ATTACHMENT C

RESPONDENT(S) ARGUMENT(S)
March 5, 2018

CalPERS Executive Office
P.O. Box 942701
Sacramento, CA 94229-2701

Respondent Argument

To: Cheree Swedensky, Assistant to the board
Re: Lila Gutierrez denial for disability retirement

To Whom It May Concern:

I am writing this letter to appeal your decision in denying me for Disability Retirement benefits. It is my hope that we can settle this matter promptly and in a fairly manner. I feel that the reasoning laid forth in my denial letter were unsubstantiated and questionable at best. Reviewing the denial letter, it is evident that majority of the decision to find me not eligible for disability retirement benefits was based on Dr. Henrichsen Independent medical evaluation. This is a physician compensated by California Public Retirement System (CalPERS) who does not have myself as the patient in his best interest, and for these reasons his evaluation should not be the key influence in determining my eligibility. Dr. Henrichsen was able to evaluate me one time over two years ago, and with this single evaluation was able to contradict all of the many other specialist evaluations and studies that were done on me. Not only is there over four active physicians who have a different deduction of my clinical scenario, but also the Social Security has accepted all my diagnosis and physical limitations, finding me “fully favorable” for my disability social security. Based on my work injuries.

Dr. Henrichsen mentions that my symptoms were “unusual and somewhat confusing” to him, which seems to be inconsistent when compared to the numerous reports and assessment by other physicians. (see attached reports) Reviewing all the physician documents, there is no evidence of inconsistencies or contradictions that would cause such confusion. Although, my symptoms have been progressive and have increased in severity over the last few years, so any new symptoms that I have experienced are not inconsistencies but progression from my injury. In addition, looking at the Social Security Office of Disability report (page 4 paragraph 6) they also did not find my symptoms to be confusing or inconsistent, as they stated “her severity of
her description of her symptoms and limitations have been consistent and our found to be persuasive”, (Please see letter of approval)

Carpal tunnel syndrome was found to be negative by Dr. Henrichsen IME, although Dr. Yang and Dr. Sanden medical assessment revealed the diagnosis of carpal tunnel syndrome bilateral on multiple reports such as (02/21/17), (03/02/17), (03/24/17), based on positive clinical findings and electrodiagnostic evidence. In addition, the EMG Study study also indicated findings that would provide support for carpal tunnel syndrome. EMG study on 07/17/15 performed and reviewed by Dr. Radhid, documented in his assessment that 1) Enthesopathy of the elbow region, 2) Electrodiagnostic evidence of moderate right carpel tunnel syndrome, 3) enthesopathy of the wrist and carpus. Another EMG study on 09/10/16 performed and assessed by Dr. Manijeh also revealed abnormal findings that were suggestive of right mild carpal tunnel syndrome. All these findings were evident enough for a referral to have surgery for the decompression of the median nerve.

Dr. Henrichsen IME also mentions that Dr. Yangs is incorrect in reporting that a contributing source of my pain is radicular pain, specifically he claims that Dr. Yang does not have substantial support for this diagnosis. Dr. Yang not only substantiates his objective evidence from positive clinical findings in many of his reports but in addition has the objective data of MRI imaging done on 09/26/16 which mentions in their impression of the scan that there is positive imaging of C6 radiculitis, along with other cervical pathological findings.

Dr. Yang’s diagnosis was also supported by Dr. Sanden a neurosurgeon who evaluated me on 05/12/17 who mentions in his of bilateral upper extremity radiculopathy, who also referred me to receive cervical steroid injection that were denied by workmen’s compensation

Dr. Henrichsen has evaluated me one single time several years ago and it is perplexing to me how he concluded my injury and pain was caused by what he thinks to be a rheumatologically disease such as fibromyalgia. My symptoms and pain do not present like a person who suffers from Fibromyalgia, and nor do the many doctors who have evaluated me over the last several years. Many of the physicians who have evaluated have assessed me a multitude of times, never suggesting in their assessment of my pain to be caused by Fibromyalgia or finding my symptoms to be confusions or inconsistent as Dr. Henrichsen mentions. Not only have I gone through the many physical examinations from a number of physicians who do not contribute my clinical findings to be caused by fibromyalgia, but I have also undergone many painful nerve conduction studies and numerous imaging modalities, which have all never suggested my pain to be caused by fibromyalgia but have all with objective evidence to site my source of pain to be a neuropathic in origin.

Dr. Henrichsen also mentions that he does not find any evidence of swelling in my hands, but I contradict his statement because he has only seen me once and how can he suggest that there is no swelling if he does not know my baseline. He also mentions incorrectly several medications that I was taken, and also incorrectly describes my job duty Job description provided). In his report he states that there is no job duty that I am unable to perform.
Not only do I feel physically this statement to be false, but Dr. Manijeh assessment on 06/6/17 contradicts Dr. Henrichsen statement, as she states in her assessment that she finds my injuries to require permanent work restriction. Other physicians such as Dr. D’Amico, Dr. Yang and DR. Sanden have also made the assessment that my clinical picture substantiates modified work duties. Another incorrect statement that Dr. Henrichsen states was my subjective description of my pain severity in regards to my everyday living activities. He states that I say with certain activities my pain can be as severe as 10 out of 10 which he states correct, but he also states that I had no difficulties or absence of pain when I filled out the pain drawing or activates of daily living chart. I don’t understand how he can say that I had no difficulties or say that I had no pain completing these forms when he never physically saw or assessed me when I filled these forms out nor did he ask about how I completed these tasks.

Please note that I have been seen by many specialists, who have the credentials, knowledge and are actively working on their fields of medicine, unlike Doctor Henrichsen who is retired and only acting as adviser to unions like CalPERS.

Please take in consideration that Social Security office has recognized and accepted all my diagnosis and physical limitations, finding me “fully favorable” for my disability social security Benefits, see attached letter of approval.

This has been a very stressful situation for me, unfortunately I was unable to hire legal representation that could have guided me and represent me, as all Lawyers I spoke with found that litigation against PERS was very “difficult”.

I’m respectfully requesting that you overturn your negative decision on my disability retirement claim and find me eligible to be fairly compensated for all the 28 years of state service.

Sincerely

Lila Gutierrez
El Dorado Pain Management Center
1208 Suncast Lane
El Dorado Hills, CA 95762
Phone: (530) 672-1311
Phone: (916) 939-1768
Fax: (530) 672-1335

PROGRESS NOTE/REQUEST FOR AUTHORIZATION FOR CELECOXIB 200MG #30 X4RF, NORCO 10-325MG #120 X2RF AND GABAPENTIN 300MG #180 X4RF

Patient: Lila GUTIERREZ
DOB:
Age: 51
Date of Visit: 1/9/2018

Covered Body Part:
BILATERAL ARMS AND WRISTS

Employee:
Lila Gutierrez

Employer:
Employment Development Department MIC 54

WC Carrier:
SCIF

Adjuster:
Michelle Rodriguez
Phone #: 951-413-5919

Utilization Review:
UR
Fax #: 707-646-0738

PCP:
DR. MICHAEL C. YANG
Phone #: 530-672-1311
Fax #: 530-672-1335

Attorney:
Carla Castaneda
Phone #: 916-924-1100

Subjective Complaints:
Ms. Gutierrez is here for follow up. Her Diclofenac gel has been denied for long time. WC still pays other meds, mainly pills.

She is not ready still to attempt surgery for her neck as recommended by spine surgeon since there is a 50/50 chance of improvement. She wants to try the CESI first and if that helps wait as long as she can before going with the surgical options. Unfortunately, WC has denied the injection. She has met with her lawyer and she is trying to settle this case. She is in 10/10 pain in her neck and LT arm. She may go to the ER.

We have tried all the ways to get injections, but no success. Her left hand and thumb lost some function due to pain and weakness.

She is worried about not being able to use her hand.

Today we will refill her medication.

See last visit notes regarding CESI below.
She states she was approved to have CESI by WC back in May. However, she was sent to a clinic in Elk Grove to have the injection. She states that she followed up with the PA at the clinic Christina, who used to work at this office. She states that Christina told her that our office had her on all the wrong medications and switched the patient's medications. The patient states that she switched from Ultram to Norco and from Gabapentin to Lyrica. She states that Christina also ordered her a neck brace. The patient states that she never had an injection while she was there.
The patient stated that two hours after she left the clinic she got a call from Vi/C and was told the Norco, Lyrica and neck brace had been denied because that clinic is not her PTP. Patient states that she has just continued on the medications that we have prescribed.

Patient is confused why she was sent to another clinic for the CESI since Dr. Yang is her PTP for her case. She would like to have the injection done with Dr. Yang. She states she will try and get a hold of her adjuster to find out why she was sent to another office for CESI and too see if she can just get the CESI done with Dr. Yang her PTP. She underwent a QME, and the diagnosis was a herniated disc at C5-6 and bilateral mild carpal tunnel syndrome. She has been seen by a neurosurgical on March 1, Dr. Sanden. She has been recommended anterior neck fusion 3 levels. She is not wanting to go through with surgery. Her LT arm is losing strength, mobility and sensation. She is worried about how quickly it has deteriorated. Her pain is high too. She is very worried about her symptoms but is afraid to have surgery. She was denied PT and deep tissue massage.

Her pain level is 8/10.
She is requesting a refill of Gabapentin, Celebrex, Ultram and Voltaren gel.

She is not working and she has been disabled.
She went to court for SSI disability, she will hear from them in several months.

Prev. OV note:
The MRI of the cervical spine: showed that at C4-5, she has a 7 mm canal stenosis with minimal impingement of the spinal cord. There is questionable foraminal stenosis with impingement of the nerve root at C5. At C5-6, she has 6 mm canal stenosis due to bulging and spurring with possible impingement of the left C5 nerve root. At C6-7, she has bulging and spurring with possible impingement of the C7 nerve root.
As far as her symptoms, they are unchanged and are getting worse. Her symptoms include a weak grip, problems with her ADL’s, especially in the kitchen. She has pain in both upper extremities, right greater than left. She Is having now complete numbness of the left thumb, which corresponds to the C6 nerve root and a burning sensation in the 5th digit.

Per our previous notes:
She had EMG study which showed CTS. She does not want to have surgery for CTS.

She also states she feels pain in both whole arms. She feels it is bone pain inside of the arm. She states her both whole arms are tender.

The patient had an EMG study and I will check that report to see if the patient has any radiculopathy findings.

The patient has not worked for a year and she is still TTD.

The patient is a 49 y.o. female with a history of a repetitive work related injury to her arm and hand causing severe pain.

She reports she has worked for The State Government in the EDD department for the past 25+ years. Her job entails typing all day long on a keyboard. Sometimes she has to work overtime and at times works 10-15 hours in a day. She states she has pain in her hand, wrist, and arm for more than eight years. Over the two years her pain has become so severe she cannot do her job any longer.

She filed a workers’ compensation claim in 2015. She believes her pain is a chronic cumulative injury from working with her hands and fingers on the keyboard over the years.

The patient saw Dr. Schaefer, orthopedist, and he put her as permanent and stationary. She also saw a physician from US Health Clinic and she did not like their services.

The patient has been off work since April 2015. She tried to go back to work with modified duty, but she could not tolerate it. Eventually she just stopped working.

The patient had an EMG study by a physician in Roseville, but she does not recall their name. She states she was told the EMG revealed she has carpal tunnel syndrome. However, she refuses to have surgery because she is afraid surgery will make things worse.

Medications: The patient is taking some Cymbalta from her private primary care physician.

Social History: She is currently not working. She lives with her husband and children in the El Dorado Hills area. She does not smoke and denies any substance abuse.
Anticoagulation Medications:
Not taking any blood thinner medication

Current Medications:
Medications List Reviewed (01/09/18 9:02:20 AM PST)
Celecoxib Oral Capsule 200 MG (1/9/2018)
Take 1 capsule once a day
Refills: No Refills
Rx quantity: 30
Comments: Please consider 90 day supplies to promote better adherence
Norco Oral Tablet 10-325 MG (1/9/2018)
Take 1 tablet four times a day as needed for 30 day(s)
Refills: No Refills
Rx quantity: 120
Gabapentin Oral Capsule 300 MG (1/9/2018)
Take 2 capsules three times a day for 30 day(s)
Refills: 2
Rx quantity: 180

Medication list reviewed. updated (01/09/2018 PST)

Allergies:
No Known Allergies Confirmed - 01/09/18 9:02:25 AM PST

Allergy list reviewed. updated (01/09/2018 PST)

Problem list reviewed.

Past Medical History:
Asthma; Depression
No Hypertension; No Cancer; No Epilepsy; No Cerebrovascular Accident (CVA); No Myocardial Infarction; No Anxiety; No Kidney Disease; No Liver Disease; No Diabetes; No Arthritis; No Angina; No Bleeding Problems

Problem list reviewed. updated (01/09/2018 PST)

Past Medical History Reviewed (05/16/2017 PST)

Surgical History:
right shoulder

Social History:
Non-Smoker; Alcohol use: Non-Drinker; No drug use.
Living Situation: Lives with spouse.

Social History Reviewed (05/16/2017 PST)

Family History:

Family History Reviewed (05/16/2017 9:43:24 AM PST)
No family history of Depression, Anxiety, Substance Abuse, Neck pain, Back pain, cancer.

Review of Systems:
The patient has symptoms of excessive fatigue; seizures; drowsiness; difficulty falling asleep; difficulty remaining asleep.
There are no symptoms of fever; chills; unplanned weight loss; chest pain; shortness of breath; wheezing; nausea; vomiting; abdominal pain; bowel incontinence; constipation; urinary incontinence; muscle weakness; bleeding disorders; low platelet count; dizziness; syncope; difficulty walking; feeling depressed.

Physical Examination:
Weight 190 lbs; Height 5 ft 4 in; BMI 32.6
01/09/2018 9:02 AM (PST)
Respiration Rate 16; Pulse Rate 110 bpm; Blood Pressure 140 / 90 mm/Hg; Pain Level: 10
01/09/2018 9:03 AM (PST)
Respiration Rate 16; Pulse Rate 78 bpm; Blood Pressure 140 / 90 mm/Hg; Pain Level: 8

General: 50 yo female, NAD, WDWN, A&Ox3, engaging, here alone, no evidence of overmedication or sedation.

Neck: On exam of the back, palpation of the cervical area reveals moderate spasm, as well as both trapezi. Range of motion at the neck is decreased in all planes. She has positive facet loading test.
Abdomen: obese.

BACK: She also has a moderate amount of spasm over the thoracic area and the lumbar area.

Rectal/Genitalia: deferred

Upper extremities: On exam of the upper extremities, she has diffuse tenderness in both upper extremities. Tinel's sign is positive, but more pronounced on the right side. Today she is especially tender at the wrist and the IP joints. She has decreased sensation to light touch and pinprick on the left thumb. Her grip is weak on the left.

Skin: intact without lesions or rashes

Psych: Alert and cooperative, concerned, upset, affect, normal attention span and concentration. Today she is tearful about her forced retirement, as this goes on and off..

Diagnosis/Assessment:
(M54.13) - Radiculopathy of cervicothoracic region
(G56.00) - Carpal tunnel syndrome
(M47.812) - Degenerative arthritis of cervical spine

Treatment Plan:
Monthly follow up for medication refill. We will give her Norco instead of Ultram for her acute wrist pain. #120. I will give her three month meds. The next FU will be in April.

Her pain is still very high in her neck and arms. she is having trouble lifting her RT arm above her head and her RT arm very weak. Her pain level is 10/10

Everything is being denied by her WC. She is working with her lawyer.

She will return in 12 weeks.

Prescriptions Written Today:
Celecoxib Oral Capsule 200 MG
Take 1 capsule once a day
Refills: 4
Rx quantity: 30
Comments: Please consider 90 day supplies to promote better adherence
Norco Oral Tablet 10-325 MG
Take 1 tablet four times a day as needed for 30 day(s)
Refills: No Refills
Rx quantity: 120
Gabapentin Oral Capsule 300 MG
Take 2 capsules three times a day for 30 day(s)
Refills: 4
Rx quantity: 180

Treating Provider: Michael CYang MD
Electronically Signed By: Michael CYang MD
Electronically signed: 1/16/2018 8:14:16 PM
El Dorado Pain Management Center
1208 Suncast Lane
El Dorado Hills, CA 95762
Phone: (530) 672-1311
Phone: (916) 939-1768
Fax: (530) 672-1335

Progress note/Requesting authorization for Voltaren gel 1% # 5 tubes. Ultram 50 mg. every 4-6 hours. Celebrex 200 M.G QD. REQUEST AUTHORIZATION FOR PT AS PER QME and Cervical epidural injection at left C5-6 level and a Neurosurgical evaluation for her c spine stenosis.

Patient: Lila Gutierrez
DOB: 
Age: 50
Date of Visit: 11/1/2016
Covered Body Part:
BILATERAL ARMS AND WRISTS

Employee: 
Lila Gutierrez
Employer: 
Employment Development Department MIC 54
WC Carrier: SCIF
Adjuster: 
Michelle Rodriguez
Utilization Review: UR
DOI: 03/26/2015
Claim #: 06083410
Phone #: 951-413-5919
Fax #: 707-846-0738

Subjective Complaints:
Ms. Gutierrez underwent an MRI of the cervical spine. At C4-5, she has a 7 mm canal stenosis with minimal impingement of the spinal cord. There is questionable foraminal stenosis with impingement of the nerve root at C5. At C5-6, she has 6 mm canal stenosis due to bulging and spurring with possible impingement of the left C6 nerve root. At C6-7, she has bulging and spurring with possible impingement of the C7 nerve root. She will be reevaluated on May 2017 at a QME.

As far as her symptoms, they are unchanged and getting worse. Her symptoms it concluded a weak grip, problems with her ADL’s, especially in the kitchen. She has pain in both upper extremities, right greater than left. She is having now complete numbness of the left thumb, which corresponds to the C6 nerve root.

As far as her medications, she doesn’t think that the gabapentin is of any help and that Voltaren gel helps very little.

Per our previous note:
She had EMG study which showed CTS. She does not want to have surgery for CTS.

She also states she feels pain in both whole arms. She feels it is bone pain inside of the arm. She states her both whole arms are tender.

The patient had an EMG study and I will check that report to see if the patient has any radiculopathy findings.

The patient has not worked for a year and she is still TTD.

The patient is a 49 y.o. female with a history of a repetitive work related injury to her arm and hand causing severe pain.

She reports she has worked for The State Government in the EDD department for the past 25+ years. Her job entails typing all day long on a keyboard. Sometimes she has to work overtime and at times works 10-15 hours in a
Social History Reviewed updated (11/29/2016 US/Pacific)

Family History:

No family history of Depression, Anxiety, Substance Abuse, Neck pain, Back pain, cancer.

Review of Systems:
There are no symptoms of excessive fatigue; fever; chills; unplanned weight loss; chest pain; shortness of breath; wheezing; nausea; vomiting; abdominal pain; bowel incontinence; constipation; urinary incontinence; muscle weakness; bleeding disorders; low platelet count; dizziness; syncope; seizures; drowsiness; difficulty walking; feeling depressed; difficulty falling asleep; difficulty remaining asleep.

Physical Examination:
Weight 200 lbs; Height 5 ft 5 in; BMI 33.3
11/29/2016 11:19 AM (US/Pacific)
Respiration Rate 16; Pulse Rate 72 bpm; Blood Pressure 142 / 90 mm/Hg; Pain Level: 7
General: 50 yo female, NAD, WDWN, A&C)x3, engaging, here alone, no evidence of overmedication or sedation.

Neck: On exam of the back, her cervical spine leans forward and to the right. The left side of the C spine looks short due to spasm. The left trapezius is raised. Palpation of the cervical area reveals severe spasm, right greater than left as well as both trapezi. Range of motion at the neck is decreased in all planes. She has positive facet loading test.

Abdomen: obese.

BACK: She also has a moderate amount of spasm over the over the thoracic area and severe tender spasm in the lumbar area.

Rectal/Genitalia: deferred.

Upper extremities: On exam of the upper extremities, she has diffuse tenderness in both upper extremities. Tinel's sign is positive, but more pronounced on the right side. Today she is especially tender at the wrist and the IP joints. She has decreased sensation to light touch and pinprick on the left thumb.

Skin: intact without lesions or rashes.

Psych: Alert and cooperative, concerned, upset, verbose mood and affect, normal attention span and concentration. Today she is tearful about her forced retirement.

Diagnosis/Assessment:
(M54.13) - Radiculopathy of cervicothoracic region
(G56.00) - Carpal tunnel syndrome
(M47.812) - Degenerative arthritis of cervical spine

Treatment Plan:
She is not yet permanent and stationary. She is not working. She is applying social security disability. She has an attorney.

I discussed her options, which include the cervical epiduralsteroid injection at the left C5-6 level and neurosurgical intervention due toher young age and spinal stenosis.

I will see her next month.

Jose R. Sanchez MD

Prescriptions Written Today:
CeleBREX Oral Capsule 200 MG
Take 1 capsule once a day for 30 day(s)
Refills: No Refills
Rx quantity: 30

Treating Provider: Michael C Yang MD
Electronically Signed By: Michael C Yang MD
Electronically signed: 11/29/2016 2:57:00 PM
day. She states she has pain in her hand, wrist, and arm for more than eight years. Over the two years her pain has become so severe she cannot do her job any longer.

She filed a workers' compensation claim in 2015. She believes her pain is a chronic cumulative injury from working with her hands and fingers on the keyboard over the years.

The patient saw Dr. Schaefer, orthopedist, and he put her as permanent and stationary. She also saw a physician from US Health Clinic and she did not like their services.

The patient has been off work since April 2015. She tried to go back to work with modified duty, but she could not tolerate it. Eventually she just stopped working.

The patient had an EMG study by a physician in Roseville, but she does not recall their name. She states she was told the EMG revealed she has carpal tunnel syndrome. However, she refuses to have surgery because she is afraid surgery will make things worse.

Medications: The patient is taking some Cymbalta from her private primary care physician.

Social History: She is currently not working. She lives with her husband and children in the El Dorado Hills area. She does not smoke and denies any substance abuse.

Anticoagulation Medications:
Not taking any blood thinner medication

Current Medications:
Medications List Reviewed (11/01/16 11:43:13 AM US/Pacific)
Ultram Oral Tablet 50 MG (11/1/2016)
Take 1 tablet every 4 hours as needed for 30 day(s)
Refills: No Refills
Rx quantity: 180
CeleBREX Oral Capsule 200 MG (10/28/2016)
Take 1 capsule once a day for 30 day(s)
Refills: No Refills
Rx quantity: 30
Voltaren External Gel 1 % (7/6/2016)
Take 2-4 grams three times a day as needed for 30 day(s) max 12grams a day
Refills: No Refills
Rx quantity: 3
Gabapentin Oral Capsule 300 MG (8/30/2016)
Take 2 capsules three times a day for 30 day(s)
Refills: 2
Rx quantity: 180

Medication list reviewed. updated (11/01/2016 US/Pacific)

Allergies:
No Known Allergies Confirmed - 11/01/16 11:43:27 AM US/Pacific

Allergy list reviewed. updated (11/01/2016 US/Pacific)

Problem list reviewed.

Past Medical History:
Asthma; Depression
No Hypertension; No Cancer; No Epilepsy; No Cerebrovascular Accident (CVA); No Myocardial Infarction; No Anxiety; No Kidney Disease; No Liver Disease; No Diabetes; No Arthritis; No Angina; No Bleeding Problems

Problem list reviewed. updated (11/01/2016 US/Pacific)

Past Medical History Reviewed updated (11/01/2016 US/Pacific)

Surgical History:
right shoulder

Social History:
Non-Smoker; Alcohol use: Non-Drinker; No drug use.
Living Situation: Lives with spouse.
Family History:

No family history of Depression, Anxiety, Substance Abuse, Neck pain, Back pain, cancer.

Review of Systems:
The patient has symptoms of excessive fatigue; muscle weakness; drowsiness; difficulty falling asleep; difficulty remaining asleep.
There are no symptoms of fever; chills; unplanned weight loss; chest pain; shortness of breath; wheezing; nausea; vomiting; abdominal pain; bowel incontinence; constipation; urinary incontinence; bleeding disorders; low platelet count; dizziness; syncope; seizures; difficulty walking; feeling depressed.

Physical Examination:

Weight 200 lbs; Height 5 ft 5 in; BMI 33.3
11/01/2016 11:44 AM (US/Pacific)
Respiration Rate 16; Pulse Rate 70 bpm; Blood Pressure 138 / 98 mm/Hg; Pain Level: 8

General: 50 yo female, NAD, WDWN, A&Ox3, engaging, here alone, no evidence of overmedication or sedation.

Neck: On exam of the back, her cervical spine leans forward and the left trapezius is raised, as well as her right one, but today right greater than left. Palpation of the cervical area reveals severe spasm, right greater than left. Range of motion at the neck for flexion is 50% of normal, extension is 25% of normal, lateral rotation is 25% normal to the left and the right and on lateral bending, she has positive facet loading test.

Abdomen: obese.

BACK: She also has a moderate amount of spasm over the over the thoracic area and severe tender spasm in the lumbar area.

Rectal/Genitalia: deferred

Upper extremities: On exam of the upper extremities, she has diffuse tenderness in both upper extremities, right greater than left. Tinel's sign is positive, but more pronounced on the right side. Today she is especially tender at the wrist and the IP joints. She has decreased sensation to light touch and pinprick on the left thumb.

Skin: intact without lesions or rashes

Psych: Alert and cooperative, concerned, upset, verbose mood and affect, normal attention span and concentration. Today she is tearful about her forced retirement.

Diagnosis/Assessment:

Diagnosis Reviewed - 11/01/16 11:43:04 AM US/Pacific
(G56.00) - Carpal tunnel syndrome
(M47.812) - Degenerative arthritis of cervical spine
(M54.13) - Radiculopathy of cervicothoracic region

Treatment Plan:

She is permanent and stationary. She is not working. She is applying social security disability. She has an attorney.

I would like to ask WC approve voltaren gel to treat her arthritic pain in both hands. It is FDA approved therapy. The Celebrex has not been approved yet either.

I discussed her options, which include the cervical epidural steroid injection at the left C5-6 level and neurosurgical intervention due to her young age and spinal stenosis.

I will see her next month.

Jose R. Sanchez MD

Prescriptions Written Today:

Ultram Oral Tablet 50 MG
Take 1 tablet every 4 hours as needed for 30 day(s)
Subjective Complaints:

Ms. Gutierrez underwent an MRI of the cervical spine. At C4-5, she has a 7 mm canal stenosis with minimal impingement of the spinal cord. There is questionable foraminal stenosis with impingement of the nerve root at C5. At C5-6, she has 6 mm canal stenosis due to bulging and spurring with possible impingement of the left C6 nerve root. At C6-7, she has bulging and spurring with possible impingement of the C7 nerve root. So the MRI was done on an industrial basis, but my request for a neurosurgical evaluation and a cervical epidural steroid injection was denied. Apparently the cervical spine is not included or is in dispute. She underwent a QME, but I don't have that note yet. On a positive note, we did get approval for Voltaren gel, and Celebrex. She will be reevaluated on May 2017 by the QME.

As far as her symptoms, they are unchanged and are getting worse. Her symptoms include a weak grip, problems with her ADL’s, especially in the kitchen. She has pain in both upper extremities, right greater than left. She is having now complete numbness of the left thumb, which corresponds to the C6 nerve root.

Per our previous note:

She had EMG study which showed CTS. She does not want to have surgery for CTS.

She also states she feels pain in both whole arms. She feels it is bone pain inside of the arm. She states her both whole arms are tender.

The patient had an EMG study and I will check that report to see if the patient has any radiculopathy findings.

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The patient is a 49 y.o. female with a history of a repetitive work related injury to her arm and hand causing severe pain.

She reports she has worked for The State Government in the EDD department for the past 25+ years. Her job entails typing all day long on a keyboard. Sometimes she has to work overtime and at times works 10-15 hours in a day. She states she has pain in her hand, wrist, and arm for more than eight years. Over the two years her pain has become so severe she cannot do her job any longer.

She filed a workers' compensation claim in 2015. She believes her pain is a chronic cumulative injury from working with her hands and fingers on the keyboard over the years.
The patient saw Dr. Schaefer, orthopedist, and he put her as permanent and stationary. She also saw a physician from US Health Clinic and she did not like their services.

The patient has been off work since April 2015. She tried to go back to work with modified duty, but she could not tolerate it. Eventually she just stopped working.

The patient had an EMG study by a physician in Roseville, but she does not recall their name. She states she was told the EMG revealed she has carpal tunnel syndrome. However, she refuses to have surgery because she is afraid surgery will make things worse.

Medications: The patient is taking some Cymbalta from her private primary care physician.

Social History: She is currently not working. She lives with her husband and children in the El Dorado Hills area. She does not smoke and denies any substance abuse.

Anticoagulation Medications:
Not taking any blood thinner medication

Current Medications:
Medications List Reviewed (11/29/16 11:16:25 AM US/Pacific)
Voltaren External Gel 1 % (11/29/2016)
Apply to affected areas twice a day
Refills: 5
Rx quantity: 5
Ultram Oral Tablet 50 MG (11/1/2016)
Take 1 tablet every 4 hours as needed for 30 day(s)
Refills: No Refills
Rx quantity: 180
CeleBREX Oral Capsule 200 MG (11/29/2016)
Take 1 capsule once a day for 30 day(s)
Refills: No Refills
Rx quantity: 30
Voltaren External Gel 1 % (7/6/2016)
Take 2-4 grams three times a day as needed for 30 day(s) max 12grams a day
Refills: No Refills
Rx quantity: 3
Gabapentin Oral Capsule 300 MG (8/30/2016)
Take 2 capsules three times a day for 30 day(s)
Refills: 2
Rx quantity: 180

Medication list reviewed. updated (11/29/2016 US/Pacific)

Allergies:
No Known Allergies Confirmed - 11/29/16 11:16:48 AM US/Pacific

Allergy list reviewed. updated (11/29/2016 US/Pacific)

Problem list reviewed.

