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ADJ12217188	ADJ12217216	ADJ	MEDICAL DOCS	P & S REPORT	C:\fakepath\Sandra Seeram P&S report by Dr. Curtis 3-31-2020.pdf	Delete
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Re: Sandra Seeram vs. JP Morgan Chase Bank
WCAB #: ADJ12217216

(PROOF OF SERVICE BY MAIL - 1013a, 2015.5 C.C.P.)

I am a resident of/employed in the aforesaid county, State of California; I am over the age of eighteen years and not a party to the within action; my business/residence address is: 14531 Hamlin Street, Van Nuys, CA 91411.

On 03-27-2020, I served the foregoing document described as:

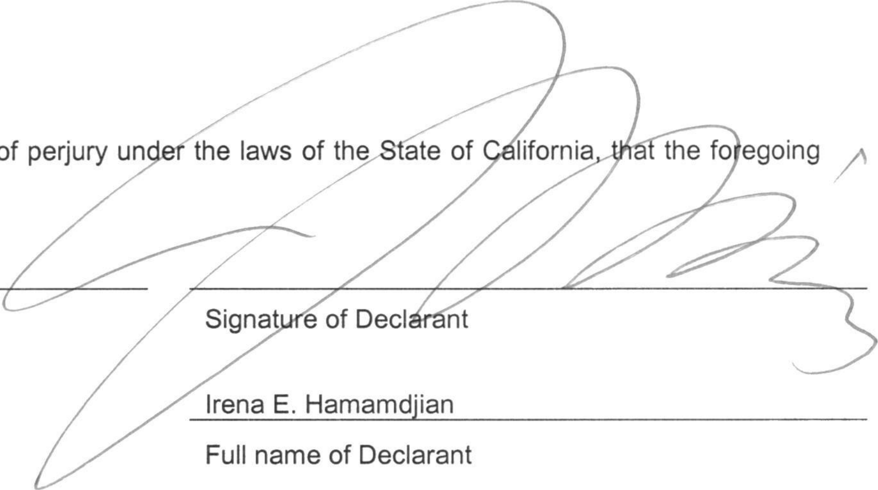
PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT WITH PSYCHOLOGICAL TEST RESULTS, REQUEST FOR AUTHORIZATION FORM, PR-4 FORM, AND ITEMIZED STATEMENT

On the interested parties in this action by placing the true copy thereof, enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Van Nuys, California, addressed as follows:

WCAB#:ADJ12217216
(Report served upon applicant attorney)

Applicant Attorney:
Natalia Foley, Esq.
5753 E Santa Ana Cyn Rd Ste. G#616
Anaheim, CA 92807

I certify (or declare), under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.



03-27-2020
Date

Signature of Declarant

Irena E. Hamamdjian
Full name of Declarant

www.hamlinpsychecenter.com

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Thomas A. Curtis, M.D.

Clinical Director
Roberta Jalbuena, Ph.D.

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MARCH 17, 2020

BROADSPIRE
P.O. BOX 14645
LEXINGTON, KY 40512

RE:	SEERAM, SANDRA
WCAB #:	ADJ12217216
CLAIM #:	189103909
EMPLOYER:	JP MORGAN CHASE BANK
SSN:	105-68-8936
DOB:	11/19/1968
DOI:	CT: 11/16/2018 - 05/02/2019
DOE:	01/10/2020

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT WITH PSYCHOLOGICAL TEST RESULTS ITEMIZED STATEMENT

IT IS REQUESTED THAT PROMPT PAYMENT BE MADE FORTHWITH.
IRS REFERENCE #95-4581634

SERVICE RENDERED	UNITS	CPT CODE	AMOUNT BILLED
REPORT CHARGE PER PAGE	7	WC004	$ 196.22
PHYSICIAN FACE-TO-FACE	1	99215	$ 210.25
BEFORE AND/OR AFTER FACE-TO-FACE	1	99358	$ 157.91
BEFORE AND/OR AFTER FACE-TO-FACE	2	99359	$ 154.02
TOTAL FOR EVALUATION			**$718.40**

CONTINUED ON NEXT PAGE

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT WITH PSYCHOLOGICAL TEST RESULTS ITEMIZED STATEMENT

IT IS REQUESTED THAT PROMPT PAYMENT BE MADE FORTHWITH.
IRS REFERENCE #95-4581634

SERVICE RENDERED	UNITS	CPT CODE	AMOUNT BILLED
PSYCHOLOGICAL TESTING (12 UNITS MAX)			
BECK HOPELESSNESS SCALE (0.5 hr)	1	96138.25	
BECK ANXIETY INVENTORY (0.5 hr)	1	96139.25	
BECK DEPRESSION INVENTORY (0.5 hr)	1	96139.25	
INSOMNIA SEVERITY INDEX (0.5 hr)	1	96139.25	
BECK SUICIDE SCALE (0.5 hr)	1	96139.25	
PERSONALITY ASSESSMENT SCREENER (1 hr)	2	96139.25	
MULTISCORE DEPRESSION INVENTORY (1 hr)	2	96139.25	
MMPI-2 (2 hours)	4	96139.25	
TOTAL FOR TESTING	**12.00**		**$ 703.92**
TOTAL AMOUNT DUE			**$1,422.32**

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PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT WITH PSYCHOLOGICAL TEST RESULTS

MARCH 17, 2020

BROADSPIRE
P.O. BOX 14645
LEXINGTON, KY 40512

NATALIA FOLEY, ESQ.
5753 E SANTA ANA CYN RD STE. G#616
ANAHEIM, CA 92807

RE:	**SEERAM, SANDRA**
WCAB #:	**ADJ12217216**
CLAIM #:	**189103909**
EMPLOYER:	**JP MORGAN CHASE BANK**
SSN:	**105-68-8936**
DOB:	**11/19/1968**
DOI:	**CT: 11/16/2018 - 05/02/2019**
DOE:	**01/10/2020**

Gentlepersons:

Ms. Sandra Seeram, a 51-year-old branch manager for JP Morgan Chase Bank, completed psychological evaluation and testing on 01/10/2020 at the Long Beach office.

INTRODUCTION

On 05/22/2019, Ms. Seeram submitted an Application for Adjudication of Claim for Workers' Compensation Benefits citing a cumulative trauma date of injury from 11/16/2018 to 05/02/2019 involving her stress and psyche.

It would appear that Ms. Seeram's claim has become denied.

