles was pending. She had minimal relief with acupuncture. She had moderate functional difficulties.

Assessment: She had coping skills deficits in managing pain and presented with musculoskeletal deficits as follows: muscle/soft tissue length deficit of upper trapezius – levator scapula, mobility deficit of cervical, strength/stabilization deficit of cervical, rotator cuff, scapular stabilizers, postural/body mechanics awareness deficit, and therefore would need skilled physical therapy, patient education, verbal/manual cueing techniques to be able to reach his functional goals above mentioned. She was appropriate for 8 sessions integrated pain program on August 2019.

Plan: She was to return for exercise check and progression of functional therapeutic exercises.

Initial Psychiatry Evaluation, signed by Mahlet Girma, M.D., Kaiser Permanente, dated September 13, 2019.

History of Present Illness: The applicant presented to the clinic for initial psychiatric evaluation.

Current Psychiatric Symptoms: She had anxiety. She was seeking services due to being referred by her pain management practitioner, who informed her that her physical pain might be tied to her anxiety level. She had been experiencing anxiety since 2017 when a new supervisor was hired at her work whom reportedly been verbally abusive, unsupportive, harasses her and discriminates against her. She had gone to HR to resolve concerns but HR had not taken action. She had constant worry, rumination, racing thoughts, racing heart, panic symptoms, crying spells, hot flashes, anger, poor focus, irritability, confusion, headaches, stomachaches, tingling in fingers/feet, nausea, stomach pain, muscle tension, weight gain/overeating, etc. Her stress was causing her performance to decrease at work, which led to missing bonuses and corrective action. She was called out of work often and had now been on disability since March 2019. She was at risk of losing her job. She could not drive for more than 15 minutes without starting to feel panic. She had just recently realized that her physical health was tied to her stress, and would like therapy at this time to deal with the stress.

Medication: She was currently being prescribed Cymbalta 60 mg/day.

Mood: She had irritable mood, decreased sleep, increased appetite, weight gain, decreased concentration, decreased energy/fatigue, low self-esteem and tearfulness.

Past Psychiatric Treatment: She had seen Dr. Marsee for 1 visit in 2018, never had a therapist.

Psychosocial History: She was currently on disability since March 2019. She was married. She was living with her husband and children (22 and 16). Her relationship with her family has become strained because of the financial stress in the home due to patient being on disability.

Family Psychiatric History: Her brother had anxiety attacks, also believes sister and mom had anxiety.

Current Outpatient Medications: She was on Cymbalta 30 mg, Mobic 15 mg, Levothyroxine 88 mcg, Topamax 100 mg, Narcan 4 mg, Lidoderm 5% top patch, Robaxin 500 mg, Vitamin D3 1,000

unit, Mevacor 20 mg, Midazolam injection 5 mg, Fentalyn injection 100 mcg, and Ketorolac injection 30 mg.

Allergies: She is allergic to Penicillin, Prednisone, and Tessalon.

Mental Status Examination: She had good grooming and was well dressed. She had cooperative behavior. She had good eye contact. Speech was normal. Motor was normal. Mood was anxious. Affect was appropriate. Thought form, thought content, and concentration were normal. She was oriented to person, place, time and situation. Memory was grossly intact. Insight was average. Judgement was unimpaired.

Assessment: She presented for evaluation and treatment of anxiety. Her current symptoms appeared to be consistent with a diagnosis of GAD and unspecified depression. Risk factors included severity of symptoms, but protective factors included access to care.

DSM-5 Diagnoses: 1) Generalized anxiety disorder. 2) Depressive disorder, other specified.

Treatment Plans and Recommendation: She was to increase Cymbalta to 90 mg for anxiety and mood. She was recommended individual psychotherapy and group psychotherapy, and light exercise. She was to continue off for now and recommended discussing work-related issues with her HR department. She was to return to clinic in 4 weeks.

Primary Treating Physician's Progress Report, signed by Thomas Curtis, M.D., dated October 7, 2019.

Subjective Complaints: The applicant had continued symptoms of both anxiety and depression.

Diagnoses: 1) Major depressive disorder, single episode. 2) Generalized anxiety disorder. 3) Psychological factors affecting medical conditions (stress-intensified headache, neck/shoulder/low back tension/pain, nausea, chest pain, shortness of breath, constipation, abdominal pain/cramping diarrhea and possible stress-aggravated high blood pressure).

Treatment Plan: She was recommended psychiatric medication and CBT psychotherapy.

Work Status: She required a medical leave of absence from October 7, 2019 to January 7, 2020. She was found to be temporarily totally disabled on a combined physical and psychological basis.

Progress Note, signed by Thomas Curtis, M.D., Hamlin Psyche Center, dated October 7, 2019.

Presenting Complaints: The applicant complained of depression, changes in appetite, lack of motivation, decreased energy, changes in weight, and difficulty staying sleep. She had excessive worry, jumpiness, tension, agitation, panic attacks, feeling "keyed up" or on edge, inability to relax, and pressure. She had disturbing memories. She was hearing voices. She had tension headaches, muscle tension, increased pain, dermatological reaction, and abdominal pain/cramping.

Mental Status Examination: She was casually dressed. She was depressed, visibly anxious, and agitated.

Disability Status: She was temporarily totally disabled.

Diagnoses: 1) Major depressive disorder, single episode. 2) Generalized anxiety disorder. 3) Psychological factors affecting medical conditions.

Prescription, signed by Thomas Curtis, M.D., dated October 7, 2019.

Wellbutrin 100 mg #60, Buspar 10 mg #60, and Ambien 50 mg #14 were prescribed.

Request for Authorization, signed by Thomas Curtis, M.D., dated October 7, 2019.

Authorization for Wellbutrin 100 mg #60, Buspar 10 mg #60, and Ambien 50 mg #14 was requested.

Psychiatric Progress Note, signed by Mahlet Girma, M.D., Kaiser Permanente, dated October 11, 2019.

Subjective: The applicant was recommended to increase Cymbalta to 90 mg after the last visit. She currently had anxiety rated as 7/10, but it ramped up this past week. The social security got denied. She had poor sleep but getting better. She had difficulty staying sleep. She had tired energy.

Medication: She increased her Cymbalta, and had mild GI side effect but went away. She reported that it had helped with pain.

Therapy: She was still waiting to start therapy, next week.

Mental Status Examination: She was good grooming and well dressed. She had cooperative behavior. She had good eye contact. Speech was normal. Motor was normal. Mood was anxious. Affect was anxious. Thought form, thought content, and concentration was normal. She was oriented to person, place, time and situation. Memory was grossly intact. Insight was average. Judgement was improving.

Assessment: She presented for follow up treatment of GAD. In interim, she continued to feel quite anxious, but had some relief from increased Cymbalta.

DSM-5 Diagnoses: Generalized anxiety disorder.

Treatment Plans and Recommendation: She was recommended to increase Cymbalta to 120 mg, however she prefer to wait until her pain management doctor weans her off of Topamax. She was to continue Cymbalta 90 mg. She was to start individual and group therapy. She was to consider resources through Center for Healthy Living at KP. Taper Topamax per pain management's

recommendations. Recommend exercise as tolerated. She had off work note. She was to return to clinic in 4-6 weeks.

Primary Treating Physician's Initial Comprehensive Report, signed by Gayle Windman, Ph.D., dated October 28, 2019.

History of the Work Injury: The applicant began her employment at JP Morgan Chase Bank on December 27, 1988. Her last day of work was on March 15, 2019. She was placed on disability by Dr. Helen Chung, a physical medicine specialist. As a branch manager, her job duties included managing employees, managing customer experience, managing sales, counting cash, conducting audits, conducting daily meetings and opening and closing the bank. She received average written work performance work evaluations. For her good work, she also received bonuses and raises in pay. She had disturbing experiences of stress at work. After she became transferred to another branch in May 2018, the market director, Kathy, promised her help. She was overwhelmed. She opened new accounts, safe deposit boxes and performed teller work. There was repetitive ladder climbing and the pulling out of the safe deposit boxes. She also audited cash including the lifting and counting of heavy coins. She did everyone else's job duties. She also described harassment by Kathy, who frequently singled her out during conference calls and meetings. Kathy questioned why she did certain things. Kathy would micro managed her in front of her co-workers and compared her branch to other, high performing branches with sufficient staff. This was an unfair comparison. She worked about 10 hours a day. There were further stressors. In January 2019, she was transferred again. The new location was under performing. Before too long, the performance level of the branch had increased. They completed a renovation of the bank as well. She was very busy with all of this. She had no time for lunch. She also had to care for her children. The branch located at Fairfax was far from her home. She asked Kathy to find a branch closer to her home. She experienced chest tightness and headaches. She had difficulty standing and walking. 911 was called. She was transported to Kaiser at Cadillac. She underwent extensive blood work and an EKG. She was placed off work for 1 week. The problems persisted. Kathy made bank visits weekly. On one occasion, Kathy arrived with a pre-auditor. Kathy then yelled and screamed at her because her monitor did not have a privacy screen protector. Kathy told her that she could not pass an audit. She was humiliated in front of her staff. This was uncalled for. She had passed many audits. There was also physical trauma, which adversely influenced the emotional complications of her work stress. She developed the onset of pain in her neck, wrists and hands in 2017. She continued to work with increased pain. She consulted with her doctor at Kaiser. An MRI was taken of her neck, which revealed disc damage. She was referred to Harold Iseke, D.C. She was unable to perform her usual job duties. She took an intermediate leave of absence. She remained symptomatic. Her emotional condition would be further described in other sections of the report below.

