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skc/rag

Patient Name:	Lugo Sr., Martin B.
Claim No:	005834-002603-WC-01
EAMS No:	ADJ14468138
Social Security No:	XXX-XX-1451
D.O.B.:	07/30/1964
Employer:	Westpac Labs Inc.
Date of Injury:	CT 01/01/2019 – 04/05/2021
Date of Evaluation:	06/24/2022

Initial Psychological Comprehensive Medical Legal Evaluation

I am providing a medical-legal report pursuant to the Brower decision and Section 9793 (c) of Title 8, California Code of Regulations, which defines a comprehensive medical-legal evaluation (CME) as an evaluation of an injured worker with results in the preparation of a narrative medical report and is performed by a QME, AME or primary treating physician for the purpose of proving or disproving a contested claim, or at the request of the patient or at the request of the patient's attorney. Under Section 9793 (b), a contested claim is where the claims administrator has accepted liability for a claim and a disputed medial fact exists. Under Section 9793 (20, a disputed medical fact means an issue in a dispute concerning treatment for the employee's medical condition.

Relative to Labor Code Section 4062.3 (e) of the California Labor Code, a party has a due process right to present evidence on material issues to support a claim and elicit opinions from an expert witness (Evans vs. LAC 10 CCC 271; City of Torrance vs. WCAB 49 CCC 601; Abron vs. WCAB 38 CCC 591; Fremont Indemnity Co. vs. WCAB 49 CCC 288).

Comment:

This report will serve as medical evidence to address the contested Psychological claim of Mr. Martin Lugo Sr.

In patients who have entered a chronic state of pain, (ACOEM Guidelines, page 109, paragraph 4), "The treatment of chronic pain requires specialized knowledge, substantial time, and access to multidisciplinary care." This patient suffers from a serious and chronic medical condition which has persisted without a full cure for over 90 days and requires ongoing treatment to maintain remission or prevent deterioration, allowing the patient to be treated outside of the MPN for up to a year. This condition is serious and chronic and requires ongoing treatment to prevent deterioration. Because of these conditions, the patient falls under the category of Chronic Pain Treatment Guidelines MTUS. Chronic pain is defined as "any pain that persists beyond the anticipated time of healing." Per Title 8 C.C.R. §9792.20(c).

Per the Supreme Court, beginning on January 1, 2014, under the law, Affordable Care Act builds on the Mental Health Parity and Addiction Equity Act of 2008 to extend federal parity protections to insurers. The parity law aims to ensure that when coverage for mental health and substance use conditions is provided, it is generally comparable to coverage for medical and surgical care.

Based on the criteria, the report qualifies for procedure code ML201 as there are extraordinary circumstances relating to the medical condition for which this applicant was examined. The best proof regarding the complexity of this evaluation is the medical/legal report, which reflects the complex issues.

Pursuant to Labor Code Sections 4620, 4621, and 4622 the evaluation and report of the examinee are based on the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. The medical-legal billing codes used are effective 04/01/2021.

There is a med-legal report and there is no PPO or other discounts allowed. Based on the California Code of Regulations 9793 Paragraph (h), 9795, and Paragraphs (b), (c), and (d), this report is billed under ML201.

The time involved in psychological testing includes 4 hours of administrative, 2 hours of interpretation, 2 hours in writing the results, and defining the tests (8.0 units) complex psychological testing. This complex psychological testing was administered for diagnostic purposes, as well as to thoroughly explore issues of personality, cognition malingering, and /or exaggeration. Complex psychological testing was recommended and performed as it goes beyond the routine screening battery. As stated in the Psychiatrist Protocol adopted by the Industrial Medical Council on July 16, 1992, and amended on March 18 and October 25, 1993, complex psychological testing gives an in-depth view of the patient. Routine testing relying upon self-administered inventories may be insufficient in cases where elaborations; reading language and intellect real barriers, or confessional states exist (pp. 9-10).

The evaluation included 8 hours of psycho-diagnostic test administration, scoring, and interpretation. 2 hours face to face, 2 hours of medical research, 10 hours of report preparation time. Total hours spent 22 hours.

The report is a complex comprehensive medical-legal evaluation. My summary and report are as follows:

PATIENT SUMMARY:

The patient was seen on June 24, 2022, for a med-legal psychological evaluation as requested by his attorney, Natalia Foley, Workers Defenders Law Group, 751 S. Weir Canyon, Suite 157-455, Anaheim, CA 92808. As such, this report is billed as an ML-201 with associated psycho-diagnostic testing as requested.

The report contains material that may be misunderstood or misinterpreted by an examinee. For certain individuals, exposure could be destructive. If this report is to be discussed at all with the examinee, an appropriate professional who will ensure that the information is used therapeutically and not destructively should conduct it in a clinical setting. Please be advised that there is strong advice that if this material is to be shared with the claimant, it be done so by a psychologist or psychiatrist who has the proper training to interpret the conclusions contained herein.

The conclusions herein are based upon all of the information available to the undersigned to date. Therefore, I reserve the right to alter my findings and conclusions should further information arise hereafter that would warrant my doing so.

INTRODUCTION:

The patient submitted an Application for Adjudication of Workers' Compensation benefits citing a cumulative trauma injury from January 1, 2019 through April 5, 2021. On June 4, 2020, the patient was rear-ended by a drunk driver on Bushard and Ellis, injuring his neck, lower back, and right knee. The second injury occurred on March 23, 2021, when he stopped at his last route. While opening the company vehicle door and getting in the car, he felt a sharp pain in his hip and inner groin pelvic area.

According to Labor Code 3208.3. (a) A psychiatric injury shall be compensable if it is a mental disorder which causes disability or needs for medical treatment and it is diagnosed pursuant to procedures promulgated under paragraph (4) of subdivision (j) of Section 139.2 Until these procedures are promulgated, it is diagnosed using the terminology and criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or the terminology and diagnostic criteria of other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine. (b) (1) In order to establish that a psychiatric injury is compensable, an employee shall demonstrate by a