There was a letter dated 09/23/2019 submitted by the applicant attorney, Natalia Foley, Esq., referring Ms. Seeram to Dr. Thomas Curtis for psychological evaluation and treatment. Dr. Curtis was designated as the primary treating physician.

Further treatment may be required on an as-needed basis. However, an estimate of permanent and stationary residuals can now be made.

This report would comprise the applicant's comprehensive permanent and stationary psychological evaluation.

Would the defendant please provide copies for review of all reports, records, witness statements, depositions and all other discovery documents in this matter. This request would be ongoing for new documents.

IDENTIFYING DATA

Ms. Sandra Seeram is a 51-year-old female. She completed her associate's degree. She identifies as Hindu. She currently lives in Torrance with her husband, Vijai (51), her son, Kamron (22) and her daughter Karina (16).

HISTORY OF THE WORK INJURY

Ms. Seeram began her employment at JP Morgan Chase Bank on 12/27/1988. Her last day of work there was on 03/15/2019.

Ms. Seeram was placed on disability by Dr. Helen Chung, a physical medicine specialist.

As a branch manager, Ms. Seeram's job duties included managing employees, customer experience and sales, counting cash, conducting audits and daily meetings and opening and closing the bank.

Ms. Seeram received average written work performance work evaluations. For her good work, she also received bonuses and raises in pay.

Ms. Seeram described disturbing experiences of stress at work. After Ms. Seeram became transferred to another branch in May 2018, the market director, Kathy, promised her help. Ms. Seeram was overwhelmed. Ms. Seeram 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.

Ms. Seeram also described harassment by Kathy, who frequently singled her out during conference calls and meetings. Kathy questioned why Ms. Seeram did certain things. She micromanaged Ms. Seeram in front of her coworkers and compared her branch to other, high

performing branches with sufficient staff. This was an unfair comparison. Ms. Seeram worked about ten hours a day.

There were further stressors. In January 2019, Ms. Seeram 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. Ms. Seeram 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. Ms. Seeram asked Kathy to find a branch closer to her home.

Ms. Seeram 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 one week.

The problems persisted. Kathy made weekly bank visits. On one occasion, Kathy arrived with a pre-auditor. Kathy then yelled and screamed at Ms. Seeram because her monitor did not have a privacy screen protector. Kathy told her that she could not pass an audit. Ms. Seeram was humiliated in front of her staff. This was uncalled for. Ms. Seeram had passed many audits.

There was also physical trauma, which adversely influenced the emotional complications of her work stress. Ms. Seeram 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. Ms. Seeram was referred to Harold Iseke, D.C. She was unable to perform her usual job duties. She took an intermediate leave of absence.

INTERIM HISTORY

Since the prior evaluation at this office, Ms. Seeram received five CBT sessions 11/05/2019 to the present and continuing with Gilda Ruelas, MFT. There has also been the provision of psychotropic medications including Cymbalta, Celexa and Clonazepam. The treatment has 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 below, the treatment has been beneficial.

Ms. Seeram reported improvements in depression and anxiety. Ms. Seeram reported improvements in her social functioning. She has been better able to communicate effectively with people because she has felt less irritable and angry. There has been increased interest in daily activities such as dressing appropriately. She has felt less tired during the day. There have also been improvements in Ms. Seeram's ability to maintain her attention on a movie.

Since the prior evaluation at this office, Ms. Seeram has 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 Ms. Seeram as manager of the Beverly LA branch with her friend. Ms. Seeram 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, Ms. Seeram 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, Ms. Seeram will be referred to an internist. Dr. Iseke will address her orthopedic complaints.

Despite the passage of time and the input of treatment, there has been the persistence of significant emotional complications.

No amount of emotional treatment could reasonably be expected to completely erase the adverse impact and complications of Ms. Seeram's work injuries. Any improvement of symptoms would now be expected to occur, if at all, at a slower rate over a more prolonged period of time. Therefore, in consideration of all relevant factors, the psychological condition can be considered as stabilizing into permanent and stationary status for practical rating purposes.

Ms. Seeram has remained symptomatic. Her emotional condition will be described in more detail below.

APPLICANT'S REPORT OF EMOTIONAL SYMPTOMS

Ms. Seeram reported persistent depressive mood plus symptoms including changes in appetite, decreased interest and motivation, insomnia, decreased energy, difficulty thinking and feelings of inadequacy.

Ms. Seeram experienced recurring periods of anxiety with symptoms including recurrent panic attacks, excessive worry, difficulty controlling her worry, feelings of restlessness, feeling "keyed up" and on edge, difficulty concentrating, irritability, muscle tension, abdominal distress, feelings of terror, fear of dying, derealization, feeling like she is choking, jumpiness and feeling pressured.

There were unprovoked crying episodes that occurred multiple times per week.

Ms. Seeram experienced stress-intensified medical symptoms with worsened headache, neck/shoulder/back muscle tension/pain, nausea, chest pain, shortness of breath, palpitations, constipation and abdominal pain/cramping.

Due to her mental disorder, Ms. Seeram 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. There were problems with stress-related constipation and diarrhea. Ms. Seeram 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. Ms. Seeram developed decreased sexual interest due to depression, anxiety, emotional withdrawal, irritability and anger. Ms. Seeram developed difficulty falling and staying asleep due to depression, anxiety and worry. Because of her insomnia, Ms. Seeram experienced morning headaches, trouble concentrating and a change in her personality.

Due to her emotional distress, Ms. Seeram had difficulty interacting appropriately with others including family members, friends and neighbors. Ms. Seeram became emotionally withdrawn. Due to her mental disorder, Ms. Seeram developed attitudes that impaired her ability to socialize including guardedness, defensiveness, mistrustfulness and suspiciousness. Ms. Seeram became irritable and impatient with people. There were problems with becoming short-tempered and being prone to inappropriate angry outbursts. Ms. Seeram 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 Ms. Seeram yelled at others.

Because of Ms. Seeram's emotional disturbances, there was difficulty paying attention, concentrating and remembering things. Ms. Seeram experienced problems with distractibility, slowed thinking, mental confusion, mental blocking and loss of her train of thought. Because of her cognitive impairment, Ms. Seeram had difficulty communicating her thoughts. Ms. Seeram's 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. Ms. Seeram also had problems remembering where she left things around the house, telephone numbers, appointments and

birthdays, directions and what people told her. Due to Ms. Seeram's depression and anxiety, there was psychological fatigue and energy depletion.