Applicant's Report of Emotional Symptoms: She had persistent depressive mood plus symptoms including changes in appetite and weight, decreased interest, insomnia, decreased energy, difficulty thinking, feelings of inadequacy and recurrent thoughts of death. She experienced recurring periods of anxiety with symptoms including excessive anxiety and worry, difficulty controlling worry, restlessness, feeling "keyed up" or on edge, difficulty concentrating, irritability, muscle tension, abdominal distress, irritability, muscle tension, terror, fear of immediate death, derealization, choking, jumpiness and pressure. There were unprovoked crying episodes that

occurred multiple times a week. She experienced stress-intensified medical symptoms with worsened headache, neck/shoulder/low back tension/pain, nausea, chest pain, shortness of breath, constipation, abdominal pain/cramping, diarrhea and possible stress-aggravated high blood pressure. Due to her mental disorder, she experienced impairment in her daily activities including her personal hygiene, bodily habits, eating habits, sexual habits, sleep habits. Because of her nervousness, there was increased urinary frequency. There were problems with stress-related constipation and diarrhea. Due to stress-related overeating and depressive inactivity, she developed a gain of weight of about 10 pounds. She experienced a depressively decreased interest in her basic self-care activities including combing her hair and dressing appropriately without prompting. In addition, there was decreased motivation to perform normal housekeeping activities including making her bed, cooking a meal, doing the dishes, vacuuming and engaging in yard work. She developed decreased sexual interest due to depression, anxiety, withdrawal, irritability, anger and damaged self-esteem. She developed difficulty falling and staying asleep due to depression, anxiety, worry and nightmares. She used Topiramate and Meloxicam to fall asleep. Because of her insomnia, she experienced excessive daytime sleepiness, morning headaches and trouble concentrating. Due to her emotional distress, she had difficulty interacting appropriately with others including family members, friends and neighbors. She became emotionally withdrawn. Due to her mental disorder, she developed attitudes that impaired her ability to socialize including guardedness, defensiveness, mistrustfulness, suspiciousness and fearfulness. She became irritable and impatient with people. There were problems with short-temperedness and inappropriate outbursts. There was insufficient emotional control such that she yelled at others. Because of her emotional disturbances, there was difficulty paying attention, concentrating and remembering things. She experienced problems with distractibility, slowed thinking, mental confusion, mental blocking and loss of her train of thought. Because of her cognitive impairment, she had difficulty communicating her thoughts. Her cognitive functioning became impaired such that there was difficulty in her ability to watch a TV show or movie. She also had problems remembering where she left things around the house, telephone numbers, appointments, birthdays, directions and what people told her. Due to her depression and anxiety, there was psychological fatigue and energy depletion.

Personal and Family History: She was the 1st of 3 of children. She was born and raised in New York City. She moved to Southern California in May 1992. Her mother achieved a high school level education with a reported occupation of homemaker. She described her relationship with her mother as mostly positive. However, her mother had issues with verbal abuse. Her father achieved a college education with a reported occupation in computer science. Her relationship with her father as mostly positive. However, her father had issues with alcoholism. She described her childhood as happy and normal. She had no significant childhood problems with peer relations, school behavior, school performance or adolescent turmoil. She had been married to her husband, since March 23, 1992. She described their relationship as strained. Due to her physical pain and disability, as well as other problems not related to her disability, there had been issues in their relationship. Her cousin died in approximately March 2002. She experienced a normal period of grief and mourning. There were issues of family illness. Her father had multiple strokes. Her father's condition had worsened. Her father's condition contributed to her current emotional distress.

Personal Life Stressors: She experienced potentially traumatic issues in adulthood. She experienced bank robberies while at JP Morgan Chase Bank in 1989, 1993, 2003 and 2007. As a result of these robberies, she continued to feel unsafe at JP Morgan Chase Bank.

Work History: She was employed by JP Morgan Chase Bank as a branch manager from about December 27, 1988 to March 15, 2019.

Prior Work Injuries: She reported other work injuries. She filed a stress case in 2012. There was a psyche component. She had not yet recovered. In 2012, she injured her neck, back and knees due to heavy lifting. She had not yet recovered. These records should be reviewed.

Psychological History: In regard to her mental health history, she reported no previous episodes of comparable emotional upset or confusion. She had never undergone psychiatric hospitalization. There had been no suicide attempts. Her brother had anxiety. She was prescribed Cymbalta in 2017. She received psychiatric treatment at Kaiser starting in 2019.

Personal Habits: In regard to her personal habits, she was not a smoker and that she rarely consumed alcoholic beverages. Due to her current work related issues, her drinking has increased. She had never been arrested for drunk driving; nor have there been any alcohol-related arrests. She denied the use of any illegal drugs or the abuse of any legal ones.

Medical History: She was diagnosed with migraine headaches in November 2017. She was diagnosed with hypothyroid. In regard to medication usage, she had recently taken Levothyroid, Cymbalta, Meloxicam, Robaxin, and Topamax.

Mental Status Examination: She was casually dressed. She initially presented guarded due to depression and anxiety caused by physical pain and disability. Once rapport had been established, she became more open and revealing. Her manner of communication was depressed, particularly when revealing that she prefers to stay at home and limits her daily activities. Her thought processes were noted to be anxious, particularly when revealing that she worries about her future. She was preoccupied with worries about her career future and economic future. She had fears of continued intractable pain. There did not appear to be a loss of contact with reality in the form of visual or auditory hallucinations. There was no evidence of frank paranoia or delusions of persecution. There appeared to be an absence of frank schizophrenia or other psychosis. She was oriented to the day of the week and date. She was able to retain the recollection of 3 simple items. She recalled past serial Presidents was adequate. Her ability to perform simple calculation -- the subtraction of serial sevens from 100 – appeared to be unimpaired. She demonstrated diminished cognitive functioning in the clinical interview situation. She was noted to be revealing of defects in concentration. It appeared most likely that her cognitive deficits were caused by overwhelmed psychological coping mechanisms. Her motivation to recover appeared impaired by aspects of depression. There was no discernible indication of malingering. Overall, her credibility was deemed to be average. Relevant to her need for treatment, her capacity for psychological insight and good psychological judgment was observed to be essentially unimpaired.

Psychological Test Results: Overall, her psychological test results were abnormal. The psychological testing revealed abnormality in all of the tests measuring emotional functioning.

On the Beck Depression Inventory, her score of 36 placed her in the severe range of subjective depression, according to Beck scoring criteria.

On the Beck Anxiety Inventory (BAI), her total score of 34 indicated a severe level of anxiety according to Beck scoring criteria.

On the Beck Hopelessness Scale (BHS), her score of 9 would be interpreted as reflecting a moderate level of hopelessness according to Beck scoring criteria.

On the Beck Scale for Suicidal Ideation (BSS), the score generated by her was 4. This indicates a need for emotional treatment to reduce or remove suicidal ideation.

On the Insomnia Severity Index (ISI), her total score of 23 indicated moderate insomnia according to ISI scoring criteria.

On the Major Depression Inventory (MDI), her total score of 42 indicated severe depression according to MDI scoring criteria.

On the Generalized Anxiety Disorder Screener (GAD-7), her total score of 21 indicated a probable anxiety disorder according to GAD-7 scoring criteria.

On the Personality Assessment Screener (PAS), she obtained a score of 99.32, in the marked range.

On the Negative Affect scale, she obtained a score of 92.4, indicating marked feelings of unhappiness and tension.

On the Health Problems scale, she obtained a score of 96.1, indicating marked concern for health problems.

On the Psychotic Features scale, she obtained a score of 95.1, indicating marked paranoid thinking.

On the Social Withdrawal scale, she obtained a score of 91.5, indicating marked social difficulties.

On the Hostile Control scale, she obtained a score of 50.4, indicating moderate aggression.

On the Suicidal Thinking scale, she obtained a score of 62.1, indicating moderate suicidal thinking.

On the Alienation scale, she obtained a score of 82.9, indicating marked difficulty with attachment.

On the Anger Control scale, she obtained a score of 97.1, indicating marked difficulty with anger.