preponderance of the evidence that actual events of employment were predominant as to all causes combined of the psychiatric injury. (2) Notwithstanding paragraph (1), in the case of employees whose injuries resulted from being a victim of a violent act or from direct exposure to a significant violent act, the employee shall be required to demonstrate by a preponderance of the evidence that actual events of employment were a substantial cause of the injury. (3) For the purposes of this section, "substantial cause" means at least 35 to 40 percent of the causation from all sources combined.
(c) It is the intent of the Legislature in enacting this section to establish a new and higher threshold of compensability for psychiatric injury under this division.
(d) Notwithstanding any other provision of this division, no compensation shall be paid pursuant to this division for a psychiatric injury related to a claim against an employer unless the employee has been employed by that employer for at least six months.
The six months of employment need not be continuous. The subdivision shall not apply if the psychiatric injury is caused by a sudden and extraordinary employment condition. Nothing in this subdivision shall be construed to authorize an employee, or his/her dependents, to bring an action at law or equity for damages against the employer. For a psychiatric injury, where those rights would not exist pursuant to the exclusive remedy doctrine set forth in Section 3602 in the absence of the amendment of this section by the act adding this subdivision. (e) Where the claim for compensation is filed after the notice of termination of employment or layoff, including voluntary layoff and the claim is for an injury occurring prior to the time of notice of termination or layoff. No compensation shall be paid unless the employee demonstrates by a preponderance of the evidence that actual events of employment were predominant as to all causes combined of the psychiatric injury and one or more of the following conditions exist:
(1) Sudden and extraordinary events of employment were the cause of the injury.
(2) The employer has notice of the psychiatric injury under Chapter 2 (commencing with Section 5400) prior to the notice of termination or layoff. (3) The employee's medical records existing prior to notice of termination or layoff contain evidence of treatment of the psychiatric injury. (4) Upon a finding of sexual or racial harassment by any trier of fact, whether contractual, administrative, regulatory, or judicial. (5) Evidence that the date of injury, as specified in Section 5411 or 5412, is subsequent to the date of the notice of termination or layoff, but prior to the effective date of the termination or layoff.
1(f) For purposes of this section, an employee provided notice pursuant to Sections 44948.5, 44949, 44951, 44955, 44955.6, 72411, 87740, and 87743 of the Education Code shall be considered to have been provided a notice of termination or layoff only upon a district's final decision not to reemploy that person. (g) A notice of termination or layoff that is not followed within 60 days by that termination or layoff shall not be subject to the provisions of this subdivision, and this subdivision shall not apply until receipt of a later notice of termination or layoff. The issuance of frequent notices of termination or layoff to an employee shall be considered a bad faith personnel action and shall make this subdivision inapplicable to the employee. (h) No compensation under this division shall be paid by an employer for a psychiatric injury if the injury was substantially caused by a lawful, nondiscriminatory, good faith personnel action. The burden of proof shall rest with the party asserting the issue. (i) When a psychiatric injury claim is filed

against an employer, and an application for adjudication of a claim is filed by an employer or employee, the division shall provide the employer with information concerning psychiatric injury prevention programs. (j) An employee who is an inmate, as defined in subdivision (e) of Section 3351, or his/her family on behalf of the inmate, shall not be entitled to compensation for a psychiatric injury except as provided in subdivision (d) of Section 3370.

HIPAA RECORDS RELEASED FOR LITIGATION PURPOSES:

HIPAA does not apply, as this is a medical-legal psychological case report subject to perusal by assigned parties. All records that are released to attorneys and insurance companies are in full compliance with said State Laws and thus supersede any HIPPA rules and regulations.

HISTORY OF THE INCIDENT AS REPORTED BY THE PATIENT:

The patient is a 57-year-old male who appeared his stated age. After explaining the process and limitations of confidentiality, we proceeded with the interview.

The patient complains of pain in his upper, mid, and lower back; left hip; bilateral shoulders; bilateral ankles; bilateral foot; right elbow; right hand; right knee; and right arm. Pain has caused him to feel very depressed. He has sleep disturbance, lack of motivation, irritability, low-stress tolerance, anxiety, nervousness, and fear. He is unable to focus or concentrate.

The patient was hired as a Medical Courier with Western Labs Inc. in November 2018. The job duties involved picking up lab work from multiple locations and accounts as well as delivering and picking up supplies. He is currently not employed by the same employer. He is currently not working. He last worked on March 25, 2021.

The following is the history of the injury that the patient reported to me:

The patient reports that two injury dates are being claimed. His first injury occurred on June 4, 2020, when he was ending his shift. He was on his way home in a company car at a stop light on the cross streets of Bushard and Ellis, traveling northbound on Bushard. He was waiting at a stop light when he was rear-ended by a drunk driver. He sustained injuries to his neck, lower back, and right knee. His seat was completely reclined from the impact and he experienced severe pain. He immediately called 911 and Fountain Valley Police Department responded to the scene. The paramedics also responded and treated him and the driver of the other vehicle. After an investigation by the Police Department, the driver was arrested for DUI. The patient was taken to Hoag Hospital's emergency room by a friend and was treated for his injuries. His immediate supervisor, Blake Prewett, was informed of the incident. The following day after the accident, the company's Safety Representative, Angela Roberts, contacted him to begin

the process of Workers' Compensation paperwork and asked him to go see the company-authorized urgent care. Several days after the injury, he returned back to work. He continued to work with physical limitations and his employer did not provide any modified duty.

The patient reports that his second injury occurred on March 23, 2021. He was at the last stop of his route and after opening the door of his company vehicle, as he kneeled down to get in, he felt a very sharp pain in his left hip and inner groin pelvic area. The pain was so intense that he had to sit back for 15 minutes until the pain subsided a little bit. He got to the lab to turn in all the lab work for the day. As he stepped out of the vehicle, he experienced extreme difficulty and pain while trying to walk. For at least two months before this injury, he has been experiencing a lot of discomfort in his left hip area. He believed this resulted from the constant repetitiveness of getting in and out of a small vehicle, 25-35 times a day, 5-6 days a week. He missed a day of work and he advised his employer of his injury but his employer did not send him to urgent care. The following day, he tried to go back to work but was unable to complete his shift and was sent home. He was off work for another couple of days and then took himself to urgent care to get treated for his injury and advised them it was work-related. They kept him off work for a few days and after a few days, he contacted his employer and they arranged for Workers' Compensation paperwork to go to urgent care where he continued to receive treatment and therapy. Presently, he is still experiencing pain from both injury dates and it is progressively worsening.

The patient reports that he experienced unsafe working conditions during the pandemic, as in most cases while working, they were not supplied with PPE required to safely perform their job duties.

The patient reports that he did not experience any physical harassment, unfair criticism, favoritism, demotion, or sexual harassment.

ASSOCIATED PHYSICAL SYMPTOMS:

The patient reports the following physical complaints:

The patient complains of lower back pain, rated as 8/10; neck pain, rated as 6/10; bilateral shoulder pain, rated as 2/10; right arm and wrist pain with tingling and numbness multiple times a day, rated as 4/10; right knee pain, rated as 2/10; left hip pain, rated as 6/10; upper back pain, rated as 2/10; and right leg pain, rated as 4/10.

The patient also complains of arthritis, sciatica, vision problems, fatigue, tremors, cancer, diabetes, sleep disturbances, dental problems, sinus problems, high blood pressure, ringing in the ears/tinnitus, frequent urination, swelling in hands/ankles/feet, numbness, excessive thirst, changes in appetite, weight gain, constipation, and stomach pain. The patient complains of pain in the neck, upper back, mid-back, lower

back, left hip, bilateral shoulders, right elbow, right hand, right knee, bilateral ankles, bilateral foot, and right arm.

ASSOCIATED EMOTIONAL SYMPTOMS:

The patient reports the following emotional symptoms:

The patient reports that he has been experiencing extreme pain which has caused him to feel depressed with emotional distress.

The patient describes his current emotional state as depressed, sad, tearful, tired, insecure, isolated, withdrawn, angry, irritable, fearful, and avoidant. He has a lack of motivation, sleep disturbance, low-stress tolerance, grouchiness, moodiness, lack of sexual desire, anxiety/anxiousness, and nervousness. He cannot concentrate or focus. He has been eating more. He is unsure/fearful about the future.