PERSONAL AND FAMILY HISTORY

Ms. Seeram was the first of three of children. She was born and raised in New York City. She moved to Southern California in 05/1992.

Ms. Seeram's mother, Dolly (72), achieved a high school level education with a reported occupation of homemaker. Ms. Seeram described her relationship with her mother as mostly positive, despite her issues with verbal abuse.

Ms. Seeram's father, Bejai (74), achieved a college education with a reported occupation in computer science. Ms. Seeram described her relationship with her father as mostly positive, despite his issues with alcoholism.

Ms. Seeram described her childhood as happy and normal. She reported no significant childhood problems with peer relations, school behavior, school performance or adolescent turmoil.

Ms. Seeram has been married to her husband, Vijai, since 05/23/1992. She described their relationship as strained due to her work-related pain, disability and depression.

Ms. Seeram's cousin, Robby, died in approximately March 2002. Ms. Seeram experienced a normal period of grief and mourning.

There were family issues. Ms. Seeram reported that her father has had multiple strokes. She reported that her family lives in Florida. Although Ms. Seeram has 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 will move back there soon to reunite with them soon. She has also become used to her father's invalidism without significant added depression.

INJURY AND LEGAL HISTORY

Ms. Seeram reported no previous significant accidents and no significant prior litigation. Additionally, there have been no past convictions of any felonies.

FINANCIAL HISTORY

Ms. Seeram reported no significant prior financial issues.

PERSONAL LIFE STRESSORS

Ms. Seeram reported no personal life stressors aside from those described elsewhere.

WORK HISTORY

Ms. Seeram was employed by JP Morgan Chase Bank as a branch manager from about 12/27/1988 to 03/15/2019.

PRIOR WORK INJURIES

Ms. Seeram reported other work injuries. Ms. Seeram reported that she experienced bank robberies while at JP Morgan Chase Bank in 1989, 1993, 2003 and 2007. There were no claims filed. As a result of these robberies, Ms. Seeram has continued to feel unsafe at JP Morgan Chase Bank.

Ms. Seeram reported that she filed a stress case in 2012. As well, in 2012, Ms. Seeram, injured her neck, back and knees due to heavy lifting. She has not yet recovered from these injuries. Any associated records should be reviewed.

PSYCHOLOGICAL HISTORY

In regard to her mental health history, Ms. Seeram reported no previous episodes of comparable emotional upset or confusion. She has never undergone psychiatric hospitalization. There have been no suicide attempts.

Ms. Seeram reported that her brother had anxiety.

Ms. Seeram reported that she was prescribed Cymbalta in 2017. Ms. Seeram received psychiatric treatment at Kaiser starting in 2019.

PERSONAL HABITS

In regard to her personal habits, Ms. Seeram stated that she is not a smoker and that she rarely consumes alcoholic beverages. Due to Ms. Seeram's current work related issues, her drinking has increased. She has never been arrested for drunk driving; nor have there been any alcohol-related arrests. Ms. Seeram denied the use of any illegal drugs or the abuse of any legal ones.

MEDICAL HISTORY

Ms. Seeram reported she was diagnosed with migraine headaches in 11/2017. Ms. Seeram also indicated that she was diagnosed with hypothyroidism.

In regard to medication usage, Ms. Seeram has recently taken Levothyroid, Cymbalta, Meloxicam, Robxin, Topamax.

MENTAL STATUS EXAMINATION

Ms. Seeram presented in interview as a 51-year-old female who was casually dressed.

Ms. Seeram 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 front of her employees. Once rapport had been established, Ms. Seeram became more open and revealing.

Ms. Seeram's 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 employees' jobs as well as her managerial work.

Ms. Seeram's thought processes were noted to be pressured, anxious, distraught and distressed, 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 that she did not know how 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.

Ms. Seeram was oriented to the day of the week and date. Ms. Seeram was not able to retain the recollection of three simple items. Ms. Seeram's recall of 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.

Ms. Seeram 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 loses her keys. She cannot remember her to-do list. She cannot even remember where she is going. It appeared most likely that Ms. Seeram's cognitive deficits were caused by emotionally reactive confusion.

Relevant to her need for treatment, Ms. Seeram's capacity for psychological insight and good psychological judgment was observed to be essentially unimpaired.

PSYCHOLOGICAL TEST RESULTS

Overall, Ms. Seeram's psychological test results were massively abnormal. The psychological testing revealed abnormality in all of the tests measuring emotional functioning.

The Beck Depression Inventory score of 41 placed Ms. Seeram in the severe range of subjective depression, according to Beck scoring criteria.

There was the administration of the Beck Anxiety Inventory (BAI). This test consists of descriptive statements of anxiety, which are endorsed on a 4-point scale. The BAI measures the severity of self-reported anxiety in adult outpatients over the age of 17 years. In this case, the total score of 48 indicated a severe level of anxiety according to Beck scoring criteria.

The Beck Hopelessness Scale (BHS) has served as an important adjunct in psychotherapy as a predictor of suicide during therapy, as a lead to assessing suicidal ideation, as a clue to the source and resolution of a clinical impasse and as a technique to facilitate movement in psychotherapy. The BHS score yields only an estimate of the overall severity of a person's negative attitudes about the future. In addition, hopelessness has repeatedly been found to be a better predictor of suicidal intention than depression per se. In this particular case, the BHS score of 18 would be interpreted as reflecting a severe level of hopelessness according to Beck scoring criteria.

The Beck Scale For Suicide Ideation (BSS) not only serves as a screening device to detect suicidal ideation, it also measures the severity of suicidal potential and risk. The ratings for 19 items are calculated such that the total BSS score can range from 0 to 38, from normal to maximal risk. Within this range, the score generated by Ms. Seeram was 0.

There was the administration of the Insomnia Severity Index (ISI), which measures the severity of self-reported insomnia. This test consists of rating descriptive statements of the patient's current sleep patterns, which are endorsed on a 5-point scale. In this case, the total score of 16 indicated moderate insomnia according to ISI scoring criteria.

Ms. Seeram was provided with the Personality Assessment Screener (PAS), a self-administered, objective questionnaire representing distinct clinical problems. On the Total Scale of the PAS, a

measurement of emotional and behavioral problems, Ms. Seeram obtained a score of 99.12, in the marked range.