Overall, the PAS indicated abnormalities in negative affect, health problems, psychotic features, social withdraw, hostile control, suicidal thinking, alienation and anger control.

The NSQ (Neuroticism Scale Questionnaire) revealed abnormal emotional functioning requiring treatment.

The score of 10 Sten on the Total Scale of revealed a definite need for psychotherapy. This score placed her at approximately the 98th percentile for "total neuroticism," according to NSQ scoring criteria.

The Depression Scale score was within normal limits at a Sten of 6. This normal score probably reflected a failure on the part of her to recognize notice and report on the more subtle manifestations of depression explored by the NSQ. It should also be recalled that the NSQ Depression Scale comprises a less reliable measurement of depression when compared to the more overt Beck.

In summary, the psychological test results confirmed anxiety, depression, hopelessness, insomnia and suicidal ideation.

Diagnoses as per DSM-5: 1) Major depressive disorder, single episode. 2) Generalized anxiety disorder. 3) Psychological factors affecting medical condition (stress-intensified headache, neck/shoulder/low back tension/pain, nausea, chest pain, shortness of breath, constipation, abdominal pain/cramping, diarrhea and possible stress-aggravated high blood pressure).

Summary: Upon examination, she exhibited emotional withdrawal and depressive facial expressions when describing the physical and emotional trauma at work. She was provided with treatment including physical therapy and medication management for her neck, wrists and hands under the care of Dr. Harold Iseke, D.C. Upon examination, she was found to be too beset by stress aggravated pain and disability, too beset by stress aggravated medical symptoms and too depressed and anxious to work. She was found to be temporarily totally disabled on a combined physical and psychological basis. She was observed to become emotionally unstable and disturbed at the contemplation of an immediate return to work. If she attempted to return to work, her emotional condition would deteriorate into worsened emotional dysfunction. A disability form indicating work causation was submitted to the employer. She requires referrals to internal medicine for symptoms of stress-intensified headache, nausea, chest pain, shortness of breath, constipation, abdominal pain/cramping, diarrhea and possible stress-aggravated high blood pressure. The events of injury arising from work were predominantly causative of injury to the psyche. It would be estimated that 100% would be industrially-caused by the events described above with 0% caused by the past and personal life events and other factors. At this time, the review of the past and family history revealed no causative factors or emotional impairments of significance. Issues of apportionment would be addressed in more detail, however, when her psychological condition becomes permanent and stationary. All of the records should be reviewed prior to final opinions on apportionment. At present, it would not be possible to estimate, on a psychological basis, a return-to-work date for regular or modified work. As well, it cannot yet be determined, on a psychological basis, whether she would eventually be emotionally able to engage in the occupation, she performed at the time of the injury. In addition, it would not yet be possible to estimate the residuals of permanent emotional impairment, if any. These estimations would be provided as soon as possible, presumably when her psychological condition becomes closer to reaching permanent and stationary status. She was found to be in need of emotional treatment. Because of the need now for treatment, she would be scheduled now for psychotherapy. It should be noted that the ODG-TWC Mental Stress Chapter indicates that Cognitive Behavioral Therapy would be recommended for an initial trial of six visits and, with evidence of objective functional

improvement, a total of up to 13 to 20 Cognitive Behavioral Therapy visits over 13 to 20 weeks. Thus, the allowable total would be 26 sessions. According to the Mental Health Guidelines, there would be a request for authorization for six (6) cognitive behavior psychotherapy (CBT) sessions to be provided over the next 2 months or more. Following the provision of such psychotherapy, it would be harmful to interrupt progress while awaiting further authorization. Therefore, the course of psychotherapy on a weekly basis would continue irrespective of delays associated with the Utilization Review process and further authorization. The medical necessity and clinical rationale for such treatment would be set forth as follows: Without such treatment, the depression, anxiety, sleep problems, stress-intensified medical symptoms and the related functional impairment could worsen rather than improve as expected. Overall, an attempt would be made to provide only the amount of emotional treatment essential to improving and maintaining emotional and cognitive functioning. There would be the provision of CBT to help offset her symptoms of anxiety, panic, emotional withdrawal, isolation and depression. She was provided with instructions on sleep hygiene to facilitate better sleep, which had been shown to mitigate symptoms of depression and anxiety. She was advised to sleep as long as necessary to feel rested before getting out of bed, maintain a regular sleep schedule with a regular wake-up time, try not to force her sleep, avoid caffeinated beverages after lunch, avoid alcohol near bedtime, avoid smoking and other nicotine intake, decrease stimuli in the bedroom, avoid use of light-emitting screens before bedtime, resolve concerns and worries before bedtime and avoid daytime naps. There would also be the provision of psychotropic medication evaluation and management. Prescriptions would be provided as needed through the medical staff at this office. Adjustments in medication would be provided according to the individual needs. The frequency of medication management contacts should usually be no more than once every 3 weeks at the beginning, and when optimal, no more than every 3 to 4 months after that. It should also be recalled that, according to the ODG that there was a risk of weaning patients off of psychotropic medications and that medications "should not be stopped abruptly if used for psychiatric conditions ... [weaning] may take as long as 3 to 6 months." However, it should be appreciated that any proposed psychological treatment plan was only provisional, and that any combination of Cognitive Behavioral Therapy (CBT) and medication management might become mandatory according to any unique clinical circumstances that might arise. Page 2 of the ACOEM Guidelines indicates that, "Clinicians are obligated by public health principles to mitigate the symptoms and to prevent a delay in recovery and recurrences in the individual." Might this not occasionally require treatment before or beyond authorization when reasonable and necessary? As well, the MTUS, the ODG and the Practice Guidelines for the treatment of Psychiatric Disorders of the American Psychiatric Association are all silent on the treatment of Depressive Disorder Not Otherwise Specified in combination with Psychological Factors Affecting Medical Condition. However, in all of these sources, there were no guidelines that allow for the discontinuation of treatment by the doctor when the patient is still symptomatic and motivated for additional treatment. The ODG-TWC Mental Health chapter states, "Risk factors that support long-term treatment in terms of depression include... significant co-morbidity (psychiatric or medical)" and "residual symptoms (lack of remission) with current treatment." All of this fits her, and her current need for continued long-term treatment. In short, the discontinuation of psyche treatment in motivated symptomatic patients violates relevant treatment guidelines, particularly the American Psychiatric Association guidelines for Major Depression, which emphasizes her preference for psychotherapy plus medication. It should be noted also that the research was replete with evidence for psychotherapy being effective for chronic pain.

Request for Authorization, signed by Gayle Windman, Ph.D., dated October 28, 2019.

Authorization for cognitive behavior psychotherapy for 16 sessions was requested.

Psychiatric Progress Note, signed by Mahlet Girma, M.D., Kaiser Permanente, dated November 14, 2019.

Subjective: The applicant had anxiety rated as 8/10. She got chest pressure/pain when anxious. She had pain in neck.

Medication: She was on Cymbalta (some GI distress, but improved when splitting dose)

Therapy: After the last visit, recommended individual and group therapy (Work Health Program or Panic and Anxiety group). She was currently doing group biweekly at Workman's comp, on waitlist for individual therapy.

Services: She also gets acupuncture and chiropractic care.

Mental Status Examination: She was good grooming and well dressed. She had cooperative behavior. She had good eye contact. Speech was normal. Motor was normal. Mood was anxious and in pain. Affect was constricted. Thought form, thought content, and concentration was normal. She was oriented to person, place, time and situation. Memory was grossly intact. Insight was average. Judgement was improving.

DSM-5 Diagnoses: Generalized anxiety disorder.

Treatment Plans and Recommendation: She was to continue Cymbalta but split dose into 30 mg in the morning and 60 mg in the evening to reduce GI distress. She could use Klonopin 0.25-0.5 mg as needed for severe anxiety. She was advised not to combine with any opiates, alcohol or other substances.

She was to follow up with staff regarding starting individual therapy and/or group therapy. She was also recommended some CBT strategies including exposures. Recommend exercise as tolerated. She was to follow up with PCP. She was to return to clinic in 4-6 weeks.

Telephone Appointment Visit, signed by Denise Hom, M.D., Kaiser Permanente, dated November 26, 2019.

The applicant had on and off days. She was on long-term disability now. She ran out of Lovastatin. Laboratory was pending. She had rash and itchy bilateral arms/shoulders, and just happened.

Assessment: 1) Generalized anxiety disorder. 2) Cervical spondylosis. 3) Chronic neck pain more than 3 months.

Plan: She was to follow up with psych, PMR, and pain management. She had laboratory check.

Pain Management Follow-Up Visit, signed by Mobashshera Jabeen, P.A., Kaiser Permanente, dated December 11, 2019.

