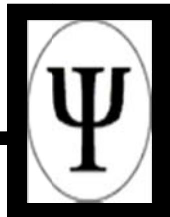

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DR. WHITEHEAD'S NEUROPSYCHOLOGY TRAINING HISTORY

Note: The only official title for a psychologist in California is 'psychologist'. The California Board of Psychology does not provide a means to be licensed as a neuropsychologist, and technically, no psychologist licensed in California should refer to themselves as a licensed neuropsychologist, as there is no official license of that type. That is the reason why a few years ago, the DWC deleted the designation of a Q.M.E. in Neuropsychology, even though it is a well-known specialty area for psychologists. The psychologist who specializes in neuropsychology services does so out of their own interest in the specialty area, by having specialized training in neuropsychology, obtaining the necessary neuropsychological test instruments, and engaging in intensive self-study and utilization of neuropsychology test instruments in ongoing specialty practice.

I first became involved with neuropsychology services before I was a licensed psychologist, that while working as an Organizational Psychology Analyst for Eagle Technology, a defense contractor in the 1987 to 1990 time frame. I worked under the supervision of multiple human factors and organizational psychologists working on complex projects for Department of Defense organizations. Work included the use of proprietary neuropsychological measures, instruments, and methods used in developing technologically enhanced military training programs, and adapting human behavior and senses to enhance training program effectiveness, including the use of the rapidly developing technologies of that era.

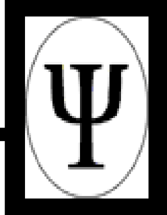
While working toward my psychology license, I then participated in a paid internship at Behavioral Medicine Research, that in the 1992 to 1994 time frame. This was a psychopharmacology research company in San Diego, and was also a rapidly expanding player in the new world of managed care. While there, I worked under the supervision of a psychiatrist and a psychologist, and became very well versed in the use of psychological and neuropsychological testing services in the psychopharmacology research realm. (Please see the attached letter of reference).

After completing my written and oral psychology licensing boards in 1994, I was granted my Psychology License in 1994.

While initially focusing on practice development in the treatment service area, I recognized that psychological and neuropsychological evaluation services were in high demand in a number of practice areas. I began to engage in specialized training and self-study in neuropsychology In addition to standard treatment services, I became heavily involved psychological and neuropsychological evaluation services for San Diego Superior Court, San Diego Human Services, San Diego Juvenile Probation, Social Security Disability system, and the DWC Workers Compensation system, and other organizations. Additionally I received many referrals for neuropsychological evaluation services from psychiatrists, neurologists, and hospital programs.

Utilizing my past experience and training, I applied for the QME programs in both psychology and neuropsychology, becoming certified in those specialties by the Department of Industrial Relations, Division of Workers Compensation, in 1996. By 1997 I submitted applications and was accepted to the American Board of Forensic Examiners, and the American Board of Psychological Specialties, in the specialty of Neuropsychology. (See Attached). I have been working in the trenches ever since performing high levels of neuropsychological evaluations for a variety of clients.

In the ensuing 22 years, I have been hard at work providing a wide variety of clinical, Social Security, QME, IME and AME services in psychology and neuropsychology. I provide professional, clear, detailed evaluation services that always strive to answer detailed and complex referral questions in a professional and practical manner. I do not write reports in academic-speak or psychobabble. I write my reports using common sense, practical explanations of real word effects or non-effects of head injury or other neuropsychological factors. I have provided a recent sample AME Report for your review.



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POST GRADUATE PROFESSIONAL CONFERENCE/CONTINUATION TRAINING RECEIVED

10/31/92 to 01/15/92 (70 Hours)	**Psychology Licensure Review - Complete Review of Field** Including testing/evaluation treatment and treatment planning Association for Advanced Clinical Training
03/28/93 to 04/14/93 (40 Hours)	**Psychology Orals Licensure Review** Focused Review of Field, with special emphasis on testing, testing administration, testing evaluation, assessment and synthesis of testing, treatment modalities, and treatment planning including testing/evaluation and treatment planning Association for Advanced Clinical Training
09/16/95 (6 Hours)	**The Psychologist in the Legal System** Professional Practice Seminars
09/09/95 (6 Hours)	**Forensic Use of the MMPI-A and MMPI-2** University of Minnesota
03/05/96 (4 Hours)	**Qualified Medical Evaluator Review** Industrial Medical Council/Judge O'Brien
05/18/96 to 05/19/96 (18 Hours)	**Essential Psychopharmacology - A Course for Practicing Psychologists** San Diego Psychological Association
11/09/96 (6 Hours)	**Advances in the Treatment of Attention Deficit Disorders in Children and Adults** Institute for Behavioral Healthcare
04/10/97 (7.5 Hours)	**Forensic Psychology Practice Workshop** NCS Assessments
04/11/97 (7.5 Hours)	**Using Psychological Tests in Forensic Practice** NCS Assessments
05/03/97 (7 Hours)	**Detection & Treatment of Alcohol & Substance Abuse** University of California San Diego
05/28/97 (4 Hours)	**Neuropsychological Screening of Adolescents** County of San Diego Mental Health Services

07/28/97 **Neuropsychological Assessment: Clinical Practice and Applications**
(15 Hours) New England Educational Institute

12/11/97 **Forensic & Expert Witness Symposium**
(11 Hours) American College of Forensic Examiners

09/26/97 **Adult Cognitive Assessment: New Developments in the WAIS3/WMS3**
(7 Hours) The Psychological Corporation

09/27/97 **Workplace Harassment & Violence**
(6 Hours) Center for Professional Education

05/04/98 **Corporate Crisis Intervention**
(7 Hours) Crisis Management International

05/05/98 **Threat of Violence Consultation**
(7 Hours) Crisis Management International

01/23/99 **Assessment of Violent Juvenile Offenders**
(7 Hours) American Academy of Forensic Psychology

02/20/2000 **Advanced Forensic Psychology: Issues & Applications**
(24 Hours) American Academy of Forensic Psychology

03/30/2001 **Advanced Course on Legal and Ethical Issues**
(6 Hours) Professional Psych Seminars

09/22/2001 **Malingering, Factitious Disorder & Secondary Gain: The Hidden Agenda in Psychological Assessment**
(6 Hours) Professional Psych Seminars

03/08/2002 **Pain Control: Fibromyalgia, Migraines & Chronic Pain**
(6 Hours) Institute for Natural Resources

06/22/2002 **Assessment & Treatment of Psychological Disability**
(6 Hours) Professional Psych Seminars

10/10/2002 **Psychological Evaluations for Juvenile Court**
(3.5. Hours) County of San Diego Health & Human Services

11/23/2002 **Psychological Testing in the Civil Forensic Arena**
(6 Hours) Professional Psych Seminars

03/22/2004 **QME & AME Report Writing Mastery**
(2 Hours) Current Compensation Seminars

03/22/2004 **ABC's for Qualified Medical Evaluators (QME's)**
(6 Hours) Current Compensation Seminars

02/05/2005 **Impairment to Disability – Evaluating the Accuracy or Inaccuracy of**
(6 Hours) **AMA Impairment Conclusions & Conversions to Disability Ratings**
LawWorm Seminars

03/03/2005 **Psychological Independent Medical Evaluations:**
(7 Hours) **Clinical, Ethical & Practical Issues**
American Academy of Forensic Psychology

04/29/2005 **Law & Ethics: Risk Management in Clinical Practice**
(6 Hours) Alliant International University

05/09/2006 **Psychological Testing in the Civil Forensic Arena**
(6 Hours) Professional Psych Seminars

05/11/2007 **Assessing the Mental Health Status of Older Adults**
(6 Hours) Health Education Network LLC

09/08/2008 **The Doctors Report – Making it Substantial Evidence**
(4 Hours) California Society of Industrial Medicine & Surgery

01/17/2009 **Navigating the QME-AME Labyrinth**
(4 Hours) California Society of Industrial Medicine & Surgery

05/17/2011 **Psychiatric Disorders in the Aging Population**
(6 Hours) Cross Country Education

01/16/2012 **QME Spine Surgery Psychological Screening**
(6 Hours) Behavioral Health CE.COM

01/24/2012 **QME Psychiatric Impairment: A Comprehensive Review of the GAF**
(3 Hours) Behavioral Health CE.COM

02/26/2012 **QME Chronic Pain Management / Concepts**
(3 Hours) Behavioral Health CE.COM

03/22/2012 **Introduction to the MMPI-2 RF – Part 1**
(6 Hours) Pearson Assessments

03/23/2012 **Introduction to the MMPI-2 RF – Part 2**
(6 Hours) Pearson Assessments

12/18/2013 **QME MTUS Chronic Pain Medical Treatment Guidelines**
(12 Hours) Behavioral Health CE.COM

01/28/2014 **Cultural Responsiveness in Psychology Training and Practice**
(2 Hours) California Psychological Association

01/28/2014 **Suicide: Assessing Risk, and Providing Intervention and Treatment**
(2 Hours) California Psychological Association

07/16/2015 **Pain Management and Overmedication**
(3 Hours) California Psychological Association

05/06/2015 **DSM-5 in Plain English**
(6 Hours) Cross Country Education

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SAMPLE REPORT WITH CHANGED NAMES AND IDENTIFYING INFORMATION CHANGED/REDACTED/DISGUISED

AGREED MEDICAL EVALUATION (A.M.E.) IN NEUROPSYCHOLOGY

NAME: L********* C**********
CLAIM#: ******* (Athens Administrators)
WCAB#: ADJ*******
DATE OF ALLEGED INDUSTRIAL INJURY: 05/17/2017
EMPLOYER AT TIME OF ALLEGED INJURY: Del Mar Union School District
CURRENT EMPLOYMENT STATUS: On Temporary Total Disability
A.M.E. EVALUATION DATE: 08/01/2018
DATE A.M.E. REPORT SERVED: 08/22/2018

INFORMED CONSENT

I explained to this client that I was appointed to perform this evaluation as part of a formal administrative / legal process, and that all the information provided to me could be used in my report which must then be submitted to all authorized parties as required by law. The applicant signed a form that also advised this. The applicant completed the evaluation with this understanding.

BILLING METHOD

THIS IS AN AGREED MEDICAL EVALUATION (A.M.E). MEDICAL-LEGAL EVALUATION.
THIS REPORT IS BEING BILLED UNDER ML-104-94 OF REGULATION 9795.
THIS IS DUE TO THE FOLLOWING QUALIFYING FACTORS:

1) Two or more hours of face-to-face time were spent with the patient.
2) Two or more hours of record review were required.
3) Two or more hours of medical research were required, to examine issues related to the clinical and medical-legal issues pertinent to the case.
4) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors
5) Addressing the issue of medical causation upon written request of the party or parties requesting the report, or if a bona fide issue of medical causation is discovered in the evaluation
6) Complex issues of permanent and stationary status, temporary disability, permanent disability and apportionment were addressed, upon request of the party or parties requesting the report.
7) A complex and comprehensive neuropsychological / psychological evaluation which was the primary focus of this medical-legal evaluation.

DOCUMENTS REVIEWED FOR THIS EVALUATION

07/09/2018 Agreed Medical Evaluator Cover Letter signed by both:

Devin J. Andriesen, Esq. DIETZ, GILMOR & CHAZEN 7071 Convoy Court, Suite 300 San Diego, CA 92111 619-236-8550 619-236-9028	Matthew Verduzco, Esq. Law Offices of Matthew Verduzco 2525 Camino Del Rio S, Suite 145 San Diego, CA 92108 619-213-1588 619-227-9797

With the following list of Documents Enclosed by CD-ROM

--- omitted for identification concerns ---

AME MEDICAL-LEGAL INTAKE AND INTERVIEW

GENERAL SOCIAL HISTORY

She was born in P******, Washington, but her family moved to the San Diego area when she was age 5, and she grew up primarily here. Her parents remained a couple throughout her childhood, and are still together. Her father worked primarily as a San Diego City Firefighter. Her mother worked in a variety of secretarial positions on and off. She had no brothers but one younger sister, younger by three years. She describes the family as a very happy family, and she was involved in a lot of sports and horse activities through her childhood. She reports a basic idyllic and happy childhood and adolescence.

There was no problematic use of drugs or alcohol by the parents. There was no domestic violence, physical abuse, excessive argumentation nor any kinds of abuse or trauma experienced by the applicant during childhood or adolescence.

She moved out of the home at age 21, when she was working as postal worker and bought her own first home.

She has been married one time. She married at age 24 to K** C*******, and they were married for almost 10 years. They had two sons, K*** (currently age 30) and K*** (currently age 28). She says that this was not a happy marriage, “and I stayed way to long”. She describes a lot of primarily emotional abuse. There was also some domestic violence. “He would never slap me or hit me, but he would throw me, and then stop and walk away. Sometimes he would push me up against a table or something and push so that say the corner of a table was poking into my back and hurting me.” She denies any major injuries during these episodes, stating there were never any head injuries. “I was more about power and control than anything else”. She reports the idea that he was rather sadistic. They divorced in 1996.

She reports no major relationship history since then. “I date, but I don’t know if I can trust enough to ever get married again. She presently living with her parents since she was unable to afford to continue living in the condo she was living in at the time of her workplace injury.

She has close and ongoing happy contact with her parents and children.

EDUCATIONAL HISTORY

She attended public schooling during elementary and junior high grades, and was place in mainstream classes. She attended a private Christian high school. She graduated high school in 1980. She attended both Grossmont College and Southwestern College. She never completed a degree program, but she had enough credits to get a national certification in surgical technology.

EMPLOYMENT HISTORY

Her first real fulltime job was at Costco, where she worked as a cashier, inventory worker, and vault worker. She worked there from about 1980 to about 1984, though she is not totally sure of those dates.

She was hired by the United States Postal Service in 1984, hired as a clerk. She progressed on into other more complex positions using sorting equipment, postal routing equipment and window clerk. She worked there from 1984 to 1989. She stopped working there due to the heavy workload, and a desire to spend time with her children.

She later went back to school and earned enough credits to get her national certification in surgical technology. She then was hired by UCSD Medical Center in 1992. She worked there until 1996.