The Negative Affect scale is indicative of personal distress correlated with depression and anxiety. On the Negative Affect scale, Ms. Seeram obtained a score of 100.0, indicating extreme feelings of unhappiness and tension.

The Health Problems scale measures concerns over health problems and somatic complaints. On the Health Problems scale, Ms. Seeram obtained a score of 96.1, indicating marked concern for health problems.

The Psychotic Features scale measures potential for psychotic thought processes focusing on features of paranoid psychosis. On the Psychotic Features scale, Ms. Seeram obtained a score of 95.1, indicating marked paranoid thinking.

The Social Withdrawal scale reflects social detachment and discomfort in relationships. On the Social Withdrawal scale, Ms. Seeram obtained a score of 91.5, indicating marked social difficulties.

The Hostile Control scale assesses an individual's characteristic patterns of relating to others in a manner characterized by needs for self-control and inflated self-image. On the Hostile Control scale, Ms. Seeram obtained a score of 50.4, indicating moderate aggression.

The Alienation scale measures attachment problems. On the Alienation scale, Ms. Seeram obtained a score of 90.5, indicating marked difficulty with attachment.

The Anger Control scale measures difficulties in managing anger. On the Anger Control scale, Ms. Seeram obtained a score of 63.1, indicating moderate difficulty with anger.

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

The Multiscore Depression Inventory, a 118-item questionnaire exploring subjective symptoms of depression, revealed the following scores and interpretations.

The 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 Ms. Seeram's 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 measures 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 of 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 70, 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, 47, 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 may 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 the patient 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.

MEDICAL RECORD REVIEW

There was a Primary Treating Physician's Initial Evaluation and Report by Harold Iseke, D.C. dated 07/10/2019.

Subjective Complaints: Ms. Seeram complained of frequent frontal sharp, and throbbing headache. Exacerbation stress and activity. She took Topamax to release pain.

She complained of 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 flex, ext-esp on a computer.

She complained of constant and mid upper/mid back pain and stiffness becoming sharp moderate pain with sudden or repetitive movement, lifting 10 pounds, sitting, walking, bending, and twisting.

She complained of activity-dependent moderate sharp, stabbing right wrist pain, stiffness and numbness, associated with reaching, grabbing/grasping, gripping, squeezing, pushing, and pulling repetitively.

She complained of activity-depended moderate sharp, stabbing left wrist pain, stiffness and numbness, associated with reaching, grabbing/grasping, squeezing, pushing, and pulling repetitively.

She complained of activity-dependent moderate sharp, stabbing left hand pain and stiffness, associated with reaching, grabbing/grasping, gripping, squeezing, pushing and pulling repetitively.

She complained of activity-dependent moderated right knee pain and stiffness, associated with sudden or repetitive movement, lifting 10 pounds, standing, walking, pushing, and pulling repetitively.

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

There was a complaint of loss of sleep due to pain.

She said that due to prolonged pain and financial hardship, she felt like her condition would never improve which was causing stress.

There was tenderness to palpation of the bilateral trapezii, cervical paravertebral muscles, spinous processes and suboccipitals. There was muscle spasm of the cervical paravertebral muscle and suboccipitals. Cervical compressions was positive, bilaterally.

There was tenderness to palpation of the lateral Levator scapulae, bilateral trapezii, spinous processes, thoracic paravertebral muscles and thoracolumbar junction. There was muscle spasm of the bilateral Levator scapulae, bilateral rhomboids, bilateral scapular area, bilateral trapezii and thoracic paravertebral muscles. Kemp's was positive.

There was tenderness to palpation of the anatomical snuffbox, dorsal wrist, hypothenar, lateral wrist, thenar and volar wrist. There was muscle spasm of the forearm, hypothenar and thenar. Tinel's was positive bilaterally. Phalen's was positive bilaterally.

There was tenderness to palpation of the anterior knee, lateral knee, medial popliteal fossa and posterior knee. There was muscle spasm of the anterior knee, lateral medial knee and posterior knee. Verus was positive, bilaterally.

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) Hemangioma of skin and subcutaneous tissue. 7) Unspecified sprain of right wrist, initial encounter. 8) Unspecified mononeuropathy of right upper limb. 9) Unspecified sprain of left wrist, initial encounter. 10) Pain in left wrist. 11) Pain in hand and fingers. 12) Pain in left hand. 13) Reaction to severe stress, and adjustment disorders. 14) Chronic pain due to trauma. 15) Myositis, unspecified. 16) Contracture of muscle, unspecified site.

Treatment/Therapy Recommendations: She was recommended to undergo EMG/NCV of bilateral upper extremities, acupuncture once a week for six weeks, and chiropractic treatment, once per week for six weeks.

Work Status: She was placed on temporary total disability.

Causation: In view of Ms. Seeram's history, present complaints, mechanism of injury and clinical finding, it was Mr. Hamid's opinion that her symptomatology was a result of the specific work-related injuries that occurred on CT: 05/17/2018 to 05/18/2019, during the course of her employment for JP Morgan chase.

Apportionment: Apportionment was not an issue at that time, but would be discussed at the time of discharge.

There was a Request for Authorization for Medical Treatment by Harold Iseke M.D., dated 07/10/2019.

Diagnoses: 1) Unspecified mononeuropathy of right upper limb. 2) Chronic pain due to trauma. 3) Pain in left wrist. 4) Spinal enthesopathy, thoracic region. 5) Other cervical disc displacement, unspecified cervical region.

Treatment Requested: Ms. Seeram was requesting authorization for acupuncture, chiropractic, and EMG/NCV bilateral upper extremities.

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 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 Ms. Seeram's reaction to severe stress and adjustment disorders.

DIAGNOSES AS PER DSM-5

According to DSM-5 criteria, to qualify for a diagnosis of Major Depressive Disorder, there must be symptoms including depression that has lasted for more than two weeks plus five (5) or more of the following criteria: (1) changes in appetite, (2) decreased interest and motivation, (3) insomnia, (4) decreased energy, (5) difficulty thinking, (6) feelings of inadequacy, and (7) recurrent thoughts of death. In this case, Ms. Seeram has developed depression that has lasted for more than two weeks with changes in appetite, decreased interest and motivation, insomnia, decreased energy, difficulty thinking and feelings of inadequacy that have impaired her social and occupational functioning. Furthermore, Ms. Seeram's depressive symptoms are not attributable to the effects of a substance or any other medical condition. Therefore, Ms. Seeram qualifies for Major Depressive Disorder.

