Advanced Pain Specialists *of Southern California*

Gary L. Baker, M.D., A Professional Corporation

5750 Downey Avenue, #306 • Lakewood, California 90712 • Fax (562) 408-6491

www.advpainspecialists.com

Gary L. Baker, M.D., *Director*
James A. Kim, M.D.
Jaime Guerrero, PA
M. Jabeen, PA-C
Dean X. Nghiem, PA-C

Locations:
Lakewood (562) 408-4636
Van Nuys (818) 783-2084
Santa Ana (714) 210-0122
Rancho Cucamonga (888) 824-2144
Riverside (888)824-2144

September 12, 2016

Gary Baker, M.D.
5750 Downey Ave #306
Lakewood, CA 90712

PAIN MEDICINE RE-EVALUATION

PATIENT NAME:	**Daniel Doran**
PATIENT NUMBER:	**12927**
DATE OF BIRTH:	**06/04/1966**
EMPLOYER:	**Benedict & Benedict**
INSURANCE COMPANY:	**State Comp Ins Fund (Santa Ana) (4526)**
CLAIM NUMBER:	**05814232**
DATE OF INJURY:	**07/11/2012**
DATE OF EVALUATION:	**September 12, 2016**

INTRODUCTION:

Mr. Daniel Doran is a 50 years old Male who presents for a pain medicine follow-up visit and reexamination on September 12, 2016.

The patient was seen in our Rancho Cucamonga office, 10841 White Oak Avenue, Suite 208, Rancho Cucamonga, CA 91730.

INDICATIONS FOR A NARRATIVE REPORT:

Indications for submitting this report include: **periodic report**, authorization appeal.

Mr. Doran is status post a "work related injury". The injury occurred in the course of his usual work duties.

SUBJECTIVE COMPLAINTS:

Mr. Doran reports the following complaints:

Neck pain. The pain radiates down the bilateral upper extremities.

Upper extremity pain. Pain is in the right wrist, hand, fingers, thumb and radiates to the right forearm. The pain occurs constantly. The pain is aggravated by hand function. The patient describes the pain as burning, electricity, sharp and moderate in severity. The patients pain is accompanied by muscle weakness, numbness and tingling. There is intermittent pain in the left wrist and hand with numbness and tingling.

Insomnia.

Pain is rated as 8/10 in intensity with medications.
Pain is rated as 9/10 in intensity without medications.

The patient's pain is reported as recently worsened.

The patient reports continuous nausea.

The patient also reports constipation as moderate.

ACTIVITIES OF DAILY LIVING LIMITATION:

The patient reports ongoing activity of daily living limitations in the following areas due to pain: self care & hygiene, activity, hand function, sleep and sex.

Pain Impact on Function:

Interference with activities of daily living due to pain over the past month is rated as 9 (on a scale of 1 to 10 where "0" is no interferance and "10" is unable to carry on any activities).

The above pain intensity and pain interference scales are adapted from "Guidelines for Prescribing Controlled Substances for Pain- Appendix 9" (Medical Board of California 2014). "Based on prior research, the interpretation of scores on these items are as follows: Average/ Usual Pain Intensity 1-4 (mild), 5-6 (moderate), and 7-10 (severe). Pain-related interferance with activities 1-3 (mild), 4-6 (moderate), and 7-10 (severe). Although pain intensity and pain-related interference with activities are highly correlated and tend to change together, it is recommended that change over time be tracked for pain intensity and pain-related interference with activities separately when using these two items. For an individual patient, a reduction in pain intensity and improvement in pain-related interference with activities of two points is considered moderate but clinically significant improvement".

INTERVAL HISTORY:

Patient completed a fluoroscopic evaluation of the spinal cord stimulator on 3/15/16 and reprogramming of the SCS. Lead position is normal.
Insomnia secondary to pain is worsening.

Chief concern now request to replace current SCS IPG/ Battery with a non-rechargeable one. He has had ongoing difficulty charging the spinal cord stimulator IPG/ Battery due to malposition of the battery and patient has limited use of right hand to position charger to overcome malposition.

The SCS IPG/Battery appears to have either moved or was mal-positioned initially so that it does not lie flush with patient's skin. It is also painful in its current position. The SCS otherwise works well so the leads would not have to be replaced.

Report also night-time aggravation of right upper extremity as he is not able to protect the arm adequately as he sleeps. Requested splint to protect right wrist/hand for night-time use only. Discussed will avoid daytime use to avoid atrophy or loss of ROM. Splint was received and is helpful with sleep but it is 1 size too small. He is in the process of getting it re-done.

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MEDICATIONS:

Current medications noted below.