The patient reports he is depressed about his physical limitations due to his injuries.

The patient reports he is anxious due to the incapability of his future.

The patient reports he is experiencing insomnia as his pain wakes him up multiple times a night and his sleep problems are due to worrying.

The patient reports he is not having interpersonal relationship problems.

CURRENT ACTIVITIES/LIFESTYLE CHANGES:

The patient's current activities/lifestyle changes are as follows:

The patient reports that he does not do much because of his injuries. It is difficult to get through the day because of his pain. His quality of life has been deeply negatively impacted.

The patient reports that his hobby of going to church is very limited. His walking is very difficult. He can no longer play sports because of his pain. He cannot enjoy time with his grandson as he would like to. Standing in social gatherings is difficult.

The patient reports that he has severe difficulty getting restful sleep. He has moderate difficulty with engaging in sexual activity. He has mild difficulty with the ability to remember; the ability to understand and remember detailed instructions, the ability to understand and remember very short and simple instructions; carrying out detailed instructions and maintaining attention and concentration for an extended period of time; the ability to work in coordination with or proximity to others without being distracted by them; ability to complete normal workday and workweek without interruptions from

psychological-based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods; ability to interact appropriately with the general public; the ability to accept instructions and respond appropriately to criticism from supervisor; the ability to travel in unfamiliar places or use public transportation; ability to set realistic goals or make plans independently of others. The patient has no difficulty with the ability to sustain an ordinary routine without special supervision; the ability to make simple work-related decisions; the ability to ask simple questions or request assistance; the ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes; the ability to maintain socially appropriate behavior and to adhere to the basic standards of neatness and cleanliness; the ability to respond appropriately to changes in the work setting; and ability to be aware of normal hazards and take appropriate precautions.

DRUG ABUSE-ALCOHOL-TOBACCO:

The patient does not smoke tobacco. He does not drink alcoholic beverages. He does not smoke marijuana or uses illicit substances.

He denies any history of alcohol or drug abuse.

WORK HISTORY:

The patient was hired as a Medical Courier with Western Labs Inc. in November 2018. The job duties involved picking up lab work from multiple locations and accounts as well as delivering and picking up supplies. He is currently not employed by the same employer. He is currently not working. He last worked on March 25, 2021.

EDUCATIONAL HISTORY:

The patient's highest level of education is grade 12. The patient describes he was athletic and personable in high school.

CURRENT NON-INDUSTRIAL & INDUSTRIAL STRESSORS:

The patient reports difficulties during his childhood as his parents were divorced at an early age.

PAST MEDICAL HISTORY:

The patient is not allergic to any medication, food, etc.

The patient reports that he has type 2 diabetes and colon cancer as serious medical conditions.

The patient reports that he underwent gallbladder removal surgery and partial colon surgery due to cancer.

CURRENT MEDICATIONS:

The patient is currently taking prescription medications by Dr. Saffer including metformin 1000 mg twice a day, glyburide 5 mg twice a day, Jardiance 25 mg once a day, lisinopril 20 mg once a day, and atorvastatin 10 mg once a day.

PSYCHOLOGICAL HISTORY:

The patient reports that he has never received any psychological evaluation or treatment for any reason prior to his work injury. He has never sought psychological treatment for any reason aside from this work injury. He has been prescribed Xanax for depression by the doctor. He has never experienced similar symptoms of stress, anxiety, or depression before this work injury.

PREVIOUS LEGAL HISTORY:

The patient had a Workers' Compensation claim which was immediately settled due to the company went bankrupt. He was involved in a lawsuit that was immediately settled due to the company was going bankrupt.

The patient has never had any previous legal problems. He has never been charged with drunk driving. He has never been arrested, convicted of a crime, or spent time in jail or prison.

PREVIOUS MEDICAL TREATMENT:

The patient reports that he received physical therapy and acupuncture recommended by Dr. Komberg in April 2021.

The patient reports that he has been seen by Dr. Dizay, an orthopedist, in the City of Garden Grove on January 24, 2022. He is currently not being treated by a personal or family physician.

The patient is currently not receiving any treatment.

FAMILY MEDICAL/PSYCHIATRIC HISTORY:

The patient reports that his family medical history is unknown as he was adopted at birth.

SOCIAL HISTORY:

The patient was born on July 30, 1964, in Torrance, California. He was raised by his adoptive parents. He does not know about the marital status of his birth parents. He does not know about his biological parents. He has a half-brother, Big Fork (age 72), who lives in Montana.

The patient reports that he was never married. He is currently single. He does not live with his significant other. He describes his current attitude toward sexual activity as poor.

The patient has one son, Martin R. Lugo Jr. (age 25). He has a good and loving relationship with his child. He spends quality time with his son. He currently lives alone. His son lives in Huntington Beach, California.

The patient's current source of income is Workers' Compensation benefits of $580 every 2 weeks since April 2021.

MEDICAL RECORDS REVIEWED:

None are present; however, should they become available, we will be happy to review them.

MENTAL STATUS EXAMINATION:

The patient impressed me as a credible, reliable historian of industrial events and their sequelae. There was no evidence of rambling, pressured, or retarded speech patterns in general.

The immediate stream of thought was rational, relevant, and coherent. Associations were tight. There was no evidence of flight of ideas, fragmentation of thought processes, circumstantial or tangential. There was no indication of significant memory deficits.

Assessment of reality was within normal limits.

There was no indication of psychotic thought processes, such as hallucinations, delusions, or ideas of reference. The patient was oriented to person, place, time, and situation. Sensorium was clear. Insight and judgment were adequate.

MENTAL STATUS EXAM SCALE:

A 0-5 scale is used below to quantify the patient's level of depression and anxiety. The number translates as follows:

0	None	No Discomfort
1	Minimal	Causing Discomfort
2	Slight	Detectable Discomfort
3	Moderate	Noticeable Discomfort
4	Moderate to Severe	Marked Discomfort
5	Severe	Unable to Perform Work Function

Pt.'s Presenting Depressive Affect: 3
Pt.'s Presenting Anxiety Affect: 3

PSYCHOLOGICAL TESTING:

The following tests are given at this Clinic as part of the evaluation. In accordance with the guidelines specified in the Administrative Director's "Psychiatric Protocols", they are utilized mainly as screening instruments. The information obtained from the test results is helpful in the development and implementation of a treatment plan. These tests are all structured, standardized measurement devices that assist in diagnostic information in validity/malingering, activities of daily living, and physical symptoms and provide objective medical substantial evidence.

TESTING:

Total hours of psychological testing, scoring, and interpretation: 8 hours.

TESTS ADMINISTERED:

The Beck Depression and Hopelessness Survey: 0.30 hrs.
The Beck Anxiety Survey: 0.30 hrs.
Suicide Probability Scale: 0.30 hrs.
Wahler Physical Symptoms Inventory: 0.75 hrs.
Minnesota Multiphasic Personality Inventory-2: 2.5 hrs.
Trauma Symptoms Inventory: 0.30 hrs.
Malingering Probability Scale: 0.75 hrs.
Mental Status Checklist: 0.30 hrs.
Clinical Interview: 1.30 hrs.

EXPLANATION OF TESTS:

Beck Anxiety Inventory (BAI):

The Beck Anxiety Inventory is a 21-question self-report inventory, which asks the patient to choose from a hierarchy of levels of anxiety-related symptomatology for each question. This is a self-rating device to delineate the nature, intensity, and frequency of anxiety-related symptomatology.

Beck Depression Inventory (BDI):

The Beck Depression Inventory (BDI) has been widely used for the assessment of cognition associated with depression for both psychiatric patients as well as depression in healthy individuals. It has been found to detect depression as well as longer and more structured interviews (Groth-Marnat, 1999). The 21 items in the BDI relate to such areas as a sense of failure, guilt feelings, irritability, sleep disturbance, and loss of appetite.

Suicide Probability Scale (SPS):

The SPS is designed to assess the risk of suicidal behavior. It consists of 36 items representing clinical markers of suicide risk. Indicators include interpersonal isolation, isolation, feelings of hopelessness, and impulsivity. The Scale is widely used in clinics, emergency rooms, inpatient settings, and suicide prevention programs.

Wahler Physical Symptoms Inventory:

This measure is designed to elicit information that suggests the degree of the patient's preoccupation with physical symptoms.

Malingering Probability Scale:

The Malingering Probability Scale is used to assess dissemination effects on memory tests and exaggeration or feigning of memory complaints. It serves as a check to determine if other test results in the neuropsychological battery might be affected by the subject's malingering, fabricating, or other deliberate attempts to manipulate the testing process for the subject's own gain.

The Minnesota Multiphasic Personality Inventory-2 (MMPI-2):

This test is a true-false self-report personality inventory. It provides an understanding of a wide range of personality traits and symptom patterns. The MMPI-2 instrument consists of 568 items that are classified into profiles reflecting one's personality type as well as including scales specifically designed to measure malingering.

Trauma Symptom Inventory (TSI):

TSI is a 100-item test of posttraumatic stress and other psychological sequelae of traumatic events.

Mental Status Checklist for Adults (MSC-A):

The Adult version of the Mental Status Checklist (MSC) was developed as an aid for the completion of a thorough intake or mental status examination. It is intended as a survey measure to assist in the review of those topics which have traditionally been addressed in the mental status examination including a neurological assessment consisting of person, place, and time; impaired memory, and/or cognitive impairment.

Mr. Martin's **Scores Follow:**

Beck Depression Inventory	36	Beck Anxiety Inventory	39

Suicide Probability Scale		
Suicide Risk	0	No

Wahler Physical Symptoms Inventory	
Patient's Preoccupation Level	Moderate

Nausea, headaches, neck aches or pains, upper back, mid back, lower back, feeling hot or cold regardless of the weather, arm or leg aches or pains, shakiness, swelling of arms, hands, legs, or feet, difficulty sleeping, backaches, intestinal or stomach trouble, trouble with teeth, numbness, or lack of feeling in any part of the body, aches or pains in hands or feet, abnormal blood pressure, burning, tingling or crawling, skin trouble (rashes, boils or itching), feeling tired, muscle weakness, dizzy spells, muscular tension, difficulty breathing (shortness of breath, asthma, etc), twitching muscles, poor health in general, excessive gas, gaining weight, bowel trouble (constipation or loose bowels), chest pain, and hay fever or other allergies.

MMPI-2 T Scores							
L	55	MM/DD/YYY Y	80	Pa	79	Si	52
F	65	Hy	61	Pt	61		
K	49	Pd	54	Sc	55		
Hs	53	Mf	55	Ma	54		

Malingering Probability Scale			
Profile Consistent With:	Malingering	**X**	Non-Malingering

Mental Status Checklist for Adults (MSC-A) (Summarized)		
The patient scores on the Mental Status Checklist for Adults suggest that the patient is experiencing a severe degree of situational anxiety, stress, and depressed mood. The level of responsiveness was worried and anxious, the level of distress was severe, and the patient expressed a moderate degree of somatic concerns.		
Trauma Symptom Inventory (TSI)		
Suggestive of PTSD:	Yes	X No

COMMENTS ON TESTING:

The patient's Depression Inventory-II shows severe depression and his Beck Anxiety Inventory scores show severe anxiety.

There is no concern for suicidal ideation at this time based on the SSPS.

The patient's results of the Wahler Physical Symptoms Inventory reflected a moderate level of concern for nausea, headaches, neck aches or pains, upper back, mid back, lower back, feeling hot or cold regardless of the weather, arm or leg aches or pains, shakiness, swelling of arms, hands, legs, or feet, difficulty sleeping, backaches, intestinal or stomach trouble, trouble with teeth, numbness, or lack of feeling in any part of the body, aches or pains in hands or feet, abnormal blood pressure, burning, tingling or crawling, skin trouble (rashes, boils or itching), feeling tired, muscle weakness, dizzy spells, muscular tension, difficulty breathing (shortness of breath, asthma, etc), twitching muscles, poor health in general, excessive gas, gaining weight, bowel trouble (constipation or loose bowels), chest pain, and hay fever or other allergies.

The validity configuration on the MMPI-2 reflected an L scale score of 55, an F scale score of 65, and a K scale score of 49, reflecting an appropriate balance between admitting and denying social faults. He made no attempt to either feign or exaggerate symptoms. The elevated D scale suggests the presence of moderate depression, worry, and somatic complaints. The elevation on the Pa scale reflects interpersonal sensitivity, guardedness, feeling mistreated, suspiciousness, and mistrust, entirely consistent with the nature of the work-related stress and the workers' compensation system itself would also cause a normative increase in Pa of being in a litigious case in addition to anxiety, tension, insomnia, and chronic worry. The testing performed is suggestive and consistent with his history and diagnosis.

The Malingering Probability Scale was not indicative of malingering.

The patient scores on the Mental Status Checklist for Adults suggest that the patient is experiencing a severe degree of situational anxiety, stress, and depressed mood. The level of responsiveness was worried and anxious, the level of distress was severe, and the patient expressed a moderate degree of somatic concerns.

DSM-IV-TR and 5 DIAGNOSES:

Axis I:	309.81	(F43.10)	Posttraumatic stress disorder
	338.4	G89.4	Chronic pain disorder
	780. 52	(G47.00)	Insomnia disorder

Axis II: (V71.09) No Diagnosis

Axis III: Description of physical disorders: Nausea, headaches, neck aches or pains, upper back, mid back, lower back, arm or leg aches or pains, shakiness, swelling of arms, hands, legs, or feet, difficulty sleeping, backaches, intestinal or stomach trouble, trouble with teeth, aches or pains in hands or feet.

Axis IV: No longer used.

Axis V: Current GAF: 58

Workers' compensation still requires us to use GAF from DSM IV in order to have a WPI number: WPI = 18%.

Global Assessment of Functioning (GAF) Scale
(From DSM-IV-TR, p. 34.)

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness.

91-100 Superior functioning in a wide range of activities, life's problems never seem to | get out of hand, is sought out by others because of his/her many positive qualities. No symptoms.

81-90 absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities. Socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family members).

71-80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after a family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).

61-70 **some mild symptoms** (e.g. depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household)**, but generally functioning well, and has some**

meaningful interpersonal relationships.

51-60 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

41-50 Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

31-40 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., a depressed person avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

21-30 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).

11-20 some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

1-10 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

GAF=58 WPI=18

California GAF to WPI table from the SCHEDULE FOR RATING PERMANENT DISABILITIES, January 2009: Psychiatric Impairment GAF to WPI Conversion						
GAF=WPI	GAF=WPI	GAF=WPI	GAF=WPI	GAF=WPI	GAF=WPI	GAF=WPI
1 = 90	2 = 89	3 = 89	4 = 88	5 = 87	6 = 87	7 = 86
8 = 85	9 = 84	10 = 84	11 = 83	12 = 82	13 = 82	14 = 81
15 = 80	16 = 80	17 = 79	18 = 78	19 = 78	20 = 77	21 = 76
22 = 76	23 = 75	24 = 74	25 = 73	26 = 73	27 = 72	28 = 71
29 = 71	30 = 70	31 = 69	32 = 67	33 = 65	34 = 63	35 = 61
36 = 59	37 = 57	38 = 55	39 = 53	40 = 51	41 = 48	42 = 46
43 = 44	44 = 42	45 = 40	46 = 38	47 = 36	48 = 34	49 = 32
50 = 30	51 = 29	52 = 27	53 = 26	54 = 24	55 = 23	56 = 21

57 = 20	58 = 18	59 = 17	60 = 15	61 = 14	62 = 12	63 = 11
64 = 9	65 = 8	66 = 6	67 = 5	68 = 3	69 = 2	>70 = 0

DSM-5 CRITERIA:

The patient met the following diagnostic criteria:

Based on all the information currently available to me, including the patient's history, results of routine psychological testing, and my clinical impressions; his symptoms meet the full criteria.

Posttraumatic Stress Disorder

PTSD state as specified is a DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th Ed.) diagnosis assigned to individuals who have PTSD symptoms are characterized by having directly experienced the traumatic event(s) with marked physiological reactions to internal or external cues that resemble an aspect of the traumatic event(s). Symptoms may include; experiencing avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s); exaggerated negative beliefs or expectations about oneself, others, or the world, distorted cognitions about the cause that lead the individual to blame himself/herself or others; negative emotional state (e.g., fear, horror, anger, guilt, or shame); diminished interest or participation in significant activities; feelings of detachment and inability to experience positive emotions; problems with concentration and sleep disturbance. Symptoms clinically impair social, occupational, or other important areas of functioning.

Chronic Pain Disorder

This is a condition in which individuals have somatic symptoms associated with significant distress and impairment. This diagnosis is made on the basis of positive symptoms and signs (distressing somatic symptoms plus abnormal thoughts, feelings, and behaviors in response to these symptoms). If there is a somatic component (as opposed to an objective explanation) for chronic pain, then the somatic component adds severity and complexity to anxiety and depressive disorders and results in higher severity, functional impairment, and even refractoriness to traditional treatments.

Insomnia Disorder:

Insomnia Disorder is a DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th Ed.) diagnosis assigned to individuals who have difficulty falling asleep and/or remaining asleep at least 3 nights a week, for at least 3 months. The individual is likely to feel unrefreshed upon awakening and experience fatigue throughout the day. The

sleep disturbance causes clinically significant distress or impairment in social, occupational, educational, academic, behavioral, or other important areas of functioning.

CAUSATION:

Following careful psychological evaluation, I have determined that events that occurred at work and their sequelae appear to be AOE/COE and were the predominant (>51%) to all the causes combined to have produced a psychological injury. This injury does meet requirements under section 3208.3 for the predominant cause. The injury caused symptoms of Posttraumatic stress disorder.

I have used the AMA guidelines, which is the standard at this time, the American College of Occupational, Environment Medicine Guidelines, as well as the Guides to the Evaluation of Permanent Impairment (5th Edition, 2001) by the AMA, as well as the DSM-5 for diagnosis and DSM IV-TR for the GAF. I have also read extensively on Lexus-Nexus regarding Benson, Almaraz, Guzman and Rolda, Hikida; Brower; Larsen.

ASSESSMENT OF DISABILITY:

The patient is unable to perform his usual work.

TREATMENT RECOMMENDATIONS/PSYCHOLOGICAL CARE:

Biofeedback therapy is helpful in this type of treatment per the ODG guidelines, and I will use an emotionally focused therapy approach. I recommend weekly CBT and Biofeedback therapy sessions for three months. Psychological Testing, BDI & BAI, every other week for three months to measure progress. A referral to a psychiatrist for psychotropic medication, and I consider a referral to an orthopedic doctor for orthopedic complaints.

This type of multidisciplinary approach is the optimum intervention as defined in the California Workers Compensation Code and is also consistent with the ACOEM Guidelines adopted by SB 899. According to the Guidelines, the goals of recovery are multiple. They include: interdiction of chronicity, interdiction of fear-avoidance behavior (p. 91, 113)[1], interdiction of delayed recovery (p. 91, 362)[1], interdiction of Somatization (p. 108)[1], interdiction of functional disability (pp. 76, 78, 91, 113)[1], decreased pain perception (p. 117)[1], decreasing depression and other maladaptive behaviors (pp. 108, 109, 114, 388, 400)[1]. The final goal is to build tolerance for intolerable emotional pain and physical suffering. This treatment is considered reasonable and necessary to treat industrial injury.

ODG Psychotherapy Guidelines:
Up to seven to 20 weeks initially with up to 50 visits per year per the guidelines to be documented and assessed for efficacy.

With evidence of functional improvement to be reevaluated every 45 days per the PR-2's.

Emotion-Focused Therapy:

The theory features four types of emotional response, categories, needs under attachment' and 'identity' specifies four types of emotional processing difficulties, delineates different types of empathy, has at least a dozen different task markers, relies on two interactive tracks of emotion and narrative processes as sources of information about a client, and presumes a dialectical- constructivist model and an emotional schematic system.

The emotion schematic system is seen as the central catalyst of self-organization, often at the base of dysfunction and ultimately the road to a cure. For simplicity, we use the term emotion schematic process to refer to the complex synthesis process in which a number of co-activated emotion schemes co-apply, to produce a unified sense of sense in relation to the world. Goldman, Rhonda N.; Greenberg, Leslie S. (2015) case formulation in emotion-focused therapy: co-creating clinical maps for change. Washington D.C.: American Psychological Association. ISBN 97814338188202.

FUNCTIONAL CAPACITIES:

1) Ability to engage in Routine Activities of Daily Living. This includes activities such as self-care, personal hygiene, communication, ambulation, travel, sexual functioning, and sleep. Limitations in this area are assessed only as they relate to the mental disorder, rather than to other factors such as physical illnesses or conditions, lack of funds, or lack of transportation. It is necessary to define the extent to which the individual can engage in these activities without supervision or direction. Moderate impairment.

2) Social Functioning: This includes the ability to interact appropriately and communicate with others, such as with family members, friends, neighbors, grocery clerks, landlords, and bus drivers. Impaired social functioning is demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, and social isolation. In work settings, this domain includes the ability to respond appropriately to supervisors and work as part of a team. Moderate impairment.

3) Memory, Concentration, Persistence, and Pace: This includes the ability to sustain attention long enough to permit the timely completion of tasks commonly found in activities of daily living, or work tasks. Strengths and weaknesses in concentration and memory may be accessed through an assessment of the patient's performance on

tasks requiring short-term memory, or tasks that must be completed within a certain time limit. Moderate impairment.

4) Deterioration or Decompensation in Complex or Work-like Settings (Adaptation to stressful circumstances): This refers to the individual's ability to adapt to everyday work demands, such as attendance, making decisions, scheduling, completing tasks, and interacting with supervisors and coworkers. Impairment in this area is noted if the patient withdraws from everyday stressful situations, experiences a decline in the ability to perform activities of daily living withdraws from social relationships, or fails to complete tasks. Moderate impairment.

CLASSES OF IMPAIRMENT:

The AMA Guides indicate, in Section 14.4, that the severity of impairment due to mental disorders must be assessed with reference to a variety of factors, including the effects of treatment, the effects of structured settings (if relevant), and the type of mental disorder that is diagnosed.

For each of these four areas of functioning described above, the patient is rated on a five-category scale that describes classes of impairment (Table 14-1 of the AMA Guides). These classes are:

Class 1: No Impairment.

Class 2: Mild Impairment: Impairment levels that are compatible with most useful functioning.

Class 3: Moderate Impairment: Impairment levels that are compatible with some, but not all, useful functioning.

Class 4: Marked Impairment: Impairment levels significantly impede useful functioning.

Class 5: Extreme Impairment: Impairment levels preclude useful functioning.

In the patient's case, based on the results of the clinical interview, mental status examination, psychological testing, and record review, I have determined that he is ratable as follows:

1) Activities of Daily Living-Moderate. The patient has a Class 3 impairment. He does not get a resful sleep and sleepiness interferes with his ability to engage in most activities of daily living.

2) Social Functioning-Marked. The patient has a Class 3 impairment. He spends the majority of time at home he would isolate. He attends church very limited, he can no

longer play sports. Family relationships have become more distant because of his preoccupation with his difficulties and pain.

3) Memory, Concentration. Persistence and Pace-Marked. The patient has a Class 3 impairment. He has much difficulty remembering, concentrating, and focusing his attention.

4) Deterioration or Decompensation in Work or Work-Like Settings-Marked. The patient has a Class impairment. He is vulnerable to stress and has difficulty handling routine stresses and transitions. He has difficulty to traveling to unfamiliar places or use public transportation and the ability to set realistic goals or make plans independently of others.

APPORTIONMENT:

Based on my review, Issues of Apportionment are deferred until he is at Maximum Medical Improvement. There does not appear to be apportionment in this case; however, I will defer until he reaches.

Following careful psychological evaluation, I have determined that events that occurred at work and their sequelae appear to be AOE/COE and were the predominant (>51%) to all the causes combined to have produced a psychological injury. This injury does meet requirements under section 3208.3 for the predominant cause.

PROPRIETARY INTEREST:

I have no ownership of any of the laboratories, pharmacies, MRI offices, and/or clinics of healthcare facilities that may have been used in the evaluation.

RELATED MEDICAL RESEARCH

The following research literature provides medical evidence that the treatment modalities that I have recommended for this patient, Including cognitive-behavioral and individual/group supportive psychotherapy, relaxation training, hypnosis, and a combination of psychotherapy and psychotropic medications prescribed by a psychiatrist, are reasonable and necessary for the treatment of patient's emotional symptomatology and persistent chronic pain.

ACOEM's Occupational Medicine Practice Guidelines
"The psychology literature contains much information about meditation, relaxation techniques, and biofeedback for stress and anxiety using these techniques can be Preventive or helpful for patients with specific physiologic responses to stress. Relaxation techniques include meditation, relaxation response, and progressive

relaxation. These techniques are advantageous because they may modify the manifestations of daily, continuous stress."

Experimental subjects suffering from chronic pain and treated in a multimodality-based setting, including the provision of psychotherapy, reported Jess pain, better control over pain, more pleasurable activities and feelings, less avoidance, and less catastrophizing. In addition, disability was reduced in terms of social roles, physical functions, and mental performance. (Basler HD, Jakle C, Kroncr-Herwig B. Incorporation of cognitive-behavioral treatment into the medical care of chronic low back patients: a controlled randomized study in German pain treatment centers. Patient Educ Couns. 1997; 31(2): 113-24.)

Farrugia, D. & Fetter, H. (2009). Chronic pain: Biological understanding and Treatment suggestions for mental health counselors. Journal of Mental Health Counseling, 31, 189-200.

There is abundant research to support the effectiveness of psychological intervention for chronic pain, especially the application of cognitive-behavioral techniques (Turk, D., & Gatchel, R. (Eds.). (2002). Psychological approaches to pain management: A practitioner's handbook. New York: Guilford Press). More than any other counseling approach, the effectiveness of cognitive-behavioral therapy (CBT) in the management and amelioration of chronic pain has been supported and empirically tested by outcome-based research (Thron, B. (2004). Cognitive therapy for chronic pain. New York: Guilford Press, Turk, D, & Gatchel, R. (Eds.). (2002). Psychological approaches to pain management. A practitioner's handbook. New York: Guilford Press). The goals of CBT are to moderate the demoralizing and potentially depressive experiences of the person in chronic pain and to encourage self-efficacy through psychological and physical behaviors that help enhance treatment outcomes (Turk, D. (2002). biopsychosocial perspective on chronic pain. In D. Turk & R. Gatchel (Eds.), Psychological approaches to pain management: A practitioner's handbook (pp. 138-158). New York: Guilford Press). **Pavlek, M. (2008). Paining out: An integrative pain therapy model. *Clinical Social Work Journal, 36:* 385-393.**

In recent years, leading pain-management centers, Centers for Mind-Body Medicine, and Centers for Complementary and Alternative Medicine (CAM) have been addressing the complexity of chronic pain by focusing on holistic, integrative approaches based on biopsychosocial modalities, mind-body healing, and alternative medicine (Caudill 1995; Osborne et al. 2006; Roclofs et al. 2002; Sandmaier 2000; Secor et al. 2004; Wallis 2005). The following modalities are effective in pain management: cognitive-behavioral therapeutic models for chronic pain (Caudill 1995; Grant and Havercamp 1995; Osborne et al. 2006), progressive relaxation (Hammond 1990; Shaw and Erlich 1987),

and clinical hypnosis for chronic pain (Barber 1996; Hammond 1990; Erickson 1994; Erickson et al. 1990; Erickson et al. 1976; Rossi and Cheek 1988). Recently, leading pain-management centers for Mind-Body Medicine and Centers for Complementary and Alternative Medicine (CAM) has been treating chronic pain through integrative approaches. Such integrative approaches are based on biopsychosocial modalities, mind-body healing, and alternative medicine (Caudill 1995; Osborne et al. 2006; Roelofs et al. 2002; Sandmaier 2000; Secor et al. 2004; Wallis 2005). These approaches support that pain has to be understood and dealt with as a complex mind-body phenomenon that impacts a person's physical, mental, social, and emotional functioning (Barber 1996; Bloch 2000; Caudill 1995; Erickson 1994; Hammond 1990; Harma ct al. 2002; Ohayon and Schatzberg 2003; Rossi and Cheek 1988). Previous research reveals that cognitive-behavioral therapy (CBT), clinical hypnosis, and progressive relaxation have been effective modalities of treatment for chronic pain (Caudill 1995; Grant and Havercamp 1995; Osborne et al. 2006; Hammond 1990; Shaw and Erlich 1987; Barber 1996; Hammond 1990; Erickson 1994; Erickson et al. 1990; Erickson et al. 1976; Rossi and Cheek 1988).

Farrugia, D. & Fetter, H. (2009). Chronic pain: Biological understanding and treatment suggestions for mental health counselors. Journal of Mental Health Counseling, 31, 189-200.

"Numerous counseling strategies have been used successfully with persons who experience acute as well as chronic pain. A recent meta-study found that cognitive-behavioral therapy, behavioral techniques, self-regulatory techniques such as hypnosis and relaxation training, and general supportive counseling all proved not only helpful for clients coping with chronic pain but also reduced pain intensity. (Hoffinan, B., Papas, R., Chatkoff, D., and Kerns, R. (2007). A meta-analysis of psychological interventions for chronic low back pain. Health Psychology, 26, 1-9).

Treatment with psychotherapy has also been shown to cause a decrease in the degree to which pain interferes with activity, increasing the ability to cope with pain, and allowing a decreased use of some medications and other physical treatments (Puder RS. Age analysis of cognitive-behavioral group therapy for chronic pain patients. Psychol Aging. I988; 3 (2): 204-7.)

Patients with mental disorders due to injuries involving pain and stress require the fellowship and spiritual elevation of group encounters with like members just as substance abuse and other medical condition patients require AA meetings or medical

condition support groups with human contact to help offset isolation, depression, and medical and emotional regression.

The following evidence in the literature documents the effectiveness of individual and group psychotherapy in chronic pain patients:

a) Gamsa A, Braha RE, Catchlove RF, The use of structured group therapy sessions in the treatment of chronic pain patients. Pain 1985; 22(1), 91-6.; Spence SH.

b) Cognitive-behavior therapy in the treatment of chronic, occupational pain of the upper limbs; a 2-year follow-up. Behav Res Ther. 1991; 29(5): 503-9.; Basler HD.

c) Group treatment for pain and discomfort. Patient Educ Couns.1993; 20(2-3): 167-75.; Li EJ, Li-Tsang CW, Lam CS, Hui KY, Chan CC.

d) The effect of a "training on work readiness" program for workers with musculoskeletal injuries: a randomized control trial (RCT) study. J Occup Rehabil 2006; 16(4): 529-41.; Thorn BE, Kuhajda MC

e) Group cognitive therapy for chronic pain. J Clin Psychol. 2006; 62(11):1355-66.)

Pavlek, M. (2008), Paining Out: An Integrative Pain Therapy Model. Clinical Social Work J, 36, 385-393.
The hypnotic phenomenon has been applied for many eras and by various cultures as a healing mechanism. The use of hypnosis first started with Franz Mesmer (1734-1815) (Battino and Thomas 1999; Erikson et al. 1990). One of the first times hypnoses was used to treat pain was in 1845 by Esdaile (1957). He was working as a surgeon in India and used hypnosis for surgical anesthesia and analgesia. In the past decade, clinical hypnosis has gained more recognition as a beneficial pain therapy tool. In 1995, A National Institute of Health (NIH) census found that clinical hypnosis is a reliable and effective modality for treating chronic and acute pain symptoms.

Aladdin, A. and Alibhai, A (2007), Cognitive hypnotherapy for depression: an empirical investigation. Intl. Journal of Clinical and Experimental Hypnosis, 55(2), 147-166. There are six clinical reasons for utilizing hypnosis with depression: (a) hypnosis amplifies subjective experience, (b) hypnosis serves as a powerful method for interrupting symptomatic patterns, c) hypnosis facilitates experiential learning, (d) hypnosis helps to bridge and to conceptualize responses', e) hypnosis provides different models of inner reality and f) hypnosis helps to establish the focus of attention. Yapko,

M.D. (1992). Hypnosis and the treatment of depressions: Strategies for change. New York: Brunner/Mazel, The rationale for inducing hypnotic trance is to produce relaxation, somatosensory changes, and a sense of control. In a research study, the participants who attended the cognitive hypnotherapy group became intrigued that for the first time in their lives, they were able to relax completely, replace their depressive feeling with a good feeling, and felt empowered to realize that their "mind is so powerful." Hypnotherapists routinely observe such changes in their patients. This study reveals that the addition of hypnotherapy, an extra component to CBT, which largely focuses on changing behaviors and automatic thoughts, enhances treatment outcomes.

The following research literature has found that cognitive therapy significantly improves symptoms compared with no treatment:

a) Gloaguen V, Cottraux J, Cucherat M, et al., A meta-analysis of the effects of cognitive therapy in depressed people 1998. JAffect Disord 1998; 49:59-72. Search date not stated; primary sources Medline, in the base, references in books and papers, previous reviews and meta-analyses, abstracts from congress presentations, and preprints sent by authors).

b) Elkin I, Shea MT, Watkins JT, et al. National Institute of Mental health treatment of depression and collaborative research program: general effectiveness of treatments. Arch Gen Psychiatry 1989; 46:971-982.

c) Mynors-Wallis LM, Gath DH, Lloyd-Thomas AR, et al. controlled trial comparing problem-solving treatment with amitriptyline and placebo for major depression in primary care. BMJ 1995; 310:441-445.

d) Dowrick C, Dunn G, Ayuso-Matcos JL, et al. Problem-solving treatment and group psychoeducation for depression: multicenter randomized controlled trial, BMJ 2000; 321: 1450-1454.

e) Bower P, Rowland N, Mellor Clark J, et al. Effectiveness and cost-effectiveness of counseling in primary care. In: The Cochrane Library, Issue 2, 2002, Oxford: Update Software. Search date 2001; primary sources Medline, Embase, Psychlit, Cochrane Controlled Trials Register; CCDAN trials register, personal contact with experts and CCDAN members, a search of unpublished sources (clinical trials, books, dissertations, agency reports, etc.), and hand searches of one journal and reference lists.

The following research literature substantiates that in patients with mild to severe depression, psychotherapy in addition to antidepressant medication is more useful/effective than either treatment alone:

a) Thase ME, Greenhouse JB, Frank E, et al. Treatment of major depression with psychotherapy or psychotherapy- pharmacology combinations. Arch Gen Psychiatry 1997; 54:1009-1015. Pooled results of six research protocols conducted 1982-1992 at the Mental Health Clinical Research Center, University of Pittsburgh School of Medicine.

b) Keller MB, McCullough JP, Klein DN, et al. A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy and their combination for the treatment of chronic depression. N. Engl J Med 2000; 342:1462-1470.

c) DeJonghe F, Kool S, Van Aalst G, Dekker J, Peen J. Combining psychotherapy and antidepressants in the treatment of depression. JAffect Discord 2001; 64:217-299.

Gould RA, Otto MW, Pollack MH, et al. pharmacological treatment of generalized anxiety disorder: a preliminary meta-analysis. Behav Res Ther 1997; 28:285-305. Search date1996; primary sources Psychlit, Medline, examination of reference lists and unpublished articles presented at national conferences.13.Cognitive-behavioral and The following ODG, APA, ACOEM Guidelines, and research literature provide medical evidence that the treatment modalities and the length of treatment recommended for this patient are reasonable and necessary.

ODG Treatment, Integrated Treatment/Disability Duration Guidelines, Pain (Chronic) (updates 12/08/09) Behavioral interventions: Recommended. The identification and reinforcement of coping skills are often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. Several recent reviews support the assertion of the efficacy of cognitive-behavioral therapy (CBT) in the treatment of pain, especially chronic back pain (CBP).

The APA Practice Guidelines for Major Depression indicate that factors of patient preference and social issues should be considered for the provision of treatment plus medication management treatment. As well, in cases of persistent Major Depression, the Practice Guidelines do not provide for the discontinuation of either modality of treatment, either psychotherapy or medication. In other words, a numerical constriction of the number of psychotherapy or medication visits with the doctor would not be consistent with the standard of care for Major Depression according to the APA Practice Guidelines: "If the patient is symptomatic, the treatment should be continued."

In treating depression, continuation treatment has been found to be effective in preventing relapse (Loonen AJ, Peer PG, Zwanikken GJ. Continuation and maintenance therapy with antidepressive agents: a meta-analysis of research. Pharm Week Sci 199I; 13:167-175. Search date not stated; primary sources references of textbooks and review articles, Medline, Embase, and review of reference lists of primary studies).

ACOEM Guidelines,
If personal or psychological factors contribute to delayed recovery, psychological, psychiatric, or other behavioral help, intervention is appropriate. Continuing medication, physical therapy, or surgery without appropriate psychological support in the face of treatment failure creates the expectation of disability.

ACOEM Guidelines,
Treatment of chronic pain requires specialized knowledge, substantial time, and access to **multidisciplinary care**. Judicial involvement of other professionals, such as psychologists, exercise and physical therapists, and other health care professionals, who can offer **extra physical or mental therapy** while the physician continues to orchestrate the whole therapeutic process can be helpful.

Chronic Pain Medical Treatment Guidelines, 8 C.C.R. ss9792.20-9792.26, MTUS (effective July 18, 2009)
"Recommended: Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are pre-existing, aggravated by the current injury, or work-related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. (Main-BMJ, 2002) (Colorado, 2002) (Gatchel, 1995) (Gatchel, 1999) (Gatchel, 2004) (Gatchel, 2005) In a large RCT, the benefits of improved depression care (antidepressant medications and/or psychotherapy) extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status, (Lin-JAMA, 2003)"

ACOEM Guidelines 2004 Second Edition, Chapter 15, Stress-Related Conditions,
"Referral for mental health professional assessment may be considered for patients who anticipated absent from work will exceed one week.

ACOEM Guidelines 2004 Second Edition, Chapter 15, Stress-Related Conditions, "Serious conditions such as serious depression and schizophrenia be defended to a specialist, while common psychiatric conditions, such as mild depression, are referred to a specialist after symptoms continue for more than six to eight weeks. The practitioner should use his or her best professional judgment in determining the type of specialist.

CONCLUSION:

In conclusion, here are the following items I have addressed in this report:

1. DIAGNOSES: The patient's clinical picture supports the following diagnoses: posttraumatic stress disorder, chronic pain disorder, and insomnia disorder.

2. CAUSATION: Following careful psychological evaluation, I have determined that events that occurred at work and their sequelae appear to be AOE/COE and were the predominant (>51%) to all the causes combined to have produced a psychological injury. This injury does meet requirements under section 3208.3 for the predominant cause.

3. MAXIMUM MEDICAL IMPROVEMENT: The patient's psychological condition has not yet reached the point of maximum medical improvement.

4. GAF: 58.

5. WHOLE PERSON IMPAIRMENT: 18%.

6. APPORTIONMENT: Based on my review, Issues of Apportionment are deferred until she is at Maximum Medical Improvement.

7. TREATMENT RECOMMENDED: . I recommend weekly CBT and Biofeedback therapy sessions for three months. Psychological Testing, BDI & BAI, every other week for three months to measure progress. A referral to a psychiatrist for psychotropic medication, and I consider a referral to an orthopedic doctor for orthopedic complaints.

8. PROGNOSIS: I would consider the patient's prognosis to be fair with the institution of the recommended treatment.

Sincerely,

Julie Goalwin, Ph.D.
Clinical Psychologist
License#: PSY#14146

cc: Diane Noble, Gallagher Bassett, P.O. Box 2840, Clinton, IA 52733

Natalia Foley, Workers Defenders Law Group, 751 S. Weir Canyon, Suite 157-455, Anaheim, CA 92808

Ellen T. Dugan, Esq. Wall McCormick Baroldi & Dugan PC P.O. Box 1619 Santa Ana, Ca 92702

DECLARATION

Pursuant to the requirements set forth in Labor Code Section 4906 G, I declare that I have not violated section 139.3 of the California Labor Code. I have not offered, delivered, received, or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or any other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

I declare under the 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, as to the information that I have indicated I received from others. As to that information, I declare under the penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe to be true.

The psychological tests are self-administered. The tests are handed to the applicant by one of the clerical staff. Instructions are included on the tests themselves. All the tests were scored and interpreted by me without the use of inside or outside computers. I dictated and reviewed this report.

Except as otherwise stated herein, the evaluation was performed, and the time spent performing the evaluation was in compliance with the guidelines if any, established by the WC Medical Unit or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5370.6 of the California Labor Code. Please be advised that the itemization of the fees for this report is attached in a separate statement. Additional fees may be required for more extensive reports or more complex situations.

Please refer to the attached itemization of charges.

I further declare under the penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 and that the information. Contained in this report and its attachments, including billing, if any, is true and correct to the best of my knowledge and belief, except as to the information I have 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.

"I have not violated Labor Code 139.3 and the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury."

Dated the 30th day of July 2022, in Los Angeles County, California.

PROOF OF SERVICE BY MAIL

Re: Martin Lugo
Claim No. 005834-002603-WC-01
DOI: CT: 01/01/2019-04/05/2021
WCAB No. ADJ14468138

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: 115 Pine Ave. #640, Long Beach, CA 90802.

I served the following documents:

Initial Psychological Comprehensive Med-Legal Report on 6/24/2022

On the interested parties in this action by placing the true copy of each document in a separate envelope addressed to each addressee, respectively, as follows.

Gallagher Bassett
P.O. Box 2840
Clinton, IA 52733

Workers Defenders Law Group
751 S. Weir Canyon, Suite 157-455
Anaheim, CA 92808

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

Executed on August 1, 2022 Signature Nonnie Osborne