According to DSM-5 criteria, to qualify for a diagnosis of Generalized Anxiety Disorder, there must be symptoms including excessive anxiety and worry, and difficulty controlling her worry, with three (3) or more of the following symptoms: (1) restlessness, (2) fatigue, (3) difficulty concentrating, (4) irritability, (5) muscle tension and (6) sleep disturbance. In this case, Ms. Seeram has developed excessive anxiety and worry, and difficulty controlling her worry, with restlessness, difficulty concentrating, irritability and muscle tension that have impaired her social and occupational functioning. Furthermore, Ms. Seeram's anxiety symptoms are not attributable to the effects of a substance or any other medical condition. Therefore, Ms. Seeram qualifies for Generalized Anxiety Disorder.

According to DSM-5 criteria, Ms. Seeram qualified for a diagnosis of Psychological Factors Affecting Medical Condition because there was the presence of the following medical symptoms—worsened headache, neck/shoulder/back muscle tension/pain, nausea, chest pain, shortness of breath, palpitations, constipation and abdominal pain/cramping—and because these medical symptoms have been exacerbated by her mental disorder. As well, these symptoms are not better accounted for by another mental disorder.

Therefore, on a psychodiagnostic basis, the most appropriate categories of mental disorder as applied to Ms. Seeram would be as follows:

F32.9	Major Depressive Disorder, Single Episode
F41.1	Generalized Anxiety Disorder
F54	Psychological Factors Affecting Other Medical Conditions (stress-intensified headache, neck/shoulder/back muscle tension/pain, nausea, chest pain, shortness of breath, palpitations, 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

Ms. Sandra Seeram, a 51-year-old branch manager for JP Morgan Chase Bank, completed psychological evaluation and testing on 01/10/2020 at the Long Beach office.

Ms. Seeram began her employment at JP Morgan Chase Bank on 12/27/1988. Her last day of work there was on 03/15/2019.

In this particular case, the 51-year-old branch manager for JP Morgan Chase Bank, an employee who worked there for about 31 years, revealed a history of injury at work as follows. Ms. Seeram described disturbing experiences of stress at work. After Ms. Seeram became transferred to another branch in May 2018, the market director, Kathy, promised her help. Ms. Seeram was overwhelmed. Ms. Seeram 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. Ms. Seeram also described harassment by Kathy, who frequently singled her out during conference calls and meetings. Kathy questioned why Ms. Seeram did certain things. She micromanaged Ms. Seeram in front of her co-workers and compared her branch to other, high performing branches with sufficient staff. This was an unfair comparison. Ms. Seeram worked about ten hours a day. There were further stressors. In January 2019, Ms. Seeram 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. Ms. Seeram 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. Ms. Seeram asked Kathy to find a branch closer to her home. Ms. Seeram 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 one week. The problems persisted. Kathy made bank visits weekly. On one occasion, Kathy arrived with a pre-auditor. Kathy then yelled and screamed at Ms. Seeram because her monitor did not have a privacy screen protector. Kathy told her that she could not pass an audit. Ms. Seeram was humiliated in

front of her staff. This was uncalled for. Ms. Seeram had passed many audits. There was also physical trauma, which adversely influenced the emotional complications of her work stress. Ms. Seeram 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. Ms. Seeram was referred to Harold Iseke, D.C. She was unable to perform her usual job duties. She took an intermediate leave of absence. Ms. Seeram has 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 Ms. Seeram as manager of the Beverly LA branch to replace her with a friend. Ms. Seeram 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, Ms. Seeram 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, Ms. Seeram will be referred to an internist. Dr. Iseke will address her orthopedic complaints. For the continuing emotional symptoms, Ms. Seeram was referred to this office. Despite the passage of time, Ms. Seeram has remained symptomatic with persistent depression, anxiety, panic attacks, irritability, mistrust, insomnia, nightmares of Kathy and difficulty concentrating. Unfortunately, due to the disturbing experiences of stress at work including the work overload, undermining, unfair criticism, yelling and screaming and inherent work stress of managing understaffed banks, all under a known difficult director who picked favorites from her clique and who stressed Ms. Seeram to the point of the loss of her career of 31 years in banking, all resulting in an unwanted early retirement; due to the stress-aggravated physical pain and disability involving primarily the neck and hands with generalized radiation resulting from the cumulative physical trauma; due to the other stress-aggravated medical symptoms including the worsened headache, neck/shoulder/back muscle tension/pain, nausea, chest pain, shortness of breath, palpitations, constipation and abdominal pain/cramping; and due to the resultant mental disorder with damaged self-esteem, emotional withdrawal, mistrust, psychological fatigue, panic attacks, mental confusion, insufficient emotional control and cognitive impairment with concentration/attention/memory deficits, there would be residuals of permanent mental and behavioral impairment to a marked degree according to the AMA Guides with a GAF of 50 according to the DSM-IV-TR with a WPI of 30.

The following opinions have been offered based upon the assumption that the facts gleaned from the applicant and other cited sources are basically correct and accurate. I would reserve the option to change my opinions upon the receipt of additional records or information from other sources. It would be requested again that I be offered an opportunity to review all available documents in this case. However, based upon the information available at this time, the following conclusions and recommendations will be offered with "reasonable medical probability."

<u>It would appear from the history and examination that Ms. Seeram has been temporarily totally disabled on an emotional basis from her last day of work at JP Morgan Chase Bank on about 03/15/2019 to the present and continuing, hopefully until her condition becomes more stabilized in the near future.</u>

Although there may be some further expected slow change in the positive direction, and although Ms. Seeram may need continued supportive psychotherapy, it would not be expected that further substantial recovery or deterioration would be anticipated in the next year beyond the projected estimate of permanent emotional impairment set forth below.

It should also be kept in mind that an applicant's condition should be considered to be stabilized into permanent and stationary status after the medical condition has been stabilized for a sufficient period of time. According to these considerations, Ms. Seeram's psychological condition can be considered as becoming permanent and stationary assuming the provision of

supportive psychotherapy on an as-needed basis and assuming a period of continuing disability until finally stabilized on a psychological basis.

The degree of permanent emotional impairment would be set forth as marked.