History of Present Illness: The applicant presented with neck and joints pain since 2012 – started gradually - due to work related stress - increased workload - pain radiating to both upper extremity and lower extremity with numbness, tingling, weakness on and off. Her neck pain was feeling better. She was feeling less stressed. She was on long-term disability for 2 years. She wanted to get better before going back to work. She was trying to eat healthy and follow up all her medical recommendations. She had aching, stabbing, sharp, and throbbing pain every day rated as 6/10. Symptoms had been progressively worsening. She had pain aggravated by walking, exercise, standing, sitting, and activity. She had pain alleviated by resting. Physical therapy did not helped. Acupuncture had helped pain.

Physical Examination: She was oriented to person, place, and time. She was well developed, well nourished, and in no distress. Mood, memory, affect, and judgement were normal.

Assessment: 1) Cervical spondylosis. 2) Chronic neck pain more than 3 months.

Plan: She was to limit Acetaminophen use and not to exceed more than 3,000 mg. She was to refill Mobic 15 mg. She was to continue Robaxin 500 mg, Cymbalta 20 mg, and Topamax 100 mg. She was to follow up with physical therapy, cognitive behavior therapy classes, Dr. Coyle, and acupuncture. Schedule with trigger point injection as needed for upper back pain. She was to follow up TAV in 6 weeks to review pain medication.

Primary Treating Physician's Progress Report, signed by Harold Iseke, D.C., dated January 8, 2020.

Subjective Complaints: The applicant complained of activity-dependent temporal to frequent to constant achy, sharp, throbbing headache radiating to head with blurred vision and light sensitivity. She had headaches exacerbated with stress, activity and prolonged work. She had constant moderate achy neck pain and stiffness becoming severe pain radiating to right arm with numbness and tingling with sudden or repetitive movement, lifting 10 pounds, looking up, looking down, twisting and flexion, and extension especially on a computer. She had constant mild upper/mid back pain and stiffness becoming sharp to moderate pain with sudden or repetitive movement, lifting 10 pounds, sitting, walking, bending and twisting. She had activity-dependent moderate sharp, stabbing right wrist pain, stiffness and numbness, associated with reaching, grabbing/grasping, gripping, squeezing, pushing and pulling repetitively. She had activity-dependent moderate sharp, stabbing left wrist pain, stiffness and numbness, associated with reaching, grabbing/grasping, gripping, squeezing, pushing and pulling repetitively. She had activity-dependent moderate sharp, stabbing right hand pain, stiffness and numbness, associated with reaching, grabbing/grasping, gripping, squeezing, pushing and pulling repetitively. She had activity-dependent moderate sharp, stabbing left hand pain and stiffness, associated with reaching, grabbing/grasping, gripping, squeezing, pushing and pulling repetitively. She had activity-dependent mild right knee pain and stiffness, associated with sudden or repetitive movement, lifting 10 pounds, standing, walking, bending, kneeling, twisting and squatting. She had activity-

dependent mild left knee pain and stiffness, associated with sudden or repetitive movement, lifting 10 pounds, standing, walking, bending, kneeling, twisting and squatting.

Patient Self-Assessment: Patient's self-assessment form (AMA Guides 5th Edition; Table 18-4 page 576) I. PAIN (Rated 0-10; 0-None and 10-Excruciating) a) Pain now was 8. b) Pain at its worst was 8. c) Pain on the average was 7. d) Pain aggravated by activity was 9. e) Frequency of pain was 9. II. ACTIVITY LIMITATION (Rated 0-10; 0-None and 10- unable to perform) a) Pain interfere with your ability to walk 1 block was 7. b) Pain prevent you from lifting 10 pounds was 10. c) Pain interfere with ability to sit for 1\12 hour was 9. d) Pain interfere with ability to stand for 1\12 hour was 9. e) Pain interfere with ability to get enough sleep was 9. f) Pain interfere with ability to participate in social activities was 8. g) Pain interfere with ability to travel 1 hour by car was 10. h) Pain interfere with general daily activities was 8. i) Limit activities to prevent pain from getting worse was 9. j) Pain interfere with relationships with family/partner/significant others was 8. k) Pain interfere with ability to do jobs around home was 9. l) Pain interfere with ability to shower or bathe without help was 5. m) Pain interfere with ability to write or type was 9. n) Pain interfere with ability to dress yourself was 5. o) Pain interfere with ability to engage in sexual activity was 9. p) Pain interfere with ability to concentrate was 8. III. MOOD (Rated 0-10; 0-Extremely good and 10- Extremely bad) a) Overall mood was 9. b) Over past week, how anxious or worried had been due to pain was 9. c) Over past week, how depressed have you been due to pain was 8. d) Over past week, how irritable had been due to pain was 8. e) In general, how anxious/worried about performing activities because they might make pain/symptoms worse was 9.

Activities of Daily Living: She had some difficulty taking a bath, dressing, going to the toilet, reclining, grasping, and differentiate between what she touch. She had difficulty with writing comfortably, typing, standing, sitting, walk normally, climbing stairs, riding on land forms of transportation, driving a vehicle, flying on a plane, sleep restfully, and sleep normally at night. She was unable to do lifting.

Diagnoses: 1) Radiculopathy, cervical region. 2) Other cervical disc displacement, unspecified cervical region. 3) Cervicalgia. 4) Spinal enthesopathy, cervical region. 5) Pain in thoracic spine. 6) Spinal enthesopathy, thoracic region. 7) Hemangioma of skin and subcutaneous tissue. 8) Unspecified sprain of right wrist, initial encounter. 9) Unspecified mononeuropathy of right upper limb. 10) Unspecified sprain of left wrist, initial encounter. 11) Pain in left wrist. 12) Pain in hand and fingers. 13) Pain in left hand. 14) Reaction to severe stress, and adjustment disorders. 15) Major depressive disorder, single episode, unspecified. 16) Anxiety disorder, unspecified. 17) Irritability and anger. 18) Chronic pain due to trauma. 19) Myositis, unspecified. 20) Contracture of muscle, unspecified site.

Treatment Plan: She had reached maximal improvement at this facility and released from care. She was recommended examination once a week for 4 weeks for cervical region, thoracic region, and chronic pain due to trauma.

Work Status: She was remained off work until February 22, 2020.

Work Health Program Assessment, signed by Linda Silver, L.C.S.W., Kaiser Permanente, dated February 11, 2020.

The applicant was employed at JP Morgan Chase Bank as a Branch Manager for approximately 31 years.

Stressor Related to Work: She reported "I think it started a few years ago, last March I got a new boss, seemed very nice but then all the yelling and screaming, and then I started having all this pain, and the harping and visits, and then the pain got so bad I couldn't move, I stopped working in March of 2019.... Long term disability, going to the doctor, first they started with acute stress, the last day I worked, I had 3 visits from the boss, I had an MRI, degenerative disc disorder, and her visit was so intense and so degrading, in front of my employees, going through a whole remodel in the building, that night the employees leave the vault open, so you can figure the stress they put me under because I had to report this, so for 6 weeks the drama, screaming on conference calls, one employee goes off on me, you can imagine the stress they are under, and all trying to put the blame on me, my manager was calling me that day with my review and everyone else got cost of living raises but I wasn't going to get it....she gave me a merit raise though, so much stress, I wish I had called HR right then, and I did eventually call HR but after I was off, she has a lot of openings under her and now I realize why, the pain was getting worse and now I realize why..." Shares her pain/muscle tension escalated to the point she had difficulty driving home due to numbness in her right leg. Describes panic attacks, and "my body swelling up, just talking about going back to work... Everything came back again, the pain and numbness." She reported "I have to get back to work because I only have 3 more years and then I can retire". She had Workman's Comp filing and treatment. She had meeting with Dr. Girma in October. She had plans to transfer stated "I gave up that branch, once you are out 6 months..." She had history of enduring "robberies and yelling and screaming". She reported "yeah, you see the gun at ya". Stressor had caused the following clinically significant symptoms: low mood, tearfulness, feelings of hopelessness, nervousness, excessive worry, jitteriness, panic attacks, somatic complaints, body pains, headaches, numbness, difficulty focusing and concentrating, memory issues "I was forgetting so many things", difficulty making decisions, loss of appetite, gastrointestinal issues, and insomnia.

Symptoms cause: Subjective Distress was moderate. Functional Impairment was moderate to severe.

Onset/Frequency/Duration of Symptoms: Onset was within 3 months of stressor onset. Duration of Symptoms was more than 6 months (if stressor is recurrent or continuous or with enduring consequences).

Safety Issues/Risks: She was at low risk for safety issues at this time.

Assessment: Generalized anxiety disorder, trauma and stressor related disorder. She experienced maladaptive reactions to identifiable psychosocial stressors occurring within a short time after onset of the stressor. They were manifested by impairment in occupational and social functioning, and by symptoms (depression, anxiety, etc.) that were in excess of a normal and expected reaction to the stressor.

Plan: She would engage and participate in Work Health Program for 4 weeks. She would attend Work Health Program Orientation this morning at 10 to 11:30 a.m.