1 Amitriptyline Hcl 50 Mg Tab SIG: take 1 po qhs prn
2 Neurontin 800 Mg Tablet SIG: Take 1 by mouth every 6 hours.
3 Glipizide 10mgs (Other MD)
4 Metformin 2000 Mgs (Other MD)

ALLERGIES:

Vital Signs:
Height: 6'0".
Weight: 175 pounds.
Hand Dominance: ambidextrous.

PHYSICAL EXAM:

Observation:

The patient was noted to be alert, oriented and cooperative. The patient was observed to be in moderate distress.

Cervical Examination:
Spinal vertebral tenderness was noted in the cervical spine C5-7. The range of motion of the cervical spine was moderately limited due to pain. Pain was significantly increased with flexion, extension and bilateral rotation. Sensory examination shows decreased sensitivity to touch along the C5-7 dermatome in the right upper extremity.

Upper Extremity Examination:
Inspection of the right hand reveals . The range of motion of the right hand limited extension fingers. Grip strength testing with the Jamar Hand Dynamometer (lbs.) was left - 60, 60, 50 and not possible on the right.

TREATMENT PROVIDED AT TODAY'S VISIT:

Treatment provided at today's visit included the following:

SCS mgmt:
SCS system adjusted with medtronic rep to optimize pain coverage. System otherwise works well but having continued problem properly charging the SCS unit.

PATIENT ASSESSMENTS:

ISI:
The Insomnia Severity Index (ISI) was administered Apr 11, 2016 as a screening tool to quantify insomnia severity. Questions include level of difficulty falling asleep, level of difficulty staying asleep, early waking problems, satisfaction with sleep pattern, impact of sleep disturbance perceived by others, level of distress regarding sleep pattern, and sleep disturbance interference on daily functioning. (Validation of the Insomnia Severity Index as an outcome measure for insomnia research: Sleep Medicine, pages 297-307, July 2000). The patient had a total score of 23. Based on this score it was determined that the patient has (22-28) severe clinical insomnia.

BDI-II:
The Beck Depression Inventory II (BDI-II) is a psychological screening and assessment tool administered Apr 11, 2016 as part of Mr. Doran's comprehensive pain management evaluation.
ACOEM 2nd Edition specifically addresses the need to evaluate psychological components of chronic pain in treatment planning. "The clinician should be alert to the incipient development of chronic pain syndrome and should secure a psychological assessment if necessary. Referral for pain management may also be indicated." (ACOEM 2nd Edition pg. 115). Satisfactory results from a detailed psychological assessment are required prior to discography (ACOEM 2nd Edition pg. 305). "Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standard tests as the second edition of the Minnesota Multiphasic Personality Inventory (MMPI-2) " (pg. 306).
The Official Disability Guidelines (ODG Treatment in Workers' Compensation, Pain and Stress/Mental Chapters, 2007) also supports the use of psychological assessments in treatment of patients with chronic pain. Specifically the BDI-II and the MMPI-II are published tests included in the list of 26 tests evaluated. These tests were judged to have acceptable evidence of validity and reliability. Per ODG (Pain Chapter, 2007), "Published tests are also generally more difficult to fake, as access to test materials is restricted to qualified professionals.".
BDI scoring subtotal page one: 22. Subtotal page two: 23. Total score: 45. Score Guidelines: Levels of depressions 29-63: Severe. Based on the findings of moderate to severe depression, further evaluation with the MMPI-II is indicated. A referral to a qualified Psychiatrist or Psychologist may be considered for evaluation and/ or treatment.

DISCUSSION:

Medtronic cervical SCS was implanted approximately 2014 by Dr. Cohen. Replacement of the new SCS IPG/Battery for reasons above will help to allow change to MMI status.

WORK STATUS:

Currently not working.
Based on the patient's current condition, the patient is considered total temporarily disabled and has been instructed to remain off work for 1 month.

DIAGNOSES (ICD-10):

Ongoing Type 2 Complex Regional Pain Syndrome, right upper extremity (G56.40); Peripheral Neuropathy (G60.9); status post spinal cord stimulator (SCS) implant (OOHUOMZ); Diabetes Mellitus, type 2 with hyperglycemia -stable (E11.65); hx. right thumb non-displaced fracture; malposition SCS IPG/Battery.

TREATMENT PLAN:

Treatment recommendations at this time are as follows:

Follow up:

The patient will return to the clinic for follow-up in 1 month.

Additional Treatment Recommendations:

Patient awaits replacement of a Spinal cord stimulator battery.
The battery migrated and is poorly positioned for the charger.