The AMA Guides set forth issues for the doctor to assess relevant to the individual's attitude and other issues as follows: The physician should initially assess matters of motivation, secondary gain and fiscal incentives. Ms. Seeram's motivation to recover appeared good but impaired by depression, fatigue, hopelessness and disillusionment. There were not any discernible indications of malingering for secondary gain. Overall, Ms. Seeram and her account of her injuries were deemed to be of average credibility.

In formulating the following estimation of psychological impairment, there was no information considered from work evaluations, rehabilitation programs, day care programs, community mental health centers, shelter workshops or hospital discharge summaries. The reader would be referred to the medical record review section, if any, of this report above for an analysis of ancillary sources of information. Likewise, there was no reliable information gleaned from observing Ms. Seeram complete the pencil-and-paper psychological tests such as the MMPI-2. The effects or side effects of psychotropic medications would not be a significant determinant of permanent emotional impairment in this analysis.

The method of evaluating psychiatric impairment according to the AMA guidelines involves the assessment and recording of the extent of function in four main categories, areas or aspects of functioning to be estimated in five classes of impairment as set forth within the Mental and Behavioral Disorders Impairment Chart below.

MENTAL AND BEHAVIORAL DISORDERS IMPAIRMENT CHART

Area or Aspect of Functioning	Class I No Impairment	Class II Mild Impairment Discernable impairment levels are compatible with most useful functioning	Class III Moderate Impairment Identified impairments are compatible with some, but not all, useful functioning	Class IV Marked Impairment* Impairment levels significantly impede useful functioning	Class V Extreme Impairment** Impairment or limitation is not compatible with or levels preclude useful functioning
Activities of Daily Living			✓		
Social Functioning				✓	
Concentration, Persistence and Pace			✓		

Adaptation				✓	

** Taken alone, a Marked Impairment would not completely preclude functioning, but together with marked limitation in another class, it might limit useful functioning.*
*** Extreme impairment in only one area or marked impairment in two or more spheres would be likely to preclude the performance of any complex task, such as one involving recreation or work, without special support or assistance, such as that provided in a sheltered environment.*
Furthermore, a moderate impairment does not imply a 50% limitation in useful functioning, and an estimate of moderate impairment in all four categories does not imply a 50% impairment of the whole person.

ACTIVITIES OF DAILY LIVING

Due to her mental disorder, Ms. Seeram 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. There were problems with stress-related constipation and diarrhea. Ms. Seeram 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. Ms. Seeram developed decreased sexual interest due to depression, anxiety, emotional withdrawal, irritability and anger. Ms. Seeram developed difficulty falling and staying asleep due to depression, anxiety and worry. Because of her insomnia, Ms. Seeram experienced morning headaches, trouble concentrating and a change in her personality. These factors would correlate with a moderate impairment in activities of daily living.

SOCIAL FUNCTIONING

Due to her emotional distress, Ms. Seeram had difficulty interacting appropriately with others including family members, friends and neighbors. Ms. Seeram became emotionally withdrawn. Due to her mental disorder, Ms. Seeram developed attitudes that impaired her ability to socialize including guardedness, defensiveness, mistrustfulness and suspiciousness. Ms. Seeram became irritable and impatient with people. There were problems with becoming short-tempered and being prone to inappropriate angry outbursts. Ms. Seeram 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 Ms. Seeram yelled at others. If Ms. Seeram 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 Ms. Seeram's emotional disturbances, there was difficulty paying attention, concentrating and remembering things. Ms. Seeram experienced problems with distractibility, slowed thinking, mental confusion, mental blocking and loss of her train of thought. Because of her cognitive impairment, Ms. Seeram had difficulty communicating her thoughts. Ms. Seeram's 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. Ms. Seeram also had problems remembering where she left things around the house, telephone numbers, appointments and birthdays, directions and what people told her. Due to Ms. Seeram's 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 Ms. Seeram 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 supervisors and peers. If Ms. Seeram 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 decompensations in the workplace. Ms. Seeram's industrial injury should probably be considered analogous in some ways to an unwanted divorce. The loss of the employment relationship becomes associated with feelings of insecurity, damaged self-esteem and difficulties with subsequent attachments. She worked in the same career in banking for about 31 years. Overall, Ms. Seeram's 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 four main categories of mental and behavioral impairment, the AMA Guides indicate that independence, appropriateness and effectiveness of activities should also be considered. According to the evidence above, independence would be estimated 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

As described in the history and examination above, it was observed that Ms. Seeram's symptoms of psychiatric injury were visibly 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 causes constituting greater than 50% of all of the causal factors, in Ms. Seeram's case, 100% industrial as explained below.

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 Ms. Seeram's psychological injury should be considered industrial, there would be other factors to consider relevant to issues of apportionment. For instance, Ms. Seeram reported that her father has had multiple strokes. She reported that her family lives in Florida. Although Ms. Seeram has 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 will move back there soon to reunite with them soon. She has 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 were considered and did not appear to be causative of emotional impairment. For the sake of time and expense, there will not be an inclusion here of factors for which apportionment was considered but not effected. 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. Ms. Seeram worked there for 31 years. It would be overly speculative to assume that Ms. Seeram 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 Ms. Seeram's 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.

Based on the given history, and the available medical records, there is no substantial medical evidence establishing that other factors have caused permanent disability. It is my belief, according to my understanding of *Escobedo vs. Marhsall's* that apportionment of permanent disability to other factors can only be made "provided there is substantial medical evidence establishing that these other factors have caused permanent disability."

Ms. Seeram 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 does not look good for recovery in this area within the foreseeable future.

If Ms. Seeram were to attempt a formal vocational assessment at this time, she may well be found to be non-feasible for vocational rehabilitation. Her stress-intensified pain, depression, anxiety, psychological fatigue, diminished stamina, impaired concentration and related overwhelmed emotions may well cause an inability to continue to cognitively function, to relate to 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 may 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, Ms. Seeram has become eligible for Social Security Disability benefits.

Future psychological treatment benefits would be recommended.

It may 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 one year of weekly supportive psychotherapy sessions be set aside for Ms. Seeram 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.

Ms. Seeram should also be provided with her psychotropic medications to be set aside for another year.

The amount of necessary treatment could extend beyond the aforementioned estimate proffered for practical settlement purposes.

It would be best for Ms. Seeram to be provided with an open-ended future psychological treatment award.

There will be further reports to follow on an as-needed basis.

DISCLOSURE

The preparation of this report complies with Labor Code 4628. 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, I believe it to be true.