Progress Note, signed by Linda Silver, L.C.S.W., Kaiser Permanente, dated February 11, 2020.

The applicant was informed of WHP schedule, what to expect from WHP, attendance guidelines, and receiving weekly work status reports of their employer.

Progress Note, signed by Linda Silver, L.C.S.W., Kaiser Permanente, dated February 11, 2020.

The applicant and members shared what they had gained from the program with new incoming members. She reported "my perception will make a big difference in understanding problems." She supported one another and provided appropriate feedback. She worked towards goals by attending group. Self-assessed on a Depression/Anxiety scale (with 1 as min symptoms and 10 as severe symptoms) as 7/8 and self-assessed on an Anger meter relaying a high of 9 for the week.

Patient Message, signed by Flor Maria, L.V.N., Kaiser Permanente, dated February 11, 2020.

The applicant had been scheduled for TAV with Mobashshera Jabeen, P.A., on April 8, 2020.

Progress Note, signed by Linda Silver, L.C.S.W., Kaiser Permanente, dated February 18, 2020.

She participated in an interactive topic discussion on cognitive behavioral therapy and how it treats depression. Topic included an introduction to CBT as well as examining the causes and processes of one's depression and how to identify and overcome depressive thoughts and beliefs. Handouts were utilized to review/give examples of limited thinking patterns/cognitive distortions including polarized thinking, catastrophizing, magnifying, self-fulfilling prophecy, should statements, mind reading, discounting, generalizing, labelling, mental filter, magnification, and emotional reasoning. She reported, "the grass is not greener on the other side". Self-assessed on a Depression/Anxiety scale (with 1 as min symptoms and 10 as severe symptoms) as 6/7 and self-assessed on an Anger meter relaying a high of 10 for the week.

Call Documentation, signed by Linda Silver, L.C.S.W., Kaiser Permanente, dated February 18, 2020.

The applicant was unable to attend the classes from February 20, 21, 25, 27, and 28, 2020 due to his father's health condition. She was able to attend on March 3, 2020 and going forward.

Progress Note, signed by Latrice Mitchell, M.F.T., Kaiser Permanente, dated March 4, 2020.

Subjective: The applicant had been noticing that the reaction she had around work was a trauma response. She described how she grew up with her father being very angry, mom critical, and not feeling supported. She described the interaction and the feelings that arose during that time as well as the feelings triggered currently. Discussed and processed her concerns that she had constant

feeling of fear and worry. Discussed and practiced coping skills to help reduce anxiety as well as identify areas of safety. She had previous session February 5, 2020. She attended initial therapy session with this therapist. She described the amount of stress she had undergone while at work states, the stress affected her physically, mentally and emotionally which lead to her having to take time away from work. She recently had a conversation with one of her providers where they discussed her returning to work. The conversation triggered increased anxiety and depression symptoms. She believed she needed more support to work through these challenges. Provided psycho-education on trauma stress and anxiety also discussed and learned about self-care.

Objective: She was dressed appropriate for weather and occasion. She had appropriate eye contact. She was open and talkative. She was cooperative, motivated, and receptive to services. She had anxiety and mood congruent affect. Stream of Consciousness was within normal limits. She was alert and oriented to person, place, and time. Thought process was coherent, relevant, and logical.

Progress Towards Goals: She discussed ways to help reduce fear and anxiety symptoms

Diagnosis: 1) Generalized anxiety disorder. 2) Depressive disorder, other specified.

Functional Impairment/Medical Necessity: Significant emotional distress/anxiety symptoms which interfere with her enjoyment of life and daily functioning, and which might continue to escalate without intervention. She would benefit from psychotherapy and/or meds to return to prior level of functioning.

Risk Assessment: She was aware and expresses willingness to utilize ER protocol and 24-hour Behavioral health number.

Level of Impairment: Moderate.

Treatment Plan: She had individual therapy, medication management, and group therapy. She was to follow up with safety and journal writing. She was to return to clinic in 2 weeks individual therapy for 6 months. She was to follow up with self-care.

Primary Treating Physician's Permanent and Stationary Report, signed by Thomas Curtis, M.D., dated March 17, 2020.

Interim History: The applicant received 5 CBT sessions November 5, 2019 to the present and continuing with Gilda Ruelas, MFT, since the prior evaluation. There had also been the provision of psychotropic medications including Cymbalta, Celexa, and Clonazepam. The treatment had been directed towards the relief not only of anxiety, depression, and sleep disruption, but also to the reduction of multiple stress-related medical complaints. As indicated, the treatment had been beneficial. She had improvements in depression and anxiety. She had improvements in her social functioning. She had been better able to communicate effectively with people because she felt less irritable and angry. There had been increased interest in daily activities such as dressing appropriately. She felt less tired during the day. There had also been improvements in her ability to maintain her attention on a movie. Since the prior evaluation, she remained unable to work.

primarily because of her anxiety caused by the multiple inherent stressors, the work overload, being humiliated by the market director and generally undermined, and being transferred around. There was also favoritism with a clique such that the market director, Kathy, replaced her as manager of the Beverly LA branch with her friend. She was subjected to unfair criticisms and inappropriate blame for understaffing. There were multiple managers who quit because of Kathy, a known difficult and essentially incompetent director who had become bitter in her demotion. In the end, she became stressed out to the point of nervous breakdown and panic attacks resulting in an ER hospitalization at Kaiser. Due to the persistent stress-intensified medical symptoms, she would be referred to an internist. Dr. Iseke would address her orthopedic complaints. Despite the passage of time and the input of treatment, there had been the persistence of significant emotional complications, birthdays, directions and what people told her. Due to her depression and anxiety, there was psychological fatigue and energy depletion.

Mental Status Examination: She was casually dressed. She initially presented as defensive and guarded due to depression and anxiety. This was particularly evident when she described all the yelling and screaming by a manager and a coworker in from of her employees. Once rapport has been established, she became more open and revealing. Her manner of communication was tense and pressured, particularly when revealing all the stressors at work including all the bank robberies and her employees being taken away from her, how she had to do the employee's jobs as well as her managerial work. Her thought processes were noted to be pressured, anxious, distraught and distress, particularly when revealing how the market manager, Kathy, told her in front of people that she did not know how to manage a bank and to pass an audit even though she had passed several audits. There did not appear to be a loss of contact with reality in the form of visual or auditory hallucinations. There was no evidence of frank paranoia or delusions of persecution. There appeared to be an absence of frank schizophrenia or other psychosis. She was oriented to the day of the week and date. She was not able to retain the recollection of 3 simple items. She recalled past serial Presidents was adequate. There was indication of slowed performance in simple calculation. Her performance in subtracting serial sevens from 100 was, while accurate, excessively slow and labored. She demonstrated diminished cognitive functioning in the clinical interview situation. She was noted to be rambling, defective in recall and revealing of defects in concentration. She would lose her keys. She could not remember her to-do list. She could not even remember where she was going. It appeared most likely that her cognitive deficits were caused by emotionally reactive confusion. Relevant to her need for treatment, her capacity for psychological insight and good psychological judgment was observed to be essentially unimpaired.

Psychological Test Results: Overall, her psychological test results were massively abnormal. The psychological testing revealed abnormality in all of the tests measuring emotional functioning.

On the Beck Depression Inventory, her score of 41 placed her in the severe range of subjective depression, according to Beck scoring criteria.

On the Beck Anxiety Inventory (BAI), her total score of 48 indicated a severe level of anxiety according to Beck scoring criteria.

On the Beck Hopelessness Scale (BHS), her score of 18 would be interpreted as reflecting a severe level of hopelessness according to Beck scoring criteria.

On the Beck Scale for Suicidal Ideation (BSS), the score generated by her was 0.

On the Insomnia Severity Index (ISI), her total score of 16 indicated moderate insomnia according to ISI scoring criteria.

On the Personality Assessment Screener (PAS), she obtained a score of 99.12, in the marked range.

On the Negative Affect scale, she obtained a score of 100.0, indicating marked feelings of unhappiness and tension.

On the Health Problems scale, she obtained a score of 96.1, indicating marked concern for health problems.

On the Psychotic Features scale, she obtained a score of 95.1, indicating marked paranoid thinking.

On the Social Withdrawal scale, she obtained a score of 91.5, indicating marked social difficulties.

On the Hostile Control scale, she obtained a score of 50.4, indicating moderate aggression.

On the Alienation scale, she obtained a score of 90.5, indicating marked difficulty with attachment.

On the Anger Control scale, she obtained a score of 63.1, indicating marked moderate difficulty with anger.

Overall, the PAS indicated abnormalities in negative affect, health problems, psychotic features, social withdraw, hostile control, suicidal thinking, alienation and anger control.