Past Medical History:
Asthma; Depression
No Hypertension; No Cancer; No Epilepsy; No Cerebrovascular Accident (CVA); No Myocardial Infarction; No Anxiety; No Kidney Disease; No Liver Disease; No Diabetes; No Arthritis; No Angina; No Bleeding Problems

Problem list reviewed. updated (11/29/2016 US/Pacific)

Past Medical History Reviewed updated (11/29/2016 US/Pacific)

Surgical History:
right shoulder

Social History:
Non-Smoker; Alcohol use: Non-Drinker; No drug use.
Living Situation: Lives with spouse.
PR-2. BY THIS REPORT, I REQUEST AUTHORIZATION FOR A NEUROSURGICAL EVALUATION OF THE HERNIATED DISC AT C5-6, SINCE IT IS SYMPTOMATIC.

Patient: Lila Gutierrez  
DOB:  
Age: 50  
Date of Visit: 12/27/2016  
Covered Body Part:  
BILATERAL ARMS AND WRISTS  

Employee:  
Lila Gutierrez  
DOI: 03/26/2015  

Employer:  
Employment Development Department MIC 54  
Claim #: 06083410  

WC Carrier:  
SCIF  

Adjuster:  
Michelle Rodriguez  
Phone #: 951-413-5919  

Utilization Review:  
UR  
Fax #: 707-646-0738  

Attorney:  
Carla Castaneda  
Phone #: 916-924-1100  

Subjective Complaints:  
Ms. Gutierrez underwent a QME, and the diagnosis was a herniated disc at C5-6 and bilateral mild carpal tunnel syndrome. Dr. Ryan was the QME who stated that she needs further treatment to the neck and wrists. In the interim, she was forced to retire.  
The MRI of the cervical spine showed that at C4-5, she has a 7 mm canal stenosis with minimal impingement of the spinal cord. There is questionable foraminal stenosis with impingement of the C5 nerve root. At C5-6, she has 6 mm canal stenosis due to bulging and spurring with possible impingement of the left C6 nerve root. At C6-7, she has bulging and spurring with possible impingement of the C7 nerve root. So the MRI was done on an industrial basis, but my request for a neurosurgical evaluation and a cervical epidural steroid injection was denied. Apparently the cervical spine is not included or is in dispute, however, the QME included the cervical area and the diagnosis. She will be reevaluated on May 2017 by the QME.  
As far as her symptoms, they are unchanged and are getting worse. Her symptoms include a weak grip, problems with her ADL’s, especially in the kitchen. She has pain in both upper extremities, right greater than left. She is having now complete numbness of the left thumb, which corresponds to the C6 nerve root.  

Per our previous note:  
She had EMG study which showed CTS. She does not want to have surgery for CTS.  

She also states she feels pain in both whole arms. She feels it is bone pain inside of the arm. She states her both whole arms are tender.  
The patient had an EMG study and I will check that report to see if the patient has any radiculopathy findings.  
The patient has not worked for a year and she is still TTD.  
The patient is a 49 y.o. female with a history of a repetitive work related injury to her arm and hand causing severe pain.
She reports she has worked for The State Government in the EDD department for the past 25+ years. Her job entails typing all day long on a keyboard. Sometimes she has to work overtime and at times works 10-15 hours in a day. She states she has pain in her hand, wrist, and arm for more than eight years. Over the two years her pain has become so severe she cannot do her job any longer.

She filed a workers' compensation claim in 2015. She believes her pain is a chronic cumulative injury from working with her hands and fingers on the keyboard over the years.

The patient saw Dr. Schaefer, orthopedist, and he put her as permanent and stationary. She also saw a physician from US Health Clinic and she did not like their services.

The patient has been off work since April 2015. She tried to go back to work with modified duty, but she could not tolerate it. Eventually she just stopped working.

The patient had an EMG study by a physician in Roseville, but she does not recall their name. She states she was told the EMG revealed she has carpal tunnel syndrome. However, she refuses to have surgery because she is afraid surgery will make things worse.

Medications: The patient is taking some Cymbalta from her private primary care physician.

Social History: She is currently not working. She lives with her husband and children in the El Dorado Hills area. She does not smoke and denies any substance abuse.

Anticoagulation Medications: Not taking any blood thinner medication

Current Medications:
Medications List Reviewed (12/27/16 11:44:29 AM US/Pacific)
Voltaren External Gel 1 % (11/29/2016)
Apply to affected areas twice a day
Refills: 5
Rx quantity: 5
Ultrad Oral Tablet 50 MG (12/27/2016)
Take 1 tablet every 4 hours as needed for 30 day(s)
Refills: No Refills
Rx quantity: 180
CeleBREX Oral Capsule 200 MG (12/27/2016)
Take 1 capsule once a day for 30 day(s)
Refills: No Refills
Rx quantity: 30
Voltaren External Gel 1 % (7/6/2016)
Take 2-4 grams three times a day as needed for 30 day(s) max 12grams a day
Refills: No Refills
Rx quantity: 3
Gabapentin Oral Capsule 300 MG (12/27/2016)
Take 2 capsules three times a day for 30 day(s)
Refills: 2
Rx quantity: 180

Medication list reviewed. updated (12/27/2016 US/Pacific)

Allergies:
No Known Allergies Confirmed - 12/27/16 11:44:37 AM US/Pacific

Allergy list reviewed. updated (12/27/2016 US/Pacific)

Problem list reviewed.

Past Medical History:
Asthma; Depression
No Hypertension; No Cancer; No Epilepsy; No Cerebrovascular Accident (CVA); No Myocardial Infarction; No Anxiety; No Kidney Disease; No Liver Disease; No Diabetes; No Arthritis; No Angina; No Bleeding Problems

Problem list reviewed. updated (12/27/2016 US/Pacific)
Past Medical History Reviewed updated (12/27/2016 US/Pacific)

Surgical History:
right shoulder

Social History:
Non-Smoker; Alcohol use: Non-Drinker, No drug use.
Living Situation: Lives with spouse.

Social History Reviewed updated (12/27/2016 US/Pacific)

Family History:

Family History Reviewed updated (12/27/2016 11:45:46 AM US/Pacific)

No family history of Depression, Anxiety, Substance Abuse, Neck pain, Back pain, cancer.

Review of Systems:
There are no symptoms of excessive fatigue; fever; chills; unplanned weight loss; chest pain; shortness of breath; wheezing; nausea; vomiting; abdominal pain; bowel incontinence; constipation; urinary incontinence; muscle weakness; bleeding disorders; low platelet count; dizziness; syncope; seizures; drowsiness; difficulty walking; feeling depressed; difficulty falling asleep; difficulty remaining asleep.

Physical Examination:
Weight 200 lbs; Height 5 ft 5 in; BMI 33.3
12/27/2016 11:45 AM (US/Pacific)
Respiration Rate 16; Pulse Rate 76 bpm; Blood Pressure 136 / 84 mm/Hg; Pain Level: 8

General: 50 yo female, NAD, WDWN, A&Ox3, engaging, here alone, no evidence of overmedication or sedation.

Neck: On exam of the back, her cervical spine leans forward and to the right. The left side of the C spine looks short due to spasm. The left trapezius is raised. Palpation of the cervical area reveals severe spasm, right greater than left as well as both trapezi. Range of motion at the neck is decreased in all planes. She has positive facet loading test.

Abdomen: obese.

BACK: She also has a moderate amount of spasm over the over the thoracic area and severe tender spasm in the lumbar area.

Rectal/Genitalia: deferred

Upper extremities: On exam of the upper extremities, she has diffuse tenderness in both upper extremities. Tinel's sign is positive, but more pronounced on the right side. Today she is especially tender at the wrist and the IP joints. She has decreased sensation to light touch and pinprick on the left thumb.

Skin: intact without lesions or rashes

Psych: Alert and cooperative, concerned, upset, affect, normal attention span and concentration. Today she is tearful about her forced retirement, as this goes on and off.

Diagnosis/Assessment:
(M54.13) - Radiculopathy of cervicothoracic region
(G56.00) - Carpal tunnel syndrome
(M47.812) - Degenerative arthritis of cervical spine

Treatment Plan:
She is not yet permanent and stationary. She is not working. She is applying social security disability. She has an attorney.

I discussed her options, which include the cervical epidural steroid injection at the left C5-6 level and neurosurgical intervention due to her young age and spinal stenosis.

I will see her next month.

Jose R. Sanchez MD

Prescriptions Written Today:
Ultram Oral Tablet 50 MG
Take 1 tablet every 4 hours as needed for 30 day(s)
Refills: No Refills
Rx quantity: 180
CeleBREX Oral Capsule 200 MG
Take 1 capsule once a day for 30 day(s)
Refills: No Refills
Rx quantity: 30
Gabapentin Oral Capsule 300 MG
Take 2 capsules three times a day for 30 day(s)
Refills: 2
Rx quantity: 180

Treating Provider: Michael C Yang MD
Electronically Signed By: Michael C Yang MD
Electronically signed: 12/27/2016 5:47:04 PM
PROGRESS NOTE/REQUEST FOR AUTHORIZATION FOR ULTRAM 50MG #180 AND CELEBREX 200MG #30

Patient: Lila Gutierrez
DOB: Age: 50
Date of Visit: 1/24/2017

Covered Body Part: BILATERAL ARMS AND WRISTS

Employee: Lila Gutierrez DOI: 03/26/2015
Employer: Employment Development Department MIC 54 Claim #: 06083410
WC Carrier: SCIF

Adjuster: Michelle Rodriguez Phone #: 951-413-5919
Utilization Review: Fax #: 707-646-0738
Attorney: Carla Castaneda Phone #: 916-924-1100

Subjective Complaints: Ms. Gutierrez underwent a QME, and the diagnosis was a herniated disc at C5-6 and bilateral mild carpal tunnel syndrome. Dr. Ryan was the QME who stated that she needs further treatment to the neck and wrists. In the interim, she was forced to retire. She tried to do a medical retirement with PERS and it was denied. Currently she's only getting $700 per month and this has caused a lot of strain in the family. She is seeing a psychologist more often. On a good note, she got a letter from the carrier stating that she has been approved for a neurosurgical evaluation.

The MRI of the cervical spine showed that at C4-5, she has a 7 mm canal stenosis with minimal impingement of the spinal cord. There is questionable foraminal stenosis with impingement of the nerve root at C5. At C5-6, she has 6 mm canal stenosis due to bulging and spurring with possible impingement of the left C6 nerve root. At C6-7, she has bulging and spurring with possible impingement of the C7 nerve root. So the MRI was done on an industrial basis, but my request for a neurosurgical evaluation and a cervical epidural steroid injection was denied. Apparently the cervical spine is not included or is in dispute, however, the QME included the cervical area and the diagnosis. She will be reevaluated on May 2017 by the QME.

As far as her symptoms, they are unchanged and are getting worse. Her symptoms include a weak grip, problems with her ADL’s, especially in the kitchen. She has pain in both upper extremities, right greater than left. She is having now complete numbness of the left thumb, which corresponds to the C6 nerve root.

Per our previous note: She had EMG study which showed CTS. She does not want to have surgery for CTS.

She also states she feels pain in both whole arms. She feels it is bone pain inside of the arm. She states her both whole arms are tender.

The patient had an EMG study and I will check that report to see if the patient has any radiculopathy findings.

The patient has not worked for a year and she is still TTD.
The patient is a 49 y.o. female with a history of a repetitive work related injury to her arm and hand causing severe pain.

She reports she has worked for The State Government in the EDD department for the past 25+ years. Her job entails typing all day long on a keyboard. Sometimes she has to work overtime and at times works 10-15 hours in a day. She states she has pain in her hand, wrist, and arm for more than eight years. Over the two years her pain has become so severe she cannot do her job any longer.

She filed a workers' compensation claim in 2015. She believes her pain is a chronic cumulative injury from working with her hands and fingers on the keyboard over the years.

The patient saw Dr. Schaefer, orthopedist, and he put her as permanent and stationary. She also saw a physician from US Health Clinic and she did not like their services.

The patient has been off work since April 2015. She tried to go back to work with modified duty, but she could not tolerate it. Eventually she just stopped working.

The patient had an EMG study by a physician in Roseville, but she does not recall their name. She states she was told the EMG revealed she has carpal tunnel syndrome. However, she refuses to have surgery because she is afraid surgery will make things worse.

Medications: The patient is taking some Cymbalta from her private primary care physician.

Social History: She is currently not working. She lives with her husband and children in the El Dorado Hills area. She does not smoke and denies any substance abuse.

Anticoagulation Medications: Not taking any blood thinner medication
Current Medications:
Medications List Reviewed (01/24/17 1:52:55 PM US/Pacific) 
Voltaren External Gel 1 % (11/29/2016) 
Apply to affected areas twice a day 
Refills: 5 
Rx quantity: 5 
Ultram Oral Tablet 50 MG (12/27/2016) 
Take 1 tablet every 4 hours as needed for 30 day(s) 
Refills: No Refills 
Rx quantity: 180 
CeleBREX Oral Capsule 200 MG (12/27/2016) 
Take 1 capsule once a day for 30 day(s) 
Refills: No Refills 
Rx quantity: 30 
Voltaren External Gel 1 % (7/6/2016) 
Take 2-4 grams three times a day as needed for 30 day(s) max 12grams a day 
Refills: No Refills 
Rx quantity: 3 
Gabapentin Oral Capsule 300 MG (12/27/2016) 
Take 2 capsules three times a day for 30 day(s) 
Refills: 2 
Rx quantity: 180
Medication list reviewed. updated (01/24/2017 US/Pacific)
Allergies: No Known Allergies Confirmed - 01/24/17 1:52:59 PM US/Pacific
Allergy list reviewed. updated (01/24/2017 US/Pacific)
Problem list reviewed.
Past Medical History:
Asthma; Depression
No Hypertension; No Cancer; No Epilepsy; No Cerebrovascular Accident (CVA); No Myocardial Infarction; No Anxiety; No Kidney Disease; No Liver Disease; No Diabetes; No Arthritis; No Angina; No Bleeding Problems
Progress note/Requesting authorization for Voltaren gel 1% # 5 tubes, OR Celebrex 200 M.G QD. REQUEST AUTHORIZATION FOR PT AS PER QME.

Patient: Lila Gutierrez
DOB: 
Age: 50
Date of Visit: 10/18/2016

Covered Body Part:
BILATERAL ARMS AND WRISTS

Employee: 
Lila Gutierrez

Employer: 
Employment Development Department MIC 54

WC Carrier: 
SCIF

Adjuster: 
Michelle Rodriguez

Utilization Review: 
UR

Subjective Complaints:
Ms. Gutierrez underwent an MRI of the cervical spine. About 3 weeks ago. She brought the disc, I checked and there is nothing in her system that we have received the results. I asked her to call the MRI place and see if they will fax me the results so I can add it to this note. She was told by the QME that her permanent stationary status will be changed and that she will try to return to go back to work. So far the change in permanent and stationary status has not been received, so she cannot return to work. She will be reevaluated on May 2017 at a QME.

As far as her symptoms, they are unchanged and getting worse, probably because of the colder weather. She complains that her arms feel bruised all of the time. Her symptoms it concluded a weak grip, problems with her ADL’s, especially in the kitchen. She has pain in both upper extremities, right greater than left. She also saw a doctor through PERS and was told she may also have rheumatoid arthritis, although workup in the past has been negative. In addition she also suffers from fibromyalgia.

As far as her medications, she doesn’t think that the gabapentin is of any help in that Voltaren gel helps very little.

Per our previous note:
She had EMG study which showed CTS. She does not want to have surgery for CTS.

She also states she feels pain in both whole arms. She feels it is bone pain inside of the arm. She states her both whole arms are tender.

The patient had an EMG study and I will check that report to see if the patient has any radiculopathy findings.

The patient has not worked for a year and she is still TTD.

The patient is a 49 y.o. female with a history of a repetitive work related injury to her arm and hand causing severe pain.

She reports she has worked for The State Government in the EDD department for the past 25+ years. Her job entails typing all day long on a keyboard. Sometimes she has to work overtime and at times works 10-15 hours in a
Refills: No Refills
Rx quantity: 180

Treating Provider: Michael C Yang MD
Electronically Signed By: Michael C Yang MD
Electronically signed: 11/1/2016 3:53:57 PM
The patient has symptoms of excessive fatigue; muscle weakness; drowsiness; difficulty falling asleep; difficulty remaining asleep.
There are no symptoms of fever; chills; unplanned weight loss; chest pain; shortness of breath; wheezing; nausea; vomiting; abdominal pain; bowel incontinence; constipation; urinary incontinence; bleeding disorders; low platelet count; dizziness; syncope; seizures; difficulty walking; feeling depressed.

Physical Examination:
Weight 200 lbs; Height 5 ft 5 in; BMI 33.3
10/18/2016 11:20 AM (US/Pacific)
Respiration Rate 16; Pulse Rate 70 bpm; Blood Pressure 138 / 98 mm/Hg; Pain Level: 8
General: 49 yo female, NAD, WDWN, A&Ox3, engaging, here alone, no evidence of overmedication, sedation, or withdrawal.
Neck: On exam of the back she has a very abnormal posture. Her cervical spine leans forward and the left trapezus is raised, as well as her right one but today right greater than left. Palpation of the cervical area reveals severe spasm, right greater than left. Range of motion at the neck for flexion is 75% of normal, extension is 25% of normal, lateral rotation is 25% normal to the left and the right and on lateral bending she has positive facet loading test.
Abdomen: obese.
BACK: She also has a moderate amount of spasm over the thoracic area and severe tender spasm in the lumbar area.
Rectal/Genitalia: deferred
Upper extremities: On exam of the upper extremities, she has diffuse tenderness in both upper extremities, right greater than left. Tinel's sign is positive, but more pronounced on the right side. Today she is especially tender at the wrist and the IP joints.
Skin: intact without lesions or rashes
Psych: Alert and cooperative, concerned, upset, verbose mood and affect, normal attention span and concentration. Today she is tearful about her forced retirement.

Diagnosis/Assessment:
Diagnosis Reviewed - 10/18/16 11:19:03 AM US/Pacific
(G56.00) - Carpal tunnel syndrome
(M47.812) - Degenerative arthritis of cervical spine
(M54.13) - Radiculopathy of cervicothoracic region

Treatment Plan:
She is permanent and stationary. She is not working. She is applying social security disability. She has an attorney.

I would like to ask WC approve voltaren gel to treat her arthritic pain in both hands. It is FDA approved therapy.

I will be waiting for the results of the MRI of the cervical spine.

I will see her next month.

Jose R. Sanchez MD

Treating Provider: Michael CYang MD
Electronically Signed By: Michael CYang MD
Electronically signed: 10/18/2016 3:56:34 PM
day. She states she has pain in her hand, wrist, and arm for more than eight years. Over the two years her pain has become so severe she cannot do her job any longer.

She filed a workers' compensation claim in 2015. She believes her pain is a chronic cumulative injury from working with her hands and fingers on the keyboard over the years.

The patient saw Dr. Schaefer, orthopedist, and he put her as permanent and stationary. She also saw a physician from US Health Clinic and she did not like their services.

The patient has been off work since April 2015. She tried to go back to work with modified duty, but she could not tolerate it. Eventually she just stopped working.

The patient had an EMG study by a physician in Roseville, but she does not recall their name. She states she was told the EMG revealed she has carpal tunnel syndrome. However, she refuses to have surgery because she is afraid surgery will make things worse.

Medications: The patient is taking some Cymbalta from her private primary care physician.

Social History: She is currently not working. She lives with her husband and children in the El Dorado Hills area. She does not smoke and denies any substance abuse.

Anticoagulation Medications:
Not taking any blood thinner medication

Current Medications:
Medications List Reviewed (10/18/16 11:19:09 AM US/Pacific)
Voltaren External Gel 1 % (7/6/2016)
Take 2-4 grams three times a day as needed for 30 day(s) max 12grams a day
Refills: No Refills
Rx quantity: 3
Gabapentin Oral Capsule 300 MG (8/30/2016)
Take 2 capsules three times a day for 30 day(s)
Refills: 2
Rx quantity: 180

Medication list reviewed. updated(10/18/2016 US/Pacific)

Allergies:
No Known Allergies Confirmed - 10/18/16 11:19:13 AM US/Pacific

Allergy list reviewed. updated(10/18/2016 US/Pacific)

Problem list reviewed.
Past Medical History:
Asthma; Depression
No Hypertension; No Cancer; No Epilepsy; No Cerebrovascular Accident (CVA); No Myocardial Infarction; No Anxiety; No Kidney Disease; No Liver Disease; No Diabetes; No Arthritis; No Angina; No Bleeding Problems

Problem list reviewed. updated(10/18/2016 US/Pacific)

Past Medical History Reviewed updated(10/18/2016 US/Pacific)

Surgical History: updated(10/18/2016 US/Pacific)
right shoulder

Social History:
Non-Smoker; Alcohol use: Non-Drinker; No drug use.
Living Situation: Lives with spouse.

Social History Reviewed updated(10/18/2016 US/Pacific)

Family History:
Family History Reviewed updated(10/18/2016 11:21:09 AM US/Pacific)
No family history of Depression, Anxiety, Substance Abuse, Neck pain, Back pain, cancer.

Review of Systems:
Problem list reviewed. updated (01/24/2017 US/Pacific)

Past Medical History Reviewed updated (01/24/2017 US/Pacific)

Surgical History:
right shoulder

Social History:
Non-Smoker; Alcohol use: Non-Drinker; No drug use.
Living Situation: Lives with spouse.

Social History Reviewed updated (01/24/2017 US/Pacific)

Family History:

Family History Reviewed updated (01/24/2017 1:55:00 PM US/Pacific)
No family history of Depression, Anxiety, Substance Abuse, Neck pain, Back pain, cancer.

Review of Systems:
The patient has symptoms of muscle weakness; difficulty falling asleep; difficulty remaining asleep.
There are no symptoms of excessive fatigue; fever; chills; unplanned weight loss; chest pain; shortness of breath; wheezing; nausea; vomiting; abdominal pain; bowel incontinence; constipation; urinary incontinence; bleeding disorders; low platelet count; dizziness; syncope; seizures; drowsiness; difficulty walking; feeling depressed.

Physical Examination:
Weight 200 lbs; Height 5 ft 5 in; BMI 33.3
01/24/2017 1:54 PM (US/Pacific)
Respiration Rate 16; Pulse Rate 86 bpm; Blood Pressure 124 / 84 mmHg; Pain Level: 7
General: 50 yo female, NAD, WDNW, A&Ox3, engaging, here alone, no evidence of overmedication or sedation.

Neck: On exam of the back, palpation of the cervical area reveals severe spasm, right greater than left as well as both trapezi. Range of motion at the neck is decreased in all planes. She has positive facet loading test.

Abdomen: obese.

BACK: She also has a moderate amount of spasm over the thoracic area and severe tender spasm in the lumbar area.

Rectal/Genitalia: deferred

Upper extremities: On exam of the upper extremities, she has diffuse tenderness in both upper extremities. Tinel’s sign is positive, but more pronounced on the right side. Today she is especially tender at the wrist and the IP joints. She has decreased sensation to light touch and pinprick on the left thumb. Her grip is weak on the left.

Skin: intact without lesions or rashes

Psych: Alert and cooperative, concerned, upset, affect, normal attention span and concentration. Today she is tearful about her forced retirement, as this goes on and off.

Diagnosis/Assessment:
(M54.13) - Radiculopathy of cervicothoracic region
(G56.00) - Carpal tunnel syndrome
(M47.812) - Degenerative arthritis of cervical spine

Treatment Plan:
She is not yet permanent and stationary. She is not working. She is applying social security disability. She has an attorney.

I discussed her options, which include a neurosurgical intervention due to her young age and spinal stenosis, but her left upper extremity is very symptomatic.

I will see her in 6 weeks.

Jose R. Sanchez MD
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 provide to me and, except as noted herein, that I believe it to be true.

As the primary treating physician, I, Michel C. Yang, M.D., pursuant to Labor Code 4061.5, have designated Jose R. Sanchez, M.D. to submit a report regarding all medical issues necessary to determine eligibility for compensation in this case as per Title 8, California Code of Regulations 97859(c).

Patient Education:
Patient Education Provided: (PAIN MANAGEMENT: Chronic), 01/26/17 10:11 AM US/Pacific

Treating Provider: Michael C Yang MD
Electronically Signed By: Michael C Yang MD
Electronically signed: 2/6/2017 2:25:39 PM
SCIF RECD DTE 07/15/2015 VLS CAN 51 07/15/2015 10:13 AM 059521 7 2
State of California
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

OCCUPATIONAL ORTHOPEDICS

☐ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Discharged
☐ Change in work status ☐ Need for referral or consultation ☐ Info. requested by:
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Other:

Patient:
Last Gutierrez
First Lila
M.I. M. Sex F
Address
City
State CA Zip
Occupation
SS# Phone

Claims Administrator:
Name State Comp Ins Fund
Address PO Box 3171
City Suisun City
State CA Zip
Phone (951) 697-7304
FAX ( )

Employer Name

Subjective complaints: Date of Service 06/10/15 Date of Injury ______________

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

1. ____________

2. ____________

Treatment Plan. Initial Consultation & Treatment Consultation Only Cast
Follow-Up X-ray injection Other
Physical Therapy times / week (until next appt. with physician)
MRI CT Scan Bone Scan EMG Arthrogram
Surgery Epidural Steroid
Other

WORK STATUS TODAY: Release to Full Duty Today OR Date:
Release to Modified Duty from Date:
Unable to work until ______________

WORK RESTRICTIONS: (Consider patient unable to return to work if modified duty unavailable)

Lift over 10 25 50 75 pounds None 1-2 hours 3-5 hours 6-8 hours
Stand / Walk
Sit
Bend, Stoop
Push, Pull
Climb, Squat
Overhead work
Restricted from use of Right Left Hand Arm Foot Leg
Should do sedentary work only
Restricted from driving
Other

Primary Treating Physician: (original signature, do not stamp)

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3

Signature: 
Executed at: DAMICO MD, Daniel
Name: 
Address: 7551 Timberlake Way Suite 200 Sacramento, CA 95823-5422
Call Lic. #06/10/15 (916) 525-0620
Date: 
Specialty: 
Phone: 

8615
Lila Gutierrez

Notice of Decision – Fully Favorable

I carefully reviewed the facts of your case and made the enclosed fully favorable decision. Please read this notice and my decision.

Another office will process my decision. That office may ask you for more information. If you do not hear anything within 60 days of the date of this notice, please contact your local office. The contact information for your local office is at the end of this notice.

If You Disagree With My Decision

If you disagree with my decision, you may file an appeal with the Appeals Council.

How To File An Appeal

To file an appeal you or your representative must ask in writing that the Appeals Council review my decision. You may use our Request for Review form (HA-520) or write a letter. The form is available at www.socialsecurity.gov. Please put the Social Security number shown above on any appeal you file. If you need help, you may file in person at any Social Security or hearing office.

Please send your request to:

Appeals Council
Office of Disability Adjudication and Review
5107 Leesburg Pike
Falls Church, VA 22041-3255

Time Limit To File An Appeal

You must file your written appeal within 60 days of the date you get this notice. The Appeals Council assumes you got this notice 5 days after the date of the notice unless you show you did
not get it within the 5-day period.

The Appeals Council will dismiss a late request unless you show you had a good reason for not filing it on time.

What Else You May Send Us

You or your representative may send us a written statement about your case. You may also send us new evidence. You should send your written statement and any new evidence with your appeal. Sending your written statement and any new evidence with your appeal may help us review your case sooner.

How An Appeal Works

The Appeals Council will consider your entire case. It will consider all of my decision, even the parts with which you agree. Review can make any part of my decision more or less favorable or unfavorable to you. The rules the Appeals Council uses are in the Code of Federal Regulations, Title 20, Chapter III, Part 404 (Subpart J).

The Appeals Council may:

- Deny your appeal,
- Return your case to me or another administrative law judge for a new decision,
- Issue its own decision, or
- Dismiss your case.

The Appeals Council will send you a notice telling you what it decides to do. If the Appeals Council denies your appeal, my decision will become the final decision.

The Appeals Council May Review My Decision On Its Own

The Appeals Council may review my decision even if you do not appeal. They may decide to review my decision within 60 days after the date of the decision. The Appeals Council will mail you a notice of review if they decide to review my decision.

When There Is No Appeals Council Review

If you do not appeal and the Appeals Council does not review my decision on its own, my decision will become final. A final decision can be changed only under special circumstances. You will not have the right to Federal court review.
If You Have Any Questions

We invite you to visit our website located at www.socialsecurity.gov to find answers to general questions about social security. You may also call (800) 772-1213 with questions. If you are deaf or hard of hearing, please use our TTY number (800) 325-0778.

If you have any other questions, please call, write, or visit any Social Security office. Please have this notice and decision with you. The telephone number of the local office that serves your area is (877)545-5497. Its address is:

Social Security
Suite A
3916 Missouri Flat Rd
Placerville, CA 95667-5265

Plauche F. Villere Jr.
Administrative Law Judge

Enclosures:
Form HA-L15 (Fee Agreement Approval)
Decision Rationale

cc: Jacquie Winkley Merritt
5230 Folsom Blvd
Sacramento, CA 95819
acceptable medical source designated to make equivalency findings has concluded that the claimant's impairment(s) medically equal a listed impairment.

5. The claimant has the residual functional capacity to perform sedentary work as defined in 20 CFR 404.1567(a) involving lifting and carrying no more than 10 pounds, no climbing of ladders/ropes/scaffolds, and no overhead activity and only occasional handling, fingering and feeling. The claimant is also limited to a low demand work setting consistent with simple work and changes should be introduced gradually.

In making this finding, the undersigned has considered all symptoms and the extent to which these symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence, based on the requirements of 20 CFR 404.1529 and SSR 16-3p. The undersigned also considered opinion evidence in accordance with the requirements of 20 CFR 404.1527.

In considering the claimant's symptoms, the undersigned must follow a two-step process in which it must first be determined whether there is an underlying medically determinable physical or mental impairment(s)—i.e., an impairment(s) that can be shown by medically acceptable clinical or laboratory diagnostic techniques—that could reasonably be expected to produce the claimant's pain or other symptoms.

Second, once an underlying physical or mental impairment(s) that could reasonably be expected to produce the claimant's pain or other symptoms has been shown, the undersigned must evaluate the intensity, persistence, and effects of the claimant's symptoms to determine the extent to which they limit the claimant's work-related activities. For this purpose, whenever statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, the undersigned must consider other evidence in the record to determine if the claimant's symptoms limit the ability to do work-related activities.

In support of this conclusion, the record reveals a history of musculoskeletal limitations secondary to neck, hands, and wrists. She also has pain in her shoulders, and elbows with associated numbness and tingling. She experiences fatigue and unexplained weight gain secondary to hypothyroidism. She is unable to stand/walk for any prolonged period. She has respiratory problems related to asthma and respiratory disease. In addition, she has exhibited anxiety and depressed mood related to her condition. She alleges if she engages in work-related activities for more than a short period it exacerbates her symptoms and forces her to stop these activities.

The record supports the claimant's allegations regarding the severity of her symptoms and her limitations. Her descriptions of her symptoms and limitations have been consistent and are found to be persuasive.

On September 06, 2015, claimant presented for an orthopedic consultation suffering from ongoing pain in the bilateral wrists and tingling in the fingers during the night. Diagnoses included light carpal tunnel syndrome, left wrist pain, she was advised regarding workplace restriction/duty modifications (Exhibit 3F, pg. 5).
On September 24, 2015, claimant presented for a primary care visit suffering from anxiety secondary to chronic pain and disability. She was diagnosed with worsening depressive reaction, chronic obstructive asthma with exacerbation, treated with medications for pain management (Exhibit 4F, pgs. 6-10).

On October 15, 2015, claimant presented for an orthopedic consultation with Randall K. Schaefer, M.D. She was suffering from pain in the bilateral wrists and hands secondary to repetitive use injury. She was diagnosed with right carpal tunnel syndrome, left wrist pain, advised regarding work restrictions, which precluded no pulling, gripping, or keyboard manipulation of objects with her hands (Exhibit 3F, pg. 2).

On November 05, 2015, claimant presented for a primary care visit suffering from anxiety, back pain, and neck pain with a radicular component. She was diagnosed with dysthymic disorder, cervical paraspinous muscle spasm, weight gain secondary to depression and anxiety, and she was advised regarding weight management and medications for depression/anxiety (Exhibit 4F, pg. 4).

On February 2, 2016, claimant attended a consultative psychological evaluation wherein she was diagnosed with dysthymic disorder, with a global assessment of functioning (GAF) score of 59. Michael A. Molyn, Speed, found claimants' ability to understand, remember, and carry out simple instructions appears to be unimpaired. Her ability to understand, remember, and carry out complex instructions is mildly impaired. Her ability to respond appropriately to coworkers, supervisors, and the public is unimpaired. Her ability to respond appropriately to usual work situations (attendance and safety) appears to be unimpaired. Her ability to deal with changes in a routine work setting appears to be mildly impaired. Her ability to maintain attention and concentration appears to be mildly impaired (Exhibit 6F).

On March 14, 2016, progress notes show that claimant presented for a pain management consultation suffering from pain and reduced strength in the bilateral upper extremities with associated tingling sensation bilaterally. She was diagnosed with radiculopathy of the cervicothoracic region, carpal tunnel syndrome, and degenerative arthritis of the cervical spine, treated with medications for pain management, (Exhibit 17F, pgs. 53-56).

March 31, 2016, progress notes documented claimant depressed. Cymbalta helps with depression and fibromyalgia. She has problems with obesity. She still has depression. Lacks motivation, feels sad, and feels worse because now limited in activities. She was to start Wellbutrin but did not do it. She wants to return to work, she has lost her identity end purpose by not working. She no longer enjoys doing the things that she used to do. She misses work and the work routine. She has become more depressed and has gained weight in not working. She wants to return to work and plans to do it soon (Exhibit 7F, pg. 5).

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1 A GAF score of 51-60 indicates moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers) (Diagnostic and Statistical Manual of Mental Disorders Text Revision ("DSM"), 34 (fourth ed. 2000)).
However, on May 16, 2016, Janak Mehtani, M.D., in a medical report indicated that claimant is unable to maintain gainful employment (Exhibit 9F).
On June 6, 2016, claimant presented for a pain management consultation suffering from pain in the bilateral upper extremities secondary to cumulative workplace trauma. She was diagnosed with radiculopathy or the cervicothoracic region, carpal tunnel syndrome, and degenerative arthritis of the cervical spine, treated with medications for pain management (Exhibit 17F, pgs. 44-46).

September 26, 2016, MRI radiograph of the cervical spine revealed findings significant for degenerative disc bulging/spurring greatest at C5/C6, resulting canal stenosis and impingement upon the cervical spinal cord. There is also left foraminal stenosis at this level in which cannot exclude possible impingement upon the exiting left C6 nerve root. There is degenerative disc bulging/spurring at C4/C5, resulting in canal stenosis with minimal impingement upon the cervical spinal cord. There is also question of left foraminal stenosis with possible impingement upon the exiting left C5 nerve. Degenerative disc bulging/spurring at C6/C7 with left foraminal stenosis and possible impingement upon the exiting left C7 (Exhibit 17F, pgs. 78-79).

On December 27, 2016, progress notes documented claimant suffering from pain in the bilateral upper extremities, decreased strength in the left upper extremity, and decreased sensation in the left upper extremity. She was diagnosed with radiculopathy of the cervicothoracic region, and carpal tunnel syndrome, and degenerative arthritis of the cervical spine, treated with medications for pain management (Exhibit 17F, pgs. 21-24).

On March 29, 2017, she presented for a primary care visit suffering from neck and back pain, and respiratory wheezing. She was diagnosed with hypothyroidism, neck pain, acute bilateral back pain, allergic rhinitis, and asthma, treated with medications for the management of pain and pulmonary symptoms (Exhibit 28F, pgs. 19-24).

On May 6, 2017, claimant presented for a Qualified Medical Examination suffering from midback pain, neck pain which radiates into the bilateral upper extremities, and associated weakness in the hands/wrists. Physical examination revealed tenderness to palpation of the cervical paraspinal musculature, left wrist, decreased JAMAR-measured grip strength on the left, and associated depression secondary to chrome pain and disability. She was diagnosed with C5-6 disc herniation, C6 radiculitis, bilateral carpal tunnel syndrome, and advised regarding, work restrictions and potential future care per provider, M. Ryan, M.D., statement: "I do not feel that the claimant is capable of resumption of her usual and customary work activities. I would estimate permanent work restrictions as no keyboarding, no lifting more than 10 pounds. No overhead activity" (Exhibit 15F).

On September 07, 2017, claimant presented for a primary care visit suffering from neck pain, which radiates into the left upper extremity with associated numbness and tingling in the affected limb. She was diagnosed with cervical disc disorder with radiculopathy, carpal tunnel syndrome, dysthymic disorder, treated with medications for the management of pain, muscle spasms, and insomnia (Exhibit 28F, pgs. 1-6).
Despite receiving continued conservative treatment, including acupuncture treatment and physical therapy, the record shows that the claimant continues to suffer from constant pain and significant limitations in her ability to function physically as well as mentally. The medical evidence of record demonstrates that despite regular consultation with her treating sources, and compliance with all recommended treatment modalities, the symptoms from her combination of impairments are unrelieved, and she faces significant limitations in her ability to perform in a remunerative competitive work environment and sustain ongoing work activity. Thus, after careful consideration of the evidence, the undersigned finds that the claimant’s medically determinable impairments could reasonably be expected to cause the alleged symptoms. The claimant’s statements concerning the intensity, persistence and limiting effects of these symptoms are reasonably consistent with the medical evidence and other evidence in the record for the reasons explained in this decision.

As for the opinion evidence, State agency medical consultants, Pamela Hawkins, PhD, and L. Colsky, M.D., are afforded good weight (Exhibit 1A). These opinions are consistent with at least moderate limitation in claimant maintaining concentration, persistence, or pace.

The undersigned gave partial weight to Drs. Schaefer and Vuong’ medical opinions (Exhibit 3F, pg. 2; Exhibit 4F, pg. 4). In addition to Dr. Mehtani and Dr. Molyn’ opinions (Exhibit 6F; Exhibit 9F). Partial weight is also given to State agency medical consultant, M. Bijpuria, M.D. (Exhibit 20F). However, to the extent the residual functional capacity varies from these opinions, this variation is attributable to additional evidence (including testimony at the hearing) that was not available to those consultants.

State agency medical consultants, A. Pan, M.D., and C. Eskander, M.D., are given little weight (Exhibit 1A; Exhibit 3A). These opinions are not consistent with the record as a whole, namely, the wealth of objective medical evidence supporting the legitimacy of the claimant’s alleged impairments as discussed. Moreover, the State agency medical consultants did not have the opportunity to examine the claimant or review the most recent evidence. Finally, the State agency medical consultants did not fully consider the combined effects of the claimant’s cervical spine impairment and carpal tunnel syndrome to find the claimant able to perform a reduced range of sedentary work.

Based on the foregoing, the undersigned finds the claimant has the above residual functional capacity assessment, which is supported by overall objective medical evidence of record, clinical observations, doctor statements, and hearing testimony that support a finding of “disabled.”

6. The claimant is unable to perform any past relevant work (20 CFR 404.1565).

The demands of the claimant’s past relevant work exceed the residual functional capacity.

7. The claimant was a younger individual age 45-49 on the established disability onset date (20 CFR 404.1563).

8. The claimant has at least a high school education and is able to communicate in English (20 CFR 404.1564).
SOCIAL SECURITY ADMINISTRATION
Office of Disability Adjudication and Review

DECISION

IN THE CASE OF  CLAIM FOR

Lila Gutierrez                         Period of Disability and Disability Insurance
(Claimant)                             Benefits

(Wage Earner) (Social Security Number)

JURISDICTION AND PROCEDURAL HISTORY

This case is before the undersigned on a request for hearing dated August 8, 2016 (20 CFR 404.929 et seq.). The claimant appeared and testified at a hearing held on December 18, 2017, in Sacramento, CA. The claimant is represented by Jacquie Winkley Merritt, an attorney.

The claimant is alleging disability since April 10, 2015.

The claimant submitted or informed the Administrative Law Judge about all written evidence at least five business days before the date of the claimant's scheduled hearing (20 CFR 404.935(a)).

ISSUES

The issue is whether the claimant is disabled under sections 216(i) and 223(d) of the Social Security Act. Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

There is an additional issue whether the insured status requirements of sections 216(i) and 223 of the Social Security Act are met. The claimant's earnings record shows that the claimant has acquired sufficient quarters of coverage to remain insured through December 31, 2019. Thus, the claimant must establish disability on or before that date in order to be entitled to a period of disability and disability insurance benefits.

After careful review of the entire record, the undersigned finds that the claimant has been disabled from April 10, 2015, through the date of this decision. The undersigned also finds that the insured status requirements of the Social Security Act were met as of the date disability is established.

See Next Page
Dear Dr. Roderick Sanden:

Utilization Review is to provide a review of requested medical treatment to determine medical necessity and appropriateness. Selection of a specific provider or program may be designated by the claims administrator. Questions about the financial aspects of the claim should be addressed with the claims examiner.

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; interpreting; medically necessary transportation; home health; physical therapy and diagnostics should be requested through Healthesystems (HES) (877)287-7728.

I called and spoke to the provider's office with the determination as contained in this report. LILA GUTIERREZ's Workers' Compensation insurance carrier/employer has requested utilization review.

ITEMS REQUESTED:
ITEM 1. EMG of the Bilateral Upper Extremities QTY: 1.00
ITEM 2. NCV of the Bilateral Upper Extremities QTY: 1.00
ITEM 3. Cervical CT w/o Contrast QTY: 1.00
ITEM 4. Pain Management Consultation for possible Cervical ESI QTY: 1.00
ITEM 5. Cervical X-ray (lateral, flexion, extension) QTY: 1.00

APPROVED:
ITEM 3: Cervical CT w/o Contrast QTY: 1.00
ITEM 4: Pain Management Consultation for possible Cervical ESI QTY: 1.00
ITEM 5: Cervical X-ray (lateral, flexion, extension) QTY: 1.00

DENIED:
ITEM 1: EMG of the Bilateral Upper Extremities
ITEM 2: NCV of the Bilateral Upper Extremities

MEDICAL RECORDS REVIEW PREPARED BY LICENSED HEALTHCARE PROFESSIONAL

TREATMENT REQUEST (Prospective) RFA DOS: 03/16/17 DOS: 03/02/17
ITEM 1. EMG of the Bilateral Upper Extremities QTY: 1.00
ITEM 2. NCV of the Bilateral Upper Extremities QTY: 1.00
ITEM 3. Cervical CT w/o Contrast QTY: 1.00
ITEM 4. Pain Management Consultation for possible Cervical ESI QTY: 1.00
ITEM 5. Cervical X-ray (lateral, flexion, extension) QTY: 1.00

CLINICAL SUMMARY:
Lila GUTIERREZ is a 50 year old (DOB: female with a date of injury of 03/26/15. The bilateral wrists and hands, neck (disc), bilateral shoulders, and bilateral lower arms have been accepted by the carrier. The carrier has objected the claim for back (disc).

PRIOR UR (within the last 12 months):
-03/10/16 T. Reaper, MD: APPROVED Gabapentin 300mg #540. DENIED Functional Capacity Evaluation.
-11/21/16 G. Taff, MD; EKHS UR; APPROVED: ITEM 2: Ultram 50mg QTY: 180.00 ITEM 3: Celebrex 200mg QTY: 30.00 DENIED: ITEM 1: Voltaren 1% Gel (NOTE: Claims administrator has denied the request for neurosurgical consult for the cervical spine and cervical spine injection (body part not accepted).)
-03/01/17 G. Taff, MD; EKHS UR; APPROVED: ITEM 1: Ultram 50mg QTY: 180.00 The requests for gabapentin and Celebrex have been approved by the claims administrator.

IMR FINAL DETERMINATIONS (within the last 12 moths):
-04/22/16 Maximus; OVERTURNED Denial date 3/10/16. APPROVED Functional Capacity Evaluation.
-01/19/17 Maximus; UPHELD; Denial date 11/21/16, DENIED VOLTAREN 1% GEL 5,00.

DIAGNOSTICS:
-07/17/15 I. Rashid, D.O.; Electrodiagnostic Study; Diagnostic evidence of moderate right CTS, no
evidence of left median, bilateral ulnar, radial focal neuropathy, or bilateral cervical radiculopathy.
-09/26/16 J. Hansing, MD; Cervical MRI; Degenerative disc bulging/spurring, greatest at C5/C6,
resulting in 6 mm canal stenosis and impingement upon the cervical spinal cord but without cord
compression or displacement. There is also left foraminal stenosis at this level in which I cannot exclude
possible impingement upon the exiting left C6 nerve root, degenerative disc bulging/spurring at C4/C5,
resulting in 7 mm canal stenosis with minimal impingement upon the cervical spinal cord without cord
compression or displacement seen at this level. There is also question of left foraminal stenosis with
possible impingement upon the exiting left C5 nerve, degenerative disc bulging/spurring at C6/C7
without evidence of canal stenosis or cord impingement, with left foraminal stenosis and possible
Impingement upon the exiting left C7.

PRIOR SURGERY/PROCEDURES:
No prior surgeries or procedures found in the documentation reviewed.

MEDICAL RECORD SUMMARY:
-11/01/16 J. Sanchez, MD/ M. Yang, MD; Progress note;
SUBJECTIVE: She has pain in both upper extremities right greater than left. She Is having now
complete numbness of the left thumb which corresponds to the C6 nerve root.
OBJECTIVE: Diffused tenderness to both upper extremities. Positive Tinel's, more pronounced on the
right side. Tender especially at the wrist and IP joints. Sensation decreased on left thumb.
PLAN: Not working, applying social security tisalbity. P&S.

-11/01/16 M. Yang, MD; DWC RFA: Voltaren gel 1% #5, Ultram 50mg #180, Celebrex 200mg #30,
CESI at left C5-6, Neuro consult for cervical stenosis.

-02/21/17 M. Yang, MD; Follow up; Symptoms unchanged and getting worse. Patient reported weak
grip, problems with ADL's, pain in both upper extremities, complete numbness of left thumb. Patient had
EMG and was told EMG revealed carpal tunnel syndrome but patient refuses to have surgery. Patient
taking Cymbalta from private PCP. Relevant objective findings included cervical spasm, decreased range
of motion, positive facet loading, spasm over thoracic and lumbar area, diffuse tenderness bilateral upper
extremities, decreased sensation in left thumb, weak grip on left. Diagnosis included radiculopathy of
cervicothoracic region, carpal tunnel syndrome, degenerative arthritis of cervical spine. Follow up with
neurosurgeon, provider prescribed Ultram #180, Celebrex #30, and gabapentin #180 with 2 refills.
TOTAL MED 60mg.

-02/22/17 M. Yang, MD; DWC RFA; Ultram 50mg #180, gabapentin 300mg#180 2 refills, Celebrex
200mg #30.

-03/02/17 R. Sanden, MD; Neurosurgical Cervical Spine Consultation; Patient suffered industrial injury
03/26/16 from keying for data entry, patient began to lose strength in hands. EMG revealed carpal tunnel
and MRI revealed cervical spondylitic cord impingement C4-C7. Patient presents with neck, arm, and
hand pain. Currently taking Celebrex, gabapentin for pain. 60% left, 40% right arm pain, numbness,
tingling into the thumb, middle fingers with burning and shooting up and down the arm from the neck,
patient awakens at night twice a week with rubbing out the wrists. Patient had prior right shoulder
surgery in 2002 which did not help, prior conservative care to include 16 PT visits, 10 acupuncture, no
HEP. Examination revealed cervical spasm, guarding, loss of lordosis, right rotation 60-70 degrees, left
50-60, flexion 45, extension 30, mild Spurlings sign into the left arm and shoulder with rotation and
extension, trace left brachioradialis reflex, sensory shows right greater than left forearm, thumb, index,
deltoid, middle, ring, small finger in C4-7 distribution, motor revealed weakness on the right arm with 80-90% of normal, grip testing performed, positive Tinel's bilaterally, shoulder range of motion normal bilaterally. Imaging reviewed by report only, diagnosis included C5-6 stenosis, central, foraminal with alternating UE radiculopathy, C4-5 stenosis from disc protrusion, industrial with central and foraminal stenosis, alternating radiculopathy, borderline stenosis C6-7, history of CTS. The provider requested authorization for repeat EMG/NCV, cervical x-rays to include lateral/flexion/extension to rule out instability, CT cervical spine to determine true spondylitic stenosis from possible congenital canal stenosis versus OA spondylitic cord impingement, pain management for cervical epidural steroid.

-03/16/17 R. Sanden, MD; DWC RFA; EMG/NCV bilateral upper extremities, lateral/flexion/extension x-rays of cervical spine, CT scan of cervical spine, consultation with pain management for cervical ESI.

QME/AME/P&S:
None found in records reviewed.

PHYSICIAN REVIEWER'S RATIONALE

I have reviewed the medical information contained in this report.

TREATMENT REQUESTED:
ITEM 1. EMG of the Bilateral Upper Extremities QTY: 1.00
ITEM 2. NCV of the Bilateral Upper Extremities QTY: 1.00
ITEM 3. Cervical CT w/o Contrast QTY: 1.00
ITEM 4. Pain Management Consultation for possible Cervical ESI QTY: 1.00
ITEM 5. Cervical X-ray (lateral, flexion, extension) QTY: 1.00

RECOMMENDATION:
ITEM 1. DENIED EMG of the Bilateral Upper Extremities QTY: 1.00
ITEM 2. DENIED NCV of the Bilateral Upper Extremities QTY: 1.00
ITEM 3. APPROVED Cervical CT w/o Contrast QTY: 1.00
ITEM 4. APPROVED Pain Management Consultation for possible Cervical ESI QTY: 1.00
ITEM 5. APPROVED Cervical X-ray (lateral, flexion, extension) QTY: 1.00

BRIEF CLINICAL SUMMARY:

Lila GUTIERREZ is a 50 year old (DOB: female with a date of injury of 03/26/15. The bilateral wrists and hands, neck (disc), bilateral shoulders, and bilateral lower arms have been accepted by the carrier.

"1. There is electrodiagnostic evidence for moderate right carpal tunnel syndrome.
2. There is no electrodiagnostic evidence for
a) Left median or bilateral ulnar or radial focal neuropathy.
b) Bilateral cervical radiculopathy."
(Imad Rashid D.O. 07/17/2015)

"She came to EMG showing carpal tunnel and MRI showing cervical spondylitic cord impingement C4-C5, C5-C6, C6-C7. She is here today with neck, arm, and hand pain." "We have a report only by Dr. Shin in his record of November29, 2016 referring to an
EMG/NCV, which showed carpal tunnel syndrome, which is performed at a QME."
(Roderick Sanden M.D. 03/02/2017)

RATIONALE:

ITEM 1.2. Electrodiagnostic studies are being requested in order to differentiate between CTS and other conditions, such as cervical radiculopathy. These electrodiagnostic studies were performed in 2015 "showing carpal tunnel". These studies were repeated in 2016 "which showed carpal tunnel syndrome". The 03/02/2017 report does not adequately document that a third electrodiagnostic study is medically necessary. Therefore, the requests for an EMG of the Bilateral Upper Extremities QTY: 1.00 and a NCV of the Bilateral Upper Extremities QTY: 1.00 are denied.

ITEM 3. The request for a Cervical CT w/o Contrast QTY: 1.00 is medically reasonable. Therefore, the request for a Cervical CT w/o Contrast QTY: 1.00 is approved.

ITEM 4. The additional expertise of a pain management specialist may benefit the plan or course of care. Therefore, the request for a Pain Management Consultation for possible Cervical ESI QTY: 1.00 is approved.

ITEM 5. The request for a Cervical X-ray (lateral, flexion, extension) QTY: 1.00 is medically reasonable. Therefore, the request for a Cervical X-ray (lateral, flexion, extension) QTY: 1.00 is approved.

GUIDELINES USED:

ITEM 1.2. ACOEM Occupational Medicine Practice Guidelines, 2nd edition, 2004

a. Forearm, Wrist, and Hand Complaints (page #261)

Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist.


a. Neck and Upper Back Complaints (page #178)

Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist.


a. Independent Medical Examinations (page #127)

The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise.
PHYSICIAN CONTACT:
DECISION DATE/TIME: 03/23/17 at 1:25 P.M.

Dr. Sanden’s office was called at the number provided (916-484-4444) on 03/23/17 at 1:25 P.M. I identified myself as the physician utilization reviewer for the requests contained herein. A message was left with staff member- Margaret, with the determination stated in this report.

Medical Criteria or Guidelines Used
See MD rationale.

DETAILED ICD-9/CPT INFORMATION

This request is MODIFIED as follows:
ICD: M50.22, other cervical disc displacement, mid-cervical region
Treatment: 95860, EMG of the Bilateral Upper Extremities
Quantity requested: 1.00 DENIED

ICD: M50.22, other cervical disc displacement, mid-cervical region
Treatment: 95903, NCV of the Bilateral Upper Extremities
Quantity requested: 1.00 DENIED

ICD: M50.22, other cervical disc displacement, mid-cervical region
Treatment: 70490, Cervical CT w/o Contrast
Quantity requested: 1.00 APPROVED: 1.00
To start: 03/24/2017 To end: 09/20/2017

ICD: M50.22, other cervical disc displacement, mid-cervical region
Treatment: 99203, Pain Management Consultation for possible Cervical ESI
Quantity requested: 1.00 APPROVED: 1.00
To start: 03/24/2017 To end: 09/20/2017

ICD: M50.22, other cervical disc displacement, mid-cervical region
Treatment: 72052, Cervical X-ray (lateral, flexion, extension)
Quantity requested: 1.00 APPROVED: 1.00
To start: 03/24/2017 To end: 09/20/2017

APPEAL PROCESS

TO THE INJURED WORKER, the INJURED WORKER'S REPRESENTATIVE, OR the INJURED WORKER'S ATTORNEY:

If you disagree with the utilization review decision, any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by you on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision. You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster at the number provided at the top of this letter. However, if you are represented by an attorney, please contact your attorney instead of your adjuster. 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' Rights and Obligations.
Compensation. For recorded information and a list of offices, call toll free 1-800-736-7401.

TO THE REQUESTING PHYSICIAN:

The Undersigned Reviewer at EK Health Services is available from 9:00 AM to 5:30 PM Pacific Time. If you have any questions or need clarification please call (408)973-0888. We have a 24 hour voice mail available at that number using extension 101. Our facsimile number is 408-725-1135. You may also reach us through email at info@ekhealth.com

INTERNAL VOLUNTARY APPEALS PROCESS

EK Health Services, Inc. (EKHS) has a voluntary internal utilization review appeals process for first level reviews only. This internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis. If a request for authorization is modified or non-certified, all parties including the injured worker, treating physician/provider, or the facility rendering service has the right and opportunity to initiate an internal voluntary appeal of the determination by telephone or written notification. Written notification from the requesting party for Internal Voluntary Appeals must be received within 10 calendar days from the date of the receipt of the non-certification. Participation in the Internal Voluntary Appeals Process DOES NOT extend the deadlines of the Labor Code 4610.5 or 4610.6 Process.

Through my signature below, I hereby attest that I am competent to and have the requisite license to evaluate the specific clinical issues involved in medical treatment services, and that I know of no reason for me to have recused myself from the review herein.

Sincerely,

Robert Freundlich, M.D.
CA License # G48563
Neurology
American Board of Psychiatry & Neurology
Subspecialty in Clinical Neurophysiology
Subspecialty in Epilepsy
Subspecialty in Neuromuscular Medicine
Subspecialty in Pain Medicine

Enclosed:
- DWC Form IMR (012014c)2016.pdf

Distribution:
- (attorney) Carla Castaneda Esq. via (via fax) to (916) 514-5300
- (provider) Roderick Sanden via (via fax) to (916) 484-4447
- (provider) Michael C. Yang via (via fax) to (530) 672-1335

992 S. DE ANZA SUITE 101 - SAN JOSE CA 95129 - PHONE: (877) 861 - 1595 - FAX: (408) 725 1135
WWW.EKHEALTH.COM
IMPORTANT INFORMATION FROM STATE FUND

Effective January 1, 2017, all authorized ancillary service requests for prescription drugs, durable medical equipment (DME) and supplies, interpreting, transportation, home health, diagnostics and physical therapy must be supplied only through the following State Fund-approved ancillary networks:

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

**DME, Interpretation, Transportation, Home Health, Physical Therapy, Diagnostics**
Healthesystems (HES)
(877)287-7728

Authorization of medication does not constitute approval to dispense medications from the physician’s office. All medications should be filled by an Express Scripts pharmacy. Physicians or injured employees can call (888) 201-5389 for assistance in locating an Express Scripts Network Pharmacy and all, durable medical equipment (DME) and supplies, interpreting transportation, home health, diagnostics, and physical therapy must be supplied by Healthesystems.

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

Effective September 1, 2016 to December 31, 2016 requests for the above mentioned ancillary services must be supplied by Optum or One Call.

**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.

**L.C. Section 4600.2(a)** allows insurers and self-insured employers to contract with a pharmacy benefits network to provide medicines and medical supplies.

In addition to the records listed in the report, the following records were reviewed:

**Document Date - Description**
- 03/21/2017 - State Fund-TRK#11805093
- 03/16/2017 - DWC FORM RFA Sanden, Roderick MD
Compensation. For recorded information and a list of offices, call toll free 1-800-736-7401.

TO THE REQUESTING PHYSICIAN:

The Undersigned Reviewer at EK Health Services is available from 9:00 AM to 5:30 PM Pacific Time. If you have any questions or need clarification please call (408)973-0888. We have a 24 hour voice mail available at that number using extension 101. Our facsimile number is 408-725-1135. You may also reach us through email at info@ekhealth.com

INTERNAL VOLUNTARY APPEALS PROCESS

EK Health Services, Inc. (EKHS) has a voluntary internal utilization review appeals process for first level reviews only. This internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis. If a request for authorization is modified or non-certified, all parties including the injured worker, treating physician/provider, or the facility rendering service has the right and opportunity to initiate an internal voluntary appeal of the determination by telephone or written notification. Written notification from the requesting party for Internal Voluntary Appeals must be received within 10 calendar days from the date of the receipt of the non-certification. Participation in the Internal Voluntary Appeals Process DOES NOT extend the deadlines of the Labor Code 4610.5 or 4610.6 Process.

Through my signature below, I hereby attest that I am competent to and have the requisite license to evaluate the specific clinical issues involved in medical treatment services, and that I know of no reason for me to have recused myself from the review herein.

Sincerely,

Robert Freundlich, M.D.
CA License # G48563
Neurology
American Board of Psychiatry & Neurology
Subspeciality in Clinical Neurophysiology
Subspeciality in Epilepsy
Subspeciality in Neuromuscular Medicine
Subspeciality in Pain Medicine

Enclosed:
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992 S. DE ANZA SUITE 101 - SAN JOSE CA 95129 · PHONE: (408) 725-1135 - FAX: (408) 725-1135
EMG/NCV, which showed carpal tunnel syndrome, which is performed at a QME."
(Roderick Sanden M.D. 03/02/2017)

RATIONALE:

ITEM 1.2. Electrodiagnostic studies are being requested in order to differentiate between CTS and other conditions, such as cervical radiculopathy. These electrodiagnostic studies were performed in 2015 "showing carpal tunnel". These studies were repeated in 2016 "which showed carpal tunnel syndrome". The 03/02/2017 report does not adequately document that a third electrodiagnostic study is medically necessary. Therefore, the requests for an EMG of the Bilateral Upper Extremities QTY: 1.00 and a NCV of the Bilateral Upper Extremities QTY: 1.00 are denied.

ITEM 3. The request for a Cervical CT w/o Contrast QTY: 1.00 is medically reasonable. Therefore, the request for a Cervical CT w/o Contrast QTY: 1.00 is approved.

ITEM 4. The additional expertise of a pain management specialist may benefit the plan or course of care. Therefore, the request for a Pain Management Consultation for possible Cervical ESI QTY: 1.00 is approved.

ITEM 5. The request for a Cervical X-ray (lateral, flexion, extension) QTY: 1.00 is medically reasonable. Therefore, the request for a Cervical X-ray (lateral, flexion, extension) QTY: 1.00 is approved.

GUIDELINES USED:

ITEM 1.2. ACOEM Occupational Medicine Practice Guidelines, 2nd edition, 2004

a. Forearm, Wrist, and Hand Complaints (page #261)

Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist.

ITEM 3.5.: ACOEM Occupational Medicine Practice Guidelines. 2nd Edition, 2004

a. Neck and Upper Back Complaints (page #178)

Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist.

ITEM 4. ACOEM Occupational Medicine Practice Guidelines. 2nd edition, 2004

a. Independent Medical Examinations (page #127)

The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise.
March 29, 2017

Dr. Michael C. Yang:
El Dorado Pain Management Center
1208 Suncast Lane
El Dorado Hills, CA 956729631

Re: LILA GUTIERREZ
Cl#: 06083410
Ref#: 03/26/2015
DOI: State Fund, Riverside SC
Carrier: State Fund, Riverside SC

Approval Letter

Dear Dr. Michael C. Yang:

Utilization Review is to provide a review of requested medical treatment to determine medical necessity and appropriateness. Selection of a specific provider or program may be designated by the claims administrator. Questions about the financial aspects of the claim should be addressed with the claims examiner.

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; interpreting; medically necessary transportation; home health; physical therapy and diagnostics should be requested through Healthesystems (HES) (877)287-7728.

Carrier receipt date: 03/22/2017
EKHS receipt date: 03/24/2017
Decision date: 03/29/2017 04:21PM(PT)

The request is approved.

LILA GUTIERREZ's Workers' Compensation insurance carrier/employer has requested utilization review.

ITEMS REQUESTED:
ITEM 1. Gabapentin 300 mg (#180 w/2 refills) QTY: 540.00

APPROVED:
ITEM 1: Gabapentin 300 mg (#180 w/2 refills) QTY: 540.00

-Item; Ultram 50mg #180 2. Celebrex 200mg #30; (No UR); authorized by the claims administrator.
PHYSICIAN REVIEWER'S RATIONALE

I have reviewed the medical information contained in this report.

TREATMENT REQUEST:

ITEM 1. Gabapentin 300 mg (#180 w/2 refills) QTY: 540.00

RECOMMENDATION:

APPROVED ITEM 1. Gabapentin 300 mg (#180 w/2 refills) QTY: 540.00

SUMMARY:

The injured worker is a 50 year old female Data Entry Operator for 27 years for CA Employment Development Dept with a date of injury of 03/26/15. She sustained injuries to the bilateral wrists and hands, neck (disc), bilateral shoulders, and bilateral lower arms. Treatment has included medications. The current report is dated 03/20/17. The patient has neck, arm, and hand pain rated 9/10 VAS. She is losing, strength, mobility, and sensation in the left arm. Neck: spasms, decreased motion, positive facet loading test. Positive cervical MRI. Back: spasm over thoracic and lumbar areas. Upper extremities: diffuse tenderness, positive Tinel sign, decreased sensory on left thumb, weak grip.

RATIONALE:

ITEM 1. Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The injured has neck, arm, and hand pain rated 9/10 VAS. She is losing, strength, mobility, and sensation in the left arm. On exam, there is a positive Tinel sign, decreased sensory on left thumb, weak grip. Therefore, Gabapentin 300 mg (#180 w/2 refills) QTY: 540.00 is approved.

GUIDELINES:

Gabapentin 300 mg (#180 w/2 refills) QTY: 540.00
Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. § 9792.24.2 (July 28, 2016)

Gabapentin (Neurontin) Page 87
Recommended for some neuropathic pain conditions and fibromyalgia. (Wiffen-Cochrane, 2013) Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. See Anti-epilepsy drugs (AEDs) for general guidelines, as well as specific Gabapentin listing for more information and references.

Anti-epilepsy drugs (AEDs) for pain Page 22-27
Anti-epilepsy drugs (AEDs) are also referred to as anti-convulsants.
Recommended for some neuropathic pain (pain due to nerve damage), but not for acute nociceptive pain (including somatic pain). (Gilron, 2006) (Wolfe, 2004) (Washington, 2005) (ICSI, 2005) (Wiffen-Cochrane, 2005) (Attal, 2006) (Wiffen-Cochrane, 2007) (Gilron, 2007) (ICSI, 2007) (Finnerup, 2007) (Wiffen-Cochrane, 2013) There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polynueopathapy (with diabetic polynueopathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy. (Attal, 2006) The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions. See also specific drug listings below: Gabapentin (Neurontin®); Pregabalin (Lyrica®); Lamotrigine (Lamictal®); Carbamazepine (Tegretol®); Oxcarbazepine (Trileptal®); Phenytoin (Dilantin®); Topiramate (Topamax®); Levetiracetam (Keppra®); Zonisamide (Zonegran®); & Tiagabine (Gabitril®)
Outcomes: A “good” response to the use of AEDs has been defined as a 50% reduction in pain and a “moderate” response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a
June 12, 2017

Dr. Michael C. Yang:
El Dorado Pain Management Center
1208 Suncast Lane
El Dorado Hills, CA 956729631

Dear Dr. Michael C. Yang:

Utilization Review is to provide a review of requested medical treatment to determine medical necessity and appropriateness. Selection of a specific provider or program may be designated by the claims administrator. Questions about the financial aspects of the claim should be addressed with the claims examiner.

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; interpreting; medically necessary transportation; home health; physical therapy and diagnostics should be requested through Healthesystems (HES) (877)287-7728.

Denied due to Lack of Information

I called and spoke to the provider's office with the determination as contained in this report. LILA GUTIERREZ's Workers' Compensation insurance carrier/employer has requested utilization review.

ITEMS REQUESTED:
ITEM 1. (Reconsideration DOS 5/24/17) Physical Therapy Cervical Spine (sessions)(unspecified)

992 S. DE ANZA SUITE 101 - SAN JOSE CA 95129 - PHONE: (877) 861 - 1595 - FAX: (408) 725 1135
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RC: LILA GUTIERREZ
Dale: June 12.2017
Page: 2 of 15

duration) QTY: 1.00
ITEM 2. (Reconsideration DOS 5/24/17) Deep Tissue Massage Cervical Spine (sessions)(unspecified duration) QTY: 1.00
ITEM 3. (Reconsideration DOS 5/24/17) Cervical Epidural Steroid Injection Left C7-T1 QTY: 1.00

DENIED:
ITEM 1: (Reconsideration DOS 5/24/17) Physical Therapy Cervical Spine (sessions)(unspecified duration)
ITEM 2: (Reconsideration DOS 5/24/17) Deep Tissue Massage Cervical Spine (sessions)(unspecified duration)
ITEM 3: (Reconsideration DOS 5/24/17) Cervical Epidural Steroid Injection Left C7-T1

MEDICAL RECORDS REVIEW PREPARED BY LICENSED HEALTHCARE PROFESSIONAL

Treatment Request: Reconsideration/Prospective; RFA D.O.S.: 05/25/2017

CLINICAL SUMMARY:
Lila Gutierrez is a 50-year old female Data Entry Operator (DOB: employed by Employment Development Department Mic 54. On 03/26/2015 she sustained a work-related injury due to repetitive duties. The Carrier has accepted the both wrists and hands, disc neck, both shoulders, and both lower arms and has denied the back. Currently she is retired.

PRIOR UR:
-11/21/16 G. Taff, MD; EKHS UR; APPROVED: Ultram 50mg QTY: 180. Celebrex 200mg QTY: 30.
DENIED: Voltaren 1% Gel (NOTE: Claims administrator has denied the request for neurosurgical consult for the cervical spine and cervical spine injection (body part not accepted.).)
-03/01/17 G. Taff, MD; EKHS UR; APPROVED: Ultram 50mg QTY: 180.00 The requests for gabapentin and Celebrex have been approved by the claims administrator.
-03/29/17 J. Castrejon, M.D.; EKHS UR: APPROVED: ITEM 1: Gabapentin 300 mg (#180 w/2 refills) QTY: 540.00
-05/03/17 J. Castrejon, M.D.; EKHS UR; MODIFIED: ITEM 1: Ultram 50 mg QTY: 160.00 DENIED: ITEM 2: Diclofenac Sodium 1% Gel.
-06/05/2017 B. McLean, M.D., EKHS UR: APPROVED: ITEM 1: Ultram 50mg QTY: 180.00; ITEM 2: Gabapentin 300mg QTY: 540.00; ITEM 3: Celebrex 200mg QTY: 30.00. DENIED: ITEM 4: Diclofenac Patch 13%; ITEM 5: Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified); ITEM 6: Left Cervical Epidural Steroid Injection (Level(s) Unspecified).

IMR FINAL DETERMINATIONS:
-04/22/16 Maximus; OVERTURNED Denial date 3/10/16. APPROVED Functional Capacity Evaluation.
-01/19/17 Maximus; UPHELD; Denial date 11/21/16, DENIED VOLTAREN 1% GEL 5.00.
-05/05/17 Maximus IMR: Upheld; 1. EMG of the bilateral upper extremities is not medically necessary and appropriate. 2. NCV of the bilateral upper extremities is not medically necessary and appropriate.

DIAGNOSTICS:
-07/17/15 I. Rashid, D.O.; Electrodiagnostic Study; Diagnostic evidence of moderate right CTS, no evidence of left median, bilateral ulnar, radial focal neuropathy, or bilateral cervical radiculopathy.
-09/26/16 J. Hansing, MD; Cervical MRI without contrast; IMPRESSION: Degenerative disc bulging/spurring, greatest at C5/C6, resulting in 6 mm canal stenosis and impingement upon the cervical spinal cord but without cord compression or displacement. There is also left foraminal stenosis at this level in which I cannot exclude possible impingement upon the exiting left C6 nerve root, degenerative disc bulging/spurring at C4/C5, resulting in 7 mm canal stenosis with minimal impingement upon the cervical spinal cord without cord compression or displacement seen at this level. There is also question of left foraminal stenosis with possible impingement upon the exiting left C5 nerve, degenerative disc bulging/spurring at C6/C7 without evidence of canal stenosis or cord impingement, with left foraminal stenosis and possible Impingement upon the exiting left C7.

PRIOR SURGERY/PROCEDURES: No prior surgeries or procedures found in the documentation reviewed.

MEDICAL RECORD SUMMARY:
-11/01/16 J. Sanchez, MD/ M. Yang, MD; Progress note; SUBJECTIVE: She has pain in both upper extremities right greater than left. She is having now complete numbness of the left thumb which corresponds to the C6 nerve root. OBJECTIVE: Diffused tenderness to both upper extremities. Positive Tinel's, more pronounced on the right side. Tender especially at the wrist and IP joints. Sensation decreased on left thumb. PLAN: Not working, applying social security disability. P&S.

-02/21/17 M. Yang, MD; Follow up; Symptoms unchanged and getting worse. Patient reported weak grip, problems with ADL's, pain in both upper extremities, complete numbness of left thumb. Patient had EMG and was told EMG revealed carpal tunnel syndrome but patient refuses to have surgery. Patient taking Cymbalta from private PCP. Relevant objective findings included cervical spasm, decreased range of motion, positive facet loading, spasm over thoracic and lumbar area, diffuse tenderness bilateral upper extremities, decreased sensation in left thumb, weak grip on left. Diagnosis included radiculopathy of cervicothoracic region, carpal tunnel syndrome, degenerative arthritis of cervical spine. Follow up with neurosurgeon, provider prescribed Ultram #180, Celebrex #30, and gabapentin #180 with 2 refills. TOTAL MED 60mg. -03/02/17 R. Sanden, MD; Neurosurgical Cervical Spine Consultation; Patient suffered industrial injury 03/26/16 from keying for data entry, patient began to lose strength in hands, EMG revealed carpal tunnel and MRI revealed cervical spondylotic cord impingement C4-C7. Patient presents with neck, arm, and hand pain. Currently taking Celebrex, gabapentin for pain. 60% left, 40% right arm pain, numbness, tingling into the thumb, middle fingers with burning and shooting up and down the arm from the neck, patient awakens at night twice a week with rubbing out the wrists. Patient had prior right shoulder surgery in 2002 which did not help, prior conservative care to include 16 PT visits, 10 acupuncture, no HEP. Examination revealed cervical spasm, guarding, loss of lordosis, right rotation 60-70 degrees, left 50-60, flexion 45, extension 30, mild Spurling’s sign into the left arm and shoulder with rotation and extension, trace left brachioradialis reflex, sensory shows right greater than left forearm, thumb, index, deltoid, middle, ring, small finger in C4-7 distribution, motor revealed weakness on the right arm with 80-90% of normal, grip testing performed, positive Tinel's bilaterally, shoulder range of motion normal bilaterally. Imaging reviewed by report only, diagnosis included C5-6.
stenosis, central, foraminal with alternating UE radiculopathy, C4-5 stenosis from disc protrusion, industrial with central and foraminal stenosis, alternating radiculopathy, borderline stenosis C6-7, history of CTS. The provider requested authorization for repeat EMG/NCV, cervical x-rays to include lateral/flexion/extension to rule out instability, CT cervical spine to determine true spondylitic stenosis from possible congenital canal stenosis versus OA spondylitic cord impingement, pain management for cervical epidural steroid.

-03/20/17 M. Yang, M.D.; Progress Report; SUBJECTIVE; Neck, arm, and hand pain rated 9/10 VAS. She is losing strength, mobility, and sensation in the left arm. OBJECTIVE; Neck: spasms, decreased motion, positive facet loading test. Positive cervical MRI. Back: spasm over thoracic and lumbar areas. Upper extremities: diffuse tenderness, positive Tinel sign, decreased sensory on left thumb, weak grip. DIAGNOSIS; Carpal tunnel syndrome, cervical spondylitic cord impingement C4-C7. PLAN; Surgery has been recommended. She will decide. 1. Gabapentin 300 mg (#180 w/2 refills). Ultram 50 mg #180 (MED=60), 2. Celebrex 200 mg #30. -04/18/17 M. Yang, M.D.; Progress Note: Subjective: As far as her symptoms, they are unchanged and are getting worse. Her symptoms include a weak grip, problems with her ADL’s, especially in the kitchen. She has pain in both upper extremities, right greater than left. She is having now complete numbness of the left thumb, which corresponds to the C6 nerve root and a burning sensation in the 5th digit. Objective: Neck: Palpation of the cervical area reveals moderate spasm, as well as both trapezi. Range of motion at the neck is decreased in all planes. She has positive facet loading test. Back: She also has a moderate amount of spasm over the thoracic area and lumbar area. Upper Extremities: diffuse tenderness in both upper extremities. Tinel’s sign is positive, but more pronounced on the right side Today she is especially tender at the wrist and the IP joints. She has decreased sensation to light touch and pinprick on the Left thumb. Her grip is weak on the left. Alert and cooperative, concerned, upset affect, normal attention and concentration. Today she is fearful about her about her forced retirement. Diagnoses: 1. Radiculopathy of Cervicothoracic Region, 2. Carpal Tunnel Syndrome, 3. Degenerative Arthritis of Cervical Spine. Treatment Plan: Ultram 50 mg #180, Gabapentin 300 mg X2 Refills #180, Celebrex 200 mg #30, Diclofenac Sodium 1% Gel #3, Follow up in 4 weeks. -04/26/17 M. Yang, M.D.; DWC form RFA: Ultram 50 mg #180, Gabapentin 300 mg X2 Refills #180, Celebrex 200 mg #30, Diclofenac Sodium 1% Gel #3

-05/16/17 M. Yang, M.D.; PR2: SUBJECTIVE: Complains of worsening neck pain radiating to the upper extremities, rating at 8/10. States that she has been recommended to have an anterior neck fusion 3 levels, but she is not sure if she wants to go through with surgery. Reports that left arm is losing strength. Complains of complete numbness in the left thumb. Difficulty sleeping due to pain. OBJECTIVE: Patient is obese. Moderate spasms along the cervical area and both trapeze. Cervical range of motion is decreased in all planes. Facet loading test is positive. Moderate spasms along the thoracic and lumbar areas. Diffuse tenderness along both upper extremities. Tinel’s sign is positive, but more pronounced on the right side. Tenderness along the wrist and IP joints. Decreased sensation in the left thumb. Grip strength is weak on the left. DIAGNOSIS: Radiculopathy of cervicothoracic region. Carpal tunnel syndrome. Degenerative arthritis of cervical spine. PLAN: Ultram 50mg, #180 (MED=60); Gabapentin 300mg, #180 with 2 refills; Celebrex 200mg, #30; Diclofenac Patch 1.3%, #3; Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified); Left Cervical Epidural Steroid Injection (Level(s) Unspecified). -05/23/17 DWC RFA: M. Yang, M.D.; Ultram 50mg, #180; Gabapentin 300mg, #180 with 2 refills; Celebrex 200mg, #30; Diclofenac Patch 1.3%, #3; Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified); Left Cervical Epidural Steroid Injection (Level(s) Unspecified). -05/30/17: In order to address the Request for Authorization (RFA) in its entirety, a Request For Information (RFI) was issued to render a medical decision for the complete request. A letter was faxed to Dr. Michael Yang requesting the level(s) to be
injected for the left cervical ESI and requesting the duration/frequency for the PT of the cervical spine being requested. -05/30/17: A Request for Additional Information (RFI) was sent prior to 5:30pm PST on the 5th business day from the carrier receipt date to the requesting provider, which extended the due date to the 14th calendar day from the receipt of the request. (CCR, Title 8 §9792.9(1)).

-05/25/2017 Dr. M. Yang, M.D.; No clinical documentation accompanying the request. No documentation of the number of PT, and massage therapy sessions provided.

RFA Dated 06/08/2017:
1. (Reconsideration DOS 5/24/17) Physical Therapy Cervical Spine (sessions)(unspecified duration)
2. (Reconsideration DOS 5/24/17) Deep Tissue Massage Cervical Spine (sessions)(unspecified duration)
2. (Reconsideration DOS 5/24/17) Cervical Epidural Steroid Injection Left C7-T1

-06/05/2017 DENIAL RATIONALE
ITEM 5. Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified) QTY: 1.00. The treatment request is denied based on Lack of Information. We did not receive a response to our request for Information. If the requested information is received, we will reconsider your request at that time.
ITEM 6. Left Cervical Epidural Steroid Injection (Level(s) Unspecified) QTY: 1.00 The treatment request is denied based on Lack of Information. We did not receive a response to our request for Information. If the requested information is received, we will reconsider your request at that time.

- Based on regulatory time issues the request will be sent for physician URD.

RFI INFORMATION:
-06/09/2017 In order to address the Request for Authorization (RFA) in its entirety, a Request for Information (RFI) was issued to render a medical decision for the complete request. A letter was faxed to Dr. Yang.
• Please provide us with a dated, legible, current medical records that include the subjective, objective, diagnosis, and plan (i.e.PR-2/narrative) that corresponds with the request(s) listed above.

Regarding request for Physical Therapy please provide the following
• The number of prior sessions completed in the past year
• Documentation of functional benefit derived from prior sessions
• Clear objectives and goals. There is no documentation of type of therapy and deficits to be addressed, measurable goals, and a reasonable timetable to reach these.
• Has instruction in a home exercise program taken place

Regarding request for Massage Therapy:
• Has the patient had any prior massage sessions, if yes, how many sessions and what was the benefit.

Guidelines offer: Care beyond 2 months may be indicated for certain chronic pain patients in whom massage is helpful in improving function, decreasing pain, and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached MMI and maintenance treatments have been determined. Extended durations of care beyond what is considered “maximum” may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented
on a monthly basis. Treatment beyond 2 months should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. Massage is a passive intervention and is considered an adjunct to other recommended treatment, especially active interventions (e.g., exercise).

“Functional Improvement” means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the History and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment.

Regarding request for CESI:

- Please provide documentation of conservative treatment tried/failed prior to this request
- (1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.
- (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, muscle relaxants & neuropathic drugs).
- (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.

Guidelines offer: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

Note: Performing multiple therapies at one time may cloud the effectiveness and functional improvement as to what therapy is providing the greatest benefit.

-A Request for Additional Information (RFI) was sent prior to 5:30pm PST on the 5th business day from the carrier receipt date to the requesting provider, which extended the due date to the 14th calendar day from the receipt of the request. (CCR, Title 8 §9792.9 (1)).

8 CCR §9792.9.1 (f)(3)(A) If the information reasonably necessary to make a determination under subdivision (f)(1)(A) that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

PHYSICIAN REVIEWER'S RATIONALE

I have reviewed the medical information contained in this report.

TREATMENT REQUESTED:
ITEM 1. (Reconsideration DOS 5/24/17) Physical Therapy Cervical Spine (sessions)(unspecified duration) QTY: 1.00
ITEM 2. (Reconsideration DOS 5/24/17) Deep Tissue Massage Cervical Spine (sessions)(unspecified duration) QTY: 1.00
duration) QTY: 1.00
ITEM 3. (Reconsideration DOS 5/24/17) Cervical Epidural Steroid Injection Left C7-T1 QTY: 1.00

RECOMMENDATION:
ITEM 1. Denied (Reconsideration DOS 5/24/17) Physical Therapy Cervical Spine (sessions)(unspecified duration) QTY: 1.00
ITEM 2. Denied (Reconsideration DOS 5/24/17) Deep Tissue Massage Cervical Spine (sessions)(unspecified duration) QTY: 1.00
ITEM 3. Denied (Reconsideration DOS 5/24/17) Cervical Epidural Steroid Injection Left C7-T1 QTY: 1.00

BRIEF CLINICAL SUMMARY:
Lila Gutierrez is a 50-year-old female Data Entry Operator (DOB: employed by Employment Development Department Mic 54. On 03/26/2015 she sustained a work-related injury due to repetitive duties. The Carrier has accepted the both wrists and hands, disc neck, both shoulders, and both lower arms and has denied the back. Currently she is retired.

Per most recent MD note:
5/16/17 M. Yang, M.D.; PR2: SUBJECTIVE: Complains of worsening neck pain radiating to the upper extremities, rating at 8/10. States that she has been recommended to have an anterior neck fusion 3 levels, but she is not sure if she wants to go through with surgery. Reports that left arm is losing strength. Complains of complete numbness in the left thumb. Difficulty sleeping due to pain. OBJECTIVE: Patient is obese. Moderate spasms along the cervical area and both trapeze. Cervical range of motion is decreased in all planes. Facet loading test is positive. Moderate spasms along the thoracic and lumbar areas. Diffuse tenderness along both upper extremities. Tinel’s sign is positive, but more pronounced on the right side. Tenderness along the wrist and IP joints. Decreased sensation in the left thumb. Grip strength is weak on the left. DIAGNOSIS: Radiculopathy of cervicothoracic region. Carpal tunnel syndrome. Degenerative arthritis of cervical spine. PLAN: Ultram 50mg, #180 (MED=60); Gabapentin 300mg, #180 with 2 refills; Celebrex 200mg, #30; Diclofenac Patch 1.3%, #3; Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified); Left Cervical Epidural Steroid Injection (Level(s) Unspecified). -05/23/17 DWC RFA: M. Yang, M.D.; Ultram 50mg, #180; Gabapentin 300mg, #180 with 2 refills; Celebrex 200mg, #30; Diclofenac Patch 1.3%, #3; Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified); Left Cervical Epidural Steroid Injection (Level(s) Unspecified). -05/30/17: In order to address the Request for Authorization (RFA) in its entirety, a Request For Information (RFI) was issued to render a medical decision for the complete request. A letter was faxed to Dr. Michael Yang requesting the level(s) to be injected for the left cervical ESI and requesting the duration/frequency for the PT of the cervical spine being requested. -05/30/17: A Request for Additional Information (RFI) was sent prior to 5:30pm PST on the 5th business day from the carrier receipt date to the requesting provider, which extended the due date to the 14th calendar day from the receipt of the request. (CCR, Title 8 §9792.9(1)).

RATIONALE:
ITEM 1. (Reconsideration DOS 5/24/17) Physical Therapy Cervical Spine (sessions)(unspecified duration) QTY: 1.00
The treatment request is denied based on Lack of Information. We did not receive a response to our Request for Information. If the requested information is received, we will reconsider your request at that time.
ITEM 2. (Reconsideration DOS 5/24/17) Deep Tissue Massage Cervical Spine (sessions)(unspecified duration) QTY: 1.00
The treatment request is denied based on Lack of Information. We did not receive a response to our Request for Information. If the requested information is received, we will reconsider your request at that time.

ITEM 3. (Reconsideration DOS 5/24/17) Cervical Epidural Steroid Injection Left C7-T1 QTY: 1.00
The most recent ODG update indicates cervical epidural steroid injections (ESI) are not recommended based on recent evidence, given the serious risks of this procedure in the cervical region, and the lack of quality evidence for sustained benefit. Recent evidence: ESIs should not be recommended in the cervical region, the FDA’s Anesthetic and Analgesic Drug Products Advisory Committee concluded. According to the American Academy of Neurology (AAN), ESIs do not improve function, lessen need for surgery, or provide long-term pain relief, and the routine use of ESIs is not recommended. They further said that there is in particular a paucity of evidence for the use of ESIs to treat radicular cervical pain.

The risk/benefit of the procedure does not support the medical necessity and the request is denied.

GUIDELINES:
Chronic Pain Medical Treatment Guidelines MTUS, 8 C.C.R. § 9792.24.2 (July 28, 2016) Pages 143-144
Physical medicine encompasses interventions that are within the scope of various practitioners (including Physical Therapy, Occupational Therapy, Chiropractic, and MD/DO). Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) is not indicated for addressing chronic pain in most instances; refer to the specific modality within these guidelines (e.g., massage, ultrasound). Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Refer to the specific intervention within these guidelines (e.g., exercise.) This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006). Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)
ODG Physical Therapy Guidelines –
Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.
Myalgia and myositis, unspecified (ICD9 729.1):
9-10 visits over 8 weeks
Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2)
8-10 visits over 4 weeks
Reflex sympathetic dystrophy (CRPS) (ICD9 337.2):
26 visits over 16 weeks
Arthritis (ICD9 715):
9 visits over 8 weeks
Post-injection treatment: 1-2 visits over 1 week
Post-surgical treatment: Refer to the MTUS Postsurgical Treatment Guidelines
Patients should be formally assessed after a "six-visit clinical trial" to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy.

Regarding Massage

Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. § 9792.24.2 (July 28, 2016) (p 111-112):
Massage therapy
Recommended as an option as indicated below. Massage is a passive intervention and is considered an adjunct to other recommended treatment, especially active interventions (e.g., exercise). Scientific studies show contradictory results. Furthermore, many studies lack long-term follow-up. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. This lack of long-term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain. (Hasson, 2004) A very small pilot study showed that massage can be at least as effective as standard medical care in chronic pain syndromes. Relative changes are equal, but tend to last longer and to generalize more into psychologic domains. (Walach 2003) The strongest evidence for benefits of massage is for stress and anxiety reduction, although research for pain control and management of other symptoms, including pain, is promising. The physician should feel comfortable discussing massage therapy with patients and be able to refer patients to a qualified massage therapist as appropriate. (Corbin 2005) Massage is an effective adjunct treatment to relieve acute postoperative pain in patients who had major surgery, according to the results of a randomized controlled trial recently published in the Archives of Surgery. (Mitchinson, 2007) The efficacy of massage as a stand-alone and as multimodality treatment is uncertain, according to this Cochrane review. (Haraldsson, 2007) A recent meta analysis concluded that massage might be beneficial for patients with subacute and chronic non-specific low-back pain, especially when combined with exercises and education. When massage was compared to an inert therapy (sham treatment), massage was superior for pain and function on both short and long-term follow-ups. When massage was compared to other active treatments, massage was similar to exercises, and massage was superior to joint mobilization, relaxation therapy, physical therapy, acupuncture and self-care education. Reflexology on the feet had no effect on pain and functioning. The beneficial effects of massage in patients with chronic low-back pain lasted at least one year after the end of the treatment. In comparing different techniques of massage, acupuncture massage produced better results than classic (Swedish) massage and Thai massage produced similar results to classic) (Swedish) massage. (Furlan-Cochrane, 2008) A small controlled study showed that 10 minutes of massage therapy can help repair exerciseinduced muscle damage by subduing inflammation and renewing mitochondria, similar to the way NSAIDs work. The findings suggest that the perceived positive effects of massage are a result of an attenuated production of inflammatory cytokines. (Crane, 2012)

Recommended frequency and duration of treatment: Time to Produce Effect: Immediate. Frequency: 1 to 2 times per week. Optimum Duration: 6 weeks. Maximum Duration: 2 months. (Colorado, 2006) At 2 months, patients should be reevaluated. Care beyond 2 months may be indicated for certain chronic pain patients in whom massage is helpful in improving function, decreasing pain, and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has
reached MMI and maintenance treatments have been determined. Extended durations of care beyond what is considered “maximum” may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 2 months should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. Injured workers with complicating factors may need more treatment, if functional improvement is documented by the treating physician.


Cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise.

ODG online, Neck and Upper Back (Acute and Chronic) (updated 08/25/16)
Epidural Steroid Injection (ESI)
Not recommended based on recent evidence, given the serious risks of this procedure in the cervical region and the lack of quality evidence for sustained benefit. These had been recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy), with specific criteria for use below.

While not recommended, cervical ESIs may be supported using Appendix D, Documenting Exceptions to the Guidelines, in which case:
Criteria for the use of Epidural steroid injections, therapeutic:
Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.
(1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.
(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
(3) Injections should be performed using fluoroscopy (live x-ray) for guidance
(4) No more than two nerve root levels should be injected using transforaminal blocks.
(5) No more than one interlaminar level should be injected at one session.
(6) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.
(7) Repeat injections should be based on continued objective documented pain and function response.
(8) Current research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.
(9) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
(10) Cervical and lumbar epidural steroid injection should not be performed on the same day;
(11) Additional criteria based on evidence of risk:
   (i) ESIs are not recommended higher than the C6-7 level;
   (ii) Cervical interlaminar ESI is not recommended;
   (iii) Particulate steroids should not be used. (Benzon, 2015)
Criteria for the use of Epidural steroid injections, diagnostic:
If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.
To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below:
(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;
(2) To help to determine pain generators when there is evidence of multi-level nerve root compression;
(3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g., dermatomal distribution), and imaging studies have suggestive cause for symptoms but are inconclusive;
(4) To help to identify the origin of pain in patients who have had previous spinal surgery.

PHYSICIAN CONTACT:
DECISION DATE/TIME: 6/12/17 at 10:00 AM
Dr. Yang office was called at the number provided (5306721311) on 6/12/17 at 10:00 AM. I identified myself as the physician utilization reviewer for the requests contained herein. A message was left with a staff member with the determination stated in this report.

Medical Criteria or Guidelines Used
-See MD Rationale

DETAILED ICD-9/CPT INFORMATION
This request is DENIED as follows:
ICD: M54.13, radiculopathy, cervicothoracic region
Treatment: 97110, (Reconsideration DOS 5/24/17) Physical Therapy Cervical Spine (sessions) (unspecified duration)
Quantity requested: 1.00 DENIED
ICD: M54.13, radiculopathy, cervicothoracic region
Treatment: 97124, (Reconsideration DOS 5/24/17) Deep Tissue Massage Cervical Spine (sessions) (unspecified duration)
Quantity requested: 1.00 DENIED
ICD: M54.13, radiculopathy, cervicothoracic region
Treatment: 64479, (Reconsideration DOS 5/24/17) Cervical Epidural Steroid Injection Left C7-T1
Quantity requested: 1.00 DENIED

APPEAL PROCESS
TO THE INJURED WORKER, the INJURED WORKER'S REPRESENTATIVE, OR the INJURED WORKER'S ATTORNEY:
If you disagree with the utilization review decision, any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by you on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision. You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster at the number provided at the top of this letter. However, if you are represented by an attorney, please contact your attorney instead of your adjuster. 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.

TO THE REQUESTING PHYSICIAN:

The Undersigned Reviewer at EK Health Services is available from 9:00 AM to 5:30 PM Pacific Time. If you have any questions or need clarification please call (408)973-0888. We have a 24 hour voice mail available at that number using extension 101. Our facsimile number is 408-725-1135. You may also reach us through email at info@ekhealth.com

INTERNAL VOLUNTARY APPEALS PROCESS

EK Health Services, Inc. (EKHS) has a voluntary internal utilization review appeals process for first level reviews only. This internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis. If a request for authorization is modified or non-certified, all parties including the injured worker, treating physician/provider, or the facility rendering service has the right and opportunity to initiate an internal voluntary appeal of the determination by telephone or written notification. Written notification from the requesting party for Internal Voluntary Appeals must be received within 10 calendar days from the date of the receipt of the non-certification. Participation in the Internal Voluntary Appeals Process DOES NOT extend the deadlines of the Labor Code 4610.5 or 4610.6 Process.

Through my signature below, I hereby attest that I am competent to and have the requisite license to evaluate the specific clinical issues involved in medical treatment services, and that I know of no reason for me to have recused myself from the review herein.

Sincerely,

Brian Y. McLean,  MD
CA License #: G68234
Anesthesiology
Addiction Medicine
Diplomate, American Board of Addiction Medicine

Enclosed:
- DWC Form IMR (012014c)2016.pdf
IMPORTANT INFORMATION FROM STATE FUND

Effective January 1, 2017, all authorized ancillary service requests for prescription drugs, durable medical equipment (DME) and supplies, interpreting, transportation, home health, diagnostics and physical therapy must be supplied only through the following State Fund-approved ancillary networks:

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

DME, Interpretation, Transportation, Home Health, Physical Therapy, Diagnostics
Healthesystems (HES)
(877)287-7728

Authorization of medication does not constitute approval to dispense medications from the physician’s office. All medications should be filled by an Express Scripts pharmacy. Physicians or injured employees can call (888) 201-5389 for assistance in locating an Express Scripts Network Pharmacy and all, durable medical equipment (DME) and supplies, interpreting transportation, home health, diagnostics, and physical therapy must be supplied by Healthesystems.

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

Effective September 1, 2016 to December 31, 2016 requests for the above mentioned ancillary services must be supplied by Optum or One Call.

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.

L.C. Section 4600.2(a) allows insurers and self-insured employers to contract with a pharmacy benefits network to provide medicines and medical supplies.
In addition to the records listed in the report, the following records were reviewed:

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03/02/2017 - Sanden, Roderick, MD;
03/01/2017 - EK-Approval letter
01/19/2017 - Maximus federal services- Independent med review f
May 03, 2017

Dr. Michael C. Yang:
El Dorado Pain Management Center
1208 Suncast Lane
El Dorado Hills, CA 956729631

Re: LILA GUTIERREZ  Cert#: Employment Development
Ci#: 06083410  Er: Department Mic 54
Ref#:  Er: Michelle Martin
DOI: 03/26/2015  Adj Phn: (951) 413-5919
Carrier: State Fund, Riverside SC  Tracking #: E000011838222

Modified due to Lack of Medical Necessity

Dear Dr. Michael C. Yang:

Utilization Review is to provide a review of requested medical treatment to determine medical necessity and appropriateness. Selection of a specific provider or program may be designated by the claims administrator. Questions about the financial aspects of the claim should be addressed with the claims examiner.

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; interpreting; medically necessary transportation; home health; physical therapy and diagnostics should be requested through Healthesystems (HES) (877)287-7728.

Carrier receipt date: 04/26/2017
EKHS receipt date: 04/26/2017
Verbal decision date: 05/03/2017 02:42PM

I called and left a message with the determination as contained in this report. LILA GUTIERREZ's Workers' Compensation insurance carrier/employer has requested utilization review.

ITEMS REQUESTED:
ITEM 1. Ultram 50 mg QTY: 180.00

992 S. DE ANZA SUITE 101 - SAN JOSE CA 95129 - PHONE: (877) 861 - 1595 - FAX: (408) 725 1135
WWW.EKHEALTH.COM
ITEM 2. Diclofenac Sodium 1% Gel QTY: 3.00

MODIFIED:
ITEM 1: Ultram 50 mg QTY: 160.00

DENIED:
ITEM 2: Diclofenac Sodium 1% Gel

ITEM 3. Gabapentin 300 mg #180 with 2 Refills QTY: 540.00, ITEM 4. Celebrex 200 mg QTY: 30.00 - No UR - Authorized by Claims Administrator.

MEDICAL RECORDS REVIEW PREPARED BY LICENSED HEALTHCARE PROFESSIONAL.

TREATMENT REQUEST: (Prospective) D.O.S.: 04/18/2017, DWC Form RFA: 04/26/2017
ITEM 1. Ultram 50 mg QTY: 180.00
ITEM 2. Diclofenac Sodium 1% Gel QTY: 3.00

CLINICAL SUMMARY:
Lila Gutierrez is a 50 year old (DOB: female Data Entry Operator for 27 years for CA Employment Development Dept with a date of injury of 03/26/15. The bilateral wrists and hands, neck (disc), bilateral shoulders, and bilateral lower arms have been accepted by the carrier. The carrier has objected the claim for back (disc). She is currently retired.

PRIOR UR:
-11/21/16 G. Taff, MD; EKHS UR; APPROVED: Ultram 50mg QTY: 180. Celebrex 200mg QTY: 30. DENIED: Voltaren 1% Gel (NOTE: Claims administrator has denied the request for neurosurgical consult for the cervical spine and cervical spine injection (body part not accepted)).
-03/01/17 G. Taff, MD; EKHS UR; APPROVED: Ultram 50mg QTY: 180.00 The requests for gabapentin and Celebrex have been approved by the claims administrator.
-03/29/17 J. Castrejon, M.D.; EKHS UR: APPROVED: ITEM 1: Gabapentin 300 mg (#180 w/2 refills) QTY: 540.00

MAXIMUS IMR FINAL:
-04/22/16 Maximus; OVERTURNED Denial date 3/10/16. APPROVED Functional Capacity Evaluation.
-01/19/17 Maximus; UPHELD; Denial date 11/21/16, DENIED VOLTAREN 1% GEL 5.00.

DIAGNOSTICS:
-07/17/15 I. Rashid, D.O.; Electrodiagnostic Study; Diagnostic evidence of moderate right CTS, no evidence of left median, bilateral ulnar, radial focal neuropathy, or bilateral cervical radiculopathy.
-09/26/16 J. Hansing, MD; Cervical MRI; Degenerative disc bulging/spurring, greatest at C5/C6, resulting in 6 mm canal stenosis and impingement upon the cervical spinal cord but without cord
compression or displacement, There is also left foraminal stenosis at this level in which I cannot exclude possible impingement upon the exiting left C6 nerve root, degenerative disc bulging/spurring at C4/C5, resulting in 7 mm canal stenosis with minimal impingement upon the cervical spinal cord without cord compression or displacement seen at this level. There is also question of left foraminal stenosis with possible impingement upon the exiting left C5 nerve, degenerative disc bulging/spurring at C6/C7 without evidence of canal stenosis or cord impingement, with left foraminal stenosis and possible Impingement upon the exiting left C7.

PRIOR SURGERY/PROCEDURES: No prior surgeries or procedures found in the documentation reviewed.

QME/AME/P&S: None found in records reviewed.

MEDICAL RECORD SUMMARY:
-11/01/16 J. Sanchez, MD/ M. Yang, MD; Progress note; SUBJECTIVE: She has pain in both upper extremities right greater than left. She Is having now complete numbness of the left thumb which corresponds to the C6 nerve root. OBJECTIVE: Diffused tenderness to both upper extremities. Positive Tinel’s, more pronounced on the right side. Tender especially at the wrist and IP joints. Sensation decreased on left thumb. PLAN: Not working, applying social security tisalbity. P&S.

-02/21/17 M. Yang, MD; Follow up; Symptoms unchanged and getting worse. Patient reported weak grip, problems with ADL’s, pain in both upper extremities, complete numbness of left thumb. Patient had EMG and was told EMG revealed carpal tunnel syndrome but patient refuses to have surgery. Patient taking Cymbalta from private PCP. Relevant objective findings included cervical spasm, decreased range of motion, positive facet loading, spasm over thoracic and lumbar area, diffuse tenderness bilateral upper extremities, decreased sensation in left thumb, weak grip on left. Diagnosis included radiculopathy of cervicothoracic region, carpal tunnel syndrome, degenerative arthritis of cervical spine. Follow up with neurosurgeon, provider prescribed Ultram #180, Celebrex #30, and gabapentin #180 with 2 refills. TOTAL MED 60mg.

-03/02/17 R. Sanden, MD; Neurosurgical Cervical Spine Consultation; Patient suffered industrial injury 03/26/16 from keying for data entry, patient began to lose strength in hands, EMG revealed carpal tunnel and MRI revealed cervical spondylitic cord impingement C4-C7. Patient presents with neck, arm, and hand pain. Currently taking Celebrex, gabapentin for pain. 60% left, 40% right arm pain, numbness, tingling into the thumb, middle fingers with burning and shooting up and down the arm from the neck, patient awakens at night twice a week with rubbing out the wrists. Patient had prior right shoulder surgery in 2002 which did not help, prior conservative care to include 16 PT visits, 10 acupuncture, no HEP. Examination revealed cervical spasm, guarding, loss of lordosis, right rotation 60-70 degrees, left 50-60, flexion 45, extension 30, mild Spurlings sign into the left arm and shoulder with rotation and extension, trace left brachioradialis reflex, sensory shows right greater than left forearm, thumb, index, deltoid, middle, ring, small finger in C4-7 distribution, motor revealed weakness on the right arm with 80-90% of normal, grip testing performed, positive Tinel’s bilaterally, shoulder range of motion normal bilaterally. Imaging reviewed by report only, diagnosis included C5-6 stenosis, central, foraminal with alternating UE radiculopathy, C4-5 stenosis from disc protrusion, industrial with central and foraminal stenosis, alternating radiculopathy, borderline stenosis C6-7, history of CTS. The provider requested authorization for repeat EMG/NCV, cervical x-rays to include lateral/flexion/extension to rule out instability, CT cervical spine to determine true spondylitic stenosis from possible congenital canal stenosis versus OA spondylitic cord impingement, pain management for cervical epidural steroid.
03/20/17 M. Yang, M.D.; Progress Report; SUBJECTIVE; Neck, arm, and hand pain rated 9/10 VAS. She is losing, strength, mobility, and sensation in the left arm. OBJECTIVE; Neck: spasms, decreased motion, positive facet loading test. Positive cervical MRI. Back: spasm over thoracic and lumbar areas. Upper extremities: diffuse tenderness, positive Tinel sign, decreased sensory on left thumb, weak grip. DIAGNOSIS; Carpal tunnel syndrome, cervical spondylitic cord impingement C4-C7. PLAN; Surgery has been recommended. She will decide. 1. Gabapentin 300 mg (#180 w/2 refills). Ultram 50 mg #180 (MED=60), 2. Celebrex 200 mg #30.

04/18/17 M. Yang, M.D.; Progress Note: Subjective: As far as her symptoms, they are unchanged and are getting worse. Her symptoms include a weak grip, problems with her ADL’s, especially in the kitchen. She has pain in both upper extremities, right greater than left. She is having now complete numbness of the left thumb, which corresponds to the C6 nerve root and a burning sensation in the 5th digit. Objective: Neck: Palpation of the cervical area reveals moderate spasm, as well as both trapezi. Range of motion at the neck is decreased in all planes. She has positive facet loading test. Back: She also has a moderate amount of spasm over the thoracic area and lumbar area. Upper Extremeties: She has diffuse tenderness in both upper extremities. Tinel’s sign is positive, but more pronounced on the right side Today she is especially tender at the wrist and the IP joints. She has decreased sensation to light touch and pinprick on the Left thumb. Her grip is weak on the left. Alert and cooperative, concerned, upset affect, normal attention and concentration. Today she is fearful about her forced retirement. Diagnoses: 1. Radiculopathy of Cervicothoracic Region, 2. Carpal Tunnel Syndrome, 3. Degenerative Arthritis of Cervical Spine. Treatment Plan: Ultram 50 mg #180, Gabapentin 300 mg X2 Refills #180, Celebrex 200 mg #30, Diclofenac Sodium 1% Gel #3, Follow up in 4 weeks.

04/26/17 M. Yang, M.D.; DWC form RFA: Ultram 50 mg #180, Gabapentin 300 mg X2 Refills #180, Celebrex 200 mg #30, Diclofenac Sodium 1% Gel #3

PHYSICIAN REVIEWER'S RATIONALE

I have reviewed the medical information contained in this report.

TREATMENT REQUEST:

ITEM 1. Ultram 50 mg QTY: 180.00
ITEM 2. Diclofenac Sodium 1% Gel QTY: 3.00

RECOMMENDATION:

MODIFIED ITEM 1. Ultram 50 mg QTY: 160.00
DENIED ITEM 2. Diclofenac Sodium 1% Gel QTY: 3.00

SUMMARY:

The injured worker is a 50 year old female Data Entry Operator for 27 years for CA Employment Development Dept with a date of injury of 03/26/15. She sustained injuries to the bilateral wrists and hands, neck, bilateral shoulders, and bilateral lower arms. Treatment has included medications and imaging studies. The current report is dated 04/18/17. The injured workers symptoms are unchanged and
are getting worse. Her symptoms include a weak grip, problems with her ADL’s, especially in the kitchen. She has pain in both upper extremities, right greater than left. She is having now complete numbness of the left thumb, which corresponds to the C6 nerve root and a burning sensation in the 5th digit. Neck: Palpation of the cervical area reveals moderate spasm, as well as both trapezi. Range of motion at the neck is decreased in all planes. She has positive facet loading test. Back: She also has a moderate amount of spasm over the thoracic area and lumbar area. Upper Extremities: She has diffuse tenderness in both upper extremities. Tinel’s sign is positive, but more pronounced on the right side. Today she is especially tender at the wrist and the IP joints. She has decreased sensation to light touch and pinprick on the left thumb. Her grip is weak on the left.

RATIONALE:

ITEM 1. Ultram is an Opioid like medication that is used for pain. There is documentation that the injured has been on Ultram and was approved refill in March 2017. The guidelines allow continued use of Opioids when there is documentation of a VAS pain scale as well as functional improvement in ADLs. Review of the current medical report does not document a VAS pain scale with and without Ultram. There is no documentation of functional improvement. In fact, there is mention that her symptoms are unchanged and are getting worse. Her symptoms include a weak grip, problems with her ADL’s, especially in the kitchen. Therefore, Ultram 50 mg QTY: 180.00 is modified to 160.00 to begin the weaning process.

ITEM 2. Diclofenac is a topical anti-inflammatory that is used for pain and inflammation. The guidelines do not recommend this topical as a first-line treatment, but recommend it as an option for patients at risk of adverse effects from oral NSAIDs, after considering the increased risk profile with diclofenac. The PTP has not documented any risk of adverse effects from oral NSAIDs to support the request. Therefore, Diclofenac Sodium 1% Gel QTY: 3.00 is denied.

GUIDELINES:

Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. § 9792.24.2 (July 28, 2016); Page 168

Tramadol (Ultram)

See MTUS Opioids Treatment Guidelines for general recommendations on the use of opioids. Tramadol is a centrally acting synthetic opioid analgesic and it provides inferior analgesia compared to a combination of Hydrocodone/ acetaminophen. (Turturro, 1998) As of November 2013, Tramadol has been designated a Schedule IV controlled substance. (DEA, 2013) Tramadol has unreliable analgesic activity and potential side effects such as serotonin syndrome. (Ray, 2013)

ITEM 2. Diclofenac Sodium 1% Gel QTY: 3.00

MEDICAL TREATMENT UTILIZATION SCHEDULE MTUS; Chronic Pain Medical Treatment Guidelines § 9792.24.2 July 28,2016

Diclofenac, topical (Flector®, Pennsaid®, Voltaren® Gel)

Not recommended as a first-line treatment, but recommended as an option for patients at risk of adverse effects from oral NSAIDs, after considering the increased risk profile with diclofenac. See specific topical diclofenac listings: Flector® patch (diclofenac epolamine); Pennsaid® (diclofenac sodium topical solution); & Voltaren® Gel (diclofenac). For more details, see also Topical analgesics, Non-steroidal antiinflammatory agents (NSAIDs), and the diclofenac topical listing.
Topical analgesics
Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, α-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, γ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. [Note: Topical analgesics work locally underneath the skin where they are applied. These do not include transdermal analgesics that are systemic agents entering the body through a transdermal means. For example, see Duragesic® (fentanyl transdermal system).]

PHYSICIAN CONTACT:
DECISION DATE/TIME: 5/3/17 AT 2:30 P.M.
The PTPs office was called at the number provided 530)672-1311 at 2:30 P.M. on 5/3/17. I identified myself as the physician utilization reviewer for the requests contained herein. A message was left on a message machine as to the determination stated in this report.

Medical Criteria or Guidelines Used
See MD Rationale.

DETAILED ICD-9/CPT INFORMATION
This request is MODIFIED as follows:
ICD: M54.13, radiculopathy, cervicothoracic region
Treatment: S5000, Ultram 50 mg
Quantity requested: 180.00 APPROVED: 160.00
To start: 05/03/2017 To end: 10/30/2017
ICD: M54.13, radiculopathy, cervicothoracic region
Treatment: S5000, Diclofenac Sodium 1% Gel
Quantity requested: 3.00 DENIED

APPEAL PROCESS
TO THE INJURED WORKER, the INJURED WORKER’S REPRESENTATIVE, OR the INJURED WORKER’S ATTORNEY:
If you disagree with the utilization review decision, any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by you on the enclosed Application for
Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision.
You have a right to disagree with decisions affecting your claim. If you have questions about the
information in this notice, please call your adjuster at the number provided at the top of this letter.
However, if you are represented by an attorney, please contact your attorney instead of your adjuster. 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.

TO THE REQUESTING PHYSICIAN:

The Undersigned Reviewer at EK Health Services is available from 9:00 AM to 5:30 PM Pacific Time. If
you have any questions or need clarification please call (408)973-0888. We have a 24 hour voice mail
available at that number using extension 101. Our facsimile number is 408-725-1135. You may also
reach us through email at info@ekhealth.com

INTERNAL VOLUNTARY APPEALS PROCESS

EK Health Services, Inc. (EKHS) has a voluntary internal utilization review appeals process for first level
reviews only. This internal appeals process is a voluntary process that neither triggers nor bars use of the
dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an
optional basis. If a request for authorization is modified or non-certified, all parties including the injured
worker, treating physician/provider, or the facility rendering service has the right and opportunity to
initiate an internal voluntary appeal of the determination by telephone or written notification. Written
notification from the requesting party for Internal Voluntary Appeals must be received within 10
calendar days from the date of the receipt of the non-certification. Participation in the Internal Voluntary
Appeals Process DOES NOT extend the deadlines of the Labor Code 4610.5 or 4610.6 Process.

Through my signature below, I hereby attest that I am competent to and have the requisite license to
evaluate the specific clinical issues involved in medical treatment services, and that I know of no reason
for me to have recused myself from the review herein.

Sincerely,

Joseph Castrejon, MD
CA License #: A55607
American College of Occupational & Environmental Medicine
Diplomate, American Board of Family Medicine

Enclosed:
- DWC Form IMR Report#6
IMPORTANT INFORMATION FROM STATE FUND

Effective January 1, 2017, all authorized ancillary service requests for prescription drugs, durable medical equipment (DME) and supplies, interpreting, transportation, home health, diagnostics and physical therapy must be supplied only through the following State Fund-approved ancillary networks:

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

DME, Interpretation, Transportation, Home Health, Physical Therapy, Diagnostics
Healthesystems (HES)
(877)287-7728

Authorization of medication does not constitute approval to dispense medications from the physician’s office. All medications should be filled by an Express Scripts pharmacy. Physicians or injured employees can call (888) 201-5389 for assistance in locating an Express Scripts Network Pharmacy and all, durable medical equipment (DME) and supplies, interpreting transportation, home health, diagnostics, and physical therapy must be supplied by Healthesystems.

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

Effective September 1, 2016 to December 31, 2016 requests for the above mentioned ancillary services must be supplied by Optum or One Call.

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.

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

In addition to the records listed in the report, the following records were reviewed:

992 S. DE ANZA SUITE 101 - SAN JOSE CA 95129 - PHONE: (877) 861 - 1595 - FAX: (408) 725 1135
WWW.EKHEALTH.COM
Document Date - Description
04/26/2017 - State Fund; Trk# 11838222
04/26/2017 - DWC RFA; Yanh, Michael, MD
04/26/2017 - State Fund; Trk# 11838277
04/26/2017 - DWC RFA; Yang, Michael, MD
04/18/2017 - Yang, Michael, MD; Progress Report
04/18/2017 - Yang, Michael, MD; Progress Report W/Auth Req
04/04/2017 - Maximus
03/29/2017 - UR Review Report #: 5 UR GUTIERREZ, LILA [UR_CA_SC
03/29/2017 - EK
03/29/2017 - EK
03/27/2017 - Certified Letter sent to GUTIERREZ, LILA for Repor
03/24/2017 - UR Review Report #: 4 UR GUTIERREZ, LILA [UR_CA_SC
03/24/2017 - DWC Form IMR (012014c)2016.pdf
03/24/2017 - State Fund - Track#11808835
03/23/2017 - EK Health - UR Letter to the Non-Physician Provide
03/22/2017 - DWC Form RFA - Yang, Michael MD
03/22/2017 - DWV RFA; Yang, Michael, MD
03/21/2017 - State Fund-TRK#11805093
03/20/2017 - Yang, Michael MD - Progress Note/Auth Req
03/20/2017 - Yang, Michael, MD; Progress Report W/Auth Req
03/16/2017 - DWC FORM RFA Sanden, Roderick MD
03/16/2017 - DWC RFA; Sanden, Roderick, MD
03/02/2017 - Sanden, Roderick MD-Neurosurgical c-spine consult
03/02/2017 - Sanden, Roderick, MD;
03/02/2017 - Sanden, Roderick, MD;
03/01/2017 - UR Review Report #: 3 UR GUTIERREZ, LILA [UR_CA_SC
03/01/2017 - EK-Approval letter
02/25/2017 - State Fund trk#11754029
02/22/2017 - DWC RFA - Yang, Michael MD
02/21/2017 - Yang, Michael MD - Progress Note
01/19/2017 - Maximus federal services- Independent med review f
11/22/2016 - Certified Letter sent to GUTIERREZ, Lila for Repor
11/21/2016 - UR Review Report #: 2 UR GUTIERREZ, Lila [UR_CA_SC
11/21/2016 - DWC Form IMR (012014c)2016.pdf
11/16/2016 - State Fund Referral Form Tracking #11697480
11/01/2016 - DWC Form RFA - Yang, Michael MD
11/01/2016 - Yang, Michael MD - Progress Note
10/28/2016 - Yang, Michael MD - Progress Note
10/18/2016 - DWC Form RFA - Yang, Michael MD
10/17/2016 - Yang, Michael MD - RFA
09/26/2016 - No Dr. Info - MRI Cervical SPINE
09/20/2016 - DWC Form RFA - Yang, Michael MD
09/20/2016 - Yang, Michael MD - Progress Note
08/30/2016 - Yang, Michael MD - Progress Note
07/08/2016 - Yang, Michael MD - RFA
07/08/2016 - DWC Form RFA - Yang, Michael MD
07/06/2016 - Yang, Michael MD - Progress Note
06/10/2016 - Yang, Michael MD - RFA
06/10/2016 - DWC Form rfa - Yang, Michael MD
06/10/2016 - YANG, Michael MD - Progress Notes
06/07/2016 - Yang, Michael MD - Progress Note
04/26/2016 - Yang, Michael MD - Progress Note
04/22/2016 - IMR Final Determination Letter
04/05/2016 - Yang, Michael MD - RFA
04/05/2016 - DWC Form RFA - Yang, Michael MD
03/30/2016 - URD to Dr. Michael Yang
03/29/2016 - Yang, Michael MD - Progress Note
03/10/2016 - DWC Form IM - Yang, Michael MD
June 05, 2017

Dr. Michael C. Yang:
El Dorado Pain Management Center
1208 Suncast Lane
El Dorado Hills, CA 956729631

Re: LILA GUTIERREZ
Cl#: 06083410
Ref#: 03/26/2015
DOI: 03/26/2015
Carrier: State Fund, Riverside

Cert#: Employment Development
Er: Department Mic 54
Adj: Michelle Martin
Adj Phn: (951) 413-5919
Tracking #: E000011862784

Modified due to Lack of Medical Necessity

Dear Dr. Michael C. Yang:

Utilization Review is to provide a review of requested medical treatment to determine medical necessity and appropriateness. Selection of a specific provider or program may be designated by the claims administrator. Questions about the financial aspects of the claim should be addressed with the claims examiner.

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; interpreting; medically necessary transportation; home health; physical therapy and diagnostics should be requested through Healthesystems (HES) (877)287-7728.

Carrier receipt date: 05/23/2017
EKHS receipt date: 05/24/2017
Verbal decision date: 06/02/2017 03:30PM

I called and spoke to the provider's office with the determination as contained in this report. LILA GUTIERREZ's Workers' Compensation insurance carrier/employer has requested utilization review.

ITEMS REQUESTED:
ITEM 1. Ultram 50mg QTY: 180.00
ITEM 2. Gabapentin 300mg QTY: 540.00
ITEM 3. Celebrex 200mg QTY: 30.00
ITEM 4. Diclofenac Patch 1.3% QTY: 3.00
ITEM 5. Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified) QTY: 1.00
ITEM 6. Left Cervical Epidural Steroid Injection (Level(s) Unspecified) QTY: 1.00

APPROVED:
ITEM 1: Ultram 50mg QTY: 180.00
ITEM 2: Gabapentin 300mg QTY: 540.00
ITEM 3: Celebrex 200mg QTY: 30.00

DENIED:
ITEM 4: Diclofenac Patch 1.3%
ITEM 5: Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified)
ITEM 6: Left Cervical Epidural Steroid Injection (Level(s) Unspecified)

-05/30/17: In order to address the Request For Authorization (RFA) in its entirety, a Request For Information (RFI) was issued to render a medical decision for the complete request. A letter was faxed to Dr. Michael Yang requesting the level(s) to be injected for the left cervical ESI and requesting the duration/frequency for the PT of the cervical spine being requested.

-05/30/17: A Request for Additional Information (RFI) was sent prior to 5:30pm PST on the 5th business day from the carrier receipt date to the requesting provider, which extended the due date to the 14th calendar day from the receipt of the request. (CCR, Title 8 §9792.9(l))

-05/30/17: HCP called Dr. Yang's office and left a voice message requesting the level(s) to be injected for the left cervical ESI and requesting the duration/frequency for the PT of the cervical spine being requested.

-06/01/17: HCP called Dr. Yang's office and left another voice message requesting the level(s) to be injected for the left cervical ESI and requesting the duration/frequency for the PT of the cervical spine being requested. As of today, we have not received the requested information.

MEDICAL RECORDS REVIEW PREPARED BY LICENSED HEALTHCARE PROFESSIONAL

TREATMENT REQUESTED: (Prospective); RFA; D.O.S.: 05/16/17
ITEM 1. Ultram 50mg QTY: 180.00
ITEM 2. Gabapentin 300mg QTY: 540.00
ITEM 3. Celebrex 200mg QTY: 30.00
ITEM 4. Diclofenac Patch 1.3% QTY: 3.00
ITEM 5. Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified) QTY: 1.00
ITEM 6. Left Cervical Epidural Steroid Injection (Level(s) Unspecified) QTY: 1.00

CLINICAL SUMMARY:
Lila GUTIERREZ is a 50 year old (DOB: female employee for Employment Development as a Data Entry Operator who was injured due to repetitive duties while at work on 03/26/15. The current work status is retired. The both wrists and hands, disc neck, both shoulders, and both lower arms have been accepted by the carrier. The carrier has objected to the claim for disc back.

PRIOR UR:
-11/21/16 G. Taff, MD; EKHS UR; APPROVED: Ultram 50mg QTY: 180. Celebrex 200mg QTY: 30. DENIED: Voltaren 1% Gel (NOTE: Claims administrator has denied the request for neurosurgical consult for the cervical spine and cervical spine injection (body part not accepted).)
-03/01/17 G. Taff, MD; EKHS UR; APPROVED: Ultram 50mg QTY: 180.00 The requests for gabapentin and Celebrex have been approved by the claims administrator.
-03/29/17 J. Castrejon, M.D.; EKHS UR: APPROVED: ITEM 1: Gabapentin 300 mg (#180 w/2 refills) QTY: 540.00
-05/03/17 J. Castrejon, M.D.; EKHS UR; MODIFIED: ITEM 1: Ultram 50 mg QTY: 160.00 DENIED: ITEM 2: Diclofenac Sodium 1% Gel.

IMR FINAL DETERMINATIONS:
-04/22/16 Maximus; OVERTURNED Denial date 3/10/16. APPROVED Functional Capacity Evaluation.
-01/19/17 Maximus; UPHELD; Denial date 11/21/16, DENIED VOLTAREN 1% GEL 5.00.
-05/05/17 Maximus IMR: Upheld; 1. EMG of the bilateral upper extremities is not medically necessary and appropriate. 2. NCV of the bilateral upper extremities is not medically necessary and appropriate.

DIAGNOSTICS:
-07/17/15 I. Rashid, D.O.; Electrodiagnostic Study; Diagnostic evidence of moderate right CTS, no evidence of left median, bilateral ulnar, radial focal neuropathy, or bilateral cervical radiculopathy.
-09/26/16 J. Hansing, MD; Cervical MRI without contrast; IMPRESSION: Degenerative disc bulging/spurring, greatest at C5/C6, resulting in 6 mm canal stenosis and impingement upon the cervical spinal cord but without cord compression or displacement, There is also left foraminal stenosis at this level in which I cannot exclude possible impingement upon the exiting left C6 nerve root, degenerative disc bulging/spurring at C4/C5, resulting in 7 mm canal stenosis with minimal impingement upon the cervical spinal cord without cord compression or displacement seen at this level. There is also question of left foraminal stenosis with possible impingement upon the exiting left C5 nerve, degenerative disc bulging/spurring at C6/C7 without evidence of canal stenosis or cord impingement, with left foraminal stenosis and possible Impingement upon the exiting left C7.

PRIOR SURGERY/PROCEDURES:
None found in the records reviewed.

MEDICAL RECORD SUMMARY:
-11/01/16 J. Sanchez, MD/ M. Yang, MD; Progress note; SUBJECTIVE: She has pain in both upper extremities right greater than left. She Is having now complete numbness of the left thumb which
corresponds to the C6 nerve root. OBJECTIVE: Diffused tenderness to both upper extremities. Positive Tinel's, more pronounced on the right side. Tender especially at the wrist and IP joints. Sensation decreased on left thumb. PLAN: Not working, applying social security disability. P&S.

-02/21/17 M. Yang, MD; Follow up; Symptoms unchanged and getting worse. Patient reported weak grip, problems with ADL's, pain in both upper extremities, complete numbness of left thumb. Patient had EMG and was told EMG revealed carpal tunnel syndrome but patient refuses to have surgery. Patient taking Cymbalta from private PCP. Relevant objective findings included cervical spasm, decreased range of motion, positive facet loading, spasm over thoracic and lumbar area, diffuse tenderness bilateral upper extremities, decreased sensation in left thumb, weak grip on left. Diagnosis included radiculopathy of cervicothoracic region, carpal tunnel syndrome, degenerative arthritis of cervical spine. Follow up with neurosurgeon, provider prescribed Ultram #180, Celebrex #30, and gabapentin #180 with 2 refills. TOTAL MED 60mg.

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-03/20/17 M. Yang, M.D.; Progress Report; SUBJECTIVE; Neck, arm, and hand pain rated 9/10 VAS. She is losing, strength, mobility, and sensation in the left arm. OBJECTIVE; Neck: spasms, decreased motion, positive facet loading test. Positive cervical MRI. Back: spasm over thoracic and lumbar areas. Upper extremities: diffuse tenderness, positive Tinel sign, decreased sensory on left thumb, weak grip. DIAGNOSIS; Carpal tunnel syndrome, cervical spondylitic cord impingement C4-C7. PLAN; Surgery has been recommended. She will decide. 1. Gabapentin 300 mg (#180 w/2 refills). Ultram 50 mg #180 (MED=60), 2. Celebrex 200 mg #30.

-04/18/17 M. Yang, M.D.; Progress Note: Subjective: As far as her symptoms, they are unchanged and are getting worse. Her symptoms include a weak grip, problems with her ADL’s, especially in the kitchen. She has pain in both upper extremities, right greater than left. She is having now complete numbness of the left thumb, which corresponds to the C6 nerve root and a burning sensation in the 5th digit. Objective: Neck: Palpation of the cervical area reveals moderate spasm, as well as both trapezi. Range of motion at the neck is decreased in all planes. She has positive facet loading test. Back: She also has a moderate amount of spasm over the thoracic area and lumbar area. Upper Extremities: She has
diffuse tenderness in both upper extremities. Tinel's sign is positive, but more pronounced on the right side. Today she is especially tender at the wrist and the IP joints. She has decreased sensation to light touch and pinprick on the Left thumb. Her grip is weak on the left. Alert and cooperative, concerned, upset affect, normal attention and concentration. Today she is fearful about her about her forced retirement. Diagnoses: 1. Radiculopathy of Cervicothoracic Region, 2. Carpal Tunnel Syndrome, 3. Degenerative Arthritis of Cervical Spine. Treatment Plan: Ultram 50 mg #180, Gabapentin 300 mg X2 Refills #180, Celebrex 200 mg #30, Diclofenac Sodium 1% Gel #3, Follow up in 4 weeks.

-04/26/17 M. Yang, M.D.; DWC form RFA: Ultram 50 mg #180, Gabapentin 300 mg X2 Refills #180, Celebrex 200 mg #30, Diclofenac Sodium 1% Gel #3

-05/16/17 M. Yang, M.D.; PR2: SUBJECTIVE: Complains of worsening neck pain radiating to the upper extremities, rating at 8/10. States that she has been recommended to have an anterior neck fusion 3 levels, but she is not sure if she wants to go through with surgery. Reports that left arm is losing strength. Complains of complete numbness in the left thumb. Difficulty sleeping due to pain. OBJECTIVE: Patient is obese. Moderate spasms along the cervical area and both trapeze. Cervical range of motion is decreased in all planes. Facet loading test is positive. Moderate spasms along the thoracic and lumbar areas. Diffuse tenderness along both upper extremities. Tinel's sign is positive, but more pronounced on the right side. Tenderness along the wrist and IP joints. Decreased sensation in the left thumb. Grip strength is weak on the left. DIAGNOSIS: Radiculopathy of cervicothoracic region. Carpal tunnel syndrome. Degenerative arthritis of cervical spine. PLAN: Ultram 50mg, #180 (MED=60); Gabapentin 300mg, #180 with 2 refills; Celebrex 200mg, #30; Diclofenac Patch 1.3%, #3; Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified); Left Cervical Epidural Steroid Injection (Level(s) Unspecified).

-05/23/17 DWC RFA: M. Yang, M.D.; Ultram 50mg, #180; Gabapentin 300mg, #180 with 2 refills; Celebrex 200mg, #30; Diclofenac Patch 1.3%, #3; Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified); Left Cervical Epidural Steroid Injection (Level(s) Unspecified).

-05/30/17: In order to address the Request For Authorization (RFA) in its entirety, a Request For Information (RFI) was issued to render a medical decision for the complete request. A letter was faxed to Dr. Michael Yang requesting the level(s) to be injected for the left cervical ESI and requesting the duration/frequency for the PT of the cervical spine being requested.

-05/30/17: A Request for Additional Information (RFI) was sent prior to 5:30pm PST on the 5th business day from the carrier receipt date to the requesting provider, which extended the due date to the 14th calendar day from the receipt of the request. (CCR, Title 8 §9792.9(1))

PHYSICIAN REVIEWER'S RATIONALE

I have reviewed the medical information contained in this report.

TREATMENT REQUESTED:
ITEM 1. Ultram 50mg QTY: 180.00
ITEM 2. Gabapentin 300mg QTY: 540.00
ITEM 3. Celebrex 200mg QTY: 30.00
ITEM 4. Diclofenac Patch 1.3% QTY: 3.00  
ITEM 5. Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified) QTY: 1.00  
ITEM 6. Left Cervical Epidural Steroid Injection (Level(s) Unspecified) QTY: 1.00  

RECOMMENDATION:  
ITEM 1. Approved Ultram 50mg QTY: 180.00  
ITEM 2. Approved Gabapentin 300mg QTY: 540.00  
ITEM 3. Approved Celebrex 200mg QTY: 30.00  
ITEM 4. Denied Diclofenac Patch 1.3% QTY: 3.00  
ITEM 5. Denied Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified) QTY: 1.00  
ITEM 6. Denied Left Cervical Epidural Steroid Injection (Level(s) Unspecified) QTY: 1.00  

BRIEF CLINICAL SUMMARY:  
Lila GUTIERREZ is a 50 year old (DOB: female employee for Employment Development as a Data Entry Operator who was injured due to repetitive duties while at work on 03/26/15. The current work status is retired. The both wrists and hands, disc neck, both shoulders, and both lower arms have been accepted by the carrier. The carrier has objected to the claim for disc back.  

Per most recent MD note:  
05/16/17 M. Yang, M.D.; PR2: SUBJECTIVE: Complains of worsening neck pain radiating to the upper extremities, rating at 8/10. States that she has been recommended to have an anterior neck fusion 3 levels, but she is not sure if she wants to go through with surgery. Reports that left arm is losing strength. Complains of complete numbness in the left thumb. Difficulty sleeping due to pain. OBJECTIVE: Patient is obese. Moderate spasms along the cervical area and both trapeze. Cervical range of motion is decreased in all planes. Facet loading test is positive. Moderate spasms along the thoracic and lumbar areas. Diffuse tenderness along both upper extremities. Tinel's sign is positive, but more pronounced on the right side. Tenderness along the wrist and IP joints. Decreased sensation in the left thumb. Grip strength is weak on the left. DIAGNOSIS: Radiculopathy of cervicothoracic region. Carpal tunnel syndrome. Degenerative arthritis of cervical spine. PLAN: Ultram 50mg, #180 (MED=60); Gabapentin 300mg, #180 with 2 refills; Celebrex 200mg, #30; Diclofenac Patch 1.3%, #3; Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified); Left Cervical Epidural Steroid Injection (Level(s) Unspecified).  

Prior UR:  
05/03/17 J. Castrejon, M.D.; EKHS UR; MODIFIED: ITEM 1: Ultram 50 mg QTY: 160.00 DENIED: ITEM 2: Diclofenac Sodium 1% Gel.  

RATIONALE:  
ITEM 1. Ultram 50mg QTY: 180.00  
Per Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. § 9792.24.2 (July 28, 2016), Regarding treatment of chronic pain with opiates, the MTUS provides requirements for the treating physician to provide assessments of function so that treatment intervention a response can be measured. Evidence of functional improvement, maintenance of function that would otherwise deteriorate and close monitoring are necessary and essential for the continued support of any treatment intervention. The available clinical information documents IW is a candidate for cervical spine surgery. MED is within guidelines. The available clinical information supports the medical necessity of continued opiates
and the request is approved. Future requests for opiate refills must be accompanied by objective measures of functional improvement (Oswestry Index, etc.), urine drug screen, and attempt of opiate wean/taper and an updated and signed pain contract between the provider and claimant.

ITEM 2. Gabapentin 300mg QTY: 540.00
The available clinical information documents chronic neuropathic pain. Treatment with anticonvulsant is guideline supported and the request is approved.

ITEM 3. Celebrex 200mg QTY: 30.00
The available clinical information documents an inflammatory component to chronic pain. Treatment with NSAID is guideline supported as first-line therapy at the lowest dose and shortest duration and is approved.

ITEM 4. Diclofenac Patch 1.3% QTY: 3.00
The available clinical information does not document failure of first-line agents including antidepressants. The available clinical information does not support the medical necessity and the request is denied.

ITEM 5. Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified) QTY: 1.00
The treatment request is denied based on Lack of Information. We did not receive a response to our Request for Information. If the requested information is received, we will reconsider your request at that time.

ITEM 6. Left Cervical Epidural Steroid Injection (Level(s) Unspecified) QTY: 1.00
The treatment request is denied based on Lack of Information. We did not receive a response to our Request for Information. If the requested information is received, we will reconsider your request at that time.

GUIDELINES:
MTUS OPIOIDS TREATMENT GUIDELINES July 28, 2016, page 9
(See MTUS for full text, pgs. 32-52)

OPIOIDS FOR CHRONIC PAIN (3 months or more of treatment)

1) Considerations
   (a) Document at every visit
      • Consult CURES (see Use of CURES to Ensure Safe and Effective Opioid Use pgs. 40-41)
      • Perform complete physical exam and UDT (see Use of Urine Drug Testing (UDT) pgs. 41-45)
      • Screen for contraindicated physical conditions (e.g. untreated sleep disorders, severe obesity, COPD)
      • Use validated tools to screen for depression, PTSD, substance abuse
      • Advise against alcohol, sedatives/hypnotics (e.g. benzodiazepines)
      • Consult pain or addiction specialist when necessary for complex management issues (see pgs. 55-56)

2) Best Practices
   (a) Optimal use of treatment agreement
• Review with patient treatment agreement signed prior to opioid trial (e.g. possible adverse effects, consequences of diversion, misuse or abuse, not to drive)
• Ensure terms of agreement are followed
• Annually review and update treatment agreement with new signatures and modify as necessary
(b) Prescribe:
• Non-opioid treatments:
  o Physical activity, including passive and active range of motion, and physical therapy with graded exercise matched to injury
  o Medication (e.g. acetaminophen, NSAIDs)
  o Cognitive Behavioral Therapy
  o Complimentary treatment (e.g. acupuncture, massage, yoga)
• Opioid Treatment
  o Lowest effective dose of short active opioid producing analgesia and improved function (no more than 80mg/day MED, for those on higher doses, attempt to wean to less than 80mg/day MED)(see Documentation of Morphine Equivalents pg. 55)
  o Avoid intravenous, intramuscular, sublingual, submucosal, and transdermal (except buprenorphine) administration of opioids for chronic pain if the patient is able to tolerate oral medication
(c) Titration period to find stable effective (“maintenance”) dose (see pgs. 48-49)
• Regular face-to-face visits every 4 weeks
• More frequent visits (every 2 weeks) if
  o 1) titrating doses above 80mg/day MED, as the risk of adverse effects increases with increasing dose, or
  o 2) provider suspects co-existing psychiatric problems, drug behavior problems, or medical problems
3) Monitoring
(a) At every visit
• Consult CURES
• Track and document levels of pain and function: clinically meaningful improvement (30% improvement in both pain and function level or worsening on attempt to wean; see pg. 47) is desirable to continue opioid treatment
• Document current MED
• Monitor for intolerance and non-compliance
(b) Frequency of visits after titration:
• Monthly during the first year of opioid treatment
• Quarterly thereafter
(c) Frequency of UDTs:
• 2x/year randomly for low-risk
• Up to 4x/year randomly for high-risk or high-dose (>80mg/day MED)
• At any unscheduled visit for opioids (e.g. ER visit)
(d) Apply as medically necessary
• Validated tools to screen for aberrant behavior
• UDT
• Consultation with pain or addiction specialist
4) Discontinuing (see Tapering Opioids pgs. 52-55)
(a) Indications for tapering
• Any of the following:
  o Resolution or improvement of pain
  o Lack of functional improvement
  o Intolerance
Non-compliance

- Methods

  - Step 1: 10-25% per week outpatient taper, possibly using suboxone support after patient is off opioids
  - Step 2: If step 1 fails or comorbidities hamper efforts, in-patient detox and multidisciplinary pain program may be indicated
  - If taper fails:
    - Every 6 months, attempt to wean patients on high doses for more than 6 months to below 80mg/day MED

Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. § 9792.24.2 (July 28, 2016), page 168

**Tramadol (Ultram®)**

See MTUS Opioids Treatment Guidelines for general recommendations on the use of opioids. Tramadol is a centrally acting synthetic opioid analgesic and it provides inferior analgesia compared to a combination of Hydrocodone/ acetaminophen. (Turturro, 1998) As of November 2013, Tramadol has been designated a Schedule IV controlled substance. (DEA, 2013) Tramadol has unreliable analgesic activity and potential side effects such as serotonin syndrome. (Ray, 2013)

MTUS OPIOIDS TREATMENT GUIDELINES July 28, 2016
MTUS 2009 - Chronic Pain Treatment Guidelines 7/18/2009
PAGE NUM: 93-94, 113
TREATMENT: Tramadol (Ultram; Ultram ER; generic available in immediate release tablet):

Tramadol is a synthetic opioid affecting the central nervous system. Tramadol may increase the risk of seizure especially in patients taking SSRIs, TCAs and other opioids. Do not prescribe to patients that at risk for suicide or addiction. Warning: Tramadol may produce life-threatening serotonin syndrome, in particular when used concomitantly with SSRIs, SNRIs, TCAs, and MAOIs, and triptans or other drugs that may impair serotonin metabolism. Analgesic dose: Tramadol is indicated for moderate to severe pain. (See MTUS for full text, pg 93-94.)

Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic (pg 113).

Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. § 9792.24.2 (July 28, 2016), page 87

**Gabapentin (Neurontin®)**

Recommended for some neuropathic pain conditions and fibromyalgia. (Wiffen-Cochrane, 2013) Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. See Anti-epilepsy drugs (AEDs) for general guidelines, as well as specific Gabapentin listing for more information and references.

Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. § 9792.24.2 (July 28, 2016), page 45

**Celebrex® (celecoxib)**

Celebrex® is the brandname for celecoxib, and it is produced by Pfizer. Celecoxib is a non-steroidal anti-inflammatory drug (NSAID) that is a COX-2 selective inhibitor, a drug that directly targets COX-2, an enzyme responsible for inflammation and pain. See Anti-inflammatory medications. See NSAIDs (non-steroidal anti-inflammatory drugs) for specific patient decision-making criteria. Unlike other
NSAIDs, celecoxib does not appear to interfere with the antiplatelet activity of aspirin and is bleeding neutral when patients are being considered for surgical intervention or interventional pain procedures.

Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. § 9792.24.2 (July 28, 2016), page 132
NSAIDs, specific drug list & adverse effects
Selective COX-2 NSAIDS: Celecoxib (Celebrex®) is the only available COX-2 in the United States. No generic is available. Mechanism of Action: Inhibits prostaglandin synthesis by decreasing cyclooxygenase-2 (COX-2). At therapeutic concentrations, cyclooxygenase-1 (COX-1) is not inhibited. In animal models it works as an anti-inflammatory, analgesic, and antipyretic. It does not have an anti-platelet effect and is not a substitute for aspirin for cardiac prophylaxis. Use: Relief of the signs and symptoms of osteoarthritis, rheumatoid arthritis, ankylosing spondylitis, and treatment of acute moderate pain. Side Effects: See NSAIDs, hypertension and renal function; & NSAIDs, GI Symptoms and Cardiovascular Risks. Cardiovascular: Hypertension (≤13%) CNS: headache (15.8%), dizziness (1% - 2%), insomnia (2.3%); GI: diarrhea (4% to 11%), dyspepsia (8.8% vs. 12.8% for ibuprofen and 6.2% for placebo), diarhrea (5.6%), abdominal pain (4.1% vs. 9% for ibuprofen and 2.8% for placebo), N/V (3.5%), gastroesophageal reflux (≤ 5%), flatulence (2.2%); Neuromuscular/skeletal: arthralgia (7%), back pain (3%); Respiratory: upper respiratory tract infection (8%), cough (7%), sinusitis (5%), rhinitis (2%), pharyngitis (2%); Skin Rash (2%) – discontinue if rash develops; Peripheral Edema (2.1%).
Recommended Dose: 200 mg a day (single dose or 100 mg twice a day). (Celebrex® package insert)

Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. § 9792.24.2 (July 28, 2016), page 74-75
Diclofenac
Not recommended as first line due to increased risk profile. A large systematic review of available evidence on NSAIDs confirms that diclofenac, a widely used NSAID, poses an equivalent risk of cardiovascular events to patients as did rofecoxib (Vioxx), which was taken off the market. According to the authors, this is a significant issue and doctors should avoid diclofenac because it increases the risk by about 40%. For a patient who has a 5% to 10% risk of having a heart attack, that is a significant increase in absolute risk, particularly if there are other drugs that don’t seem to have that risk. For people at very low risk, it may be an option. (McGettigan, 2011) Another meta-analysis supported the substantially increased risk of stroke with diclofenac, further suggesting it not be a first-line NSAID. (Varas-Lorenzo, 2011) In this nationwide cohort study the traditional NSAID diclofenac was associated with the highest increased risk of death or recurrent myocardial infarction (hazard ratio, 3.26; 95% confidence interval, 2.57 to 3.86 for death/MI at day 1 to 7 of treatment) in patients with prior MI, an even higher cardiovascular risk than the selective COX-2 inhibitor rofecoxib, which was withdrawn from the market due to its unfavorable cardiovascular risk profile. (Schjerning, 2011) According to FDA MedWatch, postmarketing surveillance of topical diclofenac has reported cases of severe hepatic reactions, including liver necrosis, jaundice, fulminant hepatitis with and without jaundice, and liver failure. Some of these reported cases resulted in fatalities or liver transplantation. If using diclofenac then consider discontinuing as it should only be used for the shortest duration possible in the lowest effective dose due to reported serious adverse events. Post marketing surveillance has revealed that treatment with all oral and topical diclofenac products may increase liver dysfunction, and use has resulted in liver failure and death. Physicians should measure transaminases periodically in patients receiving long-term therapy with diclofenac. (FDA, 2011) In 2009 the FDA issued warnings about the potential for elevation in liver function tests during treatment with all products containing diclofenac sodium. (FDA, 2009) With the lack of data to support superiority of diclofenac over other NSAIDs and the possible increased hepatic and cardiovascular risk associated with its use, alternative analgesics and/or nonpharmacological therapy should be considered. The AGS updated Beers criteria for inappropriate medication use includes
diclofenac. (AGS, 2012) Diclofenac is associated with a significantly increased risk of cardiovascular complications and should be removed from essential-medicines lists, according to a new review. The increased risk with diclofenac was similar to Vioxx, a drug withdrawn from worldwide markets because of cardiovascular toxicity. Rofecoxib, etoricoxib, and diclofenac were the three agents that were consistently associated with a significantly increased risk when compared with nonuse. With diclofenac even in small doses it increases the risk of cardiovascular events. They recommended naproxen as the NSAID of choice. (McGettigan, 2013) See also NSAIDs (non-steroidal anti-inflammatory drugs); NSAIDs, GI symptoms & cardiovascular risk; NSAIDs, hypertension and renal function; & NSAIDs, specific drug list & adverse effects for general guidelines. See also Zorvolex (diclofenac).

Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. § 9792.24.2 (July 28, 2016), page 76
Diclofenac, topical (Flector®, Pennsaid®, Voltaren® Gel)
Not recommended as a first-line treatment, but recommended as an option for patients at risk of adverse effects from oral NSAIDs, after considering the increased risk profile with diclofenac. See specific topical diclofenac listings: Flector® patch (diclofenac epolamine); Pennsaid® (diclofenac sodium topical solution); & Voltaren® Gel (diclofenac). For more details, see also Topical analgesics, Non-steroidal antiinflammatory agents (NSAIDs), and the diclofenac topical listing.

Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. § 9792.24.2 (July 28, 2016), Page 144
Physical therapy (PT)
See Physical medicine treatment.

Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. § 9792.24.2 (July 28, 2016), Page 143
Physical medicine treatment
Recommended as indicated below. Physical medicine encompasses interventions that are within the scope of various practitioners (including Physical Therapy, Occupational Therapy, Chiropractic, and MD/DO). Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) is not indicated for addressing chronic pain in most instances; refer to the specific modality within these guidelines (e.g., massage, ultrasound) Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Refer to the specific intervention within these guidelines (e.g., exercise.) This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006). Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)
ODG Physical Therapy Guidelines –
Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-
directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Myalgia and myositis, unspecified (ICD9 729.1):
9-10 visits over 8 weeks

Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2)
8-10 visits over 4 weeks

Reflex sympathetic dystrophy (CRPS) (ICD9 337.2):
26 visits over 16 weeks

Arthritis (ICD9 715):
9 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment: Refer to the MTUS Postsurgical Treatment Guidelines

Patients should be formally assessed after a "six-visit clinical trial" to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy.

ODG Physical Therapy Guidelines –
Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial".

Cervicalgia (neck pain); Cervical spondylosis (ICD9 723.1; 721.0):
9 visits over 8 weeks

Sprains and strains of neck (ICD9 847.0):
10 visits over 8 weeks

Displacement of cervical intervertebral disc (ICD9 722.0):
Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Post-surgical treatment (fusion, after graft maturity): 24 visits over 16 weeks

Degeneration of cervical intervertebral disc (ICD9 722.4):
10-12 visits over 8 weeks

See 722.0 for post-surgical visits

Brachia neuritis or radiculitis NOS (ICD9 723.4):
12 visits over 10 weeks

See 722.0 for post-surgical visits

Post Laminectomy Syndrome (ICD9 722.8):
10 visits over 6 weeks

Fracture of vertebral column without spinal cord injury (ICD9 805):
Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks

Fracture of vertebral column with spinal cord injury (ICD9 806):
Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 48 visits over 18 weeks

Work conditioning (See also Procedure Summary entry):
10 visits over 8 weeks

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MTUS CHRONIC PAIN MEDICAL TREATMENT GUIDELINES July 28, 2016

992 S. DE ANZA SUITE 101 - SAN JOSE CA 95129 - PHONE: (877) 861 - 1595 - FAX: (408) 725 1135
WWW.EKHEALTH.COM
Epidural Steroid Injections (ESIs)

"See MTUS Low Back Complaints for recommendations."


Cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise.

ODG online, Neck and Upper Back (Acute and Chronic) (updated 08/25/16)

Epidural Steroid Injection (ESI)
Not recommended based on recent evidence, given the serious risks of this procedure in the cervical region and the lack of quality evidence for sustained benefit. These had been recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy), with specific criteria for use below.

While not recommended, cervical ESIs may be supported using Appendix D, Documenting Exceptions to the Guidelines, in which case:

Criteria for the use of Epidural steroid injections, therapeutic:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

(1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.
(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).
(3) Injections should be performed using fluoroscopy (live x-ray) for guidance.
(4) No more than two nerve root levels should be injected using transforaminal blocks.
(5) No more than one interlaminar level should be injected at one session.
(6) In the therapeutic phase, repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year.
(7) Repeat injections should be based on continued objective documented pain and function response.
(8) Current research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections.
(9) It is currently not recommended to perform epidural blocks on the same day as facet blocks or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.
(10) Cervical and lumbar epidural steroid injection should not be performed on the same day;
(11) Additional criteria based on evidence of risk:
(i) ESIs are not recommended higher than the C6-7 level;
(ii) Cervical interlaminar ESI is not recommended;
(iii) Particulate steroids should not be used. (Benzon, 2015)

Criteria for the use of Epidural steroid injections, diagnostic:

If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.

To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the
examples below:
(1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies;
(2) To help to determine pain generators when there is evidence of multi-level nerve root compression;
(3) To help to determine pain generators when clinical findings are suggestive of radiculopathy (e.g., dermatomal distribution), and imaging studies have suggestive cause for symptoms but are inconclusive;
(4) To help to identify the origin of pain in patients who have had previous spinal surgery.

PHYSICIAN CONTACT:
DECISION DATE/TIME: 6/2/17 at 3:30 PM
Dr. Yang office was called at the number provided () on 6/2/17 at 3:30 PM. I identified myself as the physician utilization reviewer for the requests contained herein. A message was left with a staff member with the determination stated in this report.

Medical Criteria or Guidelines Used
-See MD Rationale.

DETAILED ICD-9/CPT INFORMATION

This request is MODIFIED as follows:
ICD: M47.812, spondylosis without myelopathy or radiculopathy, cervical region
Treatment: S5000, Ultram 50mg
Quantity requested: 180.00 APPROVED: 180.00
To start: 06/02/2017 To end: 11/29/2017
ICD: M47.812, spondylosis without myelopathy or radiculopathy, cervical region
Treatment: S5000, Gabapentin 300mg
Quantity requested: 540.00 APPROVED: 540.00
To start: 06/02/2017 To end: 11/29/2017
ICD: M47.812, spondylosis without myelopathy or radiculopathy, cervical region
Treatment: S5000, Celebrex 200mg
Quantity requested: 30.00 APPROVED: 30.00
To start: 06/02/2017 To end: 11/29/2017
ICD: M47.812, spondylosis without myelopathy or radiculopathy, cervical region
Treatment: S5000, Diclofenac Patch 1.3%
Quantity requested: 3.00 DENIED
ICD: M47.812, spondylosis without myelopathy or radiculopathy, cervical region
Treatment: 97799, Physical Therapy with Deep Tissue Massage of the Cervical Spine
(Duration/Frequency Unspecified)
Quantity requested: 1.00 DENIED
ICD: M47.812, spondylosis without myelopathy or radiculopathy, cervical region
Treatment: 62310, Left Cervical Epidural Steroid Injection (Level(s) Unspecified)
Quantity requested: 1.00 DENIED

APPEAL PROCESS

TO THE INJURED WORKER, the INJURED WORKER'S REPRESENTATIVE, OR the INJURED WORKER'S ATTORNEY:
If you disagree with the utilization review decision, any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by you on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision. You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster at the number provided at the top of this letter. However, if you are represented by an attorney, please contact your attorney instead of your adjuster. 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.

TO THE REQUESTING PHYSICIAN:

The Undersigned Reviewer at EK Health Services is available from 9:00 AM to 5:30 PM Pacific Time. If you have any questions or need clarification please call (408)973-0888. We have a 24 hour voice mail available at that number using extension 101. Our facsimile number is 408-725-1135. You may also reach us through email at info@ekhealth.com

INTERNAL VOLUNTARY APPEALS PROCESS

EK Health Services, Inc. (EKHS) has a voluntary internal utilization review appeals process for first level reviews only. This internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis. If a request for authorization is modified or non-certified, all parties including the injured worker, treating physician/provider, or the facility rendering service has the right and opportunity to initiate an internal voluntary appeal of the determination by telephone or written notification. Written notification from the requesting party for Internal Voluntary Appeals must be received within 10 calendar days from the date of the receipt of the non-certification. Participation in the Internal Voluntary Appeals Process DOES NOT extend the deadlines of the Labor Code 4610.5 or 4610.6 Process.

Through my signature below, I hereby attest that I am competent to and have the requisite license to evaluate the specific clinical issues involved in medical treatment services, and that I know of no reason for me to have recused myself from the review herein.

Sincerely,

[Signature]

Brian Y. McLean, MD
CA License #: G68234
Anesthesiology
Addiction Medicine
Diplomate, American Board of Addiction Medicine

Enclosed:
- DWC Form IMR (012014c)2016.pdf
IMPORTANT INFORMATION FROM STATE FUND

Effective January 1, 2017, all authorized ancillary service requests for prescription drugs, durable medical equipment (DME) and supplies, interpreting, transportation, home health, diagnostics and physical therapy must be supplied only through the following State Fund-approved ancillary networks:

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

DME, Interpretation, Transportation, Home Health, Physical Therapy, Diagnostics
Healthesystems (HES)
(877)287-7728

Authorization of medication does not constitute approval to dispense medications from the physician’s office. All medications should be filled by an Express Scripts pharmacy. Physicians or injured employees can call (888) 201-5389 for assistance in locating an Express Scripts Network Pharmacy and all, durable medical equipment (DME) and supplies, interpreting transportation, home health, diagnostics, and physical therapy must be supplied by Healthesystems.

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

Effective September 1, 2016 to December 31, 2016 requests for the above mentioned ancillary services must be supplied by Optum or One Call.

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.

L.C. Section 4600.2(a) allows insurers and self-insured employers to contract with a pharmacy benefits network to provide medicines and medical supplies.
In addition to the records listed in the report, the following records were reviewed:

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<th>Document Date</th>
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<td>DWC FORM RFA - Yang, Michael MD</td>
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<td>05/03/2017</td>
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<td>09/26/2016</td>
<td>No Dr. Info - MRI Cervical SPINE</td>
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November 02, 2017

Dr. Michael C. Yang:
El Dorado Pain Management Center
1208 Suncast Lane
El Dorado Hills, CA 956729631

Re: LILA GUTIERREZ
CI#: 06083410
Er: Employment Development
Ref#: Adjuster: Michelle Martin
DOI: 03/26/2015
Carrier: State Fund, Riverside
Tracking #: E000011998346

Modified due to Lack of Medical Necessity

Dear Dr. Michael C. Yang:

Utilization Review is to provide a review of requested medical treatment to determine medical necessity and appropriateness. Selection of a specific provider or program may be designated by the claims administrator. Questions about the financial aspects of the claim should be addressed with the claims examiner.

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; interpreting; medically necessary transportation; home health; physical therapy and diagnostics should be requested through Healthesystems (HES) (877)287-7728.

Carrier receipt date: 10/27/2017
EKHS receipt date: 11/01/2017
Verbal decision date: 11/02/2017 11:28AM

I called and spoke to the provider's office with the determination as contained in this report. LILA GUTIERREZ's Workers' Compensation insurance carrier/employer has requested utilization review.

ITEMS REQUESTED:
ITEM 1. Ultram 50mg QTY: 180.00
ITEM 2. Gabapentin 300mg QTY: 540.00

APPROVED:
ITEM 2: Gabapentin 300mg QTY: 540.00

MODIFIED:
ITEM 1: Ultram 50mg QTY: 130.00

The following item has been APPROVED by the carrier:
ITEM 3. Celebrex 200mg #30

The following item has been DENIED by the carrier:
ITEM 4. Voltaren Gel 1% #3 tubes

MEDICAL RECORDS REVIEW PREPARED BY LICENSED HEALTHCARE PROFESSIONAL.

TREATMENT REQUEST: (Prospective); RFA: 10/27/17 DOS: 10/12/17
ITEM 1. Ultram 50mg QTY: 180.00
ITEM 2. Gabapentin 300mg (#180 with 2 refills) QTY: 540.00

CLINICAL SUMMARY:
Lila GUTIERREZ is a 51-year old female Data Entry Operator (DOB: employed by Employment Development Department Mic 54. On 03/26/2015, she sustained a work-related injury due to repetitive duties. The Carrier has accepted the both wrists and hands, disc neck, both shoulders, and both lower arms and has denied the back. Currently, she is retired.

PRIOR UR:
-11/21/16 G. Taff, MD; EKHS UR; APPROVED: Ultram 50mg QTY: 180. Celebrex 200mg QTY: 30. DENIED: Voltaren 1% Gel (NOTE: Claims administrator has denied the request for neurosurgical consult for the cervical spine and cervical spine injection (body part not accepted).)

-03/01/17 G. Taff, MD; EKHS UR; APPROVED: Ultram 50mg QTY: 180.00 The requests for gabapentin and Celebrex have been approved by the claims administrator.


-03/29/17 J. Castrejon, M.D.; EKHS UR: APPROVED: ITEM 1: Gabapentin 300 mg (#180 w/2 refills) QTY: 540.00

-05/03/17 J. Castrejon, M.D.; EKHS UR; MODIFIED: ITEM 1: Ultram 50 mg QTY: 160.00 DENIED: ITEM 2: Diclofenac Sodium 1% Gel.

-06/05/2017 B. McLean, M.D., EKHS UR: APPROVED: ITEM 1: Ultram 50mg QTY: 180.00; ITEM 2:
Gabapentin 300mg QTY: 540.00; ITEM 3: Celebrex 200mg QTY: 30.00. DENIED: ITEM 4: Diclofenac Patch 13%; ITEM 5: Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified); ITEM 6: Left Cervical Epidural Steroid Injection (Level(s) Unspecified).


-07/11/17 J. Golden, MD EKHS UR: DENIED ITEM 1: Voltaren 1% Gel ** ITEM 2: Ultram 50mg #80 - Approved by Carrier; ITEM 3: Gabapentin 300mg # 180 with 2 Refills - Approved by Carrier; ITEM 4: Celebrex 200mg #30 Approved by Carrier

-08/23/17 B. Kretzmann, MD; EKHS UR; DENIED: ITEM 1. Oral Drug Screen

-09/25/17 D. Weinberg, MD; EKHS UR; MODIFIED: ITEM 1. Ultram 50mg QTY: 144/180.00

IMR FINAL DETERMINATIONS:
-04/22/16 Maximus; OVERTURNED Denial date 3/10/16. APPROVED Functional Capacity Evaluation.
-01/19/17 Maximus; UPHELD; Denial date 11/21/16, DENIED VOLTAREN 1% GEL 5.00.
-05/05/17 Maximus IMR: Upheld; 1. EMG of the bilateral upper extremities is not medically necessary and appropriate. 2. NCV of the bilateral upper extremities is not medically necessary and appropriate.
-06/06/17 Maximus; UPHELD MODIFIED: ITEM 1: Ultram 50 mg QTY: 160.00 DENIED: ITEM 2: Diclofenac Sodium 1% Gel.
-08/02/17 Maximus UPHOLD UR Denial 06/12/17: (1) Cervical ESI Left C7-T1 is not medically necessary and appropriate
-08/03/17 Maximus UPHOLD UR Denial 06/05/17: (1) Diclofenac patch 1.3% #3 is not medically necessary and appropriate

DIAGNOSTICS:
-07/17/15 I. Rashid, D.O.; Electrodiagnostic Study; Diagnostic evidence of moderate right CTS, no evidence of left median, bilateral ulnar, radial focal neuropathy, or bilateral cervical radiculopathy.

-09/26/16 J. Hansing, MD; Cervical MRI without contrast; IMPRESSION: Degenerative disc bulging/spurring, greatest at C5/C6, resulting in 6 mm canal stenosis and impingement upon the cervical spinal cord but without cord compression or displacement, There is also left foraminal stenosis at this level in which I cannot exclude possible impingement upon the exiting left C6 nerve root, degenerative disc bulging/spurring at C4/C5, resulting in 7 mm canal stenosis with minimal impingement upon the cervical spinal cord without cord compression or displacement seen at this level. There is also question of left foraminal stenosis with possible impingement upon the exiting left C5 nerve, degenerative disc bulging/spurring at C6/C7 without evidence of canal stenosis or cord impingement, with left foraminal stenosis and possible Impingement upon the exiting left C7.

-04/17/17 R. Bermudez, MD; EMG/NCS Study; CONCLUSION: study demonstrates a focal neuropathy of the right median nerve at the wrist consistent with a mild case of right carpal tunnel syndrome.

-07/03/17 UDS: Negative
PRIOR SURGERY/PROCEDURES: No prior surgeries or procedures found in the documentation reviewed.

MEDICAL RECORD SUMMARY:
-09/06/15 R. Schaefer, MD; P&S Report; Future care for the right wrist should be medication and surgical treatment; left wrist brace.

-05/06/17 M. Ryan, MD; Phys Med and Rehab QME Report; Patient has reached a permanent and stationary/maximal medical improvement level. Future medical care should consist of specialist visits, medications, physical therapy (24 sessions/year), acupuncture (24/year), steroid injections, and possible surgery.

-05/16/17 M. Yang, M.D.; PR2: SUBJECTIVE: Complains of worsening neck pain radiating to the upper extremities, rating at 8/10. States that she has been recommended to have an anterior neck fusion 3 levels, but she is not sure if she wants to go through with surgery. Reports that left arm is losing strength. Complains of complete numbness in the left thumb. Difficulty sleeping due to pain. OBJECTIVE: Patient is obese. Moderate spasms along the cervical area and both trapeze. Cervical range of motion is decreased in all planes. Facet loading test is positive. Moderate spasms along the thoracic and lumbar areas. Diffuse tenderness along both upper extremities. Tinel's sign is positive, but more pronounced on the right side. Tenderness along the wrist and IP joints. Decreased sensation in the left thumb. Grip strength is weak on the left. DIAGNOSIS: Radiculopathy of cervicothoracic region. Carpal tunnel syndrome. Degenerative arthritis of cervical spine. PLAN: Ultram 50mg, #180 (MED=60); Gabapentin 300mg, #180 with 2 refills; Celebrex 200mg, #30; Diclofenac Patch 1.3%, #3; Physical Therapy with Deep Tissue Massage of the Cervical Spine (Duration/Frequency Unspecified); Left Cervical Epidural Steroid Injection (Level(s) Unspecified).

-06/20/17 M. Yang, MD; PR-2; SUBJECTIVE: recommended for anterior neck fusion at 3 levels but not wanting to go through with surgery. Her left arm is loosing strength, mobility, and sensation. She is worried about how quickly it has deteriorated. Her pain is high, and she is very worried about her symptoms. She had an EMG in her arm up to her neck, and this has caused her a lot of pain and swelling in the left hand. Approved for CESI, denied PT and massage. Pain rated 8/10. Symptoms include weak grip, problems with ADLs, pain in both upper extremities, right greater than left. She is now having complete numbness of the left thumb. OBJECTIVE: moderate spasm in the cervical area as well as trapezii. Ranges of motion in the neck are decreased in all planes. Positive facet loading test. Moderate spasm over the thoracic and lumbar areas. Diffuse tenderness in bilateral upper extremities. Tinel's sign is positive, more on right. Especially tender at wrist and IP joints. Decreased sensation to light touch and pinprick of left thumb. Grip is weak on the left. DIAGNOSES: radiculopathy of cervicothoracic region; carpal tunnel syndrome; degenerative arthritis of cervical spine. PLAN: continue use of medications. Return in 4 weeks.

-08/03/17 M. Yanf, MD PR2: SUBJECTIVE: Seen early due to increase in neck pain. She is in so much pain that her meds are not helping at all. She is not ready for any type of surgery for her neck as recommended by spine surgeon since there is a 50/50 chance of improvement. She wants to try the CESI first and if that helps wait as long as she can before surgery options. Pain today is 9/10 with all her oral medications. She had a QME and the diagnosis was a herniated disc at C5-6 and bilateral mild carpal tunnel syndrome. She has seen Dr Sanden, neurosurgery, who recommended anterior neck fusion 3 levels. She is not wanting to go through with surgery. Her left arm is loosing strength, mobility and sensation and she is worried about how quickly it has deteriorated. Her pain is too high and she is afraid
about her symptoms but is afraid of surgery. OBJECTIVE: 5'5" 200#. On exam of upper extremities, she
has diffuse tenderness in both upper extremities. Tinel's is positivie but more pronounced on the right
side. She is especially tender at the wrist and IP joints. She has decreased sensation to light touch and
pinprick on the left thumb. Grip is weak on the left. ASSESSMENT: Radiculopathy cervicothoracic
region; Carpal tunnel syndrome; Degenerative arthritis of cervical spine PLAN: Refill Norco 10/325mg
for her acute neck pain. She is working with her attorney to get the CESI approved. Performed an in
office oral drug screen today.

-08/17/17 M. Yang, MD; PR-2; SUBJECTIVE: pain rated 9/10 today and 6-7/10 with medications.
Medications help some but still having enough pain that she is unable to do daily chores. OBJECTIVE:
diffuse tenderness in both upper extremities. Tinel's sign positive, more on right. Tender at wrist and IP
joints. Decreased sensation to light touch and pinprick on left thumb. Left grip is weak. Moderate spasm
over thoracic and lumbar area.

-09/14/17 M. Yang, MD; DWC RFA; Ultram 50mg #180, Gabapentin 300mg #180, Celebrex 200mg
#30, Voltaren gel 1%, 3 tubes.

-09/14/17 M. Yang, MD; Subjective: She is not ready still to attempt surgery for her neck as
recommended by spine surgeon since there is a 50/50 chance of improvement. Her pain level today is
9/10 today. With her oral medication her pain is a 8-7/10. The medication helps some but she is still
having enough pain that she is unable to do some of her daily chores like vacuuming and driving.
Objective: Neck; On exam of the back, palpation of the cervical area reveals moderate spasm, as well as
both trapezi. Range of motion at the neck is decreased in all planes. She has positive facet loading test.
She also has a moderate amount of spasm over the thoracic and the lumbar area. Diagnosis:
-Radiculopathy of cervicothoracic region. Carpal tunnel syndrome. Degenerative arthritis of cervical
spine. Plan: Ultram 50mg #180, Gabapentin 300mg #180, Celebrex 200mg #30, Voltaren gel 1%, 3
tubes.

-10/12/17 M. Yang, MD; PR-2; SUBJECTIVE: still not ready for neck surgery as there's a 50/50 chance
for improvement. Wants to try CESI first. Pain rated 9/10 today. With medications, it is rated 6-7/10.
Medications help some but still having enough pain that she is unable to do daily chores. OBJECTIVE:
diffuse tenderness in both upper extremities. Tinel's sign positive, more on right. Tender at wrist and IP
joints. Decreased sensation to light touch and pinprick on left thumb. Left grip is weak. Moderate spasm
over thoracic and lumbar area. DIAGNOSES: cervicothoracic radiculopathy; CTS; cervical spine
degenerative arthritis. PLAN: medication refills. Pain is still very high in neck and arms. Trouble lifting
right arm above head. Return in 4 weeks.

-10/27/17 M. Yang, MD; DWC Form RFA; ITEM 1. Ultram 50mg QTY: 180.00; ITEM 2. Gabapentin
300mg (#180 with 2 refills) QTY: 540.00; ITEM 3. Celebrex 200mg #30; ITEM 4. Voltaren Gel 1% #3
tubes

PHYSICIAN REVIEWER’S RATIONALE

I have reviewed the relevant records that pertain to this treatment request.

TREATMENT REQUESTED:
ITEM 1. Ultram 50mg QTY: 180.00
ITEM 2. Gabapentin 300mg QTY: 540.00
RECOMMENDATION:
MODIFIED ITEM 1. Ultram 50mg QTY: 130.00
APPROVED ITEM 2. Gabapentin 300mg QTY: 540.00

BRIEF CLINICAL SUMMARY:
Lila GUTIERREZ is a 51-year old female Data Entry Operator employed by Employment Development Department Mic 54. On 03/26/2015, she sustained a work-related injury due to repetitive duties. The Carrier has accepted the both wrists and hands, disc neck, both shoulders, and both lower arms and has denied the back. Currently, she is retired. The corresponding medical report is dated 09/14/17 by M. Yang, MD who notes that she is not ready still to attempt surgery for her neck as recommended by spine surgeon since there is a 50/50 chance of improvement. Her pain level today is 9/10 today. With her oral medication her pain is a 8-7/10. The medication helps some but she is still having enough pain that she is unable to do some of her daily chores like vacuuming and driving.
Diagnosis: -Radiculopathy of cervicothoracic region. Carpal tunnel syndrome. Degenerative arthritis of cervical spine.

RATIONALE:
ITEM 1. Ultram 50mg QTY: 180.00
Opiates are MTUS guideline supported and medically justified for the long term treatment of chronic non-malignant pain only if continued opiate drug treatment can be shown to provide some measure of meaningful functional benefit. Opiates are not recommended for treatment of chronic non cancer pain for longer than three months as there are no high quality peer review citations which demonstrate their therapeutic benefit as such beyond that point (Turner,2015). Prior EKUR had modified this medication for weaning because of lack of documented measurable functional benefits in an effort to maximize the claimant's medical outcome. Documentation does not include support of defined functional improvements with this medication. Records do not include drug testing results, CURES reports, evidence of a signed opiate agreement or efforts to wean the injured worker off of high doses of long term opiates. Clear medical necessity of the requested medication has not been established. A request for this medication was previously modified to QTY: 144.00 in UR on 9/25/17. MTUS guidelines recommend a slow taper in an outpatient setting using 10%-25% per week taper Therefore, the request is modified to QTY: 130.00, to allow for continuation of a taper.

ITEM 2. Gabapentin 300mg QTY: 540.00
MTUS CHRONIC PAIN MEDICAL TREATMENT GUIDELINES July 28, 2016 recommend this anti-seizure medication for the treatment of neuropathic pain, which is documented in this case. Based on the currently available information, the medical necessity has been established for this medication, and therefore, the request is approved

TREATMENT GUIDELINES USED
ITEM 2. Gabapentin 300mg QTY: 540.00
Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. § 9792.24.2 (July 28, 2016)
Gabapentin (Neurontin) Page 87
Recommended for some neuropathic pain conditions and fibromyalgia. (Wiffen-Cochrane, 2013)
Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain.
3.3.9 Maintenance of Chronic Opioid Treatment

Once a stable dose of opioid has been established (maintenance period), patients should have regular face-to-face visits with their provider (at least every three [3] months is recommended as good practice but alternate schedules may be considered if the need is documented). At these visits, the provider should monitor treatment goals, analgesia, activity (function), adverse effects, and aberrant behaviors.

1. Consider during chronic opioid treatment:
   • Patients who receive chronic maintenance doses of opioids should not meet criteria for tapering. (See Section 4.1, Indications for Tapering Opioids)
   • Additional testing as may be deemed necessary to monitor and treat patients receiving chronic opioid treatment is considered part of a medically necessary treatment and monitoring program.

2. Document the “four A’s” at each visit during the maintenance phase of chronic opioid treatment. (See Section 3.3.8, Opioid Titration and Dosing Threshold) If the patient fails to meet any of the following four criteria, the treatment should be reevaluated, including consideration of tapering. (See Section 4, Tapering Opioids)
   a. Analgesia: Meaningful improvement in level of pain.
   b. Activity: Meaningful improvement in pain interference or function.
   c. Adverse events: Whether the medication is causing severe side effects.
   d. Aberrant behavior: Current substance use disorder or evidence of diversion. If the patient has had a history of opioid use disorder, the concurrence of an addiction specialist is recommended to continue opioid treatment as well as for dose escalation.

3. Conduct semiannual attempts to wean to lower than 80 mg/day MED in patients whose dose is above 80 mg/day MED, and who have been on that dose or higher for at least 180 days (i.e., six [6] months). (See Section 4.2, Methods for Tapering Opioids)
   • Opioid medication should never be abruptly discontinued in any patient who has been treated for longer than two (2) weeks. In these patients, opioid doses should be reduced gradually as tolerated, while monitoring for symptoms of withdrawal or other adverse impact, including increase in pain, or decrease in function. (See Section 4.2, Methods for Tapering Opioids)
   • Referral to a pain specialist may be considered.

4. Advise patients at each evaluation regarding responsible storage and disposal of opioid medications. (See Section 11, Responsible Storage and Disposal of Opioid Medications)

5. Recommend that patients on chronic opioid use not perform safety-sensitive jobs, such as operating heavy equipment and motor vehicles. (See Section 4.2, Methods for Tapering Opioids) Caution patients about the potential adverse effects of opioid medications, including impacts on alertness, when engaging in personal activities.

Rationale:
The continued use of chronic opioid treatment in the injured worker should meet the statutory system goals of restoring the patient to full functional status, with the overall goal being improvement of pain, function, and return to work. No specific visit frequency applies to all patients. Select a frequency that allows close follow-up of the patient's adverse effects, pain status, and appropriate use of medication.
than two (2) weeks. In these patients, opioid doses should be reduced gradually as tolerated, while monitoring for symptoms of withdrawal or other adverse impact, including increase in pain, or decrease in function. Referral to a pain specialist may be considered to assist with the weaning process. (See Section 6, Consultation with Specialists)

It is recommended that attempts be made to taper opioids to zero in patients who meet any of the criteria listed below. In situations where there may be clinical indications for tapering to a lower dose (rather than completely off opioids), clinical justification, such as worsened pain or function with even lower doses, should be documented. Patients who have been taking over 80 mg/day MED for over six (6) months and who are making their semiannual weaning attempt need only wean to below 80 mg/day MED. [84, 89, 90] (See Section 3.3.9, Maintenance of Chronic Opioid Treatment)

1. Monitor for criteria for tapering, including the following (and document if any are present):
   - Patient expresses a desire to discontinue therapy.
   - Pain condition has resolved.
   - No documented improvement in pain and function (or patient claims a lack of effectiveness) following last increase in dose.
   - Patient does not adhere to the treatment plan (e.g., as detected through urine drug screening or CURES).
   - Illegal or dangerous activity including the following: diversion, prescription forgery, suicide attempt, involvement in a motor vehicle accident and/or arrest related to opioids, aggressive or threatening behavior in the clinic, surreptitious medication use, including use of non-prescribed prescription drugs.
   - Consumption of medication or substances that the patient has been advised not to take concomitantly (sedating medication, alcohol, benzodiazepines). Coordinate care with other providers who may be prescribing these medications.
   - Severe adverse effects or overdose events.
   - Pregnancy (refer to the Medical Board of California Guidelines for Prescribing Controlled Substances for Pain for additional information).

2. Advise patients being tapered off opioids regarding responsible storage and disposal of opioid medications. (See Section 11, Responsible Storage and Disposal of Opioid Medications)

Rationale:
The guidelines reviewed recommend tapering opioid doses when benefit is not demonstrated or there is likelihood of harm or misuse. Tapering, rather than abrupt cessation of medication, prevents withdrawal symptoms and provides the ability to monitor progress on changing treatment regimens in patients on high doses or who have been treated with opioids for extended periods. The guidelines reviewed universally agree that tapering should be considered when opioids have been ineffective, when serious adverse events have occurred, or when aberrant or illegal behaviors have occurred. [54, 56, 58, 60, 61]

4.2. Methods for Tapering Opioids

1. Complete a comprehensive assessment of the patient, including history of condition and treatment as well as comorbidities.
2. Provide to the patient and family oral and written instructions reflecting the tapering regimen chosen, including advice that the weaning process could take months.
3. Use a two-step algorithm method of tapering for all patients except those meeting Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) criteria for substance use disorder [61]:
   a. Step 1: Taper in outpatient setting using 10%—25% per week taper, with or without buprenorphine (Suboxone) support after opioid has ended. Patients should be periodically evaluated in an office setting, for example, every two to four (2—4) weeks. These cases may require pain medicine specialty and psychological support. Clonidine or other adjunctive agents may be used to provide further support.
   b. Step 2: Patients who fail Step 1 may be referred to an addiction specialist or, if they are at higher risk, may be offered an inpatient detox, accompanied by a multidisciplinary pain program lasting up to four
(4) weeks (20 full days or 160 hours), or the equivalent in part-time day sessions if required by the patient's other family and work responsibilities. The pain program may occur at the same time as the inpatient detox or in an outpatient setting right after the detox. Additionally, patients who have coexisting cardiorespiratory or other comorbid conditions that may make outpatient tapering dangerous should be tapered in an inpatient setting. Refer to MTUS Chronic Pain Guidelines for additional information.

4. Patients who meet the DSM-V criteria for substance use disorder should be treated by an addiction specialist, preferably concurrently with a pain medicine specialist. Treatment may include therapy in an inpatient multidisciplinary pain program or a dedicated inpatient substance abuse center. Maintenance therapy may be needed for six (6) months or longer, depending on circumstances. In this population, tapering down to zero may require several tapering periods that occur over several months.

5. Never abandon a patient for whom tapering is indicated. Patient abandonment is defined by the American Medical Association as “termination of a professional relationship between provider and patient at an unreasonable time and without giving the patient the chance to find an equally qualified replacement.” [123]

6. Advise patients being tapered off opioids regarding responsible storage and disposal of opioid medications. (See Section 11, Responsible Storage and Disposal of Opioid Medications)

Rationale:
While the guidelines vary in their specific tapering regimens, they consistently recommend gradual, consistent tapers over a period of weeks to months and under careful supervision. [7, 56, 61, 124]

PHYSICIAN CONTACT:
DECISION Date/Time: 11/02/17 at 11:28
I made a peer to peer call to Michael Yang, MD PH: 530-672-1311.
I identified myself as the physician utilization reviewer for the requests contained herein. The provider was not available. A message was left with Eleni as to the determination stated in this report. I provided my call back contact information.

Medical Criteria or Guidelines Used
See MD Rationale.

DETAILED ICD-9/CPT INFORMATION

This request is MODIFIED as follows:
ICD: G56.0, Carpal tunnel syndrome
Treatment: S5000, Ultram 50mg
Quantity requested: 180.00 APPROVED: 130.00
To start: 11/02/2017 To end: 05/01/2018
ICD: G56.0, Carpal tunnel syndrome
Treatment: S5000, Gabapentin 300mg
Quantity requested: 540.00 APPROVED: 540.00
To start: 11/02/2017 To end: 05/01/2018

APPEAL PROCESS

TO THE INJURED WORKER, the INJURED WORKER'S REPRESENTATIVE, OR the INJURED
If you disagree with the utilization review decision, any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by you on the enclosed Application for Independent Medical Review, DWC Form IMR-1, within 30 calendar days of receipt of the decision.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your adjuster at the number provided at the top of this letter. However, if you are represented by an attorney, please contact your attorney instead of your adjuster. 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.

TO THE REQUESTING PHYSICIAN:

The Undersigned Reviewer at EK Health Services is available from 9:00 AM to 5:30 PM Pacific Time. If you have any questions or need clarification please call (408)973-0888. We have a 24 hour voice mail available at that number using extension 100. Our facsimile number is 408-725-1135. You may also reach us through email at info@ekhealth.com

INTERNAL VOLUNTARY APPEALS PROCESS

EK Health Services, Inc. (EKHS) has a voluntary internal utilization review appeals process for first level reviews only. This internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis. If a request for authorization is modified or non-certified, all parties including the injured worker, treating physician/provider, or the facility rendering service has the right and opportunity to initiate an internal voluntary appeal of the determination by telephone or written notification. Written notification from the requesting party for Internal Voluntary Appeals must be received within 10 calendar days from the date of the receipt of the non-certification. Participation in the Internal Voluntary Appeals Process DOES NOT extend the deadlines of the Labor Code 4610.5 or 4610.6 Process.

Through my signature below, I hereby attest that I am competent to and have the requisite license to evaluate the specific clinical issues involved in medical treatment services, and that I know of no reason for me to have recused myself from the review herein.

Sincerely,

Daniel Weinberg, M.D.
CA License #: G46144
Family Medicine
American Board of Family Medicine

Enclosed:
- DWC Form IMR (012014c)2016.pdf
IMPORTANT INFORMATION FROM STATE FUND

Effective January 1, 2017, all authorized ancillary service requests for prescription drugs, durable medical equipment (DME) and supplies, interpreting, transportation, home health, diagnostics and physical therapy must be supplied only through the following State Fund-approved ancillary networks:

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

**DME, Interpretation, Transportation, Home Health, Physical Therapy, Diagnostics**
Healthesystems (HES)
(877)287-7728

Authorization of medication does not constitute approval to dispense medications from the physician’s office. All medications should be filled by an Express Scripts pharmacy. Physicians or injured employees can call (888) 201-5389 for assistance in locating an Express Scripts Network Pharmacy and all, durable medical equipment (DME) and supplies, interpreting transportation, home health, diagnostics, and physical therapy must be supplied by Healthesystems.

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

Effective September 1, 2016 to December 31, 2016 requests for the above mentioned ancillary services must be supplied by Optum or One Call.

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.

L.C. Section 4600.2(a) allows insurers and self-insured employers to contract with a pharmacy benefits network to provide medicines and medical supplies.
In addition to the records listed in the report, the following records were reviewed:

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03/31/2017 - CT C-Spine
03/24/2017 - Lab License
09/06/2015 - Schaefer, Randall MD - PTP Permanent & Stationary
December 01, 2017

Dr. Michael C. Yang:
El Dorado Pain Management Center
1208 Suncast Lane
El Dorado Hills, CA 956729631

Re: LILA GUTIERREZ
Cert#: 06083410
Cl#: Employment Development Department Mic 54
Er: Ref#: Adjuster: Michelle Martin
DDI: 03/26/2015 Adj Phn: (951) 413-5919
Carrier: State Fund, Riverside SC Tracking #: E000012017027

Approval Letter

Dear Dr. Michael C. Yang:

Utilization Review is to provide a review of requested medical treatment to determine medical necessity and appropriateness. Selection of a specific provider or program may be designated by the claims administrator. Questions about the financial aspects of the claim should be addressed with the claims examiner.

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; interpreting; medically necessary transportation; home health; physical therapy and diagnostics should be requested through Healthesystems (HES) (877)287-7728.

Carrier receipt date: 11/27/2017
EKHS receipt date: 11/27/2017
Decision date: 12/01/2017 09:15AM(PT)

I called and left a message with the determination as contained in this report.

LILA GUTIERREZ’s Workers’ Compensation insurance carrier/employer has requested utilization review.

ITEMS REQUESTED:
ITEM 1. Ultram 50mg QTY: 180.00
ITEM 2. Norco 10-325mg QTY: 90.00

APPROVED:
ITEM 1: Ultram 50mg QTY: 180.00
ITEM 2: Norco 10-325mg QTY: 90.00

The following items have been APPROVED by the carrier:

992 S. DE ANZA SUITE 101 - SAN JOSE CA 95129 - PHONE: (877) 861 - 1595 - FAX: (408) 725 1135
WWW.EKHEALTH.COM
ITEM 3. Gabapentin 300mg #180 with 2 refills
ITEM 4. Celebrex 200mg #30

The following item has been DENIED by the carrier:
ITEM 5. Voltaren Gel 1% #3 tubes

PHYSICIAN REVIEWER'S RATIONALE

I have reviewed the medical information contained in this report.

ITEMS REQUESTED
ITEM 1. Ultram 50mg QTY: 180.00
ITEM 2. Norco 10-325mg QTY: 90.00

RECOMMENDATION
ITEM 1. APPROVE Ultram 50mg QTY: 180.00
ITEM 2. APPROVE Norco 10-325mg QTY: 90.00

BRIEF CLINICAL SUMMARY
Lila GUTIERREZ is a 51-year old female Data Entry Operator (DOB: employed by Employment Development Department Mic 54. On 03/26/2015, she sustained a work-related injury due to repetitive duties. The Carrier has accepted the both wrists and hands, disc neck, both shoulders, and both lower arms and has denied the back. Currently, she is retired. -11/13/17 M. Yang, MD; PR-2; SUBJECTIVE: still not ready to attempt surgery for her neck as there is a 50/50 chance of improvement. Wants to try CESI first. She is having a flare up of pain in her left wrist and thumb area today. It is rated an 8/10. She has had no pain medication since Ultram was denied, only Celebrex and Gabapentin used. Unable to grasp anything. Worried about not being able to use her hand. Refills of medications needed. OBJECTIVE: palpation of the cervical area reveals moderate spasm as well as both trapezi. ROM is decreased in all planes. Positive facet loading test. Moderate amount of spasm over the thoracic area and lumbar area. Diffuse tenderness in both upper extremities. Tinel's sign positive, more on right. Tender at wrist and IP joints. Decreased sensation to light touch and pinprick on left thumb. Left grip is weak. DIAGNOSES: cervicothoracic radiculopathy; CTS; cervical spine degenerative arthritis. PLAN: medication refills. Pain is still very high in neck and arms. Trouble lifting right arm above head. Return in 4 weeks.

RATIONALE
ITEM 1. Ultram 50mg QTY: 180.00
ITEM 2. Norco 10-325mg QTY: 90.00

These medications are DEA schedule II opiates used to treat chronic pain. Opiates are MTUS guideline supported and medically justified for long term treatment of chronic non cancer pain and/or chronic pain syndrome only if the supportive documentation, reported at least semiannually, can show that ongoing opiate treatment provides the injured worker with some measure of meaningful functional benefits OR there is evidence that continued opiate medication will maintain an injured worker's reasonable function that otherwise would deteriorate if discontinued (MTUS 2017). Opiate medications are otherwise not recommended for the long term treatment of chronic pain beyond three months as they are not MTUS guideline supported nor are there any high quality peer review citations which justify their use for pain beyond that point (Turner, 2015). In order to monitor the effectiveness of chronic opioid treatment the following outcomes must be measured when assessing the injured worker: (a) Reduction in level of pain via a brief validated instrument (b) Functional improvement attributable to the use of opioids via a validated instrument (c) Discrepancies between the reported improvement in pain, reported level of function, and described work limitations. Injured worker's pain and function are to be documented with the following frequency: (a) first three months of opioid therapy following injury: at every visit (b) from three months to one year after initiation of chronic opioid therapy: monthly. ((c) for the duration of opioid treatment: quarterly.

In this case, there is documentation of at least 50% pain relief with the use of these medications, and objective functional improvement which include activities of daily living. Prior ekur had modified Ultram for weaning however recent medicals support functional benefits when using this medication for pain. The injured worker does not report adverse side effects and the most recent drug screen tested consistent with the injured worker's medications' regimen.
There is a signed opiate agreement on file with the provider’s office. The latest CURES report is consistent. The current
daily morphine equivalent dose does not exceed the recommended guidelines (90 mme/day) as long as functional
benefits are realized. In this case, the provider has selected a frequency that allows close follow-up of the specific
injured worker’s adverse effects, pain status, and appropriate use of all medications (MTUS 2017). Based upon an
extensive review of the documentation provided in this medical file, the medical necessities of Ultram 50mg QTY:
180.00 and Norco 10-325mg QTY: 90.00 have been established as these medications have been documented to improve
the injured worker’s general function and performance of daily living activities. Therefore these requests are approved.

GUIDELINE USED
MTUS 2017: Opioids (effective April 20, 2017)

Opioids for Treatment of Subacute or Chronic Severe Pain

Recommended.

The use of an opioid trial is recommended if other evidence-based approaches for functional restorative pain therapy
have been used, and documented to have provided inadequate improvement in function.[72, 115] An opioids trial is then
recommended for treatment of both function and pain impaired by subacute or chronic severe pain (e.g., inability to
work due to any of the following: chronic severe radiculopathy, chronic severe peripheral neuropathies, complex
regional pain syndrome (CRPS), and severe arthroses). Ongoing opioids treatment beyond the trial period would be
dependent on the results of the opioids trial [120].

Strength of Evidence – Recommended, Insufficient Evidence (I)
Level of Confidence – Low

Indications: Patients should meet all of the following:

A complete history and physical should be done, if not previously accomplished.
Reduced function is attributable to the pain. Pain or pain scales alone are insufficient reasons. [1, 118, 120, 167, 208-
217]
Both function and pain treatment goals should be established (CDC 16) before an opioid trial of 1 to 3 weeks is
attempted. Before initiating opioids, there should be plans for discontinuation in the event the goals are not met (CDC
16). Opioids should only be continued beyond the opioids trial period if both goals are met and these outweigh risks to
patient safety (CDC 16). Assessment of function and pain at least monthly in the first 3 months of treatment and then
quarterly should be documented. There should be at least 30% improvement in both pain and function to continue
opioids treatment.
A severe disorder warranting potential opioid treatment is present [e.g., CRPS, severe radiculopathy, advanced
degenerative joint disease (DJD)].[1]
Other more efficacious treatments have been documented to have failed.[1] Other approaches that should have been first
utilized include physical restorative approaches, behavioral interventions, self-applied modalities, non-opioid
medications (including NSAIDs, acetaminophen, topical agents, norepinephrine adrenergic reuptake blocking
antidepressants or dual reuptake inhibitors; also antiepileptic medications particularly for neuropathic pain) and
functional restoration. For LBP patients, this also includes[i] fear avoidant belief training and ongoing progressive
aerobic exercise, and strengthening exercises. For CRPS patients, this includes progressive strengthening exercise. For
DJD, this includes NSAIDs, weight loss, aerobic and strengthening exercises.
Be engaged in an ongoing active exercise program and comply with that prescription.
Be prescribed a non-opioid prescription(s) (e.g., NSAIDs, acetaminophen) absent a contraindication. Such non-opioids
should nearly always be the primary pain medication and accompany an opioid prescription (CDC 16). Other
medications to consider include topical agents, norepinephrine adrenergic reuptake blocking antidepressants or dual
reuptake inhibitors; also antiepileptic medications particularly for neuropathic pain).
The lowest effective dose should be used.[188] Weaker opioids should be used whenever possible.[112, 189]
Meperidine is not recommended for chronic pain due to bioaccumulation and adverse effects.
Low-dose opioids may be needed in the elderly who have greater susceptibility to the adverse risks of opioids. Those of
lower body weight may also require lower opioid doses.
Dispensing should be only what is needed to treat the pain.[ii]
Patients should be periodically reminded to not take benzodiazepines, alcohol, diphenhydramine (included in many OTC
medications), other sleep medication, or use other sedating medications.

Patients should be educated on the proper storage and disposal of opioids at the time of the initial prescription and at every visit, as secondary fatalities from misuse and accidental poisonings of children are common.

If an opioids trial is successful and there is a decision to transition to long-term opioids, extended-release/long-acting opioids may be selectively used. Long-acting opioids should be used on a scheduled basis, rather than as needed.[1] As needed opioids should generally be avoided for treatment of chronic pain, although limited use for an acute painful event (e.g., fracture, sprain) is reasonable. Sublingual fentanyl is not recommended for treatment of subacute or chronic pain. Caution is warranted with fentanyl patches due to unpredictable absorption.

Prescription databases (usually referred to as PDMP) should be checked for conflicting opioid prescriptions from other providers or evidence of misreporting.

Due to greater than 10-fold elevated risks of adverse effects and death, considerable caution is warranted among those using other sedating medications and substances including benzodiazepines, anti-histamines (H1-blockers),[109] and/or illicit substances.[105, 109, 167, 168].

Patients should not receive opioids if they use illicit substances unless there is objective evidence of significant trauma or at least moderate to severe injuries.

Considerable caution is also warranted among those who are:
older (>65 yrs.),
pregnant,
sleep apnea,
psychiatric/mental health disorders (anxiety, depression, personality disorder, suicidal),
drug-seeking behavior,
current or past substance abuse,
consuming alcohol in combination with opioids,
renal insufficiency,
hepatic insufficiency, and who are unemployed (10-fold risk of death).[109, 167]

Due to elevated risk of death and adverse effects, caution is also warranted when considering prescribing an opioid for patients with any of the following characteristics: other psychotropic medications, current tobacco use, attention deficit hyperactivity disorder (ADHD), PTSD, impulse control problems, thought disorders, COPD, or recurrent pneumonia.[78, 102, 104, 108, 109, 169-186]

Additional risks and/or adverse effects are thought to be present from other comorbidities such as chronic hepatitis and/or cirrhosis,[187] coronary artery disease, dysrhythmias, cerebrovascular disease, orthostatic hypotension, asthma, thermoregulatory problems, advanced age (especially with mentation issues, balance problems, fall risk, debility), osteopenia, osteoporosis, water retention, severe obesity, testosterone deficiency, erectile dysfunction, abdominal pain, gastroparesis, constipation, prostatic hypertrophy, oligomenorrhea, human immunodeficiency virus (HIV), ineffective birth control, herpes, alldynia, dementia, cognitive dysfunction and impairment, gait problems, tremor, concentration problems, insomnia, coordination problems, and slow reaction time. There are considerable drug-drug interactions that have been reported (see Appendices 2-3).

Attempt to wean twice a year to lower than 90mg MED if patients were previously prescribed those doses.

Frequency/Duration - Opioids use is generally initiated as a “trial” to ascertain whether the selected opioid produces functional improvement. Opioid use is generally prescribed on a regular basis,[218] [1043] at night or when not at work. [82] Only one opioid is recommended to be prescribed in a trial. More than one opioid should rarely be used. Lower opioid doses are preferable as they tend to have the better safety profiles, less risk of dose escalation,[188] less work loss,(112) and faster return to work.[189] [1042] Patients should have ongoing visits to monitor efficacy, improvement in functional status (e.g., return to work), adverse effects, compliance and surreptitious medication use. Opioid prescriptions should be shorter rather than longer duration.[219]

Indications for Discontinuation - Opioids should be discontinued based on lack of functional benefit [115], resolution of pain, improvement to the point of not requiring opioids, intolerance or adverse effects, non-compliance, surreptitious medication use, medication misuse (including self-escalation and sharing medication), aberrant drug screening results, diversion, consumption of medications or substances advised to not take concomitantly (e.g., sedating medications, alcohol, benzodiazepines). (FDA 16: Dasgupta 15)
Harms – Adverse effects are many (see section on “Opioids Benefits and Harms”). May lead to opioid dependency.


Screening Patients Prior to Initiation of Opioids

Recommended.

Screening of patients is recommended prior to initiating a trial of opioids for treatment of subacute or chronic pain. Screening should include history(ies) of depression, anxiety, personality disorder and personality profile,[189, 220, 221] [1042, 1044, 1045] other psychiatric disorder, substance abuse history, sedating medication use (e.g., anti-histamine/anti-H1 blocker), [109] benzodiazepine use, opioid dependence, alcohol abuse, current tobacco use, and other substance use history, COPD, sleep apnea, PTSD, other psychotropic medications, (severe) obesity, cognitive impairment, balance problems/fall risk, osteoporosis, and renal failure (see Appendix 1). Those who screen positive, especially to multiple criteria, are recommended to: i) undergo greater scrutiny for appropriateness of opioids (may include psychological and/or psychiatric evaluation(s) to help assure opioids are not being used instead of appropriate mental health care); ii) consideration of consultation and examination(s) for complicating conditions and/or appropriateness of opioids including by a pain specialist; iii) consultation with an addiction specialist if there is a history of substance use disorder; and iv) if opioids are prescribed, more frequent assessments for compliance, achievement of functional gains, urine drug testing, checks of the prescription drug monitoring database, review of the medical records, and symptoms and signs of aberrant use.

Strength of Evidence - Recommended, Insufficient Evidence (I)

Level of Confidence – High

Harms – Negligible. If a consultation is needed, additional costs are incurred.

Benefits – Identification of patients at increased risk of adverse effects. Improved identification of more appropriate and safe candidates for treatment with opioids. This should reduce adverse effects. In cases where the patient has elevated, but potentially acceptable risk, this may alert the provider to improve surveillance for complications and aberrant behaviors.

Maximum Daily Oral Opioid Dose for Patients with Subacute and Chronic Pain

Recommended.

The maximum daily oral dose recommended for subacute or chronic pain patients based on risk of overdose/death is 50mg MED.[171, 193] [1022, 1046] [1022]. In rare cases with documented functional improvements occurring with use above 50 mg MED, subsequent doses up to 90 mg may be considered (CDC 16), however, risks of death are much greater and more intensive monitoring is then also recommended. Lower doses should be considered in high risk patients. Caution appears warranted in all patients as there is evidence the risk of dose escalation is present even among patients enrolled in a “hold the line (stable dose) prescribing strategy” treatment arm who experienced an approximately 17% increase in dose over 12 months compared with 79% in the liberal escalating dose arm.[222] [1047] Extrapolated linearly, the hold-the-line prescribing strategy would result in average doses over 50mg within approximately 3.5 years while the liberal policy exceeded 50mg in approximately 11 months.

For patients whose daily consumption is more than 50mg MED, greater monitoring is recommended to include: i) at least monthly to not more than quarterly appointments with greater frequencies during trial, dose adjustments and with greater co-morbid risk factors and conditions; ii) at least semiannual attempts to wean below 50mg MED if not off the opioid; iii) at least semiannual documentation of persistence of functional benefit; iv) at least quarterly urine drug testing (see drug testing section); and v) at least semiannual review of medications. particularly to assure no sedating medication use (e.g., benzodiazepine, sedating anti-histamines).
Strength of Evidence – Recommended, Evidence (C)

Level of Confidence – High

Harms – None in a short-term trial. For chronic pain patients, theoretical potential to undertreat pain and thus impair function. However, there is no quality literature currently available to support that position.

Benefits – Reduced risk for adverse effects, dependency, addiction, and opioid-related deaths.

Use of an Opioid Treatment Agreement (Opioid Contract, Doctor/Patient Agreement, Informed Consent) Recommended.

The use of an opioid treatment agreement (opioid contract, doctor/patient agreement, or informed consent) is recommended to document patient education, understanding, acknowledgement of potential benefits, adverse effects, and agreement with the expectations of opioid use (see Appendix 1). [71, 72, 223-233] If consent is obtained, it is recommended that appropriate family members be involved in this agreement.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Moderate

Harms – Negligible.

Benefits – Educates the patient and significant others that these medications are high risk, with numerous adverse effects. It allows for a more informed choice and provides a framework for initiation of a trial, monitoring, treatment goals, compliance requirement, treatment expectations, and conditions for opioid cessation. Should reduce risk of adverse events and opioid-related deaths, although that remains unproven to date.

PHYSICIAN CONTACT

Date of decision/time 12/01/2017/ 0915 hours

Dr Yang’s office was called at the number provided (530-672-1311) on 12/01/2017 at 0915 hours. I identified myself as the physician utilization reviewer for the requests contained herein. A message was left on a voice mail machine with the determination stated in this report. I provided my call back information.

Medical Criteria or Guidelines Used

See MD Rationale.

DETAILED ICD-9/CPT INFORMATION

This request is APPROVED as follows:
ICD: G56.0, carpal tunnel syndrome
Treatment: S5000, Ultram 50mg
Quantity requested: 180.00 APPROVED: 180.00
To start: 12/01/2017 To end: 05/30/2018

ICD: G56.0, carpal tunnel syndrome
Treatment: S5000, Norco 10-325mg
Quantity requested: 90.00 APPROVED: 90.00
To start: 12/01/2017 To end: 05/30/2018

Sincerely.
Distribution:

- (attorney) Carla Castaneda Esq. via (via fax) to (916) 514-5300
- (provider) Michael C. Yang via (via fax) to (530) 672-1335
- (patient) LILA GUTIERREZ via (via mail) to
- (carrier contact) Martin, Michelle via (EDI)

IMPORTANT INFORMATION FROM STATE FUND

Effective January 1, 2017, all authorized ancillary service requests for prescription drugs, durable medical equipment (DME) and supplies, interpreting, transportation, home health, diagnostics and physical therapy must be supplied only through the following State Fund-approved ancillary networks:

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

DME, Interpretation, Transportation, Home Health, Physical Therapy, Diagnostics
Healthesystems (HES)
(877)287-7728

Authorization of medication does not constitute approval to dispense medications from the physician's office. All medications should be filled by an Express Scripts pharmacy. Physicians or injured employees can call (888) 201-5389 for assistance in locating an Express Scripts Network Pharmacy and all, durable medical equipment (DME) and supplies, interpreting transportation, home health, diagnostics, and physical therapy must be supplied by Healthesystems.

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

Effective September 1, 2016 to December 31, 2016 requests for the above mentioned ancillary services must be supplied by Optum or One Call.

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.

L.C. Section 4600.2(a) allows insurers and self-insured employers to contract with a pharmacy benefits network to provide medicines and medical supplies.
# NEUROSURGICAL CERVICAL SPINE FOLLOW UP

## PR-2 REQUEST FOR SURGICAL AUTHORIZATION

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Lila Gutierrez</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of visit:</td>
<td>April 6, 2017</td>
</tr>
<tr>
<td>Referring Physician:</td>
<td>Michael Yang, MD (fax: 530-672-1335)</td>
</tr>
<tr>
<td>Date of Injury:</td>
<td>March 26, 2015</td>
</tr>
<tr>
<td>Workers' Comp Carrier:</td>
<td>SCIF</td>
</tr>
<tr>
<td>Employer:</td>
<td>Employment Development Department, State of California</td>
</tr>
<tr>
<td>Claim #:</td>
<td>06083410</td>
</tr>
<tr>
<td>Adjuster:</td>
<td>Michelle Martin</td>
</tr>
<tr>
<td>UR:</td>
<td>Send to UR</td>
</tr>
<tr>
<td>Attorney:</td>
<td>Carla Sota (fax: 916-514-5300)</td>
</tr>
</tbody>
</table>

**Dear Dr. Yang:**

I had the pleasure of seeing Ms. Lila Gutierrez for a follow up appointment. Her last day of work was April 2015. She was on state disability from April 2015 through May 2016. She was sent back to modified work and willing to go to work in April 2015, however her employer would not accommodate her work restrictions. She has not received work comp benefits to date. She is now retired to retain her health benefits. Social security disability and PERS disability was both denied.

Today, her neck pain is a 7-8/10. It gets as low as a 5/10 and as high as a 9/10. Her entire left arm aches and throbs, but when she grabbing things, her left hand goes numb. There is a tingling buzzing electrical feeling into the left thumb and index finger. There is no pain in the right arm. She has bilateral grip strength weakness claiming to frequently drop objects.

**PHYSICAL EXAMINATION:**

- General: On evaluation, the patient is a well-developed, well nourished, well hydrated female appearing her stated age and in no apparent distress.
- HEENT: Clear.
- Chest: Clear.
- Cardiac: Regular.
- Abdomen: Benign.
- Musculoskeletal: Symmetric.
- Neuromuscular: Cerebral, cerebellar, and cranial nerves intact. Biceps, right 1-2, left 1. Triceps, right 1-2, left 1. Brachioradialis trace. Neck rotation to the right is 60 degrees and to the left is 50 degrees. Flexion is 45 degrees. Neck extension is 30...
degrees. Abduction is 10-15 degrees. There is a mild Spurling's sign into the left arm and shoulder with
rotation and extension. Sensory exam shows right greater than left forearm, thumb, index finger, deltoid, and
middle ring and small finger in the C4-C5-C6-C7 distribution, right greater than left. Motor exam shows
catch/give weakness on the right arm with 80-90% of normal at the right deltoid, biceps, triceps, and hand
intrinsics. Jamar dynamometry: Right is 18, 15, 18; left is 20, 18, 15. Tinel's is positive bilaterally. Forced
flexion is positive bilaterally. Shoulder range of motion is nearly normal bilaterally.

DIAGNOSTIC STUDIES/IMAGES REVIEWED:
CT scan of the cervical spine:
Date of study: March 31, 2017
There is straightening of the cervical lordosis. There is multilevel disc space narrowing and marginal
osteophytic At C4-5, there is posterior spurring with probable minimal posterior disc bulging. There is bilateral
uncovertebral joint hypertrophy with mild left facet arthropathy and mild arthropathy. At C5-6, there is a
posterior disc osteophyte complex narrowing the central canal to a mid sagittal diameter of 8 mm resulting in
mild central canal stenosis. There is also bilateral uncovertebral joint hypertrophy, left greater than the right.

5 view flexion and extension cervical spine x-ray:
Date of study: March 31, 2017
Loss of normal lordosis of the cervical spine. 1 mm anterolisthesis of C2 on C3, C3 on C4 and C4 on C5 noted
in flexion reduces with extension.

ASSESSMENT:
1. C5-C6 stenosis, central and foraminal, with alternating upper extremity radiculopathy.
2. C4-C5 stenosis from disc protrusion, industrial, with central and foraminal stenosis and alternating
   radiculopathy.
3. Borderline stenosis C6-C7, nonsurgical.
4. History of carpal tunnel syndrome.

RECOMMENDATIONS:
At this time, Ms. Gutierrez wishes to pursue surgical intervention; therefore I will request authorization for the
following:
1. C4-C5, C5-C6 anterior cervical fusion.

Once authorized, we will schedule accordingly.

She will follow up with our office in 4 weeks for ongoing care and treatment.

Thank you for allowing me to participate in the care of your patient. It is my pleasure to serve you and your
patients.

I have not violated the Labor Code Section 139.3 and the contents of this report and bill are true and correct
to the best of my knowledge. This statement is made under penalty of perjury. The patient was seen, examined
and counseled by the nurse practitioner. The diagnoses, treatment plans and imaging and work status were
reviewed with the supervising physician.

Respectfully,

Theresa Sanden, N.P.

Roderick Sanden, M.D.

Signature: ______________________________  CA License. G42245
Executed at: Carmichael, CA           Date: April 6, 2017
Name: Roderick Sanden, M.D.          Specialty: Neurosurgery
Address: 3609 Mission Ave, Suite F  Phone: 916-484-4444
   Carmichael, CA 95608
NEUROSURGICAL CERVICAL SPINE FOLLOW UP

PR-2 PROGRESS REPORT

Patient Name: Lila Gutierrez
Date of visit: May 12, 2017

Referring Physician: Michael Yang, MD
(fax: 530-672-1335)

Date of Injury: March 26, 2015
Workers’ Comp Carrier: State Comp Insurance Fund
Employer: Employment Development Department, State of California
Claim #: 06083410

Adjuster: Michelle Martin
Send to UR

UR:
(fax: 707-646-0738)

Attorney: Carla Sota
(fax: 916-514-5300)

Dear Dr. Yang:

I had the pleasure of seeing Ms. Lila Gutierrez for a follow up appointment. Last week, she had a severe flare up. She had a QME last Saturday. This report is pending. A court hearing is pending.

Today, her neck pain is a 7/10. It gets as low as a 5/10 and as high as a 10/10, in the morning when she wakes up or at night when she is trying to sleep. The neck pain is equal on the right and the left. The pain radiates into the left greater than the right, 70% on the left and 30% on the right, with aching in the tricep, top of the forearm, into the left thumb and webspace. The pain radiates down the right arm, but it is less intense. There is a tingling buzzing electrical feeling into the left thumb and index finger with numbness/tingling in both arms, left greater than right, with any arm use. There is bilateral grip strength weakness. She is right handed. She is taking Celebrex 200 mg a day and Gabapentin once a day prescribed by Dr. Michael Yang.

PHYSICAL EXAMINATION:

General: On evaluation, the patient is a well-developed, well nourished, well hydrated female appearing her stated age and in no apparent distress.

HEENT: Clear.
Chest: Clear.
Abdomen: Benign.
Musculoskeletal: Symmetric.
Neurologic: Cerebral, cerebellar, and cranial nerves intact. Biceps, right 1-2, left 1. Triceps, right 1-2, left 1. Brachioradialis trace. Neck rotation to the right is 60 degrees and to the left is 50 degrees. Flexion is 45 degrees. Neck extension is 30.
degrees. Abduction is 10-15 degrees. There is a mild Spurling's sign into the left arm and shoulder with rotation and extension. Sensory exam shows right greater than left forearm, thumb, index finger, deltoid, and middle ring and small finger in the C4-C5-C6-C7 distribution, right greater than left. Motor exam shows catch/give weakness on the right arm with 80-90% of normal at the right deltoid, biceps, triceps, and hand intrinsics. Tinel's is positive bilaterally. Forced flexion is positive bilaterally. Shoulder range of motion is nearly normal bilaterally.

DIAGNOSTIC STUDIES/IMAGES REVIEWED:
None to review at this follow up appointment.

ASSESSMENT:
1. C5-C6 stenosis, central and foraminal, with alternating upper extremity radiculopathy.
2. C4-C5 stenosis from disc protrusion, industrial, with central and foraminal stenosis and alternating radiculopathy.
3. Borderline stenosis C6-C7, nonsurgical
4. History of carpal tunnel syndrome.

RECOMMENDATIONS:
At this time, a C4-C5, C5-C6 anterior cervical fusion was requested and is pending authorization. She will follow up with our office in 4 weeks for ongoing care and treatment.

Work Status:
TTD by PTP.

Thank you for allowing me to participate in the care of your patient. It is my pleasure to serve you and your patients.

I have not violated the Labor Code Section 139.3 and the contents of this report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury. The patient was seen, examined and counseled by the nurse practitioner. The diagnoses, treatment plans and imaging and work status were reviewed with the supervising physician.

Respectfully,

Theresa Sanden, N.P.
Roderick Sanden, M.D.

CA License: G42245
Date: May 12, 2017
Specialty: Neurosurgery
Phone: 916-484-4444
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**DIAGNOSTIC STUDIES/IMAGES REVIEWED:**
None to review at this follow up appointment.

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Respectfully,

Theresa Sanden, N.P.

Roderick Sanden, M.D.

Signature: ________________________________

**Executed at:** Carmichael, CA

**Name:** Roderick Sanden, M.D.

**Address:** 3609 Mission Ave, Suite F
Carmichael, CA 95608

**CA License.** G42245

**Date:** May 12, 2017

**Specialty:** Neurosurgery

**Phone:** 916-484-4444