In further compliance with Labor Code Section 4628 (j), I declare under penalty of perjury that I personally completed the evaluation of the patient on 01/10/2020 at the Long Beach office, and that, except as otherwise stated herein, the interview and evaluation were performed by me, and that the time spent performing the evaluation was in compliance with the guidelines established by the Administrative Director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Code.

I provided the psychological test interpretations.

It should be noted that, aside from the clerical preparation of this report, any reviews deemed necessary and appropriate to identify and determine the relevant psychological issues in this matter and to determine the diagnoses, conclusions and recommendations contained in this report, have been performed by me.

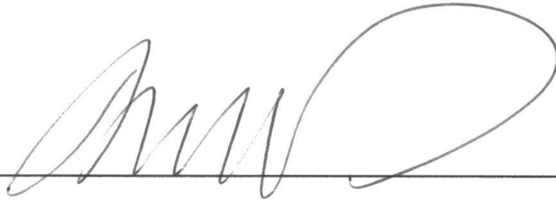
I declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3.

I also declare under penalty of perjury pursuant to Labor Code 5703 (a)(1) that the attached billing for services is true and correct to the best of my knowledge.

The opportunity to provide this evaluation has been appreciated.

If there are any questions, please feel free to contact me.

Signed on March 17, 2020 in Los Angeles County, California.



Signature:______________________________

Thomas A. Curtis, M.D. (A23197)

CERTIFIED IN PSYCHIATRY BY THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

State of California - Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

Additional pages attached ☒

This form is required to be used for ratings prepared pursuant to the 2005 Permanent Disability Rating Schedule and the AMA Guides to the Evaluation of Permanent Impairment (5th Ed.). It is designed to be used by the primary treating physician to report the initial evaluation of permanent disability to the claims administrator. It should be completed if the patient has residual effects from the injury or may require future medical care. In such cases, it should be completed once the patient's condition becomes permanent and stationary.

This form should not be used by a Qualified Medical Evaluator (QME) or Agreed Medical Evaluator (AME) to report a medical-legal evaluation.

Patient

Patient last name:	Patient first name:	MI
Seeram	Sandra	

Patient Street Address/P.O. Box	Patient City	State	Zip Code	Sex
2692 Cabrillo ave	Torrance	CA	90501	Female

Occupation	Date of Birth	Phone Number
branch manager	11/19/1968	[1] 310-561-2036

Claims Administrator

Claims Administrator Name	Claim Number
Broadspire	189103909

Claims Administrator Street Address	Claims Administrator City	State	Zip Code
P.O. Box 14645	Lexington	KY	40512

Phone Number:

Employer

Name: JP Morgan Chase Bank

Street Address	City	State	Zip Code
310 N Fairfax Ave.	Los Angeles, CA, 90036		

Phone Number:

You must address each of the issues below. You may substitute or append a narrative report if you require additional space to adequately report on these issues. *(For dates use mm/dd/yyyy.)*

Date of Injury	Last Date Worked	Date of Last Exam	Date of Current Exam	Permanent & Stationary Date
Ct: 11/16/2018 - 05/02/2019	03/15/2019	10/07/2019	01/10/2020	01/10/2020

Description of how injury/illness occurred (e.g., Hand caught in punch press; fell from height onto back; exposed 25 years ago to asbestos):

SEE NARRATIVE REPORT

Patient's Complaints:

SEE NARRATIVE REPORT

OBJECTIVE FINDINGS:

Physical Examination: (Describe all relevant findings; include any specific measurements indicating atrophy, range or

motion, strength, etc.; include bilateral measurements - injured/uninjured - for upper and lower extremity injuries.)

N/A

Diagnostic tests results (X-ray/Imaging/Laboratory/etc.):

N/A

Diagnoses:

#	Diagnosis		Code
1	Major Depressive Disorder, Single Episode	ICD-10	F32.9
2	Generalized Anxiety Disorder	ICD-10	F41.1
3	Psychological Factors Affecting Other Medical Conditions	ICD-10	F54
4		ICD-10	
5		ICD-10	
6		ICD-10	
7		ICD-10	
8		ICD-10	
9		ICD-10	
10		ICD-10	

Impairment Rating: Report the whole person impairment (WPI) for each impairment using the AMA Guides, 5th Edition, and explain how the rating was derived. List tables used and page numbers.

Impairment: Marked WPI%: 30 **Table #(s):** 14-1 Page #(s): 361-367

SEE NARRATIVE REPORT

Explanation

Impairment: ______ WPI%: ______ **Table #(s):** ______ Page #(s): ______

Explanation

Impairment: ______ WPI%: ______ **Table #(s):** ______ Page #(s): ______

Explanation

Impairment: ______ WPI%: ______ **Table #(s):** ______ Page #(s): ______

Explanation

Pain Assessment:

If the burden of the worker's condition has been increased by pain-related impairment in excess of the pain component already incorporated into the WPI rating under Chapters 3-17 of the AMA Guides, 5th Edition, specify the additional whole person impairment rating (0% up to 3% WPI) attributable to such pain. For excess pain involving multiple impairments, attribute the pain in whole number increments to the appropriate impairments. The sum of all pain impairment ratings may not exceed 3% for a single injury.

Apportionment:

Effective April 19, 2004, apportionment of permanent disability shall be based on causation. Furthermore, any physician who prepares a report addressing permanent disability due to a claimed industrial injury is required to address the issue of causation of the permanent disability, and in order for a permanent disability report to be complete, the report must include an apportionment determination. This determination shall be made pursuant to Labor Code Section 4663 and 4664, set forth below:

Labor Code Section 4663. Apportionment of permanent disability; Causation as basis; Physician's report; Apportionment determination; Disclosure by employee

(a) Apportionment of permanent disability shall be based on causation.
(b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.
(c) In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring it the course of employment an what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician stall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.
(d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disability or physical impairments.

Labor Code section 4664. Liability of employer for percentage of permanent disability directly caused by injury; Conclusive presumption from prior award of permanent disability; Accumulation of permanent disability awards

(a) The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising our of and occurring in the course of employment.
(b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden or proof.
(c) (1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. As used in this section, the regions of the body are the following:

(A) Hearing.

(B) Vision.

(C) Mental and behavioral disorders.

(D) The spine.

(E) The upper extremities, including the shoulders.

(F) The lower extremities, including the hip joints.

(G) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs (A) to (F), inclusive.

(2) Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100 percent.