On the Multiscore Depression Inventory, her total score of 69 was neither too high (greater than 105) nor too low (5 or below) so as to invalidate the standard interpretation. The total score of 69 would correspond to a T-score of 62 and a percentile score of 88. This would generally correlate with severe depression according to MDI scoring criteria.

This overview rating reflects the most valid measurement of the overall extent or degree of depression. However, the value of the MDI also lies within the analysis of subscales reflecting the subject's unique profile of depressive response. For instance, in her particular case, the T-score on the Low Energy Subscale was 58 with a percentile ranking of 79. This would indicate a mild level of fatigue. The subscale of Cognitive Difficulty measure problems with indecision and difficulty thinking clearly: The T-score on Cognitive Thinking was 63 at a percentile of 90 reflecting a severe degree of cognitive impairment due to depression. As well, the Guilt subscale correlated with a T-score of 55 and a percentile of 69 at a level of mild intensity. Additionally, the Low Self-Esteem subscale scored at a T of 63, a percentile of 90 and a degree or severe symptomology. Social Introversion generated a T of 67, a percentile of 95 and a level of severe social withdrawal and isolation. Pessimism was measured at a T of 63, a percentile of 90 and a

degree of severe hopelessness. The subscale of irritability generated a T score of 68, a percentile of 96 and a level of severe quick-temperedness and intolerance of others. Finally, the subscale of Sad Mood indicated a T of 10, a percentile of 97 and a degree of severe feelings of sadness or dysphoria.

The L, F, K scores on the MMPI-2 (3, 20, 13 raw, 4 7, 106, 46 T) indicated a technically invalid profile. The F Scale was elevated at or above 90 T.

Such MMPI-2 validity scores could reflect intense confusion, a random answering pattern due to factors including cognitive/perceptual dysfunctioning, an overwhelming of psychological coping mechanisms, a lack of cooperation, and/or an exaggeration of symptoms as a cry for help and/or as a purposeful manipulation for secondary gain (malingering). In this particular case, the most likely cause for invalidity would be a combination of factors of actual intense emotional symptomatology, overwhelmed coping mechanisms, impaired motivation and the inhibitory effects of depression, frustration, irritability, anger, fatigue and, most importantly, of personal or cultural variations of high symptom reporting tendencies. There might also be high symptom reporting due to inflation caused by anger and litigation contentiousness. At any rate, the MMPI-2 was invalid and beyond the scope of the standard principles of profile interpretation.

It should also be kept in mind relevant to the concept of invalidity that the MMPI-2 validity measurements do not indicate whether she does or does not have a mental disorder. Since a patient with mental disorder could underreport or overreport psychopathology, the measurements of defensiveness/denial and increased frequency of symptom reporting should be applied only to the issue of whether the statistical standards of interpretation can be applied to the clinical scale score and profile. Thus, measurements of the extent of symptom reporting and/or consistency apply only to the reliability of standard interpretation. This must be clarified because it should not be interpreted that the patient or her mental disorder is invalid, only that the standard interpretation should be considered invalid.

The exact T scores for clinical scales 1 through 0 were as follows: 99, 88, 77, 94, 67, 100, 81, 102, 74 and 73.

It should be noted that T scores on the MMPI-2 at or above 65 on the clinical scales are generally considered significant and abnormal.

In summary, the psychological tests were invalid for standard interpretation due to excessive randomization of true and false responses not caused by malingering or exaggeration but caused by an inability to effectively concentrate due to depression, fatigue, anxiety, irritability, frustration, cognitive impairment and impaired emotional control of frustration, irritation and anger.

Discussion: The reports of Dr. Iseke confirmed the physical aspects of injury with diagnoses set forth as follows: radiculopathy, cervical region; other cervical disc displacement, unspecified cervical region: cervicalgia; spinal enthesopathy, cervical region; pain in thoracic spine; hemangioma of skin and subcutaneous tissue; unspecified sprain of right wrist, initial encounter; unspecified of mononeuropathy of right upper limb; unspecified sprain of left wrist, initial encounter; pain in left wrist; pain in hand and fingers; pain in left hand; reaction to severe stress,

and adjustment disorders; chronic pain due to trauma; myositis, unspecified; and contracture of muscle, unspecified site. The doctor did note her s reaction to severe stress and adjustment disorders.

Diagnoses as per DSM-5: 1) Major depressive disorder, single episode. 2) Generalized anxiety disorder. 3) Psychological factors affecting medical condition (stress-intensified headache, neck/shoulder/back muscle tension/pain, nausea, chest pain, shortness of breath, constipation, and abdominal pain/cramping). GAF = 50 (current). Symptoms cause serious impairment in social and occupational functioning to the point of being unable to hold a job at present.

Summary: It would appear from the history and examination that she had been temporary totally disabled on an emotional basis from her last day of work at JP Morgan Chase Bank on about March 15, 2019 to the present and continuing hopefully until her condition becomes more stabilized in the near future. The degree of permanent emotional impairment would be set forth as marked.

Activity of Daily Living: Due to her mental disorder, she experienced impairment in her daily activities including her personal hygiene bodily functions, eating properly, sleeping effectively and functioning sexually. There were problems with stress-related constipation and diarrhea. She experienced a depressively decreased interest in her basic self-care activities including brushing her teeth, combing her hair and dressing appropriately. In addition, there was decreased motivation to perform normal housekeeping activities including making the bed, cooking a meal, doing the dishes and vacuuming the home. She developed decreased sexual interest due to depression, anxiety, emotional withdrawal, irritability, and anger. She developed difficulty falling and staying asleep due to depression, anxiety and worry. Because of her insomnia, she experienced morning headaches, trouble concentrating and a change in her personality. These factor would correlate with a moderate impairment in activities of daily living.

Social Functioning: Due to her emotional distress, she had difficulty interacting appropriately with others including family members, friends and neighbors. She became emotionally withdrawn. Due to her mental disorder, she developed attitudes that impaired her ability to socialize including guardedness, defensiveness, mistrustfulness and suspiciousness. She became irritable and impatient with people. There were problems with becoming short tempered and being prone to inappropriate angry outbursts. She experienced difficulty tolerating prolonged contact with people because of her stress-intensified pain, depression, anxiety, irritability, emotional withdrawal and anger. There was insufficient emotional control such that she yelled at others. If she were made to cope with interactions with people all day long, she would likely repeatedly break down and decompensate to the point of an inability to function at that time due to her stress-intensified pain, depression, anxiety somatization, mistrust, confusion, emotional withdrawal, irritability, agitation and insufficient emotional control. Overall, these symptoms would cause serious impairment in social and occupational functioning to the point of being unable to keep a job at this time.

Concentration, Persistence, and Pace: Because of her emotional disturbances, there was difficulty paying attention, concentrating and remembering things. She experienced problems with distractibility, slowed thinking, mental confusion, mental blocking and loss of her train of thought. Because of her cognitive impairment, she had difficulty communicating her thoughts. Her

cognitive functioning became impaired such that there was difficulty in her ability to read a magazine or book and follow the plot of a movie or TV show. She also had problems remembering where she left things around the house, telephone numbers, appointments, and birthdays, directions and what people told her. Due to her depression and anxiety, there was psychological fatigue and energy depletion. These factors would correlate with a moderate impairment in concentration, persistence and pace.

Adaptation (Deterioration or Decompensation): Relevant to issues of decompensation in complex settings it would be anticipated that she would have serious difficulty at this time being able to tolerate the stresses common to the work environment including maintaining attendance, making decisions, doing scheduling completing tasks and interacting appropriately with supervision and beers. If she were to attempt a normal work routine at this time, her emotional and stress-intensified physical symptoms would likely increase to the point of repeated mental decompensation in the workplace. Her industrial injury should probably be considered analogous in some ways to an unwanted divorce. The loss of the employment relationship becomes associated with feeling of insecurity damaged self-esteem and difficulties with subsequent attachments. She worked in the same career in banking for about 31 years. Overall, her persistent stress-intensified pain, depression, anxiety, confusion, somatization, panic problems psychological fatigue and diminished cognition would contribute to impairment in this area that would be marked. In addition to the 4 main categories of mental and behavior impairment, the AMA Guides indicated the independence, appropriateness and effectiveness of activities should also be considered. According to the evidence above, independence would be estimate as marked appropriateness as moderate and effectiveness as marked. All of these factors would correlate with an overall marked impairment according to the AMA Guides with a GAF of 50 according to the DSM IV-TR with a WPI of 30.