She was then hired by the Del Mar School District in 1996, hired on as a health technician, working in the school nurses office. She was also given time as a classroom aide, then became a special education classroom aide, that beginning in about 1999 to 2000. She worked at several different school settings until her subject workplace injury of 5/17/2017. I will discuss this in a later section.

DRUG/ALCOHOL HISTORY

She reports no drug use or alcohol use ever. She tried tobacco at age 12, for about month.

FAMILY PSYCHOLOGICAL/PSYCHIATRIC HISTORY

There is a family history on both grandparents of alcohol problems, which is one reason she has avoided alcohol.

PAST NON-INDUSTRIAL PSYCHOLOGICAL/PSYCHIATRIC HISTORY

She and her husband went to some church-based marital counseling for a several months trying to save their marriage.

Prior to her divorce, she attended some individual counseling at Kaiser, trying to determine if she wanted to end her marriage. She is not sure what sort of degree that person had. She saw that counselor for about a month.

Then after the divorce she and her children attended a court-based program family program for about 4 sessions.

PAST LEGAL HISTORY

This is her first and only workers compensation injury. She reports no other criminal or civil involvement.

PAST & CURRENT NON-INDUSTRIAL MEDICAL HISTORY

Hysterectomy 19**, abdominoplasty 19**, bariatric surgery 20** and angioma removal surgery 20**.

She was diagnosed with low thyroid about 5 years or so ago. She takes Levothyroxine for that once a day.

She also reports that she has seen chiropractors periodically from the age of 16 on due to scoliosis. She estimates that she has seen a chiropractor about twice a month for the last twenty years.

She reports that she used to be diagnosed with migraine headaches, but these had not been present the last few years.

INDUSTRIAL MEDICAL HISTORY

None apart from this case.

HISTORY OF CASE RELATED INDUSTRIAL PSYCHIATRIC/PSYCHOLOGICAL TREATMENT

She reports that she had some speech therapy and also had a recent neuropsychological intake evaluation by a Dr. **********, Psy.D. She seems unsure if she is supposed to see him again for treatment. Other than that, there has been no real mental health treatment, only that intake evaluation by Dr. K****.

SPECIFIC Q.M.E. ISSUES GATHERED FROM THE INTERVIEW WITH THE APPLICANT

On 5/17/2017, she was working doing yard duty at the school she was assigned to, K*** Elementary, keeping an eye on the students during a classroom break. The school bell rang to return to classes. As she was walking back on the blacktop playground, a student kicked a basketball and that ball struck her in the neck and head. She did not pass out, and she does not recall pain, but it knocked her off balance but she did not fall down. She suddenly felt dizzy, weak, and shaky. “I recall that my hands and arms kind of went numb, and my hands started shaking”.

She got her kids back to class, then told the teacher that she had to leave because she was feeling dizzy and shaky. Before she left, she went to the school office and told them about what had happened, and filled out an accident report. She told them that she knew she could go to the doctor, but she just wanted to go home. She drove herself home – “I maybe should not have because I was kind of dizzy, but I made it home”. She went to bed.

The next day her right hand felt numb from her right elbow down to her fingertips. Her chest muscles, trapezoids, and neck were hurting. She was also was still feeling dizzy, and was afraid to drive, so she stayed home again all day. On 05/19/2017 she finally did go to the doctor, because her problems were still there.

She went to Occupational Health at Scripps. She was examined there by a doctor who was concerned and had her transported to another Scripps location for a CATSCAN. That CATSCAN was read and the doctor told her no problems were seen. That doctor still gave her a few days off work.

When she returned to work she still was very sore and was still very tingly in her right side. “It was almost the end of the school year, and I kept hoping I would just get better once school was out because I would have a long break”. I still was feeling dizzy, had pressure in my ears, and tingling in my right arm. Also I had problems reading like I had never had before because I was an always an avid reader”.

“When school started again, I was feeling overwhelmed. I took a job at a different school, and I was just having trouble with focusing, and I kept having problems with reading and my eyes were always jumping around, and I was always feeling dizzy. One day I got so dizzy that I started shaking, and my eyes kept feeling these weird feelings. I went to the ER, but again they found nothing”.

She was written off work for two weeks by the ER doctors. She went back to work, and again began having the same problems, and went back to the ER. “A lot of it is visual, and I still have not seen a neuro-ophthalmologist that Dr. S***** has been trying to get me to, because they (the insurance carrier) keep denying it”.

She got an attorney because she was having trouble comprehending all the paper work that she was getting and did not want to ‘mess things up’. She was referred to him by a friend.

She has not worked since about November 2017. She is classed as TTD by treating neurologist Dr. S*****. No modified duty has been tried. She has had physical therapy, speech therapy, and case management by Dr. S*****. She has been seen by an ENT doctor once, and is supposed to go back for a balance test next week. That doctor wants to do an inner ear MRI.

She saw a neuropsychologist, Dr. K**** on July 5. “I was feeling much worse that day than I am today. I had incredible pain and pressure in my ears all that day and was blowing my nose all the time. I remember I filled up his trash can with tissues. My nose is runny a lot of the times and I seem to have watery eyes a lot whenever I have to start thinking and using my brain”.

As to her current problems, she says “I have dizziness to one degree or another most of the time. I also have pain all the time from about the top of my ears to my trapezoids. I also have pressure in my ears all the time, and my eyes seem to flutter a lot. I also have throbbing headaches”. She does note at this point that she used to have some migraines in the past, but that these ended years ago.

NEUROPSYCHOLOGICAL AND PSYCHOLOGICAL EVALUATION & TESTING

The *Rey 15 Test* is a screening instrument for any efforts at malingering or low effort.

The *Wide Range Achievement Test, 4th Edition, Word Reading Subtest* was employed. This subtest gives a good estimate of premorbid general intellectual ability, since reading ability is very closely related to general intellect, and remains fairly stable despite any subsequent brain injury or other cognitive loss.

The Clock Drawing Test was used as another check for cognitive problems. This is a test that looks at complex cognitive abilities such as abstraction, reasoning, verbal understanding, visual-spatial skills, memory and spatially coded knowledge in, addition to constructive skills.

The *Bender Gestalt 2nd Edition* was used as a screening test for brain injury and an overall test of visual-motor copy ability and visual-motor memory ability.

The *Trails A & B* test was employed as a test of motor speed and attention and executive functioning.

The *Wechsler Adult Intelligence Scale-4th Edition*, and the *Wechsler Memory Scales-4th Edition* were employed to provide an overview of general intellectual, cognitive, and memory functions. These latter two 'gold-standard' of neuropsychological test instruments form the basic backbone of any testing that aims at assessing current cognitive abilities and deficits.

The Category Test is considered a good test for detecting problems with Executive Functioning, Problem Solving, Abstraction Ability, Visuospatial Skills, and general Cognitive Impairment.

==

Rey 15 Item Memory Test - II

Number Rey Items Recalled - 15

This test is a screening instrument for any efforts at malingering or low effort. Because this client performed very well quickly and with no errors, this is a good indicator that she was making good effort on the neuropsychological test instruments. There were no indications based on her performance on this measure that any more sophisticated and time-consuming tests of malingering or effort needed to be administered.

Wide Range Achievement Test-4 (WRAT4)

Domain	Standard Score	%tile	Grade Level
Word Reading	104	61	>12.9

Because reading level is a cognitive skill that is many times resistant to organic damage and cognitive decline from a variety of injuries or diseases, it usually can provide a good measure of premorbid cognitive ability. Since she scored in the average range on his reading ability, we can estimate her premorbid general cognitive ability was likely somewhere around the average range.

The Clock Test

The Clock Test was developed as a screening tool for dementia, or other severe cognitive impairment. Persons with severe cognitive problems or dementia problems usually perform poorly on this test. This client's good performance did not give any indications of the type and quality of problems that are seen in cases of actual dementia or other severe cognitive impairment.

Bender Gestalt Test II (BGT-II)

TEST DOMAIN	Standard Score	%tile	Classification Label
Copy Phase Classification	105	63	Average
Recall Phase Classification	103	58	Average

Overall performance was not consistent with any major organic brain injury or damage or serious visual motor processing problems. This client's visual motor skills and visual motor memory are in the Average range.

Trails A&B

TASK	Time (Seconds)	Level of Impairment
Trails A	33	None (Normal Score)
Trails B	80	None (Normal Score)

Results of this procedure show that the claimant demonstrates Normal levels of executive skills, flexible thinking, and dealing with more than one stimulus at a time, as measured by the Trails A&B examination.

Wechsler Adult Intelligence Scale-4 (WAIS-4)

COMPOSITVE SCORE SUMMARY	Composite Score	%tile	Description (Wechsler Categories)
Verbal Comprehension Index Scale (VCI)	107	68	Average
Perceptual Reasoning Index Scale (PRI)	98	45	Average
Working Memory Index (WMI)	100	50	Average
Processing Speed Index Scale (PSI)	100	50	Average
Full Scale IQ (FSIQ)	102	55	Average
General Ability Index Scale (GAI)	100	55	Average

VERBAL COMPREHENSION INDEX (VCI) SUBTESTS	Scaled Score	%tile	VCI Subtest Ability Areas of Interest
Similarities	10	50	Verbal Concept Formation & Reasoning, Abstract Reasoning
Vocabulary	13	84	Word Knowledge & Verbal Concept Formation, Language Skills
Information	11	63	Ability to Acquire, Retain & Retrieve General Factual Knowledge

PERCEPTUAL REASONING INDEX (PRI) SUBTESTS	Scaled Score	%tile	PRI Subtest Ability Areas of Interest
Block Design	11	63	Ability to Analyze & Synthesize Abstract Visual Stimuli
Matrix Reasoning	10	50	Fluid & Visual Intelligence, Spatial Ability, Perceptual Processing
Visual Puzzles	8	25	Non-Verbal Reasoning, Ability to Analyze/ Synthesize Visual Stimuli

WORKING MEMORY INDEX (WMI) SUBTESTS	Scaled Score	%tile	WMI Subtest Ability Areas of Interest
Digit Span	11	63	Memory, Attention, Concentration, Encoding, Auditory Processing
Arithmetic	9	37	Concentration, Attention, Mental Manipulation, Numerical Reasoning
Letter-Number Sequencing	9	37	Sequential Processing, Mental Manipulation, Memory Span

PROCESSING SPEED INDEX (PSI) SUBTESTS	Scaled Score	%tile	PSI Subtest Ability Areas of Interest
Symbol Search	10	50	Visual Motor Coordination, Visual Processing Speed, Visual Memory
Coding	10	50	Psychomotor Speed, Visual Motor Coordination, Visual Perception

The Scaled Scores show how well this client performed compared to a group of individuals the same age from across the United States. Scaled Scores indicate the relationship of the client's performance rank relative to the national comparison group. A percentile rank is also reported, that shows the client's scores relative in the national comparison group. If the percentile rank were 45, for example, it would mean the client scored higher than approximately 45% of individuals in the same age group. When interpreting these scores, remember that no test score is perfectly accurate. Any individual might score slightly higher or lower if tested again on a different day.

Scaled Score	Description
>14	Superior to Very Superior
12-13	High Average
8-11	Average
6-7	Low Average
4-5	Borderline
<3	Extremely Low

General Intellectual Ability

Ms. C******** was administered 11 subtests of the Wechsler Adult Intelligence Scale–Fourth Edition (WAIS–IV). Her composite scores are derived from these subtest scores. The Full Scale IQ (FSIQ) composite score is derived from 10 subtest scores and is considered the most representative estimate of global intellectual functioning. Ms. C********'s general cognitive ability is within the average range of intellectual functioning, as measured by the FSIQ. Her overall thinking and reasoning abilities exceed those of approximately 55% of individuals her age (FSIQ = 102; 95% confidence interval = 98-106). Her ability to reason with words is comparable to her ability to reason without the use of words. Ms. C********'s verbal and nonverbal reasoning abilities are in the average range. She performed much better on verbal than on nonverbal reasoning tasks. Such differences in performance, however, are not especially unusual among her peers in general.

Verbal Comprehension

Ms. C********'s verbal reasoning abilities as measured by the Verbal Comprehension Index (VCI) are in the average range and above those of approximately 68% of her peers (VCI = 107; 95% confidence interval = 101-112). The VCI is designed to measure verbal reasoning and concept formation. Ms. C********'s performance on the verbal subtests contributing to the VCI presents a diverse set of verbal abilities, as she performed much better on some verbal tasks than others. The degree of variability is unusual and may be noticeable to those who know her well. Examination of Ms. C********'s performance on individual subtests provides additional information regarding her specific verbal abilities.

Ms. C******** achieved her best performance among the verbal reasoning tasks on the Vocabulary subtest. Her strong performance on the Vocabulary subtest was better than that of most of her peers.

The Vocabulary subtest required Ms. C******** to explain the meaning of words presented in isolation. As a direct assessment of word knowledge, the subtest is one indication of her overall verbal comprehension. Performance on this subtest also requires abilities to verbalize meaningful concepts as well as to retrieve information from long-term memory (Vocabulary scaled score = 13).

Perceptual Reasoning

Ms. C********'s nonverbal reasoning abilities as measured by the Perceptual Reasoning Index (PRI) are in the average range and above those of approximately 45% of her peers (PRI =98; 95% confidence interval = 92-104). The PRI is designed to measure fluid reasoning in the perceptual domain with tasks that assess nonverbal concept formation, visual perception and organization, visual-motor coordination, learning, and the ability to separate figure and ground in visual stimuli. Ms. C********'s performance on the perceptual reasoning subtests contributing to the PRI is somewhat variable, although the magnitude of this difference in performance is not unusual among individuals her age. Examination of Ms. C********'s performance on individual subtests provides additional information regarding her specific nonverbal abilities.

Ms. C******** achieved her best performance among the nonverbal reasoning tasks on the Block Design subtest and her lowest score on the Visual Puzzles subtest. Her performance across these areas differs significantly and suggest that these are the areas of most pronounced strength and weakness, respectively, in Ms. C********'s profile of perceptual reasoning abilities.