Medications:

The patient's medications, including psychotropic and/or pain medications were reviewed. The patient is being prescribed medications as listed below including instructions for use for the above-mentioned diagnosis. The patient was counseled as to the benefits and potential side effects of the prescribed medications. The risks include but are not limited to sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance, addiction, and possibility that the medicine will not provide complete relief. The patient was instructed to alert the prescribing physician if any of these, or any other symptom or side effect occurs. The patient was advised as to the dangers of using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for him or herself. The patient was also advised about the possible synergistic effects of alcohol while taking medications. The patient understands that medications should not be abruptly discontinued or stopped without professional guidance. The patient indicates a full understanding of these concepts and accepts the risks. The patient understands that medications are only to be taken as prescribed.

Renew current medications:

Elavil: renew as previously prescribed. **50mg 1 po qhs #30.** Beneficial with intended effect at prescribed dose.

Elavil (Amitriptyline) is a heterocyclic antidepressant prescribed to this patient as a sleep agent for chronic insomnia. ODG-TWC Worker's Compensation Drug Formulary has indicated under the status column (per ODG the most important column) that this drug is a preferred drug and is contained on the formulary. This class of medication, as an adjuvant, additionally has the benefit of modulating pain and reducing overall opiate/drug intake.

Gabapentin: renew as previously prescribed. **800mg 1 po q 6hrs #120.** Reports 40% relief from neuropathic pain with use of Gabapentin. Beneficial with intended effect at prescribed dose. Requires additional titration of higher amount.

Gabapentin (Neurontin) is an anticonvulsant class medication used for management of chronic neuropathic pain in this patient. ODG-TWC Worker's Compensation Drug Formulary has indicated under the status column (per ODG the most important column) that this drug is a preferred drug and is contained on the formulary.

1 Amitriptyline Hcl 50 Mg Tab SIG: take 1 po qhs prn QTY: 30.00
2 Neurontin 800 Mg Tablet SIG: Take 1 by mouth every 6 hours. QTY: 120.00

DISCLOSURE STATEMENT: I personally performed the evaluation of the patient and discussed and/or confirmed the pertinent aspects of the history with the patient and/or by review of the available medical records (if any). I personally interviewed the patient and reviewed the medical records set forth in this report. I personally composed and drafted the conclusions of this report.

The evaluation performed and the time spent performing such evaluation was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph (5) of subdivision (j) of Section 139.2.

I dictated the report in draft form, which was then typed and reviewed by my transcription service to ensure completeness, proper spelling, grammar and sentence structure. Upon presentation to me of the final report, I thoroughly reviewed the document prior to affixing my signature unless I was unavailable and the report was urgently needed.

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 and conform to IMC guidelines pursuant to Labor Code Section 5407.1.

Pursuant to Labor Code Section 5701 (a) (2), I hereby declare under penalty of perjury that I have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for the referral of this evaluation or consultation.

Advanced Pain Specialists of Southern California physicians have no ownership/ financial interest in any surgery centers or hospitals.

Sincerely,

Gary L. Baker, M.D., Director (*CA Lic #G78404*)
Diplomate, American Board of Anesthesiology
Diplomate, American Board of Pain Medicine
Qualified Medical Evaluator (Q.M.E.)

Report reviewed and electronically signed by Gary L. Baker, M.D., on Sep 12, 2016 in the county of Los Angeles, California.

Office address: (Rancho Cucamonga) APSSC Clinic, 10841 White Oak Ave. #208, Rancho Cucamonga, CA 91730

cc: State Comp Ins Fund (Santa Ana) (4526)

cc: WILLIAM GREENE
3419 VIA LIDO SUITE 607 Newport Beach, CA 92663

cc:

PROOF OF SERVICE BY MAIL

I, UNDERSIGNED, HEREBY DECLARE THAT I AM OVER THE AGE OF EIGHTEEN YEARS AND NOT A PARTY TO THE WITHIN ACTION. I AM EMPLOYED IN THE COUNTY OF VENTURA AND MY BUSINESS ADDRESS IS 1464 MADERA ROAD, SIMI VALLEY, CA 93065.

I SERVED THE ATTACHED ON, 09/28/2016.

PATIENT NAME: DORAN, DANIEL
DATE OF SERVICE: 09/12/2016
PROCEDURE: FOLLOW UP- COMPLEX

ON THE PARTIES IN SAID ACTION BY PLACING A TRUE COPY OF THEREOF IN A SEALED ENVELOPE WITH POSTAGE THEREON FULLY PREPAID, IN THE UNITED STATES MAIL AT SIMI VALLEY, CALIFORNIA, ADDRESSED AS FOLLOWS:

SCIF 00-49
PO BOX 65005
FRESNO, CA 93650

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT. EXECUTED AT SIMI VALLEY, CALIFORNIA ON 09/28/2016.