Is the permanent disability directly cased by an injury or illness arising out of and in the scope of employment? ☒ Yes ☐ No

Is the permanent disability caused, in whole or in part, by other factors besides this industrial injury or illness, including any prior industrial
injury or illness?

☐ Yes ☒ No

If the answer to the second question is "yes," provide below: (1) the approximate percentage of the permanent disability that is due to factors other than the injury or illness arising out of and in the course of employment; and (2) a complete narrative description of the basis for your apportionment finding.
If you are unable to include an apportionment determination in your report, state the specific reasons why you could not make this determination. You may attach your findings on a separate sheet.

SEE NARRATIVE REPORT

Future Medical Treatment: Describe any continuing medical treatment related to this injury that you believe must be provided to the patient. ("Continuing medical treatment" is defined as occurring or presently planned treatment.) And describe any medical treatment the patient may require in the future. ("Future medical treatment" is defined as treatment which is anticipated at some time in the future to cure or relieve the employee from the effects of the injury.) Include medications, surgery, physical medicine services, durable equipment, etc

Comments:

SEE NARRATIVE REPORT

Functional Capacity Assessment:
Note: The following assessment of functional capacity is to be prepared by the treating physician, solely for the purpose of determining a claimant's ability to return to his or her usual and customary occupation, and will not be considered in the permanent impairment rating. For injuries occurring on or after 01/01/2013 also complete DWC-AD Form 10133.36

Limited, but retains MAXIMUM capacities to LIFT (including upward pulling) and/or CARRY:
☐ 10 lbs. ☐ 20 lbs. ☐ 30 lbs. ☐ 40 lbs. ☐ 50 +lbs
FREQUENTLY LIFT and/or CARRY:
☐ 10 lbs. ☐ 20 lbs. ☐ 30 lbs. ☐ 40 lbs. ☐ 50 +lbs
OCCASIONALLY LIFT and/or CARRY:
☐ 10 lbs. ☐ 20 lbs. ☐ 30 lbs. ☐ 40 lbs. ☐ 50 +lbs

STAND and/or WALK a total of:
☐ 10 lbs. ☐ 20 lbs. ☐ 30 lbs. ☐ 40 lbs. ☐ 50 +lbs
SIT a total of:
☐ < 2/8 hours ☐ < 4/8 hours ☐ < 6/8 hours ☐ < 8/8 hours

PUSH and/or PULL (including hand or foot controls):
☐ UNLIMITED ☐ LIMITED

(Describe degree of limitation)

ACTIVITIES ALLOWED:

Climbing:	☐ Frequently	☐ Occasionally	☐ Never
Balancing:	☐ Frequently	☐ Occasionally	☐ Never
Stooping:	☐ Frequently	☐ Occasionally	☐ Never
Kneeling:	☐ Frequently	☐ Occasionally	☐ Never
Crouching:	☐ Frequently	☐ Occasionally	☐ Never
Crawling:	☐ Frequently	☐ Occasionally	☐ Never
Twisting:	☐ Frequently	☐ Occasionally	☐ Never
Reaching:	☐ Frequently	☐ Occasionally	☐ Never
Handling:	☐ Frequently	☐ Occasionally	☐ Never
Fingering:	☐ Frequently	☐ Occasionally	☐ Never
Feeling:	☐ Frequently	☐ Occasionally	☐ Never
Seeing:	☐ Frequently	☐ Occasionally	☐ Never
Hearing:	☐ Frequently	☐ Occasionally	☐ Never
Speaking:	☐ Frequently	☐ Occasionally	☐ Never

Describe in what ways the impaired activities are limited:

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Environmental restrictions (e.g., heights, machinery, temperature extremes, dust, fumes, humidity, vibration, etc.):

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Can this patient now return to his/her usual occupation? ☐ **Yes** ☐ **No**

List information you reviewed in preparing this report, or relied upon for the formulation of your medical opinions:
Medical Records:

SEE NARRATIVE REPORT

Written Job Description (You may attach form DWC-AD 10133.33 for injuries occurring on or after 01/01/2013):

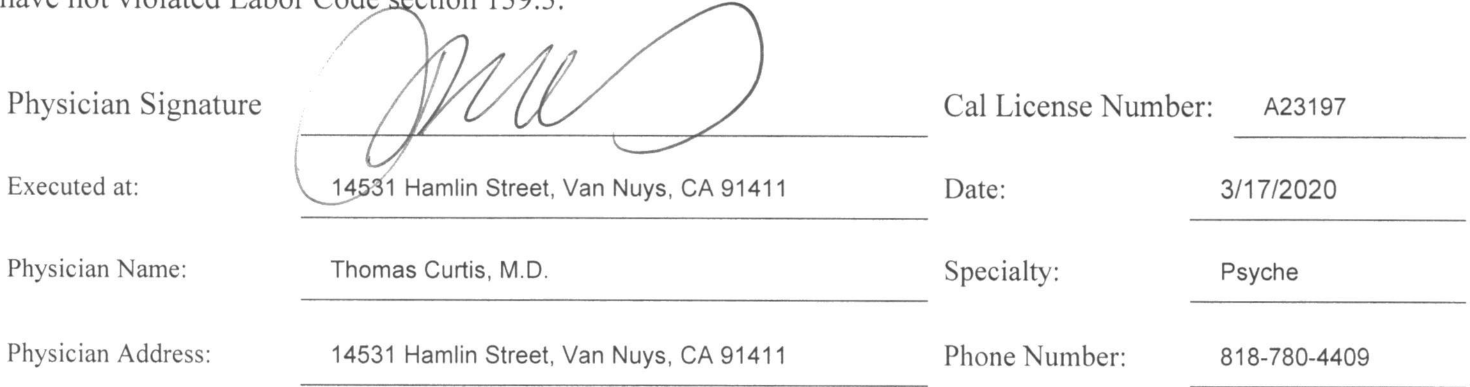
SEE NARRATIVE REPORT

Other:

SEE NARRATIVE REPORT

Primary Treating Physician (original signature, do not stamp)

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3.



Physician Signature		Cal License Number:	A23197
Executed at:	14531 Hamlin Street, Van Nuys, CA 91411	Date:	3/17/2020
Physician Name:	Thomas Curtis, M.D.	Specialty:	Psyche
Physician Address:	14531 Hamlin Street, Van Nuys, CA 91411	Phone Number:	818-780-4409

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