The Block Design subtest required Ms. C******** to use two-color cubes to construct replicas of two-dimensional, geometric patterns. This subtest assesses nonverbal fluid reasoning and the ability to mentally organize visual information. More specifically, this subtest assesses her ability to analyze part-whole relationships when information is presented spatially. Performance on this task also may be influenced by visual-spatial perception and visual perception-fine motor coordination, as well as planning ability (Block Design scaled score = 11). The Visual Puzzles subtest required Ms. C******** to view a completed puzzle and select three response options that, when combined, reconstruct the puzzle, and do so within a specified time limit. This subtest is designed to measure nonverbal reasoning and the ability to analyze and synthesize abstract visual stimuli. Performance on this task also may be influenced by visual perception, broad visual intelligence, fluid intelligence, simultaneous processing, spatial visualization and manipulation, and the ability to anticipate relationships among parts (Visual Puzzles scaled score = 8).

Working Memory

Ms. C********'s ability to sustain attention, concentrate, and exert mental control is in the average range. She performed better than approximately 50% of her peers in this area (Working Memory Index (WMI) = 100; 95% confidence interval 93-107).

Processing Speed

Ms. C********'s ability in processing simple or routine visual material without making errors is in the average range when compared to her peers. She performed better than approximately 50% of her peers on the processing speed tasks (Processing Speed Index [PSI] = 100; 95% confidence interval 92-108).

Summary

Ms. C******** is a 56-year-old female who completed the WAIS–IV. Her general cognitive ability, as estimated by the WAIS–IV, is in the average range (FSIQ = 102). Ms. C********'s verbal comprehension and perceptual reasoning abilities were both in the average range (VCI = 107, PRI = 98). Ms. C********'s ability to sustain attention, concentrate, and exert mental control is in the average range (WMI = 100). Ms. C********'s ability in processing simple or routine visual material without making errors is in the average range when compared to her peers (PSI = 100).

Wechsler Memory Scales-4 (WMS-4)

(WMS–IV Flexible Alternate Index 4 Subtest Method allowed by WMS-IV Manual)

PRIMARY SUBTEST SCALED SCORES	Scaled Score	%tile	Description
Logical Memory I	8	25	Memory for two very short stories immediately after read out loud
Logical Memory II	7	16	Memory for the two very short stories after a delay
Visual Reproduction I	10	50	Ability to reproduce figures immediately after being shown
Visual Reproduction II	8	25	Ability to reproduce figures after a delay

ALTERNATE INDEX SCORE SUMMARY	Index Score	%tile	Wechsler Categories	Index Description
Immediate Memory	93	32	Average	Ability to remember information immediately
Delayed Memory	85	16	Low Average	Ability to remember information after a delay
Auditory Memory	88	21	Low Average	Ability remember auditory information
Visual Memory	95	37	Average	Ability remember visual information

Interpretation of WMS–IV Results
Ms. C******** was administered 4 subtests of the Adult battery of the Wechsler Memory Scale–Fourth Edition (WMS–IV), from which her index scores were derived.

Specific Auditory Memory Abilities-Auditory Forgetting and Retrieval Scores
The degree to which Ms. C******** forgot the story details she learned during the immediate condition of Logical Memory I can be determined by comparing her delayed recall performance to that of others with a similar level of immediate recall (LM II Immediate Recall vs. Delayed Recall contrast scaled score = 9). This comparison indicates that Ms. C******** is able to recall story details after a delay as well as expected, given her level of immediate recall.
Specific Visual Memory Abilities-Visual Forgetting and Retrieval Scores
The degree to which Ms. C******** forgot the details and relative spatial relationship among elements of the designs presented during the immediate recall of the Visual Reproduction subtest can be determined by comparing her ability to recall and draw the designs after a delay to that of individuals with a similar level of immediate ability (VR Immediate Recall vs. Delayed Recall contrast scaled score = 8). Based on this comparison, Ms. C******** is able to recall and draw this type of visual information after a delay as well as expected, given her level of immediate recall.

Wide Range Assessment of Memory & Learning -2nd Ed. (WRAML-2)

(Core Subtests & Indexes Only, as allowed by WRAML-2 Manual)

Core Subtests	*Scaled Score*	*Percentile*
Story Memory	10	50
Design Memory	11	63
Verbal Learning	9	37
Picture Memory	9	37
Finger Windows	10	50
Number Letter	10	50

Index Name	*Index Score*	*Percentile*	*Description*
Verbal Memory	97	42	Average
Visual Memory	100	50	Average
Attention/Concentration	100	50	Average
General Memory	98	45	Average

Verbal Memory Index

The Verbal Memory Index is an estimate of how well the client can learn and recall both meaningful verbal information and relatively rote verbal information. It is derived from the sum of the Story Memory subtest and the Verbal Learning subtest. When consistent performance exists between the two subtests comprising this index, the index presents a reasonable estimate of verbal memory abilities.

More specifically, Verbal Memory Index performance is correlated with abilities for everyday tasks (e.g., remembering stories, conversations, or information from lectures; following directions; recalling items from a “things to do” list). Related academic tasks can include the ability to recall the content of information that was read earlier, the ability to learn lists of scientific terms, or the ability to remember vocabulary words.

Ms. C********'s Verbal Memory Index of 97 (90% CI: 90-104; Percentile rank: 42) was found to be within the Average range. Generally, within this range on the Verbal Memory Index, Libby C******** is expected to learn and remember verbal information at a comparable level to that of adults of similar age. Within this range, the higher the estimate of verbal memory abilities, the greater is the likelihood that memory abilities will somewhat exceed those of the client's age group and present as an area of relative strength. Although remaining within the Average range, as scores fall below the mean, the greater is the likelihood that verbal memory abilities will fall somewhat lower than those of the client's age group.

Visual Memory Index

This assesses visual rote memory toward increasing visual memory demands for meaningfulness and complexity. The Visual Memory Index is an estimate of how well the client can learn and recall both meaningful (i.e., pictorial) and minimally related, rote (i.e., design) visual information. It is derived from the sum of the Picture Memory subtest and the Design Memory subtest. When consistent performance exists between the two subtests comprising this index, the index presents a reasonable estimate of visual memory ability.

More specifically, visual memory abilities may be related to day-to-day tasks (e.g., remembering the layout of the town visited a while ago, identifying different car models, remembering the location of states on a map). Related academic tasks can include the recall of information from the chalkboard, some aspects of math problems (e.g., graphs, spatial problems), and processing/recalling less verbal or nonverbal aspects of science/technology like a circuit diagram).

Ms. C********'s Visual Memory Index of 100 (90% CI: 92-108; Percentile rank: 50) was found to be within the Average range. Generally within this range on the Visual Memory Index, Ms. C******** should be expected to remember visual information at levels consistent with adults of similar age and this should be noticeable on everyday visual memory tasks. Further, because these tasks are timed, Ms. C******** may be expected to demonstrate average organizational skills for tasks that require nonverbal memory abilities.

Attention/Concentration Index

The Attention/Concentration Index is an estimate of how well the client can learn and recall relatively non-meaningful rote, sequential information. It is the sum of two subtests, Finger Windows and Number Letter. When consistent performance exists between the two subtests comprising this index, the index presents a reasonable estimate for tasks requiring brief attentional demands and/or immediate rote recall abilities.

More specifically, performance on the Attention/Concentration Index is correlated with performance on everyday tasks (e.g., remembering a dictated telephone number until it can be written down, remembering visual details of a highway sign or a billboard that one has driven by in the car). Related academic tasks can include learning phonetically irregular spelling words and following the specific details and/or a sequence of oral directions.

Ms. C********'s Attention/Concentration Index of 100 (90% CI: 91-109; Percentile rank: 50) was found to be within the Average range. Generally, within this range on the Attention/Concentration Index, Ms. C******** should perform rote memory tasks at a level that is comparable to that of adults of similar age.

General Memory Index

The General Memory Index is the sum of three separate indexes: the Verbal Memory Index, the Visual Memory Index, and the Attention/Concentration Index. Each index is composed of two subtest scores. Thus, if all six core subtests were administered, individual indexes and the General Memory Index were calculated.

Ms. C********'s General Memory Index of 98 (90% CI: 92-105; Percentile rank: 45) was found to be within the Average range. This suggests overall memory functioning is at levels commensurate with adults of similar age. That is, the General Memory Index suggests that Ms. C******** generally will perform at levels commensurate with her age group for tasks that require verbal memory and visual memory skills and across tasks that are dependent on both contextualized memory and rote memory.

The Category Test (CAT)

The CAT is one component of the Halstead-Reitan Neuropsychological Test, and is designed as a measure of executive function, to assess problem-solving capacity, and the ability to search for and discover alternative solutions to novel problems. The Category Test is considered a good test for detecting problems with Executive Functioning, Problem Solving, Abstraction Ability, Visuospatial Skills, or Cognitive Impairment.

Scoring involves recording the number of errors. Based on traditional scoring using cutoff values (cutoff scores are scores that indicate the borderline between normal and impaired functioning), scores above 41 are considered indicative of brain impairment for ages 15 to 45. For ages 46 and older, scores above 46 indicate impairment. Reitan has suggested a cutoff of 50 or 51 errors. Recommended cutoffs also vary depending on age and education level. Her error scores are shown below.

SUBTEST	ERRORS
1	1
2	0
3	7
4	14
5	11
6	1
7	3
Total	37

Because her number of errors do not meet the cutoff scores above, there are no indications of any major problems with Executive Functioning, Problem Solving, Abstraction Ability, Visuospatial Skills, or Cognitive Impairment.

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PSYCHOLOGICAL EVALUATION & TESTING CONDUCTED

Personality Assessment Inventory (PAI)

Clinical Scale	T-Score
SOM-Somatic Complaints	58
ANX-Anxiety	42
ARD-Anxiety-Related Disorders	49
DEP-Depression	55
MAN-Mania	39
PAR-Paranoia	54
SCZ-Schizophrenia	45
BOR-Borderline Features	38
ANT-Antisocial Features	41
ALC-Alcohol Problems	41
DRG-Drug Problems	48
AGG-Aggression	41
SUI-Suicide	43

The PAI is an objective clinical scale designed to assist in diagnosis, assessment of symptom levels, and treatment planning. It has multiple validity scales to assess the truthfulness of the test-taker. T-Scores above 70 on the Full Scales and Subscales are indicative of clinical level problems, as long as exaggeration or malingering are not present.

Validity of Test Results

The PAI provides a number of validity indices that are designed to provide an assessment of factors that could distort the results of testing. Such factors could include failure to complete test items properly, carelessness, reading difficulties, confusion, exaggeration, malingering, or defensiveness. For this protocol, the number of uncompleted items is within acceptable limits. Also evaluated is the extent to which the respondent attended appropriately and responded consistently to the content of test items. The respondent's scores suggest that she did attend appropriately to item content and responded in a consistent fashion to similar items.

The degree to which response styles may have affected or distorted the report of symptomatology on the inventory is also assessed. The scores for these indicators fall in the normal range, suggesting that the respondent answered in a reasonably forthright manner and did not attempt to present an unrealistic or inaccurate impression that was either more negative or more positive than the clinical picture would warrant.

Clinical Features

The PAI clinical profile reveals no elevations that should be considered to indicate the presence of clinical psychopathology. The pattern suggests a person who is experiencing some turmoil in her life that might be the source of some stress for her, but not to the point where prominent symptoms are observed. She may feel unhappy or tense at times, but, in general, her self-esteem is intact and she reports that the stress is having little impact on her ability to function.

The PAI clinical profile is entirely within normal limits. There are no indications of significant psychopathology in the areas that are tapped by the individual clinical scales.

RECORDS REVIEW AND CASE TIMELINE

Note: Documents are never read through just once. More time is always expended in analyzing, synthesizing, and re-reading and re-evaluating case material during the AME report formulation process, in order to understand the complex and comprehensive issues of the case, and thus provide a fair overview of what has occurred.

While I closely reviewed all records sent by the parties, these records below were seen as especially pertinent.

Please note that the PDF file page count came to 2,968 pages for records review.

==

Brinegar Chiropractic & Massage – Chiropractic Records, 2012 to 2013

Minimally informative records of chiropractic maintenance treatment for scoliosis.

Family First Chiropractic & Wellness Center – Chiropractic Records, 2013 to 2018

Earliest Record: 08/13/2013

Pain/Complaint- patient states that they have a complaint of pain, discomfort and loss of ROM in the cervical region.
DX 723.1

Asymmetry - Exam shows postural deficit in the cervical region (see postural analysis) Ox 781.92
ROM - Motion palpation of the cervical spine reveals segmental dysfunction and loss of segmental ROM at the C2 level. Dx. 739.