MELYSSA AGUILAR

09/28/2016

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Riverside	(888)824-2144

August 15, 2016

Gary Baker, M.D.
5750 Downey Ave #306
Lakewood, CA 90712

PAIN MEDICINE RE-EVALUATION

PATIENT NAME:	**Daniel Doran**
PATIENT NUMBER:	**12927**
DATE OF BIRTH:	**06/04/1966**
EMPLOYER:	**Benedict & Benedict**
INSURANCE COMPANY:	**State Comp Ins Fund (Santa Ana) (4526)**
CLAIM NUMBER:	**05814232**
DATE OF INJURY:	**07/11/2012**
DATE OF EVALUATION:	**August 15, 2016**

INTRODUCTION:

Mr. Daniel Doran is a 50 years old Male who presents for a pain medicine follow-up visit and reexamination on August 15, 2016.

The patient was seen in our Rancho Cucamonga office, 10841 White Oak Avenue, Suite 208, Rancho Cucamonga, CA 91730.

INDICATIONS FOR A NARRATIVE REPORT:

Indications for submitting this report include: periodic report.

Mr. Doran is status post a "work related injury". The injury occurred in the course of his usual work duties.

SUBJECTIVE COMPLAINTS:

Mr. Doran reports the following complaints:

Neck pain. The pain radiates down the bilateral upper extremities.

Upper extremity pain. Pain is in the right wrist, hand, fingers, thumb and radiates to the right forearm. The pain occurs constantly. The pain is aggravated by hand function. The patient describes the pain as burning, electricity, sharp and moderate in severity. The patients pain is accompanied by muscle weakness, numbness and tingling. There is intermittent pain in the left wrist and hand with numbness and tingling.

Insomnia.

Pain is rated as 7/10 in intensity with medications.
Pain is rated as 10/10 in intensity without medications.

The patient's pain is reported as recently worsened.

The patient reports continuous nausea.

The patient also reports constipation as moderate.

ACTIVITIES OF DAILY LIVING LIMITATION:

The patient reports ongoing activity of daily living limitations in the following areas due to pain: self care & hygiene, activity, ambulation, hand function, sleep and sex.

Pain Impact on Function:

Interference with activities of daily living due to pain over the past month is rated as 9 (on a scale of 1 to 10 where "0" is no interferance and "10" is unable to carry on any activities).

The above pain intensity and pain interference scales are adapted from "Guidelines for Prescribing Controlled Substances for Pain- Appendix 9" (Medical Board of California 2014). "Based on prior research, the interpretation of scores on these items are as follows: Average/ Usual Pain Intensity 1-4 (mild), 5-6 (moderate), and 7-10 (severe). Pain-related interferance with activities 1-3 (mild), 4-6 (moderate), and 7-10 (severe). Although pain intensity and pain-related interference with activities are highly correlated and tend to change together, it is recommended that change over time be tracked for pain intensity and pain-related interference with activities separately when using these two items. For an individual patient, a reduction in pain intensity and improvement in pain-related interference with activities of two points is considered moderate but clinically significant improvement".

INTERVAL HISTORY:

Patient completed a fluoroscopic evaluation of the spinal cord stimulator on 3/15/16 and reprogramming of the SCS.
Insomnia secondary to pain is worsening.
Chief concern now is difficulty charging the spinal cord stimulator IPG/ Battery due to malposition of the battery and patient has limited use of right hand to position charger to overcome malposition.
Report also night-time aggravation of right upper extremity as he is not able to protect the arm adequately as he sleeps. Requests splint to protect right wrist/hand for night-time use only. Discussed will avoid daytime use to avoid atrophy or loss of ROM.

MEDICATIONS:

Current medications noted below.

1 Amitriptyline Hcl 50 Mg Tab SIG: take 1 po qhs prn
2 Neurontin 800 Mg Tablet SIG: Take 1 by mouth every 6 hours.
3 Glipizide 10mgs (Other MD)
4 Metformin 2000 Mgs (Other MD)

ALLERGIES:

Vital Signs:
Height: 6'0".
Weight: 175 pounds.
Hand Dominance: ambidextrous.

PHYSICAL EXAM:

Observation:

The patient was noted to be alert, oriented and cooperative. The patient was observed to be in moderate distress.

Cervical Examination:
Spinal vertebral tenderness was noted in the cervical spine C5-7. The range of motion of the cervical spine was moderately limited due to pain. Pain was significantly increased with flexion, extension and bilateral rotation. Sensory examination shows decreased sensitivity to touch along the C5-7 dermatome in the right upper extremity.

Upper Extremity Examination:
Inspection of the right hand reveals . The range of motion of the right hand limited extension fingers. Grip strength testing with the Jamar Hand Dynamometer (lbs.) was left - 60, 60, 50 and not possible on the right.

TREATMENT PROVIDED AT TODAY'S VISIT:

Treatment provided at today's visit included the following:

SCS mgmt:
SCS system adjusted with medtronic rep to optimize pain coverage. System otherwise works well but having continued problem properly charging the SCS unit.

