COMPREHENSIVE ORTHOPEDIC CARE CENTER PC
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Anthony Francisco, Ph.D.
Clinical Neuropsychologist

Dear Gentlepersons:

Patient: **Alfredo Cordero Rojas**
Initial Psych Examination: **04/17/2025**

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

REASON FOR THE COMPREHENSIVE 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 symptomatology 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 PTP REPORT

Therefore, I have been requested to perform a comprehensive psychological. Additionally, it has been requested that I address the cause of the patient's psychological condition, treatment for the patient's psychological 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: **Alfredo Cordero Rojas**
Initial Psych Examination: **04/17/2025**

LEGAL PURPOSE OF 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 Psychological Consultation for psychological assessment only of **Alfredo Cordero Rojas** completed via telehealth.

The purpose of this 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.

April 17, 2025

Ramin R Younessi
3435 Wilshire Blvd. #2200
Los Angeles, CA 90010

Alfredo Cordero Rojas
758 Rose Ave Apt 110
Long Beach, CA 90813

Farmers Insurance – Main
P.O. Box 108843
Oklahoma City, OK 73101

Referring Physician: Dr. Scott L. Rosenzweig, MD

DIAGNOSTIC PSYCHOLOGICAL EVALUATION

IDENTIFYING INFORMATION

Regarding:	**Alfredo Cordero Rojas**
Initial Examination:	04/17/2025
Date of Stress/Injury:	CT: 06/08/2017 – 01/14/2025
Date of Birth:	06/03/1970
Employer:	Taco Surf Inc.
Occupation:	Cook
Claim Number:	7008656982-1
WCAB:	ADJ20519779

PURPOSE OF PSYCHOLOGICAL CONSULTATION

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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.

PSYCHOLOGICAL CONSULTATION

IDENTIFYING INFORMATION

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.

<u>According to Labor Code 3208.3:</u>

(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 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 weeks 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.

JOB DESCRIPTION

The patient was employed at Taco Surf Inc., a restaurant, as a cook, from 2003, took a leave of absence due to incapacity, and returned in 2017, continuing until 01/16/2025.

His responsibilities included chopping ingredients, seasoning dishes, monitoring cooking times, plating, and handling dishes. He worked 6 to 10 hours per day, five days a week.

The physical requirements of his job involved: standing, waist twisting, simple grasping, fine manipulation, walking, neck bending, neck twisting, repetitive hand use, power grasping, pushing and pulling, bending at the waist. Patient lifted 11-25 lbs frequently (3-6 hours), up to 25 pounds. Patient carried 11-25 lbs frequently (3-6 hours).

HISTORY OF THE INCIDENT AS REPORTED BY THE PATIENT

Mr. Alfredo Cordero Rojas is a 54-year-old male who sustained work-related injuries on CT: 06/08/2017 – 01/14/2025, during the course of his employment for Taco Surf Inc. as a Cook.

Patient states that, on 12/01/2024, while employed at Taco Surf Inc., a restaurant, as a cook, the patient was cooking and performing his regular duties when he suddenly began to experience pain and discomfort in his low back and right knee. He also reports developing injuries to his back, hips, knees, ankles, and feet due to the repetitive nature of his work as a cook, which

involved prolonged standing, walking, bending at the waist and neck, repetitive use of both hands, gripping, grasping, pushing, pulling, and lifting or carrying up to 25 pounds. Additionally, he reports. experiencing headaches, stress, and insomnia. The patient reported his injuries to his employer but was not offered medical assistance. He sought treatment from his primary care provider, who obtained X-rays, and went to the hospital, where he was referred to a knee specialist. The knee specialist would not see him, as they did not accept his insurance. He is currently on medical leave. X-rays of the patient's right knee revealed arthritis, and he was referred to a specialist, but was not seen due to insurance issues. The patient attended 3 sessions of chiropractic therapy in November 2024, paid out of pocket. He was prescribed anti-inflammatory medication for symptom management.

As a result of all the consecutive stressful incidents, she reportedly developed anxiety, depression, and insomnia.

CURRENT COMPLAINTS

From a psychological point of view, the patient suffers from depression, anxiety and insomnia.

From a physical standpoint, the patient reports physical pain.

TREATMENT

The patient was seen by Dr. Scott L. Rosenzweig, MD, on 02/25/2025. The patient was diagnosed with strain of muscle, fascia and tendon at neck level, initial encounter, cervicalgia, lumbago with sciatica, right side, strain of muscle, fascia and tendon of lower back, initial encounter, patellar tendinitis, left knee, pain in right knee, plantar fascial fibromatosis, pain in left ankle, pain in right ankle, acute stress reaction, headache, unspecified, headache, unspecified. The patient was recommended for physical therapy, psychology consultation.

MEDICAL HISTORY

The patient has no past medical history.

DRUG AND ALCOHOL HISTORY

Patient denies smoking tobacco and consumption of alcohol.