Tissue - Palpation of the cervical para-spinal musculature reveals spasm bilaterally. Ox 728.85
Global ROM - Upon computerized ROM exam (see exam findings), the findings reveal a loss of cervical active ROM. Dx. 728.9

Most Recent Record: 06/08/2018:

S: Patient states no change in condition compared to last visit.
O: Exam shows subluxations that are not symptomatic .
A: Patient's condition is stable at this time. Patient tolerated and responded well to treatment.
P: Continue as per discharge summary. Segments adjusted above: C3 C4

Deposition of Libby C****** 05/16 /2018**

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18 **Q. That's why I ask everybody at the school**
19 **district. I want to talk about your current**
20 **complaints. I guess just very recent in the last**
21 **two weeks, what complaints do you have that you**
22 **relate to the May 17, 2017 injury?**
23 A. Difficulty with conversation, speaking,
24 both receptive and expressive. I get very dizzy.
25 I have pressure in my ears right now really bad

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1 like before you come down from an airplane, but
2 it's like worse.
3 **Q. Is that --**
4 A. That's every day.
5 **Q. Go ahead. Anything else?**
6 A. I get nauseous. My eyes water. My nose
7 runs. It just gets progressively worse the more I
8 engage in speaking. I can't read. I can only
9 read very little. There's a visual component.
10 **Q. How long can you read before you have**
11 **problems?**
12 A. About a paragraph. It's more my eyes
13 jump away from the page. I think it's a tolerance
14 level thing. Trouble comprehending what I'm
15 reading. Off balance. I don't fall down, I just
16 fall to the side like three or four steps, you
17 know. That's on a bad day or I fall backwards
18 three or four steps until I regain my balance.
19 **Q. The pressure in the ears does that go**
20 **into like headaches or is it just in the ears?**
21 A. It's mostly just the ears. I have a lot
22 of trap pain. It's like I have muscle pain all
23 the way to here. It's like -- I'll show you.
24 It's like all -- I never have pain up here. It's
25 all here and around my ears, all this musculature,

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1 and my trap.
2 **Q. Okay.**
3 A. They told me it's because my body is
4 constantly trying to balance itself.
5 **Q. For the record, she pointed from the**
6 **base of her head down her neck on both sides to**
7 **her shoulders.**
8 A. Sometimes my clavicles but not -- that's
9 a bad, bad day when it hurts in the front. It's
10 mostly there.
11 **Q. How often do you have that pain?**
12 A. The front?
13 **Q. No. Just from the base of your head to**
14 **your shoulders?**
15 A. Every day. All day. Every night.
16 **Q. Every minute of every day?**
17 A. Yes. So I end up taking the Extra
18 Strength Tylenol so that I can sleep. This left
19 eye starts to do this when I've been talking too
20 long.
21 **Q. Twitch?**
22 A. It just does this.
23 **Q. Quickly just to stay on the neck pain --**
24 A. Yes. Thank you.
25 **Q. Let me quickly give you the way we judge**

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1 **pain a rating scale one to ten. One is minimal**
2 **pain. Ten is extreme pain, pain that will send**
3 **you to the emergency room. So how do you rate**
4 **that pain from the base of your head to jury**
5 **shoulders?**
6 A. It varies. Sometimes I wake up with it
7 at about like a three or a four. I have a pretty
8 high pain threshold anyway. But it gets to where
9 like it's a seven or eight. And that's when I
10 take the Tylenol. I don't like to take medicine
11 if I don't have to. I take it then. I use hot
12 compresses. You know, those microwavable things.
13 I've got two of them. I put those on my shoulders
14 and down my back. Sometimes it hurts down here.
15 The more constant is all of this (indicating).
16 My head throbs, but not like -- it
17 throbs enough at night where I can't sleep. I'm
18 laying there counting my heart rate, you know. So
19 I'll take the Tylenol PM to take the edge off.
20 But it's not like excruciating pain. It's like
21 muscle constant pain where I just I -- I go to the
22 store sometimes trying to keep my muscles loose.
23 **Q. Then you said you're also nauseous. How**
24 **often are you having that feeling?**
25 A. When I speak.

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1 **Q. After speech?**
2 A. When I'm speaking I get nauseous.
3 **Q. How long do you talk before you start to**
4 **get nauseous?**
5 A. About a half an hour.
6 **Q. Okay.**
7 A. Like if I go out to eat with friends or
8 whatever, I don't usually eat because I'm trying
9 to keep track of their conversation or whatever,
10 and I get nauseous, and I don't eat. So I don't
11 do that anymore.
12 **Q. The balance issues how often do you have**
13 **those, like how often do you fall over to the**
14 **side?**
15 A. It varies. Some days I have a very
16 difficult time. Other days are pretty good. But
17 going down stairs like makes me very dizzy. I
18 have to hold on. I try the escalator. It's very
19 hard to get on because the visual part, the
20 moving. If I'm not in control of the movement in
21 front of my eyes, I get really dizzy. So like
22 watching TV, just scroll a computer to watch
23 someone, it's like I jump away from it. I'm dizzy
24 all the time pretty much to varying degrees.
25 **Q. Okay. Any other symptoms that we**

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1 **haven't discussed?**
2 A. Just very, very dizzy, very off balance.
3 I have a hard time saying what I want to say. I
4 can't do -- I can't read. I walk my dog. But I
5 make sure I'm on a flat surface and there's other
6 people around.
7 **Q. So now I'm going to ask about any prior**
8 **injuries. Prior to May 17, 2017, have you ever**
9 **had any injuries to your head or any problems with**
10 **headaches?**
11 A. I used to have migraines.
12 **Q. When did you have migraines?**
13 A. I had them up until about two years ago.
14 I had them for about 10 years I would say.
15 **Q. Did you get treatment somewhere?**
16 A. I would take Imitrex whenever I needed
17 it and Naprosyn. I still have the Imitrex just
18 for fear that they come back.
19 **Q. Were you seeing any doctors?**
20 A. I saw my general practitioner.
21 **Q. Was that at Kaiser?**
22 A. Uh-huh (affirmative response).
23 **Q. Besides migraines have you had any other**
24 **head injuries or treatments for your head?**
25 A. No.

Kaiser Foundation Hospital/SCPMG Medical Records

12/10/2007 Medical Note by Darleen *****, R.N.

Spoke with pt "Stated Migraines are not being controlled with Imitrex injection, went to ER last night was given Toradol no relief, then given Dilaudid with relief." Would like to know what is the next step in managing her Migraines current plan not effective.

12/11/2007 Medical Note by Colleen D****, R.N.

Imitrex injections for now and in past took Maxalt and no relief and Topamax no relief either. I'm doing a little study right now with Dr. Matista and I only take the Imitrex for migraine when I have to.

12/18/2007 Progress Note by Marie E*****, N.P.

Constitutional: She is oriented and developed, nourished, and not distressed. Vitals normal. She appears not dehydrated.
HENT:
Head: Normocephalic.
No ear pain
No clicking or popping of the TMJD

Muscle tension in neck and shoulders
Possible jaw clenching as well
Eyes: Conjunctiva normal, pupils equal, round and reactive to light. Right eye exhibits no nystagmus.
The right eye shows no papilledema. The left eye shows no papilledema.
Neck: Normal range of motion. Neck supple.
Musculoskeletal: Normal range of motion.

Neurological: She has normal motor skills, normal sensation, normal strength, normal reflexes, and intact cranial nerves.

She is alert and oriented. She is not agitated and not disoriented. She displays no weakness, no atrophy, no tremor, facial symmetry, normal sensation, normal coordination, normal stance, normal gait, normal speech and normal cranial nerves.

She exhibits normal muscle tone. She has a normal Finger-Nose-Finger Test, a normal Heel to Shin Test and a normal Romberg Test. She shows no pronator drift.

Skin: Skin is warm and dry. No rash noted.

Psychiatric: She displays normal mood, affect and judgment.

07/22/2008 Email from Libby C****** to Le***** J*****, R.N.**

Hi Dr. M****,
I guess we are back to the drawing board. First, if you could please give me a referral back to Neurology as it has been more than a year since I have seen her. My migraines are lasting a week now, I am finding myself "clumsy" and I need to see her about adjusting my meds or another means of treatment. Also, if you would please fill out the form (I forgot the name of the one you used before)to give to my employer that I may miss work approx once a month due to my condition (migraines), to protect me. I will do the sleep apnea study on the 30th. I hope this is what is causing all the trouble. I thought Cushings Disease was it for sure as the signs and symptoms are almost identical. Is there something else that mimics these symptoms? Let me know if I should come and see you before the sleep study is done. I am off of work until Aug 20th so I am available anytime to do testing and try to figure out why my body is constantly "inflamed". Even my gums! Thx Libby

08/10/2008 William N**, M.D.**

SLEEP STUDY, UNATTENDED, INCLUDING VENTILATIONS, RESP EFFORT, ECG

The diagnostic portion of the study indicates mild Obstructive Sleep Apnea.

Due to the mild nature of the patient's sleep apnea, CPAP titration was not recommended.

Treatment interventions for mild sleep apnea would include weight loss, a jaw advancement device, positioning therapy and avoiding alcohol and sedatives.

A referral back to the sleep clinic could be considered should the patient's symptoms worsen in the future.

08/13/2008 Questionnaire Filled out for Kaiser Postive Choice Wellness Center

48. What do you think is the basic, underlying cause of your weight problem?
Post Traumatic Stress? Migraines?
12 Years of constant stress?

I have been getting testing for the constant weight gain and migraines. I'm hoping my body is just tired & storing because of the contstant stress of the last 12 yrs. Maybe once I start this my body will quit protecting itself and let go of the fat storing. I see that as my only barrier.

08/27/2008 Progress Note by Thomas M****, P.A.

PSYCHOLOGICAL

- Patient has been to her doctor 10 or more times in the past 12 months
- Patient reports her stress level is: moderate
- Patient reports that she has been threatened, abused, or raped as an adult.
- She is having serious problems with her finances
- She has difficulty staying asleep
- She has difficulty feeling rested after a night's sleep
- Patient currently reports extreme fatigue or exhaustion
- her extreme fatigue or exhaustion began more than 12 months ago
- her extreme fatigue or exhaustion does not improve with exercise, physical activity, or as the day progresses

10/01/2008 Progress Note by Joseph P****, M.D.

Libby D C******** is here for follow-up for migraine without aura. She has 6 headache days per month. She describes a unilateral headache, back of the neck and teeth pain and neck area. The pain lasts for several days in duration Positive light and sound sensitivity , confusion, with nausea and vomiting. 6 days past month using Imitrex injection 2x per day x 3 days straight. No longer on Topamax bc she was training for the 3 day breast cancer walk.

At the last visit consultation(s) neurology 2007 was prescribed Topamax and this was/were tolerated. Side effects none. Pt reports a 2 types of headache in headache days Pt reports 30 days in 30 days month. Current rescue meds none. Optifast started about 4weeks ago.

Sleep apnea work up this past summer and found to be borderline.

Patient Active Problem List:
OBESITY (BMI 30-39.9) (278.00C)
COMMON MIGRAINE, NOT INTRACTABLE (346.10D)
DEPRESSION (311A)
DYSPEPSIA (536.8A)

CT HEAD WITH AND WITHOUT CONTRAST
HISTORY: Right-sided headaches.

Computed tomographic views of the head were performed at 5 mm intervals. After obtaining an written and informed consent, an intravenous infusion of 100 cc of Omnipaque 350 was injected and imaging through the head was repeated using the same perimeters.

FINDINGS: There is no mass effect, no intracranial hemorrhage. There are no enhancing lesions with contrast.

IMPRESSION:
Negative CT of the head with and without contrast.

Past Medical History:
DEPRESSION 8/16/2006
OBESITY (BMI 30-39.9) 8/16/2006
COMMON MIGRAINE, NOT INTRACTABLE 7/27/2006

Past tried meds:
Amerge, Vicodin, Paxil for depression without improvement unknown how long she was on this
Soma, Flexeril, Cozar, kava kava

Neurological: She is alert and oriented. She has normal motor skills, normal sensation, normal strength, normal reflexes and intact cranial nerves. She is not agitated and not disoriented. She displays no weakness, no atrophy, no tremor, facial symmetry, normal stance and normal speech. No cranial nerve deficit or sensory deficit. She exhibits normal muscle tone. She has a normal Finger-Nose-Finger Test, a normal Heel to Shin Test, a normal Romberg Test and a normal Tandem Gait Test. She shows no pronator drift. Gait normal. Coordination and gait normal.

Psychiatric: Mood, memory, affect and judgment normal.

02/22/2009 Diagnostic Imaging Report by Harvey R****, M.D.

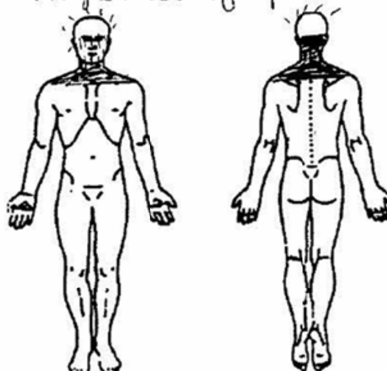
XR CERVICAL SPINE, AP, LAT, OBLIQUES, ODONTOID AP, lateral and oblique views of the cervical spine show the bony cortices to be intact. The joint spaces are well maintained. There is slight decrease in usual incremental disc space height at C5-6. There is minimal anterior spurring. There is also minimal posterior spurring without significant neural foraminal impingement. There are no cervical ribs. There are no fractures or subluxations.

IMPRESSION: Degenerative disc disease at C5-6, otherwise unremarkable study.

02/26/2009 Questionnaire and Progress Note by Yvonne M****, M.D. on 02/16/2009

1. In the space below, please **describe the problem** that brings you here today. **What caused this problem?**
   After many years, we still don't know. migraines - frequent dibilitating

2. **Shade in on the body chart** where you are having pain, numbness (can't feel), tingling, weakness, or other symptoms.



3. Do you have any symptoms of:
   ☒ **PAIN** : Where? Shoulders, neck, Base & Skull →
   ☒ **Always there** ☐ **Comes and goes**

   ☐ **NUMBNESS/TINGLING** : Where? NO →
   ☐ **Always there** ☐ **Comes and goes**

   ☐ **WEAKNESS** : Where? NO →
   ☐ **Always there** ☐ **Comes and goes**

4. Please give the **approximate date** when these symptoms first appeared. 6 yrs? Tightness + pain increases each year.

10. Is your problem: ☒ **Getting worse** ☐ **Getting better** ☐ **Staying the same**

19. Past Medical History

- ☐ Thyroid problems
- ☐ Diabetes
- ☒ Depression - situational
- ☐ Stomach Ulcer
- ☐ High blood pressure
- ☐ Stroke
- ☐ Seizure disorder
- ☐ Pacemaker/defibrillator
- ☐ Asthma or Lung disease: Which one/what type? ________
- ☐ Long term steroid use (more than 3 months) Why? ________
- ☐ Broken bones: Which bone(s)? ________
- ☐ Motor vehicle accidents: When? ________
- ☒ Other significant medical problem(s)? What? migraines
- ☐ Kidney / Liver disease (circle one or both, if apply) Type? ________
- ☐ Vascular disease (significant circulatory compromise)
- ☐ Heart problems: What type? ________ When? ________
- ☐ Cancer: What type? ________ When? ________ Current status? ________
  - For this, did you have: ☐ Chemotherapy? ☐ Radiation? ☐ Surgery?