PATIENT ASSESSMENTS:

ISI:
The Insomnia Severity Index (ISI) was administered Apr 11, 2016 as a screening tool to quantify insomnia severity. Questions include level of difficulty falling asleep, level of difficulty staying asleep, early waking problems, satisfaction with sleep pattern, impact of sleep disturbance perceived by others, level of distress regarding sleep pattern, and sleep disturbance interference on daily functioning. (Validation of the Insomnia Severity Index as an outcome measure for insomnia research: Sleep

Medicine, pages 297-307, July 2000). The patient had a total score of 23. Based on this score it was determined that the patient has (22-28) severe clinical insomnia.

BDI-II:
The Beck Depression Inventory II (BDI-II) is a psychological screening and assessment tool administered Apr 11, 2016 as part of Mr. Doran's comprehensive pain management evaluation.
ACOEM 2nd Edition specifically addresses the need to evaluate psychological components of chronic pain in treatment planning. "The clinician should be alert to the incipient development of chronic pain syndrome and should secure a psychological assessment if necessary. Referral for pain management may also be indicated." (ACOEM 2nd Edition pg. 115). Satisfactory results from a detailed psychological assessment are required prior to discography (ACOEM 2nd Edition pg. 305). "Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standard tests as the second edition of the Minnesota Multiphasic Personality Inventory (MMPI-2) " (pg. 306).
The Official Disability Guidelines (ODG Treatment in Workers' Compensation, Pain and Stress/Mental Chapters, 2007) also supports the use of psychological assessments in treatment of patients with chronic pain. Specifically the BDI-II and the MMPI-II are published tests included in the list of 26 tests evaluated. These tests were judged to have acceptable evidence of validity and reliability. Per ODG (Pain Chapter, 2007), "Published tests are also generally more difficult to fake, as access to test materials is restricted to qualified professionals.".
BDI scoring subtotal page one: 22. Subtotal page two: 23. Total score: 45. Score Guidelines: Levels of depressions 29-63: Severe. Based on the findings of moderate to severe depression, further evaluation with the MMPI-II is indicated. A referral to a qualified Psychiatrist or Psychologist may be considered for evaluation and/ or treatment.

DISCUSSION:

Positional shocks with SCS sitting to lying. Medtronic cervical SCS was implanted approximately 2014 by Dr. Cohen. Permanent implant (August 2014) not helping like temporary trial implant. Currently less than 50% pain control. Needs adjustment.

WORK STATUS:

Currently not working.
Based on the patient's current condition, the patient is considered total temporarily disabled and has been instructed to remain off work for 1 month.

DIAGNOSES (ICD-10):

Ongoing Type 2 Complex Regional Pain Syndrome, right upper extremity (G56.40); Peripheral Neuropathy (G60.9); status post spinal cord stimulator (SCS) implant (OOHUOMZ); Diabetes Mellitus, type 2 with hyperglycemia -stable (E11.65); hx. right thumb non-displaced fracture; malposition SCS IPG/Battery.

TREATMENT PLAN:

Treatment recommendations at this time are as follows:

Right wrist/hand splint (long) with thumb spica #1 (Exos Preston model).

The patient will return to the clinic for follow-up in 1 month.

Additional Treatment Recommendations:

Patient awaits replacement of a Spinal cord stimulator battery.
The battery migrated and is poorly positioned for the charger.

Medications:

The patient's medications, including psychotropic and/or pain medications were reviewed. The patient is being prescribed medications as listed below including instructions for use for the above-mentioned diagnosis. The patient was counseled as to the benefits and potential side effects of the prescribed medications. The risks include but are not limited to sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance, addiction, and possibility that the medicine will not provide complete relief. The patient was instructed to alert the prescribing physician if any of these, or any other symptom or side effect occurs. The patient was advised as to the dangers of using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for him or herself. The patient was also advised about the possible synergistic effects of alcohol while taking medications. The patient understands that medications should not be abruptly discontinued or stopped without professional guidance. The patient indicates a full understanding of these concepts and accepts the risks. The patient understands that medications are only to be taken as prescribed.

Renew current medications:

Elavil: renew as previously prescribed. **50mg 1 po qhs #30.** Beneficial with intended effect at prescribed dose.

Elavil (Amitriptyline) is a heterocyclic antidepressant prescribed to this patient as a sleep agent for chronic insomnia. ODG-TWC Worker's Compensation Drug Formulary has indicated under the status column (per ODG the most important column) that this drug is a preferred drug and is contained on the formulary. This class of medication, as an adjuvant, additionally has the benefit of modulating pain and reducing overall opiate/drug intake.