Causation/Apportionment: It was observed that her symptoms of psychiatric injury were visible connected to the causative events within her work at JP Morgan Chase Bank. The actual events of employment were predominant as to all causes combined, the work-related caused constituting greater than 50% of all of the causal factors, in her case, 100% industrial. Of the 100% industrial psyche causation, about 60% would be attributed to the disturbing events at work described above, with only 40% attributed to the underlying impairment caused by the pain and disability in and of itself absent the industrial stress-aggravated muscle tension pain and increased pain perception due to industrial depression. Although the cause of her psychological injury should be considered industrial, there would be other factors to consider relevant to issues of apportionment. For instance, her father has had multiple strokes. Her family lives in Florida. Although she had been separated from her family in Florida again because the bank would not let her transfer back there, she has learned to cope with this because the bank caused such separation before and because she anticipates that she would move back there soon to reunite with them soon. She had also become used to her father's invalidism without significant added depression. For a more in-depth review of all of the personal life factors, past injury factors and other factors, the reader would be referred to the pertinent history and medical record review sections of this report above. The other possibly causative apportionable factors as explained in the past and family history sections of this report above was considered and did not appear to the causative of emotional impairment. For the sake of time and expense, there would not be an inclusion here of factors for which apportionment was considered but not affected. It should also be appreciated relevant to apportionment that despite

the aforementioned factors and more there were indications of previously unimpaired work performance at JP Morgan Chase Bank prior to the disability due to work. She worked there for 31 years. It would be overly speculative to assume that she would have sustained any of the aforementioned factors of emotional impairment absent the events of injury at work and their aftermath. There would not appear to be a basis for apportionment. All of the records should be reviewed prior to a final opinion on apportionment. Apportionment should be assessed according to causation. It would be concluded that 100% of her permanent disability was caused as a direct result of the industrial injuries arising out of and occurring in the course of her employment, and 0% of the disability was caused by other factors both prior to and/or subsequent to the industrial injuries. She would not yet be able to resume her regular duties as a bank manager because of her continued inability to control her emotions and her continued inability to adequately concentrate to work with numbers and not caused repeated errors. The prognosis did not look good for recovery in this area within the foreseeable future. If she were to attempt a formal vocational assessment at this time, she might well be found to be non-feasible to vocational rehabilitation. Her stress-intensified pain, depression, anxiety, psychological fatigue, diminished stamina impaired concentration and related overwhelmed emotions might well cause an inability to continue to cognitive function to relate people and to stay working and keep on working day after day in any vocational assessment, rehabilitation or work setting at this time. These factors might well preclude successful vocational rehabilitation within the foreseeable future. Because of the poor prognosis for the attainment of any substantial gainful employment within the foreseeable future, she had become eligible for Social Security Disability benefits. Future psychological treatment benefits would be recommended. It might be useful for practical settlement purposes to estimate the amount of future treatment benefits following the settlement of the current Workers' Compensation matter. It would be recommended that the provision of approximately 1 year of weekly supportive psychotherapy sessions be set aside for her to be utilized intermittently as needed for the rest of her life to help relieve flare-ups of the emotional pain and suffering and the reduced psychological coping ability caused by the industrial injury to her psyche. She should also be provide with her psychotropic medications to be set aside for another year. The amount of necessary treatment could extend beyond the aforementioned estimate preferred for practical settlement purposes. It would be best for her to be provided with an open-ended future psychological treatment award. There would be further reports to follow on an as-needed basis.

Telephone Appointment Visit, signed by Jennifer Shortt, L.C.S.W., Kaiser Permanente, dated April 10, 2020.

The applicant continued improvement in mood and reviewed progress. She began to better understand her physical and emotional pain. She was practicing assertion skills and finding ways to connect with herself. She disclosed getting upset with family members yesterday. She had identified pressure building until she could no longer contain her anger. She explored how therapy might bring emotions to the surface, including reactivated feelings and memories. She was also considered the potential for misdirected anger. Reviewed grounding exercises. Finding HeadSpace to be helpful. Energy was low to fair. Mood was anxious and depressed yet noticeably brighter sounding. She was not in crisis.

Diagnosis: Anxiety disorder, depressive disorder.

Treatment Plan: She was continue Intensive Outpatient Program telephone appointment visits until resuming in-person groups; additional treatment as indicated by primary providers.

Office Visit, signed by Ki Young Yoo, M.D., Kaiser Permanente, dated April 22, 2020.

History of Present Illness: The applicant presented for rash on face and dark brown bumps for 2 weeks. She had rash on back and arms. She had it once only earlier this year. However, there was documentation from progress notes that she had it as early as 2011. She had scratches at the sites in the past. She was currently using urea cream 40%. She tried Elocon, Protopic, and Lidex ointment. She had hair loss on scalp.

Physical Examination: She was well developed and well nourished. She was alert and appropriate.

Assessment: 1) Macular amyloid/lichen amyloid. 2) Acne excoriee on face. 3) Androgenetic alopecia.

Plan: She must stop rubbing, scratching, and avoid friction. She needed gentle care. She was to continue urea. She was to apply thin layer of hq6%, kojic acid 3%, tretinoin 0.025%, and hydrocortisone 2.5% to dark spots at bedtime for 3 months. She had hc 2.5% cream for 2 times a day until smooth. She was to try minoxidil 2% topical first and then 5%. She was to return to clinic as needed.

Telephone Appointment Visit, signed by Jennifer Shortt, L.C.S.W., Kaiser Permanente, dated April 22, 2020.

The applicant continued improvement in mood, however disclosed having a difficult day yesterday where after perceiving criticism from family members, she became angry and yelled at them all. She was in reflecting on what happened, she recognized the triggers and how she could have handled it differently with better identifying how she was feeling and what she needed throughout the day. She was recognizing the role her panic level had in her mood and considered ways to better communicate her pain level to family and ask for what she needed. Identified emotionally healthy communication skills. Set goals, including communicating with family and attending to her own emotional needs. Energy was low to fair. Mood was anxious and depressed. She was in crisis.

Diagnosis: Anxiety disorder, depressive disorder.

Treatment Plan: She was to extend and continue Intensive Outpatient Program telephone appointment visits until resuming in-person groups; additional treatment as indicated by primary providers.

Telephone Appointment Visit, signed by Jennifer Shortt, L.C.S.W., Kaiser Permanente, dated May 20, 2020.

The applicant had low mood, but was continuing to practice stress management skills and self-care. Update on health issues and upcoming appointments/procedures. Discussed services and

treatment plan. including provider extending off work status report with return to work date now July 1, 2020. She processed her thoughts and feelings s associated with return to work date and believing she was unprepared to handle the stress associated with work. She stressed wanting a program that would prepare her for bank robberies (career in banking). Discussed difference between being too medically impaired to work and not wanting to return to current job/position. She then disclosed that she was never medically cleared to return to work. She repeatedly stated, "I'm so confused..." With supportive confrontation, she was able to calm herself and identify plan for the next couple of days as well as plan to plan for the next few weeks. Reviewed grounding skills. She was to benefit from additional supports at this time, including IOP Aftercare TAV weekly, 1:1, DBT skills when offered again, and medication follow-ups. She also wanted to return to WHP explaining that due to COVID-19 she only completed the first 2 weeks (agreed to route message to WHP coordinator regarding request). Receptive to services, learning new skills, and practicing healthier coping mechanisms. She agreed to follow up. She seemed noticeably agitated and defensive when return to work date was brought up. Mood was depressed and anxious. She was not in crisis.

Diagnosis: Generalized anxiety disorder, depressive disorder.

Treatment Plan: She was to continue Intensive Outpatient Program aftercare; additional treatment as indicated by primary providers, including pain management programs, individual psychotherapy services, and medication follow-ups.

Telephone Appointment Visit, signed by Jennifer Shortt, L.C.S.W., Kaiser Permanente, dated May 27, 2020.

The applicant had some improvement since speaking with OD therapist who called after triaging her e-mail addressed to this writer (see chart). She was appreciating the support and having the opportunity to express herself. She was practicing stress management skills and accepting support from a friend. Gathered information to better understand her reported short-term disability, long-term disability, treatment plan including pain management program, and what considers her options to be. Reviewed grounding skills. Engaged. Energy low. Grateful. Mood was depressed and anxious. She was not in crisis.

Diagnosis: Generalized anxiety disorder, depressive disorder.

Treatment Plan: She was to continue Intensive Outpatient Program aftercare; additional treatment as indicated by primary providers, including pain management programs, individual psychotherapy services, and medication follow-ups.

Message, signed by Jennifer Shortt, L.C.S.W., Kaiser Permanente, dated May 27, 2020.

The applicant felt like her life seemed to be crazy again. She was able to visit acupuncture yesterday May 26, 2020 to fix some of the pain, lymph nodes in her neck connected to using hands making it so swollen. She completely blanked out sitting in kitchen Saturday night, her husband and daughter had to take her upstairs trying to get her ready for bed. Her long-term disability was no longer approved. She was feeling like a failure. Doctors did not work together. Short-term

disability was declined because Dr. Girma told them she could work, even though she was in pain management and some workers comp program. She totally gave up. She would be soon at point she could not pay bills, she could not think, and she really did not care.

Call Documentation, signed by Jose Rey, MFT., Kaiser Permanente, dated May 27, 2020.

The applicant expressed frustration regarding her disability being decline, and her provider asking about her bag and telling her "at the very end," of an appointment "you're going to have to go back to work." She was not asked how many robberies she had seen, and even if she was able to go back to work, everybody was wearing masks, implying that it was triggering. She felt she had not been given the right attention/treatment, per report. She did have follow-up with Ms. Shortt, LCSW, and could wait for her call. She was doing self-care, "feed the fish" and looked at them, as well as taking deep breaths. She had children who were supportive. She had emergency protocols. She was to follow up with Ms. Shortt, LCSW.

Panel Qualified Medical Evaluation, signed by Joanne Halbrecht, M.D., dated December 4, 2020.

History of Injury: The applicant began working for JP Morgan Chase on December 27, 1988. Sometime in the summer of 2018, the staff was taken away, and while working as a Branch Manager, she had to do more activities. She described her activities as unlocking the branch doors and disarming the building in the morning. She did this with a partner. She also, with a partner, would get everything ready for the cash machines. She would open the vault where the door weighed 100 pounds and did this twice a day, so that safe deposit boxes could be accessed. The cash vault door weighed 50 pounds. She would fill the cash machine up 4-5 days a week, which included placing bricks of $20s that have $40,000-$80,000 in the bricks, and sometimes she would load $160,000. Another person would observe while she put the cash in the machine. She did this once a day 4 times a week. They had 3 machines with $5s, $20s, and $100s. She gave her tellers coins and cash and they had multiple boxes of coins weighing between 25-40 pounds, and she did this 4-5 times a day. She would cover the tellers over their lunches and open up new accounts for clients. She would climb to change merchandise promotions that were mounted on the walls and did this sometimes weekly, monthly, or quarterly. She would climb a ladder to lift safe deposit boxes for clients and sometimes have to reach overhead. She was on the computer all the time, but she did all of these other activities all the time. She was initially on the computer 8-10 hours a day and then changed the time period to 7 hours a day. She started feeling pain in the 2012 in the aforementioned body parts and went to her PCP and was referred to physical therapy and was told that she had degeneration in her neck. Her symptoms became worse in 2015. An ergonomic evaluation was performed of her workstation and she reports that nothing was changed with it. This evaluation was done before she arrived at her managerial position in 2018. The desk had a pullout for a keyboard, and this was comfortable to use, but the tele lines were not. She stated that the doctors recommended modified duty, but that was not being followed. She received her treatment through workers' compensation, and the claim was denied, so she got treatment through Kaiser. She had a separate CT claim for psych, which had been denied. She sought the advice of an attorney for all of the years that she worked and "all (her) body parts are broken," stating that it "was not fair" that some branches have help and others don't. She said repeatedly that this was not fair." She had an episode in January 2019 when she was driving to work. She felt compression

on her chest and her hands and feet were getting numb. She stated "it looked like skeleton and bones were sticking upwards." She could not move when she got to work, so she called Kaiser and the Kaiser nurse told her to call 911. She was told that she had poor circulation and "felt everything compressing against my chest" and was told that it could be anxiety. In the end, they could not figure out what it was. She stated that they ran every test and after that, she took a week off. On March 15, 2019, her doctor for disability took her off work. When asked what she had been doing since she was off work, she stated that she does cooking, cleaning, and grocery shopping with assistant. She spent much of the day on the computer for 15 minutes at a time researching how to take care of herself. She had nodules on both lungs and had excess skin on her face that was due to stress. Her skin problems began in March of 2019.

Current Complaints: She had unbearable pain in her neck, shoulder, hands, her fingertips were numb, and her hands felt like a balloon. When she was seated, the tips of her toes would become numb. She had sharp, dull, burning, aching, and throbbing, which was constant and severe. It was improved with resting, medication, acupuncture, and sleep. Pain woke her from sleep at night. Pain radiated from her legs to her feet and from her head, which gives her a headache. Pain radiated to her back. She had increased pain with squatting, kneeling, pivoting, lifting, overhead activity, reaching, going up and down stairs, standing from a seated position, sitting, standing, walking, and running. When asked what activity was the most painful, she answered "all of the above." She had stiffness, weakness, numbness, tingling, swelling, grinding, locking, catching, popping, instability, and giving way. Before she started experiencing pain, she could sit for 1 hour, stand and walk for 45 minutes, and now she could sit fix 15 minutes, and stand and walk for 10 minutes, however, she was witnessed sitting for over an hour while giving her history. Before her injury, she could lift 20 pounds to her waist and overhead, and now she could lift 5 pounds to her waist and overhead.

Current Medical Treatment: She had Duloxetine, Topiramate, Cyclobenzaprine, and Acupuncture. She did a daily home exercise program.

Activities of Daily Living: She had problems with defecation, brushing her teeth, combing hair, bathing, dressing, eating, writing, typing, speaking, standing, sitting, lying down, walking, climbing stairs, sensation in her fingers, grasping, lifting, riding in a car driving, flying, sexual function, and sleep.

Occupational History: She worked at JP Morgan Chase as Branch Manager from December 27, 1988 to present.

Past Medical History: She had chickenpox.

Medications: She was on Levothyroxine, Cyclobenzaprine, Duloxetine, and Topiramate.

Allergies: She is allergic to Penicillin.

Social History: She was married. She had 2 children. She had an Associate's degree. She had half a glass of wine per week.

Non-Work Activities: She was cooking, cleaning, and shopping with assistance. She could not return to normal life and had so much pain since work injuries.

Family History: She was significant for diabetes and stroke.

Physical Examination: She was cooperative and in no acute distress.

Diagnoses: 1) Non-specific neck, bilateral shoulder, lumbar, and bilateral lower extremity pain. 2) Non-anatomic decreased sensation of bilateral hands and bilateral lower extremities.

Causation: The cause of her pain was indeterminate as she was tender everywhere that was palpated and described numbness in a stocking distribution of bilateral lower extremities. In addition, she had full range of motion of the lumbar spine, knees, feet and ankles with 5/5 strength resisted muscle testing. Given her psychological history, it was suspected conversion disorder to be the source of her pain.

Impairment Status: Cervical spine was permanent and stationary and at MMI as of December 4, 2020. Bilateral wrists and hands were permanent and stationary and at MMI as of December 4, 2020.

Impairment Rating: Using Table 15-5, her DRE Cervical Category II with a 5% WPI due to non-verifiable radicular complaints and muscle guarding with range of motion. Bilateral hands had numbness in a non-anatomic distribution and was inconsistent with carpal tunnel syndrome and more consistent with conversion disorder. She had full range of motion and 5/5 strength with resisted muscle testing and Phalen's and carpal compression do not result in neurologic deficit in the median nerve distribution. Prior EMG in 2015 was significant for mild bilateral carpal tunnel syndrome. It was not felt that her neurologic deficit warrants an impairment rating as her neurologic complaints were non-anatomic and, thus, would use Table 6-9 for rating impairment due to herniation due to intermittent symptomatology of pain which was described throughout her medical record as causally related to work-related activities and assign for bilateral wrists and hands a 4% WPI. Combining the neck and bilateral wrists was a total 9% WPI.

Apportionment: Cervical spine x-ray was significant for degenerative disc disease and spondylosis, which significantly contributed to her impairment, and, thus, it was apportion 60% to pre-existing degenerative changes and spondylosis and 40% to cumulative trauma sustained between September 29, 2009 to January 22, 2020. Bilateral wrists and hands: There was an association of development of carpal tunnel syndrome with low vitamin D as well as diffuse joint pain and muscle weakness. Medical records document that she had a history of vitamin D deficiency and, thus, it was apportioned 20% of her bilateral wrist and hand impairment to pre-existing vitamin D deficiency and 70% as the result of cumulative trauma sustained from September 29, 2009 to January 22, 2020.

Temporary Total/Temporary Partial Disability: Deferred to the medical records for periods of temporary and partial disability which were determined by the treating physician, however, there was no documentation of that in the medical record for her musculoskeletal complaints, thus, it was concluded from her physical examination that at that time, she would have required work

modifications or being off work so as not to aggravate her symptoms. TPD September 29, 2010 to December 3, 2020.

Work Restrictions: She had restrictions of no repetitive twisting or turning of the cervical spine, no repetitive gripping or grasping or awkward movements of bilateral wrists and hands, and no lifting more than 5-pounds to the waist or overhead.

Future Medical Care and Treatment: She was recommended physical therapy for the cervical spine twice a week for 6 weeks to emphasize postural training and a home exercise program; NSAIDs, neurolytics, and muscle relaxants at a therapeutic dose; cock-up wrist splints; physical therapy twice a week for 6 weeks to include modalities; and NSAIDs at a therapeutic dose. If neurologic symptoms were more consistent, she was to repeat EMG/NCV and referral to orthopedic surgeon fellowship trained in hand.

That completes the review of records.