20. Past Surgical History

- ☐ Spine Surgery: **What and when?** ________
- ☐ Joint Replacement: **What and when?** 2000
- ☐ Other Surgery: **What and when?** Hysterectomy 1990, abdominoplasty + augmentation 1950

DIAGNOSES
Myofascial Pain Syndrome

04/06/2009 Physical Therapy Note by Caitlin L*****, P.T.

PRESENT Hx (Progression/Recent Rx): Libby D C******** is a 46 year old female with above c/c. Complaint of insidious onset. Pt reports having undiagnosed viral infection ~1999 that caused gross and profound weakness for many months. It was during this time that she had her first migraine. Pt reports also having significant stress x 13 yrs with former husband which is lessening. Pt also participated in migraine food diet which didn't help, but has lost 60 lbs on optifast since 8/08 and is still losing on modified diet, but this has had no effect on migraines. Migraines have been worse over last 2 yrs. Rx to date: massage no relief, chiropractic procedures helpful, acupuncture/acupressure no relief, and cortisone injections ~ 6 wks ago helpful right>left with more scheduled tomorrow. Medications for this c/c: imitrex not helpful, naprosyn, anti-nausea medication.

Diagnostics Test: X-rays, MRI, CT Scan, sleep studies negative. PAST Hx: as described above, h/o scoliosis.

Dominant hand: right handed.

General pain pattern: continuous, always feels tight, migraines 1x every 2 wks

Pain Scale: 5/10 currently, 5/10 at best, 7-8/10 shoulders 9/10 migraine at worst. Acceptable Pain level: 0/10
Easing Factors: heat; stretching - posterior capsule, overhead triceps, shrugs/shoulder rolls, CS circles, wall pec stretch; chiropractor

04/07/2009 Progress Note by Yvonne U*****, M.D.

Patient presents with: SHOULDER PAIN - follow up on shoulder pain

Patient states bilateral upper trapezius trigger point injections last visit helped more on right side than left. Pain almost

back to prior level. Had physical therapy eval yesterday. Xray cervical spine showed C5-6 DDD. Wants to repeat trigger point injections.

PROCEDURE NOTE: trigger point injections

DIAGNOSIS:
729.1A MYOFASCIAL PAIN SYNDROME
722.4A DEGENERATION OF CERVICAL INTERVERTEBRAL DISC

04/15/2009 Tama L **, C.H.E.**

Attended group

Week 1. Introduction and overview of 12 week group of women who have experienced trauma whether it be physical, emotional and/or sexual.

First week each new participant receives a folder of information and will be required to sign 2 Creative Art Therapy consent forms and return to facilitator. She is a continuer. She took a big step last week and sent a letter to her aunt . Libby was able to work on overcoming feelings of shame by receiving group support and validation that what she did was courageous. She journaled about a drawing she did last week and said it really is helping her to feel better about herself.

10/12/2009 Progress Note by Debra K**, R.N.**

Patient states wants to start bioidentical hormone therapy. States had a complete hysterectomy in 1989 and was taking some hormone therapy in the past. States has been feeling tired and doesn't feel like doing anything.

11/10/2010 Progress Note by Marianne R**, O.D.**

Chief Complaint/Reason for Visit:

Patient presents with: DECREASED VISION DISTANCE

Distance blur - 2 weeks ago, blurred distance vision - lasted for a few minutes - happened twice. Has been feeling dizzy lately. hx of migraine headaches. CT scan 11-3-10

Assessment:
367.4A PRESBYOPIA
367.1A MYOPIA
361.30B RETINAL DEFECT

02/03/2011 Progress Note by Lynn G**, M.D.**

Libby D C******** is a 48 year old female G2P2 started HRT 3 mos ago and is feeling much better. Less hot flushes and migraines are less frequent. Still feels depressed about not having motivation to exercise and has gained over 60 lbs last 2 yrs. She used to be athletic but now has no motivation. Works as teacher.

Medical problems Heartburn and depression

02/21/2013 Email from Libby C****** to Dr. *****

Subject: I am having surgery on March 28th

Hi Dr. M***,

Just wanted you to know that you were right and I will need to have the hemangiomas removed along with my gall bladder. Dr. Wu was glad you noticed and referred me as the one looks ready to rupture with the other putting pressure on it. So I will have a hepatic resection and cholecystectomy.

9/5/2013 Progress Note by R***, M.D.**

SWELLING OF LIMB. (primary encounter diagnosis)
Note: suspect mild venous insufficiency; will get D-dimer to rule out DVT, check other labs; encouraged increased physical activity, weight loss

DEPRESSION
Note: appears to have mild depression, likely a part of her chronic fatigue; will consider anti-depressant medication.

01/30/2015 Progress Note by N**, (M.D.)**

Assessment/Plan:
379.21 BILAT POSTERIOR VITREOUS DETACHMENT (primary encounter diagnosis)
379.57 EYE MOVEMENT DISORDER, SACCADIC
PVD- no tears, holes or detachments seen today. Patient given retinal detachment warning signs, and counseled to call immediately with any changes.
C/o saccadic eye movements, bilateral

Started in sept 2014, now increasing in frequency and happening weekly
Occasionally with some eye pain

Fast phase is always to the left, and she only notes one saccadic movement before return to normal
States she reads a lot (she is a teacher) and may be eye strain

Will check MRI to r/o orbital/intracranial pathology

02/16/15 MRI ORBITS AND BRAIN WO AND W CONTRAST by Olaf B***, M.D.**

CLINICAL HISTORY: Reason: patient complaining of saccadic eye movement disorder, happening weekly. Occasionally w/pain. No other neurologic complaints.

IMPRESSION:
1. Unremarkable limited brain MRI scan pre-and post-contrast.
2. Unremarkable post-contrast ORBIT MRI described in detail above.

07/20/2016 Emergency Department Record by Eduardo A***, M.D.**

The patient is 1 month status post gastric bypass presenting with 1 week of early satiety, nausea, bloating without vomiting and was referred by her surgeon for endoscopy. The case was reviewed

2:50 PM with the gastrointestinal OD and no elective/urgent endoscopies are available this Afternoon.The Post Bariatric Surgery Service Agreement states patient's presenting with these symptoms should be evaluated with CT Abdomen/Pelvis with IV and Oral contrast to rule out an obstruction. This was negative. Mild lipase elevation suggest possible associated pancreatitis, but given the history of cholecystectomy obstructive etiologies are unlikely. On reevaluation at 8:09 PM the patient states she is unable to tolerate a clear liquid diet. The presence of ketonuria on initial urinalysis supports likely starvation ketosis. The case was reviewed with MOD and consultation requested for observation admission, IVF, antiemetics and gastrointestinal Consultation for consideration of EGD and balloon dilatation in the morning.

PAST MEDICAL HISTORY
DEPRESSION, UNSPECIFIED
OBESITY (BMI 30-39.9)
COMMON MIGRAINE, NOT INTRACTABLE
MIGRAINE WO AURA
HX OF DYSTHYMIC DISORDER
SEVERE OBESITY, BMI 40-44.9, ADULT
HX OF CHOLECYSTECTOMY
HYPOTHYROIDISM
HX OF TOTAL HYSTERECTOMY, NO VAGINAL PAP SMEAR REQUIRED
VITAMIN D DEFICIENCY
HYPERLIPIDEMIA
PREDIABETES
HX OF ENDOMETRIOSIS
OBSTRUCTIVE SLEEP APNEA
HX OF BARIATRIC SURGERY

Neurological: She is alert and oriented to person, place, and time. No cranial nerve deficit.
Psychiatric: She has a normal mood and affect. Her behavior is normal.

05/19/2017 Doctors First Report of Occupational Injury or Illness by Vicky L***, M.D.**

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED:
Ms. C******** Is a 54-year-Old female employed by Del Mar Union School District as a special education' teacher's aide over the last 21 years. She comes in today for an initial evaluation of a work-related injury. Date of injury is 05/17/2017. The patient was accidentally kicked on the right back side of her head by a basketball that was kicked by a student. She denies initial loss of consciousness, but admits to dizziness, visual changes, disorientation, and numbness and tingling to both upper arms through hands. She denies any chest pain, shortness of breath, nausea and vomiting. She reports pain to 'her head, neck, and midback at the level of *7-8/10.* She has no prior history of similar injury or concussion.

PAST MEDICAL HISTORY: Migraines. hypothyroidism and prediabetes mellitus.
PAST SURGICAL HISTORY: Hysterectomy 1990, abdominoplasty 1996, bariatric surgery 2016 and angioma removal surgery 2013.

REVIEW OF SYSTEMS:
GENERAL: Pain characterized as 7-8110 on analog pain scale.
MENTAL HEALTH: No stress, anxiety, or depression.

GENERAL: No apparent distress. Alert and oriented X 3.

VITAL SIGNS: Weight-5 feet 9 inches; Weight-195 pounds; Pulse-63; Blood Pressure-120/76; Temperature-98 degrees.

NEUROLOGIC: Cranial nerves II-XII are grossly intact. Negative Romberg. Negative heel-toe walk. Rapid handeye coordination within normal limits. Deep tendon reflexes are 2+ bilaterally in upper and lower extremities. Immediate recall 6/6 and delayed recall 6/6.

20. DIAGNOSES: Chemical or toxic compounds involved?: YES [] NO [X]

DX #1: Closed head injury	ICD-10 #1:	S09.90XA
DX #2: Dizziness	ICD-10 #2:	R42
DX #3: Paraesthesia, both hands	ICD-10 #3:	R20.2
DX #4: Confusion and disorientation	ICD-10 #4:	F99
DX #5: Visual changes	ICD-10 #5:	H53.9

05/31/2017 Primary Treating Physician's Progress Report By Kathy L**, M.D.**

SUBJECTIVE COMPLAINTS:
Ms. C******** is a 55-year-old female who returns for reevaluation of closed head injury with date of injury of 05/17/2017. She was evaluated here on 05/19/2Q17 and was transferred to the Emergency Department secondary symptoms of dizziness, blurry vision, hand numbness and tingling, and confusion. She comes in today reporting significant: improvement of her symptoms. Her pain is down to 3/10. She reports the dizziness has almost completely subsided. She currently denies any blurry vision, numbness and tingling in the upper or lower extremities, or symptoms of confusion or disorientation. She notes persistent fatigue. Unfortunately I do not have records from her Emergency Department visit on 05/19/2017, and I relied on the patient's history regarding her evaluation there. She reports MRI scan of the brain was obtained and was noted to be within normal limits. She was offered prescription for pain medication but declined this. She currently is not using any medication for symptomatic relief. She was returned to work 2 to 3 days ago and has tolerated full duty well.

REVIEW OF SYSTEMS:
The patient was provided a complete system review questionnaire that was reviewed in its entirety.

GENERAL: Pain characterized as *3/10* on analog pain scale.
MENTAL HEALTH: No stress, anxiety or depression.

OBJECTIVE FINDINGS

NEUROLOGIC: Cranial nerves II-XII are grossly intact. Negative Romberg. Negative heel-toe walk. Rapid handeye coordination within normal limits. Deep tendon reflexes are 2+ bilaterally in upper and lower extremities. Immediate recall 6/6 and delayed recall 6/6.

DIAGNOSES:

DX #1:	Closed head injury, improving	ICD-10 #1:	S09.90XA
DX #2:	Confusion and disorientation, improved	ICD-10 #2:	F99
DX #3:	Dizziness, improving	ICD-10 #3:	R42
DX #4:	Visual changes, improved	ICD-10 #4:	H53.9
DX #5:	Bilateral hand paresthesias, improved	ICD-10 #5:	R20.2

☑ Return to FULL DUTY without limitations or restrictions on: 05/31/2017

08/08/2017 Initial Neurological Primary Treating Physician's Examination and Utilization Review Request for Balance Assessment by Thomas S***, M.D.**

This patient is a 55-year-old, right-handed woman who has been employed as a Paraprofessional at the Del Mar Unified School District from 1996 to the present. She works between 5-6.25 hours per day, five days per week. Her usual and customary work duties include teaching children with learning disabilities, behavioral support, and playground supervision. The physical demands of the job require sitting, standing, walking, continuous bending and stooping, and occasional squatting, reaching above shoulder level, crouching, kneeling, pushing, and pulling. She is required to lift up to 20 pounds frequently.

DESCRIPTION OF INJURY:
The patient states that on *05/17/2017,* she was on lunch duty and the time had come for the students to bring in their equipment. One student kicked a basketball in her direction and hit her in the right posterior occipital area. She was dazed, but did not fall to the ground. She reported the injury that same day to her employer.

She did not seek any immediate treatment, as she was hoping her symptoms would resolve. The next day, however, she was having headaches and dizziness with waves of decreased balance and fatigue.

TREATMENT RECEIVED:
The patient was first seen at the Sharp Rees-Stealy Occupational Medicine on *05/19/2017,* where she was evaluated and then 'taken to the Scripps Memorial hospital for a CAT scan. She had a CAT scan of the head performed at Scripps on *05/19/2017.* Since that time, she has followed-up with the physicians at Sharp Hospital and has been referred to my office for neurological evaluation.

CURRENT COMPLAINTS:
1. Fatigue - she will get tired at mid day and will take an hour and a half nap.
2. She has difficulty with responding to movement in the outside fields of vision.
3. She has pain in the back of her head on an intermittent basis.

She indicates that, over a 9-year period of time, approximately 20 years ago, she was exposed to Intermittent domestic violence.

09/25/2017 Neurological Primary Treating Physician's Progress Report By Thomas S***, M.D.**

INTERVAL HISTORY:
This woman has been authorized for the requested balance assessment and has been referred to the Scripps Hospital for this assessment.

She returns today stating she continues to have some episodes of dizziness with decreased balance. There continues to be some headaches. She describes some severe stabbing pains in the eyes with "quick visuals." There is mild neck pain and stiffness. Her symptoms are frequent and range from mild-to-severe in intensity.

On physical examination, there is slight difficulty with discomfort with optic kinetic testing to the right There is slight difficulty with standing on the right foot with the eyes closed.