Gabapentin: renew as previously prescribed. **800mg 1 po q 6hrs #120.** Reports 40% relief from neuropathic pain with use of Gabapentin. Beneficial with intended effect at prescribed dose. Requires additional titration of higher amount.

Gabapentin (Neurontin) is an anticonvulsant class medication used for management of chronic neuropathic pain in this patient. ODG-TWC Worker's Compensation Drug Formulary has indicated under the status column (per ODG the most important column) that this drug is a preferred drug and is contained on the formulary.

1 Amitriptyline Hcl 50 Mg Tab SIG: take 1 po qhs prn QTY: 30.00
2 Neurontin 800 Mg Tablet SIG: Take 1 by mouth every 6 hours. QTY: 120.00

Informed Consent: I, the undersigned physician, hereby certify that I have explained to the patient and/or his agent the benefits, potential discomforts, risks, and alternatives to the recommended procedure. I have also

explained that they may refuse to participate and that their refusal will not compromise their access to medical services.

DISCLOSURE STATEMENT: I personally performed the evaluation of the patient and discussed and/or confirmed the pertinent aspects of the history with the patient and/or by review of the available medical records (if any). I personally interviewed the patient and reviewed the medical records set forth in this report. I personally composed and drafted the conclusions of this report.

The evaluation performed and the time spent performing such evaluation was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph (5) of subdivision (j) of Section 139.2.

I dictated the report in draft form, which was then typed and reviewed by my transcription service to ensure completeness, proper spelling, grammar and sentence structure. Upon presentation to me of the final report, I thoroughly reviewed the document prior to affixing my signature unless I was unavailable and the report was urgently needed.

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 and conform to IMC guidelines pursuant to Labor Code Section 5407.1.

Pursuant to Labor Code Section 5701 (a) (2), I hereby declare under penalty of perjury that I have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for the referral of this evaluation or consultation.

Advanced Pain Specialists of Southern California physicians have no ownership/ financial interest in any surgery centers or hospitals.

Sincerely,

Jaime Guerrero, P.A.

Gary L. Baker, M.D., Director (*CA Lic #G78404*)
Diplomate, American Board of Anesthesiology
Diplomate, American Board of Pain Medicine
Qualified Medical Evaluator (Q.M.E.)

Report reviewed and electronically signed by Gary L. Baker, M.D., on Aug 15, 2016 in the county of Los Angeles, California.

Office address: (Rancho Cucamonga) APSSC Clinic, 10841 White Oak Ave. #208, Rancho Cucamonga, CA 91730

cc: State Comp Ins Fund (Santa Ana) (4526)
P.O. BOX 65005 Pinedale, CA 93650

cc: WILLIAM GREENE
3419 VIA LIDO SUITE 607 Newport Beach, CA 92663

cc:

cid management

Review #1192491

Friday, August 12, 2016

Gary L. Baker, M.D.
5750 Downey Ave, Suite 306
Lakewood CA 90712

Request for Additional Information

RE: Patient: Dan Doran
Claim: 05814232
State Fund tracking number: E000011612476
Document ID: c8b22f74b45442dab75c0b13fd310b7e
Date of report containing request for authorization: 8/5/2016
Date request received by State Compensation Insurance Fund: Friday, August 05, 2016
Date request received by CID: Thursday, August 11, 2016

Dear Gary L. Baker, M.D.,

We have been requested by State Compensation Insurance Fund, to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to notify you that the reviewer has determined that additional information is required to make a determination of medical necessity. We are requesting that the requesting provider submit the following information in order to allow us to complete this review:

Physician requesting authorization:
Gary L. Baker, M.D.

Specific Treatment Plan Requested:
1. Prospective request for 1 replacement of spinal cord stimulator battery a non rechargeable IPG

Information Being Requested:
Please provide results obtained from the spinal cord stimulator, including any changes in pain levels, medication usage, or functional benefits.

This information may be faxed to CID at (877) 200-6739 or mailed to PO Box 4379 Westlake Village, CA 91359.

Please feel free to contact us with any questions.

Respectfully,
CID Management

cc: Dan Doran, Patient, by Mail
1245 West Cienega Avenue Apt 201
San Dimas, CA 91773

William Green, Attorney, by Fax
714-282-9065

Review #1192491

Utilization Review strictly analyzes the medical necessity of treatment requests.
CID Management does not affirm the acceptance of this workers compensation claim.

cid management

Review #1192491

Wednesday, August 17, 2016

Gary L. Baker, M.D.
5750 Downey Ave, Suite 306
Lakewood CA 90712

Determination: CONDITIONALLY NON-CERTIFY

RE: Patient: Dan Doran
Claim: 05814232
State Fund tracking number: E000011612476
Document ID: 77f24d34e01c46b69c39b78f93af29c4
Date of report containing request for authorization: 8/5/2016
Date request received by State Compensation Insurance Fund: Friday, August 05, 2016
Date request received by CID: Thursday, August 11, 2016
Date additional information received, if applicable: N/A
Decision date: Tuesday, August 16, 2016

Dear Gary L. Baker, M.D.,

We have been requested by State Compensation Insurance Fund, to perform utilization review to determine if requested health care services are medically necessary and appropriate for this claim. This letter is to notify you that the reviewer has determined that additional information is necessary prior to making a determination of medical necessity. The requesting physician has been contacted for the necessary information; however as of this date we have not received it.

