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Anthony Francisco, Ph.D.
Clinical Psychologist

Dear Gentlepersons:

Patient: **Martin Lugo**
Initial Psych Examination: **09/16/2021**

ATTENTION: **INSURANCE ADJUSTOR - WORK COMP DIVISION ASSIGNED TO THIS PATIENT'S CASE**

REASON FOR THE COMPREHENSIVE PAIN MANAGEMENT MEDICAL/ LEGAL PSYCHOLOGICAL EVALUATION:

The Medical-Psychological Evaluation is expressly performed to provide the attorney/patient selected *primary treating/referring physician* a factorial evaluation and assessment of the psychological symptomatologies that may be affecting, interfering or delaying with the curative mechanism of the physical symptoms that are being treated by the Physical physician (PTP) for injuries that occurred as the result of an employment related accident/incident.

THE SPECIALISTS REPORT

Therefore, at the request of the Primary Treating Physician and the patient I have been requested to perform a comprehensive medical-legal evaluation. Additionally, it has been requested that I address the cause of the patient's medical condition, treatment for the patient's psychological/medical condition, and the existence, nature, duration or extent of temporary or permanent disability caused by the patient's medical condition. The complete (stress)/pain text herein explained.

Dear Gentlepersons:

Patient: **Martin Lugo**
Initial Psych Examination: **09/16/2021**

LEGAL PURPOSE OF DIAGNOSTIC PSYCHOLOGICAL CONSULTATION

This examination is being conducted in good faith pursuant to and in satisfaction of the following California Workers' Compensation rules, regulations and laws.

The following is in the spirit and in compliance and by reference of Medical Treatment Utilization Schedule (MTUS) 5307.07 Guidelines schedule adopted by the Administrative Director and MTUS 9792.20.(b), which establishes ACOEM as well as per Chapter 15 into the MTUS as the standard and guidelines for treatment. 9792.21 Adoption of the Medical Treatment Utilization Schedule and 9792.21(b) evaluation and treatment of injured workers and 9792.23 Clinical Topics and 9792.24.2 Chronic Pain Medical Treatment Guidelines Division of Workers' Compensation.

Per MTUS Guides 8 C.C.R.; 9792.20 9792.26 Pg. 1 of 127, "If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary."

MTUS guidelines under 5307.21 of the Labor Code Section 4600(b), 8 C.C.R. 9792.20–9792.26 Pg. 100 of 127, states PSYCHE EVALUATION IS RECOMMENDED with well-established diagnostic procedures not only with pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should be distinguished between conditions that are preexisting, aggravated by the current work injury or work related. Psychosocial evaluations should determine if further psychological interventions are indicated. The interpretations of the evaluations should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. MTUS guidelines under 5307.21 of the Labor Code Section 4600(b), 8 C.C.R.; 9792.20–9792.6 P. 101 of 127 states PSYCH TREATMENT IS RECOMMENDED for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder and posttraumatic stress disorder).

The Medical Treatment Utilization Schedule adopted by the state of California establishes *9792.24.2 and incorporates the use of Chronic Pain Medical Treatment Guidelines Division of Workers' Compensation* as the reference to use for the chronic pain patients. The Chronic Pain Medical Treatment Guidelines vision of Workers' Compensation specifically *establishes the necessity for The Initial Psychological Exam and Diagnostic (Psychometric) Testing*.

Therefore, by statute and according to California Workers' Compensation Law the patient is entitled to receive this psychological examination.

Dear Gentlepersons:

This is a Diagnostic Psychological Consultation for psychological-legal assessment only of Mr. Martin Lugo completed at our offices.

The purpose of this diagnostic consultation is to assist in the various psychological ways to further palliate the pain and to help expedite the recovery process of the injured worker.

It includes a discussion of presenting symptoms, purported allegations, review, if available, of medical records, and results of routine psychological testing, if administered, integrated with clinical impressions gained from personal interviews. Conclusions and recommendations are based on the enclosed clinical findings and impressions, in addition to the history as reported by the patient. The report must be considered in the absence of the defendant's statements.

Efforts and encouragements were taken to compel the patient to present the accurate and truthful relevant facts as they occurred.

With that in mind, this report was developed by Anthony Francisco, Ph.D., who personally conducted the clinical interview.

Because this patient was referred by his doctor for a determination of psychological components and symptomatology relative to a Workers' Compensation case, the report will focus and give particular and exclusive attention to the question of Workers' Compensation claim for stress/injury- related psychological symptoms.

At the beginning of the examination, the patient was informed that the purpose of the interview and the psychological profile was to provide information for a written report to you regarding his Workers' Compensation case. I explained that, in that context, our discussion and testing would not be confidential. He indicated that he understood and gave me permission to proceed on that basis.

THIS PSYCHOLOGICAL PROFILE REPORT IS CONFIDENTIAL AND PRIVILEGED. BECAUSE PATIENTS MAY MISUNDERSTAND AND/OR DISTORT THE INFORMATION ENCLOSED, DISCLOSURE CAN BE PSYCHOLOGICALLY DESTRUCTIVE AND INTERFERE WITH THE TREATMENT PROCESS. THIS REPORT IS THEREFORE NOT TO BE SHOWN TO THE PATIENT.

September 16, 2021

Workers Defenders Law Group
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Gerald Ferencz, D.C. / Edward Komberg, D.C.

SECONDARY PHYSICIAN
DIAGNOSTIC PSYCHOLOGICAL CONSULTATION

IDENTIFYING INFORMATION

Regarding:	**Martin Lugo**
Initial Examination:	09/16/2021
Social Security:	561-71-1451
Date of Stress/Injury:	CT: 01/01/2019 – 04/05/2020; 03/23/2021
Date of Birth:	07/30/1964
WCAB Number:	Unknown
Employer:	Westpac Labs, Inc.
Occupation:	Medical Courier
Referring Physician:	Gerald Ferencz, D.C. / Edward Komberg, D.C.
Face Time:	___ minutes

PURPOSE OF DIAGNOSTIC PSYCHOLOGICAL CONSULTATION

This examination is being conducted in good faith pursuant to and in satisfaction of the following California Workers' Compensation rules, regulations, and laws.

The following is in the spirit and in compliance and by reference of Medical Treatment Utilization Schedule (MTUS) 5307.07 Guidelines schedule adopted by the Administrative Director and MTUS 9792.20.(b), which establishes ACOEM as well as per Chapter 15 into the MTUS as the standard and guidelines for treatment. 9792.21 Adoption of the Medical Treatment Utilization Schedule and 9792.21(b) evaluation and treatment of injured workers and 9792.23 Clinical Topics and 9792.24.2 Chronic Pain Medical Treatment Guidelines Division of Workers' Compensation.

The Medical Treatment Utilization Schedule adopted by the state of California establishes 9792.24.2 and incorporates the use of Chronic Pain Medical Treatment Guidelines Division of Workers Compensation as the reference to use the chronic pain patients. The Chronic Pain Medical Treatment Guidelines Division of Workers' Compensation specifically establishes the necessity for The Initial Psychological Exam and Diagnostic (Psychometric) Testing.

Therefore, by statute and according to California Workers' Compensation Law the patient is entitled to receive this psychological examination.

DIAGNOSTIC PSYCHOLOGICAL CONSULTATION

IDENTIFYING INFORMATION

I saw Mr. Martin Lugo for a consultation on 09/16/2021. This patient was referred directly to me because of stress/injury/work/industrially related symptoms allegedly caused by this patient's occupation.

INTRODUCTION

Patient submitted an Application for Adjudication of Claim for Workers' Compensation benefits citing cumulative physical trauma. However during the physical examination it was discovered that psyche and related systems were involved and are affecting the patient so the examining physician needed a consultation to help in the course of the treatment.

I would appear that the defendant has lost medical control. Medical care was not offered or provided by the employer after the report of the stress/injury. According To the place of employment the employer must make an active effort to bring the employee the necessary relief. The employer's failure to act would appear to have resulted in the employer's loss of medical control. Apparently, there has not been the provision of timely, appropriate medical treatment. For instance, authorization for treatment with an appointment with a MPN physician was not provided within 24 hours after notice of work stress/injury. An examination by a MPN physician was not provided within three business days after notice of work stress/injury.

According to Labor Code 3208.3:

(a) A psychiatric stress/injury shall be compensable if it is a mental disorder which causes disability or need for medical treatment, and it is diagnosed pursuant to procedures promulgated under paragraph (4) of subdivision (j) of Section 139.2 or, 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 stress/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 stress/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 stress/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 stress/injury under this division.

(d) Notwithstanding any other provision of this division, no compensation shall be paid pursuant to this division for a psychiatric stress/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. This subdivision shall not apply if the psychiatric stress/injury is caused by a sudden and extraordinary employment condition. Nothing in this subdivision shall be construed to authorize an employee, or his or his dependents, to bring an action at law or equity for damages against the employer for a psychiatric stress/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 notice of termination of employment or layoff, including voluntary layoff, and the claim is for a stress/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 stress/injury and one or more of the following conditions exist: (1) Sudden and extraordinary events of employment were the cause of the stress/injury; (2) The employer has notice of the psychiatric stress/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 stress/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 stress/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.

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

HIPPA RECORDS RELEASED FOR LITIGATION PURPOSES

A "Professional Photocopier" and "Process Server" as defined by the Business and Professional Code Sections 22450 and 22350 and therefore, perform its job in accordance with Evidence Code of Civil Procedure and Labor code of the State of California. All records released to attorneys and insurance companies are in full compliance with said State Laws and will supersede any HIPPA rules and regulations.

PAIN DIAGNOSTIC PSYCHOLOGICAL CONSULTATION

The purpose of a psychological consultation in this context is to confirm diagnoses, to assess disability, somatic manifestations and emotional states, and to further assess psychological problems that may be affecting this patient as a consequence of the injuries described herein. This statement of purpose is consistent with The National Institute for Occupational Safety and Health ("NIOSH") which ranks psychological problems as one of the ten most important health problems affecting workers.

Our Psychiatric Diagnostic has established a clinical process to evaluate and assist patients who have treated for chronic stress/pain but have not made satisfactory progress.

Following ACOEM/AMA guidelines, we are able to evaluate patients to differently diagnose stress/pain that is organic in nature and rule out psychological impairments that identity the patient malingering and that could potentially cause or aggravate organic stress/pain.

Our goal is to identify that the patient's ability to cope and deal effectively with stress/pain and determine their psychological factors. We provide an eclectic 8 to 12 week of one or a combination of a multi-approach psychotherapy regimen of a supportive psychotherapy, biofeedback, food medication, alpha stim and/or psychiatric medication to patients who have experienced a decrease in functioning due to their stress/pain and are in need of assistance and acceptable level of functioning.

The stress/pain-related consultation is based upon the following criteria

The ACOEM/AMA guidelines (page 108, paragraph 3) note that, "the central nervous system may be altered by chronic stress/pain. Changes may occur that make people more sensitive to incoming impulses, which amplify the stress/pain. Patients with chronic stress/pain are often preoccupied with somatic symptoms, sleep, and appetite and libido disturbance in interpersonal relationships. This patient has been referred by the primary treating physician in this matter pursuant to and in compliance with applicable ACOEM/AMA Guidelines to assess symptoms due to stress/pain and to determine, if any counterbalancing factors such as maladjustment is setting in or has set in.

NECESSITY

Please note that as a result of those patients taking certain prescribed medication, it is a necessity they secure assisted transportation for their safety and the safety of others on the road.

HISTORY OF THE INCIDENT AS REPORTED BY THE PATIENT:

Mr. Martin Lugo states that he was in good health when he began his employment at the above stated location and he did not have any psychological, medical or orthopedic restrictions. There is no history of prior psychiatric restrictions or disability. He was not under a doctor's care for any chronic psychological condition. He reports stress in his job and overwork. From an emotional or psychological perspective, the patient currently describes having psychological components as a result of the stressful environment in which he had been working in; he began to internalize the stress that began to manifest itself in host of psychological symptomatologies that includes: depression, sudden anxiety, irritability and low self-esteem. From a physical perspective, the patient currently reports an industrial related stress/injury while performing his usual and customary duties. On June 4, 2020 during the course of employer he suffered a car accident. He was finishing his shift and driving in the company car. He was at a red light when he was suddenly rear-ended by a drunk female driver. Upon the impact he noticed pain to his neck and back. On March 23, 2021 he noticed increasing pain while getting inside the small company car that he was provided. He is 6 feet tall and the care small. He reports he had to sit back and rest to catch his breath due to the increasing back, hip and left side pain. From 1/1/2019-4/5/2021 during the course of employment as a Medical Courier for West Pack Labs Inc. he sustained injuries to his neck, back, hips, left side of leg, sleep disturbance.

Eventually he sought legal counsel to secure his medical care.

TREATMENT

The patient had x-rays of his neck; he was given medication for the pain and diagnosed with inflammation. He started on physical therapy. On March 29, 2021 he was seen at an Urgent Care Center was examined. He was administered pain injection (toradol) and prescribed Norco to help him with his sleep disturbance due to the pain. On or about April 2, 2021 he had x-rays done of his hips and MRI studies of his low back and pelvis. He was started a course of physical therapy..

MEDICAL HISTORY

The patient in 2010 underwent a colon surgery. Two feet of colon was removed due cancer. The patient in 2005 had Gallbladder surgery.

The patient has a history of Colon Cancer and Diabetes.

DRUG AND ALCOHOL HISTORY

Tobacco: The patient denies smoking cigarettes. Alcohol: The patient denies consuming alcoholic beverages.

LEGAL HISTORY

On or about 2018, he had a previous Workers' Compensation. Therefore, issues of apportionment may have to be discussed at the time the patient reaches permanent and stationary status.

SOCIAL HISTORY

The patient lives with his son. The patient finished all the way to the 12th grade.

PAST PSYCHOLOGICAL HISTORY

There is no history of prior psychiatric restrictions. The patient was not under a doctor's care for any chronic psychological condition. He denies previous psychological evaluation or treatment.

MEDICAL RECORD REVIEW

04/16/2021: Primary Treating Physician's Initial Comprehensive Report, Gerald Ferencz, D.C. / Edward Komberg, D.C.

Diagnoses:
1. Cervical musculoligamentous injury [S13.8XXA]
2. Rule out cervical disc [M50.20]
3. Lumbar musculoligamentous injury [S33.5XXA, S39.012A] Lumbar disc protrusion [M51.26]
4. Lumbar radiculitis [R54.16]
5. Shoulder sprain / strain, left [S43.402A, S46.912A] Shoulder sprain / strain, right [S43.401A, S46.911A]
6. Hip sprain / strain, left [S73.102A]
7. Hip internal derangement [M24.9]
8. Hip sprain / strain, right [S73.101A]

Treatment Plan:
1. Chiropractic treatment, Physiotherapy, Kinetic Activities 2-3 x per week for 6 weeks.
2. MRIs of cervical spine, left shoulder, and right shoulder, right hip. EMG/NCV of bilateral upper and lower extremities.
3. Referral: Pain Management.

Work Status: Mr. Martin Lugo is on temporary total disability through May 31, 2021.

PSYCHOLOGICAL PSYCHOMETRIC TESTING

These tests will, in the total picture of the mental status exam, history and other tests, give us a clear direction for making a proper diagnosis and appropriate recommendations as psychological testing was deemed necessary to provide objective data regarding the existence and extent of the patient's psychiatric injuries.

It must be stated again clearly that this is not a complete psychiatric examination for general mental health purposes. The only assessment that has been made is the application to the patient's mental and psychological symptoms and conditions and only those findings related to the psychological state have been detailed.

The history that was taken in relationship to this patient's stress/pain and sudden anxiety resulting from and as a consequence of the job, as well as the patient's report of any symptomatology and/or impairments including physical and mental symptoms, psychological history, social, military, or drug history, all came from my consultation of the patient's initial self-report and my personal observations and history taking and mental status examination.

The purpose of this psychological test is that it can either add or subtract to the diagnostic, prognostic, and treatment formulation for this patient's continuance. The psychological battery has been put together based on getting some good projective insights as well as an intellectual baseline and some minimal potential organic findings, if present. It may be necessary to proceed with deeper projective testing such as a Thematic Apperception Test or a Rorschach Ink Blot Test. It may also be necessary to progress further into a complete neuropsychometric battery for localization and/or ideologic agent of brain disease. If this is so, we would proceed with some very specific organic neuropsych testing in addition to the organic and projective and intellectual testing examination as well as get some personality inventory studies and some studies that check for potential malingering or feigning.

In addition, organicity is often better gleaned by objective psychological testing in addition to the objective subjective mental status examination. Last, but not least, suicide and homicide potential and death preoccupation and deep dysfunctional abilities are areas that require close scrutiny, close supervision, and even potential intervention and, therefore, certainly, when these are issues, psych-testing becomes extremely important.

A full comparative psychological battery is necessary in doing this patient's specific consultation because of the symptoms which indicate the importance of the specific tests within the full battery to determine the diagnosis properly.

These tests will in the total picture of the mental status exam, history, and other tests give us a clear direction for making a proper diagnosis and appropriate recommendations as this clear picture of depression shows us.

MENTAL STATUS EVALUATION

General Appearance: Patient appears to be about his stated age. The patient presents with acceptable personal hygiene and was appropriately dressed for the interview.

The patient is sitting stooped down walking with the aid of a cane.

Interpersonal Manner: Patient was punctual, and at all times, cooperative. He conducted himself in a normal level of consciousness. His eye contact is maintained and has a pleasant attitude under examination.

Psychomotor Activity: The patient sat in a slouching posture and presented evident discomfort. His gait and coordination appeared normal. Manual dexterity was normal.

Speech and Language: The patient was lucid and linguistically coherent, and showed a variable vocal volume and intonation. There was no evidence of developmental and cultural deficiency.

Emotionally: The patient's affect was subdued and his feeling tone was anxious.

Perception: The patient denies having auditory or visual hallucinations. The patient denies any significant subjective sensory impairment.

Thought Process: The patient shows no evidence of delusions, bizarre or magical thinking, with no loose associations.

Sensorium & Intellectual Functioning: The patient appears to be functioning at an average intellectual level,

Thought Content: He does report a focus of preoccupations regarding his health.

VARIOUS EVALUATIVE STUDIES PERFORMED

BENDER

The Bender Visual Motor Gestalt test is a test of perceptual abilities and motor skills. It is often used as a gross screening measure for the presence of brain damage. It is an untimed test and the patient is asked to reproduce eight designs. The results of this test for this patient are contraindicative of the presence of brain damage. Any deficits in the design reproduction are probably due to the patient's clinical status at this time. However, this test is not a substitute for a complete neurological assessment.

INTERPRETATION/COMMENTS/REPORT

Neuropsychological functioning: adequate.
The following abnormalities were found: none.

BECK ANXIETY INVENTORY

The Beck Anxiety Inventory (BAI), created by Dr. Aaron T. Beck and other colleagues, is a 21-question multiple-choice self-report inventory that is used for measuring the severity of an individual's sudden anxiety.

INTERPRETATION/COMMENTS/REPORT

The patient obtained a score of 15 on the Beck Anxiety Inventory, placing this patient in the range for slight to moderate sudden anxiety.

BECK DEPRESSION INVENTORY

The Beck Depression Inventory is a 21- items test designed to assess the severity of depression in adolescent and adults. The test was introduced and first used at the University of Pennsylvania Medical School in 1971. Since its introduction, the BDI has become one of the most widely accepted instruments for measuring the intensity and severity of depression. It evaluates twenty-

one symptoms and attitude including: Mood, Pessimism, Sense of Failure, Self-dissatisfaction, Guilt, Punishment, Self-dislike, Self-accusations, Suicidal Ideas, Crying, Irritability, Social Withdrawal, Indecisiveness, Body Image, Work Difficulty, Insomnia, Fatigability, Loss of Appetite, Weight Loss, Somatic Preoccupation, and Loss of Libido.

INTERPRETATION/COMMENTS/REPORT

The patient obtained a score of 16 on the Beck Depression Inventory, placing this patient in the range for slight to moderate depression.

MMPI-2

The Minnesota Multiphasic Inventory-2 is the objective test of personality. It is a self-report inventory in which the patient was asked whether statements were accurate or inaccurate self-descriptions. The profile of the patient's responses was grouped into 13 fundamental scales. Four basic scales assessed the validity of the patient's profile, indicating such test-taking attitudes as confusion, the attempt to present oneself in a favorable light or possible malingering.

INTERPRETATION/COMMENTS/REPORT

The validity indicators of L, F, K, with T-Scores of 69, 58 and 69, were within normal limits.

Most of the rest of the scale are inconsequential except for the following:

The elevation of Scale 1, the Hypochondriasis Scale, to 70-T, reflects physical complaints as a manifestation of emotional distress.

Scale 2, the Depression Scale, was elevated to 70-T, with this score reflecting an extreme degree of intense depression associated with extreme mental dysfunction.

HOOPER VISUAL ORGANIZATION TEST

The Hooper Visual Organization test is a test of the ability to recognize the pictures of cut objects. It was used to reflect underlying difficulties in neurological functioning and measure general as well as specific cognitive deficits associated with organic brain pathology.

INTERPRETATION/COMMENTS/REPORT

The patient has a total raw score of 26 making the probability of impairment very low.

RAVENS PROGRESSIVE MATRICES INTELLECTUAL QUOTIENT TEST

The Ravens Progressive Matrices is often used as a measure of general intelligence. It consists of 60 designs with a portion removed. The patient is asked to select the portion which would correctly complete the design from among several alternatives. The measure of intelligence has little interference from culture or language.

INTERPRETATION/COMMENTS/REPORT

The patient's score of 34 indicates that he is in the low-level of intellectual functioning.

WAHLERS PHYSICAL SYMPTOMS INVENTORY

The patient endorsed the following symptoms: back aches or pains, lower extremity aches or pains, difficulty sleeping, muscular weakness, muscular tensions, and twitching muscles.

INTERPRETATION/COMMENTS/REPORT

Clearly patient is suffering from psychophysiological symptomatologies as a consequence of the above described stress/injury.

ROTTER SENTENCE COMPLETION

The Rotter Sentence Completion Test is a self-report, projective test in which the patient is asked to finish, in his/her own words, 40 incomplete sentences or "stems."

Patient indicates pain and spasm.

ADULT NEUROPSYCHOLOGICAL QUESTIONNAIRE

The Adult Neuropsychological Questionnaire is a systematic means of neuropsychological assessment as a basis for preparing a comprehensive report. Included are questions that measure memory impairment, various conditions associated with dementia, brain/head injury, visual attention, digit recognition, finger tapping, laterality, aphasia, and other conditions that may compromise the patient's overall state of well being. The patient was asked to rate how patient feels before and after the stress/injury.

INTERPRETATION/COMMENTS/REPORT

On the neurological instrument, the patient indicates that there has been sleep pattern derangement since the stress/injury. The patient notes a change in weight. Patient has been experiencing headaches, dizziness. The patient notes a change in the way they walk and continues to feel discomfort.

PAIN DRAWING

On the frontal portion of the pain drawing, the patient indicates pain. On the back portion of the pain drawing, the patient indicates pain.

CAUSATION OF THE PSYCHOLOGICAL SYMPTOMS

Psychological assessment indicates that the patient is suffering psychological symptoms. The above symptoms are a direct result of the events that took place during and out of the course of his employment and are consistent with the clinical findings.

Therefore, in the absence of the industrial injuries, the patient would have almost certainly not have developed any psychological stress/injury/symptoms/condition and/or disability. As such, per LC 3208.3 (d) this claim is compensable as the psychological stress/injury occurred in connection with, as a consequence of and a function of the above described physical stress/injury. Accordingly, I currently respectfully submit that I am of the opinion that the work related incident detailed above is consistent with the psychological findings in this patient examination of occupational problems. The psychological injuries are directly interrelated to the injuries sustained in the work environment described herein. There appear to be no other cause of any material substance for the stated problems other than the injuries sustained at the workplace.