IMPRESSION:
1. Closed head injury with concussion.
2. Postconcussion syndrome with episodic dizziness and headaches.
3. Right occipital tenderness.

WORK STATUS:
She may continue to perform her usual and customary *work* duties.

12/14/2017 Neurological Primary Treating Physician's Progress Report By Thomas S***, M.D.**

I have continued to follow this patient for an industrial injury sustained on 05/17/2017 while employed by Del Mar Union School District.

INTERIM HISTORY:
I last examined this woman on November 13, 2017. She had been evaluated at the Scripps Encinitas Brain Injury Day Treatment Program and rt was determined that there were abnormal findings that needed to have therapy once a week for 6-8 weeks with balance exercises and gait training. This has apparently been approved and awaiting to coordinate the program. She also needs an eye exam because of her complaints of pain in her eyes and alternating light sensation.

CURRENT COMPLAINTS:
She states her condition is worsening significantly. She has dizziness most of the time which has increased, speech communication Causes dizziness and confusion. She describes the quality of pain as moderate to severe constant throbbing pressure and aching. She states her pain is alleviated by extra strength Tylenol, heat packs for muscle, head and eye pain and sleep.
PHYSICAL EXAMINATION:
On physical examination, she has light sensitivity and some decreased balance. She has otherwise normal strength, sensation, and reflexes in the upper and lower extremities.

IMPRESSION:
1. Closed head injury with concussion.
2. Postconcussion syndrome with episodic dizziness and headaches.
3. Right greater occipital tenderness,
4. Eye pain of uncertain etiology, rule out glaucoma.

DISCUSSION:
This woman is waiting an ophthalmologic exam to address her visual complaints and is awaiting recommended balance therapy at Scripps Encinitas Brain Injury Day Treatment Program.

01/03/2018 Vestibular/Balance Evaluation By Lee A***, PT/DPT**

PATIENT EVALUATION:

		WNL	WFL	WFL except
ROM:	UE	[X] WNL	[ ] WFL	[ ] WFL except ____
	LE	[X] WNL	[ ] WFL	[ ] WFL except ____
C/S		[X] WNL	[ ] WFL	[ ] WFL except ____
Vertebro-Basilar Artery Screen:			[ ] Positive	[ ] Negative
Strength:	UE	[ ] WNL	[X] WFL	[ ] WFL except ____
	LE	[ ] WNL	[X] WFL	[ ] WFL except ____
Vision:		[ ] WNL	[X] WFL	[X] WFL except reading glasses
Auditory:		[X] WNL	[X] WFL	[ ] WFL except ____
Sensation:		[ ] WNL	[ ] WFL	[ ] WFL except ____
Proprioception:		[ ] WNL	[ ] WFL	[ ] WFL except ____
Vibration:		[X] WNL	[ ] WFL	[ ] WFL except ____
Coordination:				
	UE	[ ] WNL	[X] WFL	[ ] WFL except FFT, FTN, RAM
	LE	[ ] WNL	[X] WFL	[ ] WFL except HTS, TT

[WNL, or Within Normal Limits, refers to a person's ability to do something compared to same age peers' ability is the same or in a range of the normal ability of that skill.]

[WFL, or Within Functional Limits, means that a person's ability is outside of the normal range, but it is sufficient for activities of daily living.]

01/30/2018 Neurological Primary Treating Physician's Progress Report and Request For Authorization By Thomas S***, M.D.**

I have continued to follow this patient for an industrial injury sustained to the head on 05/17/2017 while employed by Del Mar Union School District.

INTERIM HISTORY:
This woman had been assessed with a balance evaluation at the Scripps Encinitas Brain Injury Day Treatment Program and it was recommended that she benefit from skilled balance therapy, occupational therapy, and speech therapy once a week for 8 weeks at Scripps Encinitas Hospital. She finds that at the present time she may wake with eye muscle pain and pain in the back of the head. She has sometimes inability to write and express herself particularly when filling out forms. She takes longer to communicate. She is known to be having writing that was not very precise. There is some dizziness that appears to be worsening and some communication difficulties that are also worsening.

CURRENT COMPLAINTS:
The patient presents today with complaints of pain in the head, bilateral arms and eyes. She complains of her "head falling back when dizzy". She is dizzy "most of the time now". Her symptoms are "just increasingly worse". She describes any pain as shooting and stabbing in nature and moderate to severe in intensity; It occurs frequently and has lasted for more than six months. Warm compresses and extra strength Tylenol help to relieve her symptoms.

IMPRESSION:
1. Closed head injury with concussion.

2. Postconcussion syndrome with cognitive impairment, balance impairment, and language impairment.

3. Right occipital tenderness.

DISABILITY STATUS:
The patient is not yet permanent and stationary.

WORK STATUS:
She will continue to be temporarily totally disabled from all work activity until the next visit on March 14, 2018.

REQUEST FOR AUTHORIZATION:
1. Tesla-3 MR I of the brain to look for evidence of intracranial pathology
2. Scripps Encinitas Rehabilitation Program to address balance impairment
3. Speech evaluation to address speech impairment from her posttraumatic head injury and to proceed with appropriate treatment for this.
4. Counseling for anxiety with a psychologist.

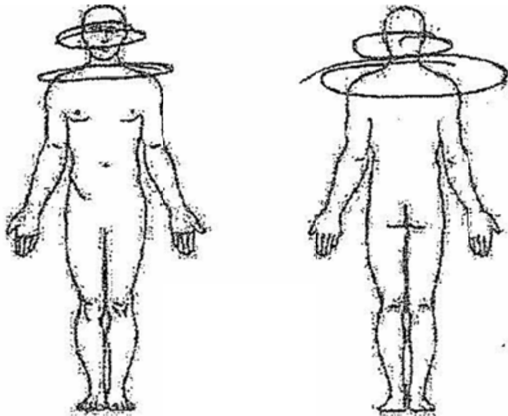
<u>03/14/2018 Neurological Primary Treating Physician's Progress Report and Request For Authorization By Thomas S***, M.D.</u>**

I saw this woman for neurological re-examination in my San Diego office on March 14, 2018. She has had balance testing and physical therapy. She continues to have increasing problems with dizziness being overwhelmed and nausea.

Physical therapist feels that the therapy is not he/ping her because the dizziness is getting worse causing increased heart rate and suggests she may benefit from visual therapy. She is going to have a speech evaluation on 03/15/201 and needs to have counseling.

IMPRESSION:
1. Closed head injury with concussion.
2. Postconcussion syndrome with cognitive impairment, balance impairmentl and
language impairment with speech evaluation planned.
3, Right occipital tenderness.
4. Anxiety and depression.
5. Balance impairment unresponsive to vestibular therapy.

Problem/Pain Diagram



<u>04/23/2018 MRI Brain Without Contrast Traumatic Brain Injury Protocol By Ross Schwartzberg, M.D.</u>

COMPARISON:
None.

INDICATIONS:
Hit with basketball in back of head over one year ago. Confusion, headaches, memory loss and speech issues. Initial point of care.

TECHNIQUE:
A variety of imaging planes and parameters were utilized for visualization of suspected pathology. This includes diffusion tensor imaging CDTI) which is perforn1ed in accordance with the American Society of Functional Neuroradiology guidelines. Images were performed without gadolinium contrast.

CONCLUSION

1. Unremarkable 3T MRI traumatic brain injury protocol without microbleeds, atrophy, evidence of axonal injury, or encephalomalacia.

2. Advanced neuroimaging techniques including diffusion tensor imaging and susceptibility weighted imaging <u>are normal</u>.

<u>05/07/2018 Neurological Primary Treating Physician's Progress Report and Request For Authorization By Thomas S*****, M.D.</u>

This woman returns to me having been evaluated at the Scripps Encinitas Brain Injury Day Treatment Program with a speech and language evaluation where there was a request for a twice-a-week treatment for 4 weeks for cognitive linguistic treatment, speech and language treatment, and family education, as well as helping to adjust to the language difficulties with postconcussion syndrome.

The patient is having increasing off balance and dizziness. She continues to have difficulties with speech, communication, and is very frustrated. She feels that there is times the left eyelid twitches, She has difficulty steeping. She Is awaiting an evaluation and potential treatment by an ear, nose, and throat specialist to address her decreased balance.

She continues to have light scotopic hypersensitivity and recommended an Irlen lens assessment, and we believe that the ongoing anxiety and difficulty with sleeping need to be addressed with neuropsychometric testing.

CURRENT COMPLAINTS
The patient presents today with complaint of "throbbing pain" in the bilateral arms. She also has pain in the head, neck and bilateral shoulders. The pain is moderate in severity and occurs constantly. It has lasted “1 year”. Extra Strength Tylenol helps to relieve her symptoms.

There may be some difficulty with convergence insufficiency. She has increased discomfort with optic kinetic testing. She appears to be anxious and depressed. She has otherwise normal strength, sensation, and reflexes in the upper and lower extremities.

IMPRESSION:
1. Closed head injury with concussion.
2. Postconcussion syndrome with cognitive impairment. balance impairment, and language impairment with speech and language difficulties
3. Right occipital tenderness.
4. Anxiety and depression.
5. Balance impairment, unresponsive to vestibular therapy.

DISCUSSION:
She has had a speech and language evaluation at the Scripps Encinitas Brain Injury Day Treatment Program. I am recommending the speech and language therapy as defined after their assessment.

She is awaiting an ear, nose, and throat assessment for her balance impairment, and I am recommending because of her light sensitivity that she have an evaluation of possible lenses for Irlen's syndrome. She should have neuropsychometric testing to determine the exact degree and nature of her cognitive and mood impairment and determine what the best course of treatment.

In the interim, she continues to be temporarily totally disabled from all work activities
and will remain so for at least the next 6 weeks.

DISABILITY STATUS:
The patient is not yet permanent and stationary.

MEDICAL RESEARCH USED IN CASE ANALYSIS

This applicant spoke a lot about symptoms of dizziness (but no vertigo), balance problems, a subjective sensation of body movement, eye and eyelid movement problems. Because I have come across cases like this in the past in treatment settings where a person has had typical migraine syndromes, which later morphed into odd neurological symptoms, I did some research on this to assist myself and the parties in understanding some medical background on this phenomenon.

FROM A WEB MD SEARCH

VESTIBULAR MIGRAINE

A vestibular migraine is a nervous system problem that causes repeated dizziness (or vertigo) in people who have a history of migraine symptoms. Unlike traditional migraines, you may not always have a headache.

There are many names for this type of problem. Your doctor might also call it:

- Migraine-associated vertigo
- Migrainous vertigo
- Migraine-related vestibulopathy

What Are the Symptoms?

Vestibular migraines don't always cause headaches. The main symptom is dizziness that comes and goes. Vestibular refers to the inner ear, which controls your hearing and balance. If you're having a vestibular migraine, you may feel:

- Dizziness that lasts more than a few minutes
- Nausea and vomiting
- Balance problems
- Extreme motion sensitivity -- feeling sick or dizzy when you move your head, eyes, or body
- Feeling disoriented or confused
- Feeling unsteady, like you're in a rocking boat
- Sensitivity to sound

What Are the Symptoms of Migraine with Brainstem Aura? (AKA Basilar Migraine)

Symptoms differ for everyone, but some are typical:

- Nausea
- Vomiting
- Sensitivity to light and sound
- Cold hands or feet
- Dizziness
- Double vision or graying of vision
- Slurred speech or trouble speaking
- Temporary blindness
- Loss of balance
- Confusion
- Trouble hearing
- Body tingling
- Loss of consciousness

These sort of migraine variants are also mentioned in the medical and clinical literature.

Vestibular migraine. Handbook of Clinical Neurology. 2010;97:755-71.

Vestibular migraine is a chameleon among the episodic vertigo syndromes because considerable variation characterizes its clinical manifestation. The attacks may last from seconds to days. About one-third of patients presents with monosymptomatic attacks of vertigo or dizziness without headache or other migrainous symptoms. During attacks most patients show spontaneous or positional nystagmus and in the attack-free interval minor ocular motor and vestibular deficits. Women are significantly more often affected than men. Symptoms may begin at any time in life, with the highest prevalence in young adults and between the ages of 60 and 70. Over the last 10 years vestibular migraine has evolved into a medical entity in dizziness units. It is the most common cause of spontaneous recurrent episodic vertigo and accounts for approximately 10% of patients with vertigo and dizziness. Its broad spectrum poses a diagnostic problem of how to rule out Menière's disease or vestibular paroxysmia. Vestibular migraine should be included in the International Headache Classification of Headache Disorders (ICHD) as a subcategory of migraine. It should, however, be kept separate and distinct from basilar-type migraine and benign paroxysmal vertigo of childhood. We prefer the term "vestibular migraine" to "migrainous vertigo," because the latter may also refer to various vestibular and non-vestibular symptoms. Antimigrainous medication to treat the single attack and to prevent recurring attacks appears to be effective, but the published evidence is weak.

Migraine with Brainstem Aura (Basilar Type Migraine), Web Publication of the American Migraine Foundation, *October 8, 2016*

Symptoms of Migraine with brainstem aura: Migraine with brainstem aura is a migraine-type that has aura symptoms originating from the base of the brain (brainstem) or both sides of the brain (cerebral hemispheres) at the same time.

People who experience migraine with brainstem aura also experience migraine with typical aura symptoms, including:

- Visual (Examples include sparkles or zigzag lights in the vision that may move or get larger. Generally on only one side of your vision).
- Sensory (Examples include numbness or tingling that travels up one arm to one side of the face).
- Speech/language symptoms (Examples include trouble producing words even though you know what you want to say or trouble understanding what people are saying).

Each symptom is fully reversible and usually only lasts up to 60 minutes each. There should not be any motor (weakness or paralysis) or retinal (vision changes or loss in one eye only) symptoms.

In addition, people with migraine with brainstem aura get brainstem aura symptoms such as:

- Dysarthria (slurred speech)
- Vertigo (feeling of movement/spinning of self or environment)
- Tinnitus (ringing in ears)
- Hypacusis (impaired hearing)
- Diplopia (double vision)
- Ataxia (Unsteady/Uncoordinated movements)
- Decreased level of consciousness

Many of these symptoms may occur with anxiety and hyperventilation, and therefore are subject to misinterpretation.

Frequency of Migraine as a Chief Complaint in Otolaryngology Outpatient Practice. BioMed Research International, Volume 2015, Article ID 173165, 6 pages.

Migraine is a common primary headache disorder. It is considered the most common cause of physician consultation for headache. It is believed that half of the patients with migraine are undiagnosed. This might be in part due to the variability in its clinical presentation. Headache and dizziness represent the only typical migraine manifestations in the head and neck area that are defined by clinical criteria (the IHS for headache and Neuhauser's for migrainous vertigo).

We know nowadays that migraine patients can as well present with multitude other head and neck symptoms. These can happen outside of the headache attack but still are believed to result from the same pathophysiologic migraine mechanisms. These atypical head and neck presentations of migraine are essentially related to the nose and the ear. The main nonheadache rhinologic symptoms include the following: facial and sinus pressure/fullness, frequently called "sinus headache," nasal congestion, and less frequently runny nose. The main non-dizziness ear symptoms include the following: ear fullness and pressure, ear pain, sound intolerance, and tinnitus. The majority of patients with these symptoms present to the otolaryngologist, who, if not experienced enough with the migraine symptoms, can easily miss the diagnosis and attribute those symptoms to primary ear or sinus disease without strong clinical evidence.

Otolaryngic manifestations of migraine include typical presentations of headache, especially when occurring in the sinus territory and dizziness. Both of these are objectively diagnosed using internationally accepted criteria. Migraine manifestations include as well atypical otologic and rhinologic symptoms.

Using these criteria, 10.8% of the patients presenting to our clinic with an ENT complaint ended up with a migraine diagnosis; this is lower than the prevalence of migraine in the general population. One-year prevalence of migraine is estimated to be 11.7%. In fact our study is not a prevalence study, but it counts only migraine symptoms as chief complaints in an ENT clinic. We believe a bigger percentage of our patients had migraine, but their presentation to the ENT clinic was for a nonmigrainous reason. This percentage of migrainous chief complaints is high enough to consider migraine as an essential part of any ENT practice.

Despite the fact that all of the migrainous chief complaints had a history of headache, only 21% had the headache as a chief complaint, while 35% presented with migrainous vertigo and around 46% presented with non-headache non-dizziness chief complaint.

This can be explained by the fact that most patients do not consider the ENT clinic as a headache clinic; they usually present to us when they believe that their symptoms are related to a primary ear or nose pathology and that their headache is secondary to the ear or nose problem, while in reality a lot of these symptoms are secondary to the headache mechanism, not the opposite.

DISCUSSION OF THE CASE

I will state for the record that when I was about halfway through with the Wechsler Adult Intelligence Scale, Fourth Edition, the applicant reported that she remembered much of this testing from a recent neuropsychological intake she had had with psychologist Dr. K**** that I had noted above. I had initially

thought that she had consulted him for psychological intake treatment, but as she went through the testing she recalled that she had taken many of the same tests with that psychologist. I still felt it worthwhile and of utility to go ahead and finish that testing. Sometimes when clients are re-administered the same neuropsychological testing in close proximity timewise to earlier neuropsychological testing, there can be what is called the 'practice effect' in which the client may score somewhat higher on the second round that on the first round of testing. This is thought to be due to some mild practice effect and the familiarity in the testing engendered by the first round of testing. She seemed to recognize both some of the items from the Wechsler Adult Intelligence Scale Fourth Edition and the Wechsler Memory Scale Fourth Edition.

(Please note that I informed the parties of this the day after my AME evaluation with this applicant. In Appendix A of this report, I list copies of the fax requests that I submitted simultaneously to the defense attorney, applicant attorney, and insurance carrier noting that they had not provided me any of the neuropsychological testing that apparently had been conducted by this Dr. K****, and requested that they agree to forward me such information. By the time of my serving of this AME report, I had not received any response from the parties. Should the parties some day agree to provide me that neuropsychological testing by Dr. K****, I can always review it and issue a supplemental AME report.)

When I realized that the applicant may have recently had some similar testing on the Wechsler scales, I decided to administer another formal battery of neuropsychological testing called the Wide Range Assessment of Memory and Learning, Second Edition. This was in order to administer an heretofore unfamiliar and new testing battery to the applicant, just in case there was any practice effect from her earlier administration of the Wechsler scales.

In reviewing all the neuropsychological testing that I performed, all scores were in the average/low average to normal range. Low average scores are not unusual in adults. There was no indication of any neuropsychological or cognitive impairment measurable on any of the objective testing that I conducted for my AME evaluation. There was no indication of malingering or low effort on the Rey 15 test. There was an indication of a probably premorbid average range intellect on the Wide Range Achievement Test, Fourth Edition. Her performance on the Clock Test showed no signs of any cognitive impairment. Her Bender Gestalt-II testing was in the average range. She performed in the normal range on the Trails A & B. all of her Wechsler scale composite scores were in the average range. Her memory scores were in the average to low average range, and low average does not indicate any significant impairment. Her performance on the Wide Range Assessment of Memory and Learning second edition was all in the average range. Her performance on The Category test did not indicate any significant cognitive problems.

So, we have an applicant who has a subjective sense of cognitive loss and neuropsychological impairment, but when measured objectively there is no indication of this. What do we make of this? We are handicapped in understanding the claimant's pre-morbid ability level, since there are no neuropsychological test scores from before the subject medical events. In the absence of any objective insight into past neuropsychological ability level, the best I can say is that the claimant is performing entirely within the average to low average range for age group.

Sometimes medical issues can create within the individual attitudinal changes that cause the perception that they are performing far below past ability level. This is referred to in the clinical literature as the "good old

days bias". For example, many persons with a variety of brain injury effects or sudden medical ailments tend to report their pre-morbid functioning as better than the average person, when some studies show that they are likely overestimating their pre-morbid ability levels. This bias can negatively impact their perception of current problems, recovery from injury, and return to work.

"Good old days" bias following mild traumatic brain injury. The Clinical Neuropsychologist. 2010 Jan;24(1):17-37.

A small percentage of people with a mild traumatic brain injury (MTBI) report persistent symptoms and problems many months or even years following injury. Preliminary research suggests that people who sustain an injury often underestimate past problems (i.e., "good old days" bias), which can impact their perceived level of current problems and recovery.

The purpose of this study was to examine the influence of the good old bays bias on symptom reporting following MTBI. The MTBI sample consisted of 90 referrals to a concussion clinic (mean time from injury to evaluation = 2.1 months, SD = 1.5, range = 0.8-8.1). All were considered temporarily fully disabled from an MTBI and they were receiving financial compensation through the Worker's Compensation system. Patients provided post-injury and pre-injury retrospective ratings on the 16-item British Columbia Post-concussion Symptom Inventory (BC-PSI). Ratings were compared to 177 healthy controls recruited from the community and a local university.

Consistent with the good old bays bias, MTBI patients retrospectively endorsed the presence of fewer pre-injury symptoms compared to the control group. Individuals who failed effort testing tended to retrospectively report fewer symptoms pre-injury compared to those patients who passed effort testing. Many MTBI patients report their pre-injury functioning as better than the average person. This can negatively impact their perception of current problems, recovery from injury, and return to work.

In a general sense, most mild traumatic brain injuries, when present, resolve relatively quickly. The applicant's allegations of having a concussion or ongoing traumatic brain injury are inconsistent with the normal recovery patter that occurs with mild traumatic brain injury. In fact, the research indicates an excellent prognosis regarding mild traumatic brain injury. An excellent review of the research literature related to the prognosis of a mild traumatic brain injury consisting of a review of 428 research studies published in the *Journal of Rehabilitation Medicine* in 2004 is entitled "Prognosis for Mild Traumatic Brain Injury: Results of the World Health Organization Collaborating Center Task Force on Mild Traumatic Brain Injury". This review study concluded that "the prognosis for a mild traumatic brain injury was good and that the majority of studies report recovery within 3 to 12 months".

My best opinion on her seeming neuropsychological and cognitive weaknesses that she reports are that these are likely coming from this complex belief or perceptual phenomenon, in the realm of the "good old days bias" as noted above. In actuality compared to her age range peers, she is almost entirely in the average range on her neuropsychological /cognitive basis, with only few low average scores. Thus, there is no objective evidence to support her complaints of neuropsychological or cognitive impairment. Why then, does she continue to have a subjective sense that she does have these?

In reviewing her medical records, I could not help but notice that many of the complaints she have now center around issues of dizziness, without vertigo, and other similar symptomology. I also note that she reported that she used to have migraine headaches. Having come across this complex set of issues

before, I provided the parties above some information that they might want to query the medical professionals with this case on as it seems logical to me that she may be experiencing some of the rare forms of migraine symptomology that I discussed in the research section above.

Certainly I'm not a medical doctor, but being aware of this medical literature I felt it my duty to point this out to the parties and to the doctors involved in the case for further consideration. This may in fact be behind why Dr. S***** is trying to have some more complex MRI and other imaging studies of her inner ear system because he is trying to further understand this complex medical issue. I think that it would certainly be useful for the parties and insurance carrier to consider allowing the studies that Dr. S***** is requesting to proceed, in order to provide further insight into this case. If Dr. S***** has further insight from the studies he requested, it may assist him in better rating her case, providing apportionment decisions, etc.

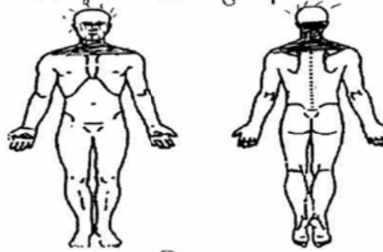
I also felt that my duty to point out that it seems clear to me that some of the other majors problems she continues to report, namely significant pain and tension in her head and trapezius area, seems by my review of the medical records to have existed long before the date of injury in this case. I re-list several of the medical records that I have listed in my initial review of records above, for ease of reading and demonstration to the parties.

<u>02/26/2009 Questionnaire and Progress Note by Yvonne M*****, M.D. on 02/16/2009</u>

1. In the space below, please **describe the problem** that brings you here today. **What caused this problem?**
   after many years, we still don't know. migraines - frequent dibilitating

2. **Shade in on the body chart** where you are having pain, numbness (can't feel), tingling, weakness, or other symptoms.

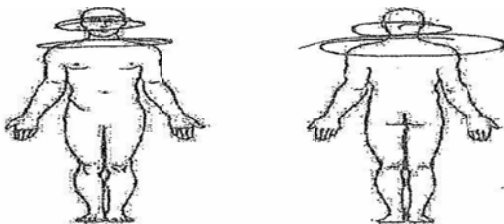
3. Do you have any symptoms of:
   ☒ **PAIN** : Where? Shoulders, neck, Base of Skull →
   ☒ **Always there** ☐ **Comes and goes**
   ☐ **NUMBNESS/TINGLING** : Where? NO →
   ☐ **Always there** ☐ **Comes and goes**
   ☐ **WEAKNESS** : Where? NO →
   ☐ **Always there** ☐ **Comes and goes**



4. Please give the **approximate date** when these symptoms first appeared. 6 yrs? Tightness + pain increases each year.

<u>03/14/2018 Neurological Primary Treating Physician's Progress Report and Request For Authorization By Thomas S*****, M.D.</u>

Problem/Pain Diagram



These two pain diagrams, created nine years apart, seem fairly consistent. The first was created by the applicant in 2009 and the latter one created on one of Dr. S*****'s forms in 2018. Both seem rather similar to me. Again I am not a medical doctor, but I'm simply pointing out similar patterns that I saw in the medical

records that I was asked to closely review. The parties may wish to share this AME report with the various medical doctors treating the applicant and pose questions as to how they opine about these seemingly similar areas of pain that have apparently existed over the past nine years

Finally, I also note that when the applicant was presented with a major psychological test instrument, The Personality Assessment Inventory, she did not elevate any of the clinical scales. This indicates no significant psychological or psychiatric problems, as well as the lack of any objectively based neuropsychological or cognitive impairments.

In my view then, in my specialty, there are no objectively verified neuropsychological or psychological impairments. Thus, I have no diagnoses or disability ratings to provide on a neuropsychological or psychological basis.

FORMAL REFERRAL QUESTIONS FROM THE A.M.E. LETTER

GENERAL REQUESTS

Please perform your usual thorough and complete examination and set forth in your report the applicant's present complaints, a complete history of injury, and your diagnosis and prognosis.

I have described all this in earlier sections. As noted above, I have no diagnoses or disability ratings to provide on a neuropsychological or psychological basis, as there was no objective indication of any such problems or conditions.

Please address the following issues when submitting your report.

Causal Relationship: Please discuss whether applicant's condition is related to the employment. Please also outline all factors contributing to claimant's condition.

There is apparently no question that she was hit in the head area by a basketball on her listed date of injury. However there is also no indication that there is any currently measurable neuropsychological or cognitive problems. Sometimes in such case one might feel that there were some somatic psychological symptoms. In her case I don't believe this is correct. Her Personality Assessment Inventory results do not support that.

She may be misperceiving some medical problems as discussed in the medical research section as having originated with her head injury. She reports freely that she has had past migraine syndrome. This is going to have to be an area that goes back to the treating neurologist and any other medical specialists that might assist in further understanding her medical condition(s). I would suggest they further consider the possible migraine related symptoms that I noted from the clinical literature .

On the other hand, she may soon be simply having a mistaken belief that she is having some neuropsychological or cognitive problems because of the "good old days bias" as described above. In such

cases a life change causes people to suddenly mis-attribute their medical event as causing problems that are actually only the previously unrecognized result of changes that occur over time with age.

For example, I perform many neuropsychological evaluations for the Social Security system for people who have had a stroke. Some of course are demonstrably impaired by testing. Others are not, and while they insist that they are having severe problems cognitively since the stroke, they are in fact performing at age level. The good old days bias attributes this phenomenon to a faulty perception of realizing changes that have in fact occurred over time, but only became noticed after a significant life event.

Other factors of her pain and tension issues related to the head and upper shoulder and chest area seem to have predated this workplace injury by about nine years, at least when we compare the 2009 pain diagram with the recent 2018 pain diagram that she drew. They seem quite similar, though I defer to further physician opinion.

Medical Treatment: Please discuss the Applicant's course of medical treatment provide with regard to his Industrial Injuries and, set forth with specificity your opinion on the following: as to each individual injury, whether the treatment provide has been reasonable and necessary to cure or relieve from the effects ofthe industrial injury; and, identify each Industrial Injury for which current treatment is needed with an analysis on whether it is prescribed pursuant to the American College of occupational and environmental medicine guidelines or other scientifically based criteria.

Of course I really cannot comment on the treatment by various medical physicians outside of my specialty area, as it is not within my purview to agree or disagree with their medical treatment decisions. I will state that it seems to me that the physicians' reports that I read seem to have engaged in typical problem-solving and diagnostic studies that are many times required in complex cases such as this.

Dr. S***** I believe is still trying to get some further imaging studies that may make more clear this issue of rare migraine syndromes that she may be experiencing (see my research section above) that are leading to her perception of dizziness, runny nose, and other subjective indications, rather than actual head injury factors. I recommend those studies be approved as they may be vital to his medical apportionment decisions.

As to any treatment by psychologist, only the evaluation that the claimant told me that she recently had by Dr. K**** seems to fit into that category. I was unable to obtain his records or reports by the time I serve this AME report. If I am ever served that report I would be glad to issue a supplemental AME report with my commentary on it. As noted though I found no neuropsychological or cognitive problems, and she did not report any clinical level problem on the Personality Assessment Inventory.

Temporary Disability: Please discuss whether applicant is permanent and stationary. If you find any permanent disability at the time of your examination, please state the subjective and objective factors and list the frequency and intensity of subjective factors. If you impose a work restriction, please provide the exact nature of such restriction.

As I found no neuropsychological or psychological impairments or disabilities, I must defer back to the treating medical physicians in their discussions of TTD status, permanent and stationary status, and permanent disability ratings and their specialty's. As far as any mild traumatic brain injury effects I can say that she must be permanent and stationary since I found no neuropsychological or cognitive problems on an objective basis. I have no work restrictions to impose in my specialty.

Permanent Disability: If claimant's condition for any industrially injured body part is currently permanent and stationary, please advise when Applicant became stationary, the injury date(s) responsible, and indicate any residual permanent disability. Please state the subjective and objective factors and list the frequency and intensity of subjective factors and indicate their effect on applicant's activities of daily living. Please provide the same analysis for any work restriction. Please set forth applicant's disability per the AMA Guidelines for Rating Permanent Disability.

Because I found no neuropsychological or psychological impairments, I have no permanent disability ratings to provide to this case. There may be some underlying complex medical factors that still need further diagnosis and case development, but these are deferred to the treating neurologist and other medical specialists in the areas that I identified through the clinical literature.

Apportionment: Under SBB 899, the law of apportionment has changed. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring 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 injury, including prior industrial injuries. If you are unable to include an apportionment determination in your report, please state the specific reasons why you could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. Additionally, new case law has further defined what is apportionable:

Because there are no objective signs of neuropsychological or cognitive or psychological impairments, I have no issues of apportionment to discuss in my specialty. I have noted above that some of her complaints may come from other complex medical issues that specialists in those areas must still further consider and opine upon. I have also noted above that a 2009 pain diagram and a 2018 pain diagram that she filled out seem quite similar, indicating that some of the physical tension and pain problems she feels in her upper body area may be of long-standing duration and preexisted well before the date of injury under consideration here.

ADDITIONAL NUMBERED QUESTIONS

1. Whether the applicant is permanent and stationary for all of her industrial injuries related to the May 17, 2017 date of injury. If so, please discuss the appropriate level of impairment under the AMA Guides *andlor* Almaraz/Guzman if necessary.

I cannot comment on all of her industrial injuries, only on the neuropsychological and psychological factors. Since I found no neuropsychological or cognitive or psychological problems, I would consider her completely permanent and stationary on issues of mild traumatic brain injury or cognitive problems, if any ever actually existed. It may be that she has mistaken those sort of problems for the complex medical issues I have shown the clinical literature for, and I have deferred back to her treating neurologist for further medical considerations. Thus, I find no apportionment issues to discuss in my specialty area.

2. Whether there is any apportionment to non-industrial factors consistent with the Escobedo line of cases. If so, please discuss how and why apportionment is applicable in this case.

There may be issues of MEDICAL apportionment given the issues I have put out for further consideration by her medical doctors, but they would have to provide those opinions. I have no input apportionment for neuropsychological or psychological issues is no such problems were objectively supported.

3. Whether the applicant requires any further, or future, medical treatment on an industrial basis. If so, please delineate all reasonable and necessary medical care.

I have no recommendations for any needed future medical treatment on an industrial basis for any neuropsychological or psychological factors as none were found. While she may subjectively feel that she has neuropsychological and cognitive problems, in an objective since she simply does not. Also on the Personality Assessment Inventory she reported no psychological factors so there is no indication of any problems in that area either, based on her own self-report on testing.

Future Medical Care: Please discuss whether applicant needs future medical care. If so, kindly state the nature of said treatment and expected duration. Please also comment on the appropriateness of all medical treatment previously provided to claimant..

Again I have no future medical care recommendations in my specialty. I have raised some issues for further consideration by her medical providers based upon my review of her records and my review of the clinical literature and common sense possibilities that arose in that review. However medical professionals such as her treating neurologist and other medical physicians would have to now consider on a medical basis whether such are medical possibilities or not.

PHYSICIAN AFFIDAVIT

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

I further declare under penalty of perjury that I personally performed the evaluation of the patient on 08/01/2018, at 615 E Lexington, Suite 6, El Cajon , CA, 92020, and that except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code. I further declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient or the preparation of this report. I further declare under penalty of perjury that the name and qualifications of each person who performed any services in connection with the report, including diagnostic studies, other than clerical preparation, are as follows: No other persons were involved in this evaluation.

BILLING METHOD

THIS IS AN AGREED MEDICAL EVALUATION (A.M.E). MEDICAL-LEGAL EVALUATION.
THIS REPORT IS BEING BILLED UNDER ML-104-94 OF REGULATION 9795.
THIS IS DUE TO THE FOLLOWING QUALIFYING FACTORS:

1) Two or more hours of face-to-face time were spent with the patient.
2) Two or more hours of record review were required.

3) Two or more hours of medical research were required, to examine issues related to the clinical and medical-legal issues pertinent to the case.
4) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors
5) Addressing the issue of medical causation upon written request of the party or parties requesting the report, or if a bona fide issue of medical causation is discovered in the evaluation
6) Complex issues of permanent and stationary status, temporary disability, permanent disability and apportionment were addressed, upon request of the party or parties requesting the report.
7) A complex and comprehensive neuropsychological / psychological evaluation which was the primary focus of this medical-legal evaluation.

"I verify under penalty of perjury that the total time I spent on the following activities is true and correct":

SERVICES UNDER THE MEDICAL-LEGAL FEE SCHEDULE (8 C.C.R. §§ 9793, 9795)

ML 104-94	*Face-to-Face Time with the Injured Worker*	*5.0 Hours*	*(20 Units)*
ML 104-94	*Reviewing the Records: Review, Analysis & Synthesis of Case Records*	*6.0 Hours*	*(24 Units)*
ML 104-94	*Medical Research: Case Related Medical/Clinical Research*	*2.0 Hours*	*(08 Units)*
ML 104-94	*Preparing the Report: Formulation: Analysis, Synthesis, Writing/Editing*	*8.0 Hours*	*(32 Units)*
	TOTAL=	*21 Hours*	*(84 Units)*

NOTE: The ML 104-94 services span the total cumulative time spent on all aspects of the AME evaluation process over time, ranging from the date of the face to face interview with the applicant, to the date of the serving of the QME report.

SERVICES UNDERTHE OFFICIAL MEDICAL FEE SCHEDULE (8 C.C.R. §§ 9789.11)

96118-59	*Neuropsychological Test Scoring, Analysis and Interpretation*	*6.0 Hours*	*(6 Units)*
96101-59	*Psychological Test Scoring, Analysis and Interpretation*	*1.0 Hours*	*(1 Unit)*

CPT Code 96101-59 is a code that requires multiple phases of action involved in the totality of testing, with major actions carried out AFTER the injured worker has departed the evaluation session.

Both 96118-59 and 96101-59 are codes that require multiple phases of action involved in the totality of testing, with major actions carried out AFTER the injured worker has departed the evaluation session.

Therefore, the majority of the very analytical services that make up the testing services are carried out AFTER and SEPARATE from injured worker contact.

These actions include the scoring of the tests, interpretation and analysis of the test results, and preparation of the narrative reporting that is to make up the explanation of the test findings.

These are time intensive services carried out AFTER the injured worker is gone, and they are vital to the testing process.

The time that I billed under 96118-59 and 96101-59 was time I expended in scoring of the tests, interpretation and analysis of the test results, and preparation of the narrative reporting, AFTER the injured worker had departed the QME appointment.

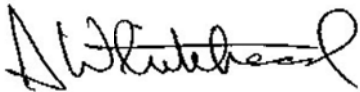
"I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury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

"I hereby declare under penalty of perjury that I have not violated Labor Code Section 139.3 in that I have not offered, delivered, received or accepted any rebate, refunds, 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."

Date of Face to Face Evaluation with the Applicant: 08/01/2018

Date AME Report Served: 08/22/2018

Signed this 22nd day of August, 2018, at San Diego County, California



Dan Whitehead, Ph.D. PSY13833

Served On the Following Parties by United States Postal Service Priority Mail with Delivery Confirmation Tracking:

1) Dietz, Gilmore & Chazen, 7071 Convoy Court, Suite 300, San Diego, CA 92111
2) L/O of Matthew Verduzco, 2525 Camino del Rio S, Suite 145, San Diego, CA 92108
3) Athens Administrators, P.O. Box 696, Concord, CA 94254
4) (Mail to Athens Administrators included AME Report, Form 1500 (02-12) Billing Form & W9 Form)

Served with the following attachments to all parties:

QME Form 122 (AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

Behavioral Medicine Resources, Inc.
9449 Balboa Ave. Suite 205
San Diego, Ca. 92123-4342
Fax #(619) 571-3981
Phone # (619) 571-1188

Murray H. Rosenthal, DO., Medical Director
Andrew Ferber, RN., MSN, Clinical Director

January 25, 1996

To Whom it May Concern:

I am writing this as a letter of reference for Dan Whitehead, Ph.D., PSY 13833.

Dr. Whitehead was associated with my managed care business as well as my research program from 1992 through 1994. In this capacity he was involved in the start up of a managed care program, including patient contact and scheduling, tracking and referral, and direct clinical services. He worked directly with customer medical practices in reporting of patient contact. He also developed treatment outcome and reporting procedures.

In our research program he performed preliminary telephone screening with research candidates, performed clinical interviews with research study candidates, using assessment tools germane to the particular study and monitored patients using clinical assessment tools throughout the course of research studies. He also provided and monitored psychoeducational aftercare programs for patients who had completed research studies.

He had experience & training with a variety of instruments including:

Minnesota Multiphasic Personality Inventory (MMPI-2)
Structured Clinical Interview for DSM-III-R (SCIDS)
Alzheimer's Disease Assessment Scale Cognitive Behavior Form (ADAS-COG)
Wechsler Intelligence Scale for Children (WISC-R)
Wechsler Adult Intelligence Scale (Revised)
Montgomery-Asberg Depression Scale (MADRS)
Symptom Checklist 90-Revised (SCL-90-R)
Clinician Administered PTSD Scale (CAPS)
Test of Variables of Attention (TOVA)
Hamilton Depression Scale (HAM-D)
Hamilton Anxiety Scale (HAM-A)
Wechsler Memory Scales
Memory Assessment Scales
Mini-Mental State Exam

Behavioral Medicine Resources, Inc.
9449 Balboa Ave. Suite 205
San Diego, Ca. 92123-4342
Fax #(619) 571-3981
Phone # (619) 571-1188

Murray H. Rosenthal, DO., Medical Director
Andrew Ferber, RN., MSN, Clinical Director

I found Dr. Whitehead to be a competent and able manager of our outpatient program. He designed and developed procedures and methods to assist in program start-up, as well as ongoing office procedures. He is a self-motivated person with character and integrity who gets the job done. I recommend him to you in the above capacity.

Sincerely,

Murray H. Rosenthal, D.O.

MHR:law

American College of Forensic Examiners Institute®

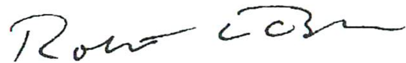
hereby recognizes

Daniel J. Whitehead, PhD

with the designation

Diplomate of the American Board of Forensic Examiners®

with all the rights and privileges pertaining thereto, so long as annual membership requirements are met and the Principles of Professional Practice are upheld.



Robert L. O'Block, MDiv, PhD, PsyD, DMin

Cyril Wecht, MD, JD, CFP, CMI-V
Chair, Executive Advisory Board

Date awarded
December 1997

Expiration Date
December 2017

Identification Number
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This designation is the property of the American College of Forensic Examiners Institute and conveys competency that the individual has met the minimum requirements to attain this designation based on the specifications set forth by the American College of Forensic Examiners Institute ACFEI. ACFEI, requires designation holders to remain in good standing by being current with yearly maintenance fees or yearly membership dues, submitting the required 30 continuing education units every three years and upholding ACFEI's code of conduct.

American College of Forensic Examiners Institute®

hereby recognizes

Daniel J. Whitehead, PhD

with the designation

Diplomate of the American Board of Psychological Specialties

with a specialty in

Neuropsychology

with all the rights and privileges pertaining thereto, so long as annual membership requirements are met and the Principles of Professional Practice are upheld.

Robert L. O'Block, MDiv, PhD, PsyD, DMin
Founder and Publisher

Cyril Wecht, MD, JD, CFP, CMI-V
Chair, Executive Advisory Board

Date awarded
April 1997

Expiration date
December 2017

Identification Number
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