At this time, we are closing this review due to lack of information. If the requesting provider does submit the requested information in the future, we will reconsider the request.

On 8/17/2016 at 11:04AM, a call was placed to Dr. Baker's office at 562-408-4636. No one was available to take the call, therefore a voice mail message was left containing: the patient's name, claim number, CID's review number, and the determinations outlined in the UR Determination section below.

Specific Treatment Plan Requested
1. Prospective request for 1 replacement of spinal cord stimulator battery a non rechargeable IPG

UR Determination
1. The prospective request for 1 replacement of spinal cord stimulator battery a non rechargeable IPG between 7/18/2016 and 2/7/2017 is conditionally non-certified .

Medical Provider Network (MPN) and Ancillary Service Information
When it is necessary to refer an injured employee to another medical provider or facility, referrals shall only be made to medical providers and facilities that are participants in the State Fund MPN and listed on the State Fund Provider Finder, which can be accessed at www.statefundca.com, click on **Find a doctor**, and then click on **Start your search now**. All authorized DME and medically necessary transportation should be requested through Cypress Care (877) 242-2871 or One Call Care Management (877) 662-9976.

IMPORTANT INFORMATION FROM STATE FUND
Effective November 1, 2015, all authorized ancillary service requests for prescription drugs, durable medical equipment (DME) and supplies, interpretation, and transportation, must be supplied only through the following State Fund-approved ancillary networks:

Prescription Drugs:
Express Scripts, Inc. (ESI)
Telephone: (888) 201-5389

DME, Interpretation, and Transportation:
Cypress Care
Telephone: (877) 242-2871

One Call Care Management
Telephone: (877) 662-9976

CCR Section 9767.3(d)(8)(I) allows an insurer, employer, or entity to include ancillary services in its medical provider network and contract with ancillary service providers to provide services and goods.

LC Section 4600.2(a) allows insurers and self-insured employers to contract with a pharmacy benefit network to provide medicines and medical supplies.

Medical bills with dates of service November 1, 2015 and after, that are submitted by non-State Fund approved ancillary providers will not be processed for payment.

In addition, authorization of medication does not constitute approval to dispense medications from the physician's office. All medication should be filled by an Express Scripts Network pharmacy. Physicians or injured employees can call (888) 571-8182 for assistance in locating an Express Scripts Network pharmacy.

Clinical Rationale
In regard to the request for 1 replacement of spinal cord stimulator battery a non rechargeable IPG , the reviewer determined that additional information was reasonably necessary in order to render a decision. CID faxed the provider on 8/12/2016 to request the following information: Please provide results obtained from the spinal cord stimulator, including any changes in pain levels, medication usage, or functional benefits.

At this time, the requested information has not been received, and the reviewer therefore recommends that the request for 1 replacement of spinal cord stimulator battery a non rechargeable IPG be conditionally non-certified. Please note that this outcome represents an administrative action taken to comply with regulatory time frame constraints, and does not represent a denial based on medical necessity. The request will be reconsidered upon receipt of the information requested.

Criteria/Guidelines Applied
In regard to the request for 1 replacement of spinal cord stimulator battery a non rechargeable IPG , this request will be evaluated in consideration of applicable evidence based guidelines upon receipt of the requested information.

Information regarding our optional reconsiderations process is attached to this determination letter.

If the requesting physician would like to discuss this determination with the reviewer, the requesting physician may contact CID at (866) 301-6568 so that a convenient time may be arranged for this discussion. All reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. PST. Please feel free to contact us should you have any additional questions regarding this claim.

Respectfully,

Marvin Pietruszka, M.D.
CA License# 30858
TX License# P1130
Board-certified in Occupational Medicine
Board-certified in Pathology

cc: Dan Doran, Patient, by Mail
1245 West Cienega Avenue Apt 201
San Dimas, CA 91773

William Green, Attorney, by Mail
3419 Via Lido Suite 607
Newport Beach, CA 92663

Utilization Review strictly analyzes the medical necessity of treatment requests.
CID Management does not affirm the acceptance of this workers compensation claim.

CID Reconsiderations Process

For any treatment request which was ***conditionally denied***, the treatment request will be reconsidered upon receipt of the requested information. The information may be faxed to the claims administrator at 707-646-6939 or may be submitted via mail to P.O. Box 65005, Pinedale, CA 93650.