RECOMMENDATIONS

1. This patient may benefit from psychotherapeutic treatment on a monthly basis which may include a variety of modalities including but not limited to behavior, supportive and/or biofeedback therapy on a monthly basis for a period of between 2 to 3 months to help interrupt the "pain-tension-pain" cycle. Progress evaluation will be conducted periodically to keep you informed of the status of the progress/regression. For this reason, he may not be considered permanent and stationary at this time.

2. It is recommended that this patient be involved in psychotherapy to maintain stability and to prevent regression and/or deterioration.

P.S. *(Prior to the related injuries, its consequences, and the subsequent Persistent stress/pain, the patient was able to function at a reasonable level on a daily basis. The patient demonstrated the ability to cope despite life stressors until the unfortunate occurrence of the stress/injury, which is considered as an unavoidable part of the same body system of the stress/injury that interferes deleteriously in his/her life/healing process. [There has not been an expectable decrease in stress/pain despite receiving treatment, thus the persistence of the plaguing emotional complaints hereinabove cited.)*

*Therefore, it is respectfully recommended that since the present psychological assessment has been secured at the request of the clinician along with its recommendation, that the aforementioned recommendation for Treatment be afforded to this patient in accordance with **AMA** and **ACOEM** guidelines; (Including but not limited to **ACOEM** [Preventing and Managing Chronic Pain: Chapter 6, pages 115-116] and [for dealing with Potentially Chronic or Chronic injuries Guidelines **ACOEM** Second Edition-Chapter 6 pages 113-114 Paragraph C.] and More)*

PSYCHOLOGICAL CARE

This patient requires psychological treatment in the form of Psychotherapy for stress reduction and assistance in coping mechanism to more adequately deal with the stress/pain. Psychological intervention will also assist in the development of resources helpful in better coping with spasm and stress/pain.

ADDITIONAL RELATED ACOEM GUIDELINES

Research demonstrates that multidisciplinary care is the treatment of choice for patients with chronic stress/pain or for patients "who are at risk for, or who have, chronic stress/pain and disability" (p.114). "Multidisciplinary treatment was found to be superior to Conventional therapy alone, had benefits that persisted over time, and was beneficial in improving return to work and decreasing use of health care. Close communication between all participating professionals is "mandatory" (p.109). The hallmarks of these approaches report return-to-work rates of more than "80% following treatment, with a high percentage of these persons still working after one year."

As demonstrated, psychological consultation and treatment is an essential component as outlined in the ACOEM guidelines. When the clinician is alerted to the development of chronic stress/pain, he/she should "secure a psychological assessment." (p.115). "Successful pain management hinges on appreciating the dynamics of each patient's case and on proactively managing factors that might delay return to work or restoration of function" (p.107). In order to provide adequate treatment to injured workers access to the standard of care must be afforded.

Psychological consultation and treatment is an essential component as outlined in the ACOEM guidelines. This type multidisciplinary approach is the optimum type of intervention for stress/pain and is an integral part of his recovery as defined in the California Workers Compensation Code and is further consistent with the ACOEM Guidelines adopted by SB899. According to the Guidelines the goals of his recovery are multiple. They include: interdiction of chronicity, interdiction of fear avoidance behavior (p.91, 113) interdiction of delayed recovery (p.91, 362), interdiction of Somatization (p.108), interdiction of functional disability (pp.76, 78, 91,113), decreased stress/pain perception (p.117), decreasing depression and other maladaptive behaviors (pp.108, 109, 114, 388, 400). The final goal is to build tolerance for intended activity, that is, the patient's return to full work duty (p. 315). Thus, the ultimate goal of any work stress/injury treatment program, functional restoration, is achieved. This treatment is considered reasonable and necessary to treat the sequelae of his stress/injury.

GOAL

The goal is to increase skills building for daily functioning. Post-psychological testing at permanent and stationary will evaluate treatment effects and the patient's ability to return to his pre-stress/injury level of functioning.

Furthermore, it is the opinion of this evaluator, that the patient's stress/pain has triggered the emotional symptoms described above, although in and of themselves, they may not rise to the level that constitutes "psychological disability"*, rather an expected reaction and adjustment to this patient's continuous experience of stress/pain. Essentially, the described symptoms are impacting the ability to recover from the injuries due to the above described tension. As such treating, addressing and helping the patient in understanding the psychodynamics of these symptoms potentiate the Pain-Tension-Pain cycle and thus aid to expedite the healing process.

* "psychological disability" (inability to work based on the psychological symptomatologies but when taken as part of the symptoms complex their role becomes evident).

DIAGNOSTIC IMPRESSION

From Third Edition Revised ICT-10

Axis I: Adjustment disorder with mixed emotional features of anxiety and depression due to chronic pain secondary to an industrially related injury/stress (F43.23)
*[**Criteria:** depressed mood, loss of interest in enjoyable activities, low self esteem, sleep difficulty, staying asleep difficulty, fatigue anxiety, muscle spasm, irritability]*

Axis II: No Diagnosis (V71.09)

Axis III: Physical Disorders and Conditions:

As diagnosed by the appropriate examining specialist:

Axis IV: Severity of Psychosocial Stressors:
Stress/Stress/injury Caused Difficulties

Axis V: Global Assessment of Functioning (GAF):
Current = 62 Prior Year = Unknown
Based on the AMA Guidelines (5th ed), a Whole Person Impairment (WPI) rating using the psychiatric relationship between WPI and the Global Assessment of Functioning (GAF) scale of the DSM-IV deems the following WPI for this patient: 12

Notation: *It should be noted neither the DSM-IV-TR nor the AMA Guides specify a minimum duration or frequency for a given disorder or condition before it reaches diagnostic criteria. Rather, the diagnosis and categorical assessment of whole person impairment is dependent on the patient's degrees of distress and/or interpersonal difficulty caused by same — and further depends on the clinical judgment of the evaluator.*

DISCUSSION:

The patient was employed with the above stated employer. On June 4, 2020 during the course of employer he suffered a car accident. He was finishing his shift and driving in the company car. He was at a red light when he was suddenly rear-ended by a drunk female driver. Upon the impact he noticed pain to his neck and back. On March 23, 2021 he noticed increasing pain while getting inside the small company car that he was provided. He is 6 feet tall and the care small. He reports he had to sit back and rest to catch his breath due to the increasing back, hip and left side pain. From 1/1/2019-4/5/2021 during the course of employment as a Medical Courier for West Pack Labs Inc. he sustained injuries to his neck, back, hips, left side of leg, sleep disturbance.

The patient was working at the above-stated location for about two and a half years. He describes the environment in which he had been working as stressful as he worked for a lab company which required him to go and pick up COVID samples him being under constant threat of contracting the insidious COVID virus. However, he continued to be internalizing the stress that began to manifest itself into a whole host of psychological symptomatologies that certainly included anxiety, depression, muscle spasm, tension, and insomnia. All of this, in addition to the above-stated industrially-related physical injuries for which he is treating chiropractically and physiotherapeutically for the persistency of the pain have all affected a change in the psychodynamics of his life, a change that has spillover many areas of his life, all of which continue to further exacerbate his overall level of frustration, anxiety, and depression.

The patient has difficulty sleeping, spasm, headaches, worry, and depression. The patient has symptoms relating to sudden anxiety.

Impairments are slight, but affecting many aspects of life. Occupationally and recreationally, this patient has been affected.

Due to the nature of these symptoms, psychotherapy is indicated for his to gain perspective on the nature of his disability and develop coping behaviors for areas of decreased functioning.

A supportive, cognitive, desensitizing form of psychotherapy should be implemented for this patient in order for his to be helped in gaining more insight and better judgment as to his areas of decreased functioning.

Psychotherapy may help reinforce stability and prevent deterioration. A supportive goal-oriented therapy may enable his to ventilate emotionally and establish solutions for his present immediate problems and set realistic goals for the future.

Absent the traumatic events, there would be no psychiatric disability. The patient's history shows an absence of criminal behavior. There has been no excessive use of drugs or alcohol. There is no pre-existing disease, the nature of which would be expected to surface at this time. There were no events prior or subsequent to the present trauma to contribute to his present disability.

CONCLUSIONS

The following is a brief review of my perception of the patient's self-report, highlighting the various problems that occurred at work physically and psychologically: The patient experienced stress/injury during and in the course of his employment. He was treating medically and physiotherapeutically. Despite the treatment, however, he continued to be under much pain and spasm.

The following is a brief review of my findings of AXIS I, highlighting the psychological difficulties that were caused by the consequent work related stress/injury: he is experiencing depression, concern, worries about his future and insomnia.

The relationship of work exposure to the disability is: **Direct**.
Non-industrial causes of the disability: **None**.
The workplace contributed to the disability in an **active way**.
Preexisting disorders, which progressed naturally: **None.**

More than 51% of this patient's psychiatric stress/injury resulted from real and/or actual events of the patient's employment.

JUSTIFICATION:

The patient continues to complain of persistent emotional sequella and reactive psychiatric and psychophysiologic symptomatology to the industrial related stressors.

Patient began treating medically/physiologically for the physical symptoms that ensued the stress/injury; however, despite the medical treatment patient continued to have symptoms of ache and discomfort.

As consequence and in addition to the physical pain patient sustained during the course of his employment, the pain persisted.

SUPPORTING DATA FOR WORK IMPAIRMENT BASED ON:

Axis I: Adjustment Disorder with Anxiety and Depressed Mood due to chronic pain secondary to an industrially related injury/stress (F43.23)

History of the stress/injury
Current presenting Problems derived from interview

WORK RESTRICTIONS

Work Function Impairments

+	0	1	2	3	4	5
Superior Ability	**Normal Range Function**	**Minimal**	**Very Slight**	**Slight**	**Moderate**	**Severe**
		Discomfort but not disabling	Detectable Impairment	Noticeable Impairment	Marked Impairment	Unable to Perform Work Function

	Function	Current Impairment	Supporting Data
1	Ability to comprehend and follow Instructions.	Slight	S.D.= 1-5
2	Ability to perform simple and Repetitive tasks.	Slight to Moderate	S.D.= 1-5
3	Ability to maintain a work pace appropriate to a given work load.	Slight to Moderate	S.D.= 1-5
4	Ability to perform complex or varied tasks.	Slight	S.D.= 1-5
5	Ability to relate to others beyond giving and receiving instructions.	Slight	S.D.= 1-5
6	Ability to influence people.	Slight	S.D.= 1-5
7	Ability to make generalizations, evaluations or decisions without immediate Supervisors.	Slight	S.D.= 1-5
8	Ability to accept and carry out responsibility for directions; control and planning.	Slight to Moderate	S.D.= 1-5

Note on Percentages of Permanent Impairment:

According to the AMA Guide to Permanent Impairment (2005), "there are no precise measures of impairment in mental disorders." Percentages are specifically not provided in the chapter on mental and behavioral disorders of the fifth edition because, "no available empirical evidence supports any method for assigning a percentage of impairment of the whole person." Rather, the AMA recommends assessing specific areas of functioning. The following is a summary of patient's limitations in those areas.

Whole Person Impairment Rating

Class 1	Class 2	Class 3	Class 4	Class 5
No impairment noted	Impairment levels are compatible with most useful functioning	Impairment levels are compatible with some but not all useful functioning	Impairment levels significantly impede useful functioning	Impairment levels preclude useful functioning

Using Table 1.2 this patient would be rated as class 2 on activities of daily living, class 2 on social functioning, class 2 on concentration and class 2 on adaptation.

Prognosis

Better with ongoing Psychotherapy:

It is estimated that patient's period of recovery from psychological symptomatology will continue over a period of approximately six to nine months, perhaps longer, as clinically indicated. Remittance of symptoms is unique to each individual. Changes in emotional functioning can be affected by any number of life events and stressors, which are, as previously noted, often unforeseeable. Prognosis is provided with this in mind.

APPORTIONMENT

Causation and Apportionment Issues:

I am aware of the recent Escobedo judicial decision permitting apportionment to pathology. According to relevant laws, S.4663 and 4664 as amended by Senate Bill (SB) 899 provides the following:

"(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 stress/injury shall in that report addresses 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 stress/injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial stress/injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or his report, the physician shall 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 stress/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 stress/injury shall, upon request, disclose all previous permanent disabilities or physical impairments."

ALSO, SECTION 4664 (A) PROVIDES:

"(e) The employer shall only be liable for the percentage of permanent disability directly caused by the injuries arising out of and occurring in the course of employment."

This would be estimated at a level beyond the legal threshold of industrial causation over 51%.

Issues of apportionment will be discussed upon patient's permanent and stationary status.

The patient's personal family histories were essentially a factor, his childhood was a factor with a stable enough childhood and personal adult life such that to presume any emotional impairment from any preexisting or non-industrial causes would be improper and overly speculative. Thus, and in consideration of *Escobedo,* there is ostensibly no basis upon which to apportion the patient's current psychological distress.

FUTURE PSYCHIATRIC CARE

Patient should be allowed follow-up consultations once month for a minimum of approximately six to nine months in psychotherapy, perhaps longer, if necessary and as clinically indicated as well as with a psychiatrist as needed in order to maintain this patient's current permanent and stationary level. The patient is a is a difficult candidate for ongoing psychotherapy sessions to continue to address his emotional symptoms, better restore his confidence and improve his overall outlook therefore the following;

REQUEST FOR AUTHORIZATION

Authorization for the above treatment protocol(s) is requested based upon medically reasonable treatment requirements and in accordance with ACOEM guidelines. This is per Labor Code 4600 and Title 8, Section 9792.6 C.C.R., and Rule 9785 (b). Therefore, we are requesting that written authorization be-sent to this-office within seven- (7) working days as required by 8 C.C.R. 9792.

DISCLOSURE NOTICE:

The history contained within this report was provided by the patient and I personally took the necessary notes. I reviewed the complete history, remarked on any additional information and made the necessary corrections and interpretation. The final draft was submitted to me for my review and signature. I reserve the right to change my opinion based on additional medical evidence.

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

DECLARATION UNDER PENALTY OF PERJURY

Pursuant to Sections LC 5703 (a) (1), I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that I have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

REASONS FOR MY OPINION

History given by the patient.
Mental status and behavior observation
Subjective complaints

Thank you for referring this patient. If I may be of further assistance in clarifying these findings and recommendations of this patient please feel free to contact me.

Signed in the County of Orange on the 15th day of April 2021.

Respectfully Submitted,

Anthony Francisco, Ph.D., Inc.
Cal. Lic. # PSY 6247
Clinical Neuropsychologist
Diplomate of the American College of Forensic Examiners
Member of the American Academy of Sleep Medicine
Member of the American Psychological Associations
Member of the California Psychological Associations

All page number references are to: Occupational Medicine Practice Guideline: Evaluation and management of Common Health Problems and Functional Recovery in Workers, Second edition, Edited by Lee S. Glass, M.D. Copyright 2004 by the American College of Occupational and Environmental Medicine

In addition to the above, the below extractions from the MTUS and ACOEM are offered as an aid for the reader's perusal.

CHRONIC PAIN MEDICAL TREATMENT GUIDELINES

Predictors of success and failure: As noted, one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help to determine who will most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. (Gatchel, 2006) The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pretreatment level of pain Linton, 2001) (Bendix, 1998) (McGeary, 2006) (McGeary, 2004) (Gatchel2, 2005) Multidisciplinary treatment strategies are effective for patients with chronic low back pain (CLBP) in all stages of chronicity and should not only be given to those with lower grades of CLBP, according to the results of a prospective longitudinal clinical study reported in the December 15 issue of Spine. (Buchner, 2007) See also Chronic pain programs, early intervention; Chronic pain programs, intensity; Chronic pain programs, opioids; and Functional restoration programs.

The biopsychosocial model of pain instead recognizes that pain is ultimately the result of the pathophysiology plus the psychological state, cultural background/belief system, and relationship/interactions with the environment (workplace, home, disability system, and health care providers). Current research is investigating the neurobiological causes for persistent pain and how structural and functional changes in the central nervous system may serve to amplify and maintain the experience and disability of certain pain condition. (Siddall and Cousins 2007) This is an area of intensive research which will contribute to the scientific evidence base in years to come.

Since these areas of the brain interact with other areas of the brain, past memories, external environmental factors, and internal cognitive factors (i.e., psychosocial factors) influence or modulate the pain experience. How the brain integrates all the input is, in part, the basis for the biopsychosocial approach to the management of pain.

As previously stated pain is a subjective experience, influenced and modulated by cognitive, emotional, and environmental elements. Psychosocial factors can affect the perception and expression of pain. These might include, but are not limited to, a tendency toward anxiety, depression, somatization, fear avoidance, emotional lability, catastrophizing, job dissatisfaction and embellishment.

Linton identified strong evidence that psychosocial variables are strongly linked to the transition from acute to chronic pain disability and that psychosocial variables generally have more impact than biomedical or biomechanical factors on back pain disability. (Linton 2000) Thus, when clinical progress is insufficient, the clinician should always be prepared to address confounding psychosocial variables, in a coordinated, multidisciplinary manner.

Importance of early identification

Patients not responding to initial or subacute management (see Clinical Topics Section MTUS) or those thought to be at risk for delayed recovery should be identified as early as possible. Simple screening questionnaires may be used early in the clinical course to identify those at risk for delayed recovery. Those at risk should be aggressively managed to avoid ineffective therapeutic efforts and needless disability. Factors that help identify at-risk patients include: (1) those unresponsive to conservative therapies demonstrated to be effective for specific diagnoses; (2) significant psychosocial factors negatively impacting recovery; (3) loss of employment or prolonged absence from work; (4) previous history of delayed recovery or rehabilitation; (5) lack of employer support to accommodate patient

Subacute Delayed Recovery

Complaints of pain are the most common obstacle to return to work. Undertreatment of pain and/or unrealistic expectations may play a role in delayed recovery. However, the subacute phase is a critical time for the injured worker, as additional time away from work may result in adverse medical, familial, economic, and psychological consequences (including overtreatment, depression and/or anxiety, which can exacerbate pain complaints). When the physician recognizes that the problem is persisting beyond the anticipated time of tissue healing, the working diagnosis and treatment plan should be reconsidered, and psychosocial risk factors should be identified and addressed. If necessary, patients should be directed toward resources capable of addressing medical and psychosocial barriers to recovery.

History and Physical Examination

Thorough history taking is always important in clinical assessment and treatment planning for the patient with chronic pain, and includes a review of medical records. Clinical recovery may be dependent upon identifying and addressing previously unknown or undocumented medical and/or psychosocial issues. A thorough physical examination is also important to establish/confirm diagnoses and to observe/understand pain behavior. The history and physical examination also serves to establish reassurance and patient confidence.

ASSESSMENT FOR EVALUATION AND RECOMMENDATIONS.

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) For the evaluation and prediction of patients who have a high likelihood of developing chronic pain, a study of patients who were administered a standard battery psychological assessment test found that there is a psychosocial disability variable that is associated with those injured workers who are likely to develop chronic disability problems. (Gatchel, 1999) Childhood abuse and other past traumatic events were also found to be predictors of chronic pain patients. (Goldberg, 1999) Another trial found that it appears to be feasible to identify patients with high levels of risk of chronic pain and to subsequently lower the risk for work disability by administering a cognitive-behavioral intervention focusing on psychological aspects of the pain problem. (Linton, 2002) Other studies and reviews support these theories. (Perez, 2001) (Pulliam, 2001) (Severeijns, 2001) (Sommer, 1998) 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) See "Psychological Tests Commonly Used in the Assessment of Chronic Pain Patients" from the Colorado Division of Workers' Compensation, which describes and evaluates the following 26 tests: (1) BHI 2nd ed Battery for Health Improvement, (2) MBHI - Millon Behavioral Health Inventory [has been superseded by the MBMD following, which should be administered instead], (3) MBMD Millon Behavioral Medical Diagnostic, (4) PAB - Pain Assessment Battery, (5) MCMI-111 Millon Clinical Multiaxial Inventory, (6) MMPI-2 - Minnesota Inventory, (7) PAI - Personality Assessment Inventory, (8) BBHI 2 Brief Battery for Health Improvement, (9) MPI Multidimensional Pain Inventory, (10) P-3 Pain Patient Profile, (11) Pain Presentation Inventory, (12) PRIME-MD - Primary Care Evaluation for Mental Disorders, (13) PHQ - Patient Health Questionnaire, (14) SF 36, (15) SIP - Sickness Impact Profile, (16) BSI - Brief Symptom Inventory, (17) BSI 18 - Brief Symptom Inventory, (18) SCL-90 - Symptom Checklist, (19) BDI–II Beck Depression Inventory, (20) CES-D Center for Epidemiological Studies Depression Scale, (21) PDS - Post Traumatic Stress Diagnostic Scale, (22) Zung Depression Inventory, (23) MPQ - McGill Pain Questionnaire, (24) MPQ-SF - McGill Pain Questionnaire Short Form, (25) Oswestry Disability Questionnaire, (26) Visual Analogue Pain Scale – VAS. (Bruns, 2001)

Outcome measures for all treatments of CRPS: Objective measures such as the Beck Depression Inventory, the State Trait Anxiety Inventory, McGill Pain Questionnaire-Short Form, the Pain Disability Index & the Treatment Outcomes in Pain Survey (the last three may not meet the APA standards for standardized test in clinical use).

Psychological Treatment

Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment

AF:mk/vs

PROOF OF SERVICE

STATE OF NEW YORK, COUNTY OF SUFFOLK

I am employed in the County of Suffolk,State Of New York. I am over the age of 18 and not a party to the within action. My business address is:

WorkCompEDI Inc., 4250 Veterans Memorial Hwy, Suite 301,Holbrook, NY 11741.

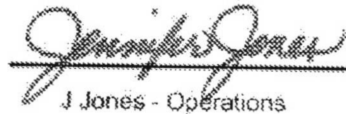
On November 3, 2021 I served the foregoing documents described as: **REQUEST FOR AUTHORIZATION, MEDICAL REPORTS, ITEMIZED BILLING STATEMENT, AND ANY SUPPORTING DOCUMENTATION for Lugo, Martin DOS: 9/16/2021 on the**

interested parties in this action by electronic transmission to:

Gallagher Basset

[X] State: I declare under penalty of perjury under the laws of the State of California that the above is true and correct

Executed on November 3, 2021, at Holbrook, New York



J Jones - Operations

S[illegible] of California, Division of Worker's Compe[illegible]tion
REQUEST FOR AUTORIZATION
DCW Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DCW Form PR-2, or equivalent narrative report substantiating the requested treatment.

X New Request ☐ Resubmission - Change in Material Facts
☐ Expedited Review: Check box if employee faces an immenent and serious threat to his or her health.
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information

Name (Last, First, Middle): Lugo, Martin
Date of Injury (MM/DD/YYYY):1/1/19-4/5/20;3/23/21; | Date of Birth (MM/DD/YYYY): 7/30/1964
Claim Number: | Employer: Westpac Labs Inc

Requesting Physician Information

Name: Edward Komberg, DC
Practice Name: Tri-City Health Group | Contact Name:
Address: 7951 Valley View | City: La Palma | State: CA
Zip Code: 90623 | Phone: (714) 994-1131 | Fax Number: (714) 994-4415
Specialty: Chiropractor | NPI Number: 1629278935
E-mail Address:

Claims Administrator Information

Company Name: | Contact Name:
Address: | City: | State:
Zip Code: | Phone: | Fax Number:
E-mail Address:

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS (if known)	Other Information (Frequency, Duration quantity, etc..)
Cervical musculoligamentous injury	[S13.8XXA]			
Rule out cervical disc	[M50.20]			
Lumbar musculoligamentous injury	[S33.5XXA, S39.012A]	Follow up		4-6 weeks
Lumbar disc protrusion	[M51.26]			

Requesting Physician Signature: [signature] | Date: 9-15-2021

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned): | Date:
Authorized Agent Name: | Signature:
Phone: | Fax Number: | E-mail Address:
Comments:

DWC Form RFA (Effective 2/2014)