LEGAL HISTORY

Patient had a previous worker’s compensation case on or about 2013.

SOCIAL HISTORY

Patient states that he lives with his brother. Patient finished high school.

PAST PSYCHOLOGICAL HISTORY

Patient has no past psychological history.

MEDICAL RECORD REVIEW

02/25/2025 Progress Note, Dr. Scott L. Rosenzweig, MD:
Diagnosis: Strain of muscle, fascia and tendon at neck level, initial encounter (S16.1XXA), Cervicalgia (M54.2), Lumbago with sciatica, right side (M54.41), Strain of muscle, fascia and tendon of lower back, initial encounter (S39.012A), Patellar tendinitis, left knee (M76.52), Pain in right knee (M25.561), Plantar fascial fibromatosis (M72.2), Pain in left ankle (M25.572), Pain in right ankle (M25.571), Acute stress reaction (F43.0), Headache, unspecified (R51.9), Headache, unspecified (R51.9).

Treatment Recommendation: The patient was recommended for physical therapy, psychology consultation.

MEDICAL TREATMENT HISTORY

Diagnosis:

- Strain of muscle, fascia and tendon at neck level, initial encounter (S16.1XXA)
- Cervicalgia (M54.2)
- Lumbago with sciatica, right side (M54.41)
- Strain of muscle, fascia and tendon of lower back, initial encounter (S39.012A)
- Patellar tendinitis, left knee (M76.52)
- Pain in right knee (M25.561)
- Plantar fascial fibromatosis (M72.2)
- Pain in left ankle (M25.572)
- Pain in right ankle (M25.571)
- Acute stress reaction (F43.0)
- Headache, unspecified (R51.9)
- Headache, unspecified (R51.9)

Treatment/Therapy recommendation:

Psychological Consultation:
I am requesting authorization for a psychological evaluation and treatment with Anthony Francisco, Ph.D. for the patient's onset of psychological symptoms.

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 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 neuro-psychometric battery for localization and/or ideologic agent of brain disease. If this is so, we would proceed with some very specific organic neuropsychic 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 AND ATTITUDE

Interpersonal Manner: Patient was punctual, and at all times, cooperative. He conducted himself in a normal level of consciousness. He has a pleasant attitude.

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

The following psychological tests were performed:

1-Complex Comprehensive Clinical Interview (CCCI)
2-Mental Status Evaluation (MSE)
3-Beck Depression Inventory (BDI)
4-Beck Anxiety Scale (BAI)
5-Hamilton Depression Scale (HAM-D)
6-Hamilton Anxiety Scale (HAM-A)
7-Post Traumatic Stress Disorder (PTSD)
8-Adult Neuropsychological Questionnaire (ANPQ)
9-Epworth Sleep Scale (ESS)

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 18 on the Beck Depression Inventory, placing this patient in the range for slight to moderate depression.

BECK ANXIETY INVENTORY

The Beck Anxiety Inventory (BAI), created by Dr. Aaron T. Beck and other colleagues, is a 21question 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 32 on the Beck Anxiety Inventory, placing this patient in the range for moderate to severe sudden anxiety.

HAMILTON PSYCHIATRIC RATING SCALE FOR DEPRESSION

The test was developed by Dr. Hamilton, and is not a "self-rating" test. Rather, applicants discuss their responses with the physician who rates their degree of depression and/or anxiety. Both are considered the most objective measure of an applicant's degree of depression and/or anxiety. Scores to determine the degree of depression and anxiety vary by clinician. The Hamilton Rating Scale for Depression is the most commonly-used psychiatric test in psychiatric pharmacologic management and in research studies because of its objectivity. This test emphasizes vegetative depressive symptoms - such as sleep, appetite, and sexual disturbance - in contrast to the Beck Depression Inventory which emphasizes affective, cognitive and vegetative symptoms. The Hamilton Rating Scale for Depression is used extensively to measure clinical improvement in levels of depression, and an antidepressant is considered efficacious if it results in 50% reduction in the applicant's scores on this test.

HAM-D Score Interpretation: (17 item scale)

- Not depressed: 0–7
- Mild (sub threshold): 8–13
- Moderate (mild): 14–18
- **Severe (moderate): 19–22**
- Very severe (severe): >23

The Hamilton Anxiety Rating Scale (HAM-A)

This is a psychological questionnaire used by clinicians to rate the severity of a patient's anxiety. Anxiety can refer to things such as "a mental state...a drive...a response to a particular situation… a personality trait...and a psychiatric disorder. The HAM-A remains widely used by clinicians. For clinical purposes, and the purpose of this scale, only severe or improper anxiety is attended to. This scale is considered a "clinical rating" of the extensiveness of anxiety.

Hamilton Anxiety Rating Scale (HAM-A)
Scoring each item is scored on a scale of 0 (not present) to 4 (severe), with a total score range of 0–56, where

SCORING:
More than 17 indicates mild in severity,
18 to 24 mild to moderate in severity
25-to 30 moderates to severe in severity

POST TRAUMATIC STRESS DISORDER

Please read each statement carefully and circle the number that best describes how often "that" (problem/injury/incident/stress) has been happening and how much it upset you over the last month. Rate each problem with respect to the traumatic event that happened.

SCORING

0 = Not at all
1 = Once a week or less/a little
2 = 2 to 3 times a week/somewhat
3 = **4 to 5 times a week/very much**
4 = 6 or more times a week/severe

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 patients overall state of well-being. The patient was asked to rate how he feels before and after the injury.

INTERPRETATION/COMMENTS/REPORT

On the neurological instrument, the patient indicates that there has been sleep pattern derangement since the injury. The patient has been experiencing headaches. He is experiencing dizziness. The patient notes a change in the way he walks. Sometimes, he does not understand the things that he reads.

EPWORTH SLEEPINESS SCALE

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can. Use the following scale to choose the most appropriate number for each situation.

Interpreting Epworth Sleepiness Scale Score

Normal	EDS	
	High Level of EDS	
0-10		
	more than 10	more than 16

A score of 10 or greater raises concern: you may need to get more sleep, improve your sleep practices, or seek medical attention to determine why you are sleepy.

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.

(California Code, Labor Code - LAB § 3208.3
California Labor Code Section 3208.3(a) states that a psychiatric injury is compensable if it's a mental disorder that causes disability or requires medical treatment. The disorder must be diagnosed using the principles, terminology, and criteria in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised (DSM-3r). For example, a general practitioner's diagnosis of depression without addressing the DSM-3r criteria is not enough to create liability.)

RECOMMENDATIONS

1. This patient may benefit from psychotherapeutic treatment which may include a variety of modalities including but not limited to behaviour (CBT), supportive therapy for a period of between 3 to 5 sessions to help interrupt the "pain-tension-pain-anxiety" cycle.

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/her 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.

TREATMENT PLAN

Continue with treatment as provided today: CBT, review intra-session assignment, monitor and reinforce progress, self-regulation/relaxation, motivational interviewing, stress management, skill development.

TREATMENT GOALS

- Reduce functional complaints
- Reduce sadness/depression/hopelessness
- Reduce anxiety
- Reduce stress
- Increase socialization
- Increased ability to induce self-relaxation
- Improved coping skills
- Explore return to work option
- Reduce and ameliorate suicidal ideation.

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 symptomatology but when taken as part of the symptoms complex their role becomes evident).

DIAGNOSTIC IMPRESSION

ICD-10-CM

Axis I: 1. Adjustment disorder with mixed emotional features of anxiety and depression secondary to work-related stressful environment causing anxiety, depression and insomnia. (F43.23)
2. Psychological factors affecting physical and medical conditions secondary to work-related stressful environment causing anxiety, depression and insomnia. (F54)

3. Acute stress reaction secondary to work-related stressful environment causing anxiety, depression and insomnia. (F43.0)

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:

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 had been working at the above stated location for many years. He was working in an environment that he describes as very stressful, as such, he began to internalize the stress that began to manifest itself into anxiety, depression and insomnia. That is in addition to the physical symptomology complex, for which he is treating with physical therapy prescribed by Dr. Scott L. Rosenzweig, M.D., orthopedic surgeon. All of the above have affected a change in the psychodynamics of his life. A change that spilled over many areas of his life. All of which continue to further exacerbate his overall level of frustration, anxiety and depression.

As a consequence of this trauma, he developed psychological symptoms, disability, and the need for treatment. The nature and severity of these symptoms impair his ability to function as well as before. He has difficulty sleeping, has a sense of worry and sadness, and lack of security.

As a consequence, he developed the physical symptoms discussed above. He worries continually and is depressed. He has difficulty sleeping, has a sense of hopelessness, sadness and lack of motivation.

A supportive, cognitive, desensitizing form of psychotherapy should be implemented for this patient in order for him 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 him to ventilate emotionally and establish solutions for his present immediate problems and set realistic goals for the future.

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 sequela and reactive psychiatric and psychophysiological 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: 1. Adjustment disorder with mixed emotional features of anxiety and depression secondary to work-related stressful environment causing anxiety, depression and insomnia. (F43.23)
2. Psychological factors affecting physical and medical conditions secondary to work-related stressful environment causing anxiety, depression and insomnia. (F54)
3. Acute stress reaction secondary to work-related stressful environment causing anxiety, depression and insomnia. (F43.0)

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

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 may have to be discussed at the time patient reaches permanent 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. 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 Long Beach 04-27-2025.

Respectfully Submitted,

Anthony Francisco, Ph.D.
Cal. Lic. # PSY 6247
Clinical Neuropsychologist
Member of the American Psychological Associations
Member of the California Psychological Associations

AF:aa