Additional Language required by California Labor Code and Regulations:

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me Amber Thomas-Kosta at 530-223-7125. However, if you are represented by an attorney, please contact your attorney instead of me.

For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

If you disagree with the utilization review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days after service of this decision. Disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6.

Medical Records Reviewed

The following is a list of documents reviewed:
7/18/2016 Progress Report Gary Baker, MD
4/11/2016 Progress Report Gary Baker, MD
2/15/2016 Initial Report Gary Baker, MD

State of California, Division of Workers' Compensation

APPLICATION FOR INDEPENDENT MEDICAL REVIEW

DWC Form IMR

TO REQUEST INDEPENDENT MEDICAL REVIEW:

1. **Sign and date this application and consent to obtain medical records.**
2. **Mail or fax the application and a copy of the written decision you received that denied or modified the medical treatment requested by your physician to:**
   DWC-IMR, c/o Maximus Federal Services, Inc, P.O. Box 138009, Sacramento, CA 95813-8009
   FAX Number: (916) 605-4270
3. **Mail or fax a copy of the signed application to your Claims Administrator.**

Type of Utilization Review: ☒ Regular ☐ Expedited	Modification after Appeal ☐
Employee Name (First, MI, Last): Dan Doran	
Address: 1245 West Cienega Avenue Apt 201 San Dimas, CA 91773	
Phone Number: 760-258-7545	Employer Name: Benedict & Benedict Plumbing Company
Claim Number: 05814232	Date of Injury (MM/DD/YYYY): 7/11/2012
WCIS Jurisdictional Claim Number (if assigned): 20120802152350363701l0	EAMS Case Number (if applicable): 8760713
Employee Attorney (if known): William Green	
Address: 3419 Via Lido Suite 607 Newport Beach, CA 92663	
Phone Number: 714-282-9020	Fax Number: 714-282-9065
Requesting Physician Name (First, MI, Last): Gary L. Baker, M.D.	
Practice Name: Advanced Pain Specialists	Specialty: Pain Medicine
Address: 5750 Downey Ave, Suite 306 Lakewood, CA 90712	
Phone Number: 562-408-4636	Fax Number: 562-408-6491
Claims Administrator Name: State Compensation Insurance Fund	
Adjuster/Contact Name: Amber Thomas-Kosta	
Address: P.O. Box 28918, Fresno, CA 93729-8918	
Phone Number: 530-223-7125	Fax Number: 707-646-8652
Disputed Medical Treatment (complete below section)	
Primary Diagnosis (Use ICD Code where practical): G5640 CAUSALGIA OF UNSPECIFIED UPPER LIMB	
Date of Utilization Review Determination Letter: Wednesday, August 17, 2016	
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? ☐ Yes ☒ No Reason:	
List each specific requested medical services, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient.	
1. 1 replacement of spinal cord stimulator battery a non rechargeable IPG -- Delay/Conditionally Non-Certified (A full listing of the adverse determinations is on the next page)	
Request for Review and Consent to Obtain Medical Records	
I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the claims administrator named above. I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.	
Employee Signature:	Date:

Full listing of adverse determinations for the Application for Independent Medical Review

1. 1 replacement of spinal cord stimulator battery a non rechargeable IPG -- Delay/Conditionally Non-Certified

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation claims administrator sent you a written determination letter that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review (IMR) of the medical treatment request by a physician who is not connected to your claims administrator. If the IMR is decided in your favor, your claims administrator must give you the service or treatment your physician requested.

IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL, DELAY, OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO ON PAGE ONE OF THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this form with a copy of the written determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your claims administrator.

- The information on the form was filled in by your claims administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.
- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. This person may sign the application for you and submit documents on your behalf.
- If the recommended medical treatment that was denied or modified must be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did **not** perform an expedited or rushed review on your physician's request, this application **must** be submitted with a statement from your physician, supported by medical records, that confirms your condition.
- Mail or fax the application and a copy of the utilization review decision to:

  DWC-IMR, c/o Maximus Federal Services, Inc.
  P.O. Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 605-4270

- **Your IMR application, along with a copy of the written determination letter, must be received by Maximus Federal Services, Inc., within thirty-five (35) days from the mailing date of the written determination letter informing you that the medical treatment requested by your treating physician was denied or modified.**
- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written determination letter.

Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (Print):	

I wish to designate

Name of Individual (Print):	

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature:		Date:

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:			
I am a/an:			
(Professional status or relationship to the Employee, e.g. attorney, relative, etc)			
Address:			
City:	State:		Zip Code:
Phone Number:		Fax Number:	
State Bar Number (if applicable):			
Representative Signature:			Date: