

RECORDS PROVIDED BY GEMINI

Case Information

STEEVIO BARDAKJIAN vs. OLIVE VIEW MEDICAL CENTER

SSN: 554812130

DOB: 05/23/1970

Case Number: SIF11540526

Claim Number: SIF11540526

Ship To:

Attn: Qualified Med Eval

Record Information

Request Number: 1544098

Copy Date: 01/20/2025

Record Type(s): Medical

Requested Location

Universal Pain Management

28212 Kelly Johnson Pkwy #155

Valencia CA 91355

Verified Location

Universal Pain Management

GABBY / MEDICAL RECORDS

819 Auto Center Dr

Palmdale CA 93551



250 Technology Way, Rocklin, CA 95765

877.739.7481 | clientsupport@gemini.legal



Gemini Legal Support, Inc., a professional photocopier organized and existing under the laws of the State of California has reviewed the attached records and attests that said records consist of 607 pages.

Executed on 01/22/2025, at Rocklin, California.

Respectfully,
Gemini Legal Support, Inc.

'REC-1544098

Records Subject: Steevio Bardadjian Date of Birth: 05/23/1970 SSN: XXX-XX-2130

DECLARATION OF CUSTODIAN OF RECORDSName of records subject: Steevio Bardadjian

I declare as follows pursuant to California Evidence Code sections 1560, 1561:

I am employed by and am the duly authorized custodian of records and am authorized to certify records for:

Universal Pain Management, Gabby / Medical Records**(Facility Name)**

Please be sure to include this Declaration along with the records you are providing to Gemini. Without a completed Declaration, this Subpoena or Authorization has not been fulfilled. If no records are being provided to Gemini, this Declaration is still required.

I certify (Please check all that apply):

- That the accompanying records are true and complete copies of records described in the Subpoena or Authorization. These records were maintained in the regular course and scope of business of the employer stated above and were prepared by authorized personnel. No records, documents or other materials have been withheld except as noted below. I further certify that I have made a diligent, thorough, and complete search of all available sources including the computer databases for both open and closed files whether in-house or in a storage facility or any other location under the control of my employer for any and all items to be produced on the attached subpoena duces tecum or authorization for records subject named above.
- That no records were produced because no records were found for the individual named on the Subpoena or Authorization. Please indicate the reason, if any, as to why records do not exist:

That partial records were produced. Please indicate below which records were not provided from those requested on the attached Subpoena or Authorization:

That all or partial records are located at the following facility:

Facility Name, Address, and Phone Number: _____

Type of Records Located at this Facility: _____

That records were provided to the Applicant Attorney of the case stated on the provided Subpoena or Authorization on _____ (date).

Records were produced in the following manner:

Records were made available to Gemini and/or its affiliate for copying and/or picking up.

Records were mailed/faxed/e-mailed to Gemini at the address listed on the Subpoena or Authorization in compliance with Evidence Code section 1560.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this Declaration is executed on 1/20/25 at Palmdale (city), State of CA.

Printed name required

Signature of custodian required

250 Technology Way | Rocklin, CA 95765
Phone 877-739-7481

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STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

Steevio Bardadjian

Claimant/Applicant,

VS.

**OLIVE VIEW MEDICAL CENTER/
Subsequent Injuries Fund (SIBTF)**

Employer/insurance Carrier/Defendant.

Case No. **SIF11540526**

(IF APPLICATION HAS BEEN FILED, CASE NUMBER
MUST BE INDICATED REGARDLESS OF DATE OF INJURY)

SUBPOENA DUCES TECUM

(When records are mailed, identify them by using above
case number or attaching a copy of subpoena)

Where no application has been filed for injuries on or after
January 1, 1990 and before January 1, 1994, subpoena will
be valid without a case number, but subpoena must be served
on claimant and employer and/or insurance carrier.

See instructions below.*

The People of the State of California Send Greetings to: Universal Pain Management

819 Auto Center Dr Palmdale, CA 93551

Gabby / Medical Records

We COMMAND YOU to appear before: Gemini Legal Support, Inc.

at 250 Technology Way Rocklin CA 95765

on the 28th day of January, 2025 at 4:02 o'clock PM to testify in the above-
entitled matter and to bring with you and produce the following described documents, papers, books and records.

-Please see Attachment 3 for a detailed description of requested records-

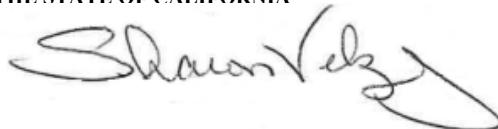
(Do not produce X-rays unless specifically mentioned above.)

For failure to attend as required, you may be deemed guilty of a contempt and liable to pay to the parties aggrieved all losses and damages sustained thereby and forfeit one hundred dollars in addition thereto.

This subpoena is issued at the request of the person making the declaration on the reverse hereof, or on the copy which is served herewith.

Date 12/19/2024

**WORKERS' COMPENSATION APPEALS BOARD
OF THE STATE OF CALIFORNIA**



Secretary, Assistant Secretary, Workers' Compensation Judge

***FOR INJURIES OCCURRING ON OR AFTER JANUARY 1, 1990,
AND BEFORE JANUARY 1, 1994**

If no Application for Adjudication of Claim has been filed, a declaration under penalty of perjury that the Employee's Claim for Workers' Compensation Benefits (Form DWC-1) has been filed pursuant to Labor Code Section 5401 must be executed properly.

**SEE REVERSE SIDE
(SUBPOENA INVALID WITHOUT DECLARATION)**



You may fully comply with this subpoena by mailing the records described (or authenticated copies, Evid. Code 1561) to the person and place stated above within ten (10) days of the date of service of this subpoena.

This subpoena does not apply to any member of the Highway Patrol, Sheriff's Office or city Police Department unless accompanied by notice from this Board that deposit of the witness fee has been made in accordance with Government Code 68097.2, et seq.

DECLARATION FOR SUBPOENA DUCES TECUM

Case No. SIF11540526

STATE OF CALIFORNIA, County of Los Angeles

The undersigned states:

That he /she is (one of) the attorney(s) of record / representative(s) for the applicant/defendant in the action captioned on the reverse hereof. That Universal Pain Management, Gabby / Medical Records

has in his/her possession or under his/her control the documents described on the reverse hereof. That said documents are material to the issues involved in the case for the following reasons:

SAID RECORDS ARE RELEVANT TO THE ALLEGATIONS AND DEFENSES BY THE PARTIES IN THE PROSECUTION OF THIS MATTER, TO PROVIDE AN ACCURATE MEDICAL HISTORY OF THE APPLICANT, TO PROVE AN INJURY AND NOTICE THEREOF, TO PROVIDE THE RIGHT TO COMPENSATION, PERMANENT AND TEMPORARY DISABILITY, MEDICAL TREATMENT, AND ANY POSSIBLE PENALTIES. PURSUANT TO LABOR CODE SECTION 5401 FORM DWC 1 HAS BEEN DULY FILED.

Declaration for Injuries on or After January 1, 1990 and Before January 1, 1994

- That an Employee's Claim for Workers' Compensation Benefits (DWC Form 1) has been filed in accordance with Labor Code Section 5401 by the alleged injured worker whose records are sought, or if the worker is deceased, by the dependent(s) of the decedent, and that a true copy of the form filed is attached hereto. (*Check box if applicable and part of declaration below. See instructions on front of subpoena.*)

I declare under penalty of perjury that the foregoing is true and correct

Executed on 12/19/2024, at VAN NUYS, California.
KOSZDIN FIELDS VAN NUYS
6151 Van Nuys Blvd
Van Nuys CA 91401

/s/ Michael Fields

Signature

Address

818-781-1503

Telephone

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of _____

I, the undersigned, state that I served the foregoing subpoena by showing the original and delivering a true copy thereof, together with a copy of the Declaration in support thereof, to each of the following named persons, personally, at the date and place set forth opposite each name.

Name of Person Served

Date

Place

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I declare under penalty of perjury that the foregoing is true and correct

Executed on _____, at _____, California.

Signature

ATTACHMENT 3

Case Name: vs. OLIVE VIEW MEDICAL CENTER

Case Number: SIF11540526

Records Subject: Steevio Bardadjian

AKA:

Date of Birth: 05/23/1970

Social Security Number: 554-81-2130

Claims #: SIF11540526

Date of Injury: 07/03/2018 -

Employee #:

Records Requested:

Need records from 05/23/1970 - Present

Any and all non-privileged physical, digital and hand-written medical records including records from May 23, 1970 to present, including but not limited to:

1. Both private and industrial records,
2. Doctors note(s)
3. Treatment and evaluation record(s)
4. Nurses note(s)
5. Inpatient and outpatient record(s)
6. Correspondence, lab result(s), diagnostic test result(s)
7. Requests for authorizations (RFAs)
8. Medical and radiology report(s)
9. Phone logs and Sign in sheet(s)
10. Patient note(s)
11. Patient intake form(s)
12. Patient demographics form(s)
13. Physical therapy record(s)
14. Physical therapy progress note(s)
15. Medical history form(s)
16. Occupational records
17. Emergency room records
18. Work Status Report(s)
19. Telephonic recordings
20. Digital appointment recordings
21. Pharmacy and prescription records

MUST INCLUDE RECORDS FROM Universal Pain Management AT 28212 KELLY JOHNSON PKWY
#155, VALENCIA, CA 91355

Ref #: REC-1544098

000005

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address): Michael Fields, Esq. KOSZDIN FIELDS VAN NUYS 6151 Van Nuys Blvd Van Nuys CA 91401 TELEPHONE NO.: 818-781-1503 E-MAIL ADDRESS (Optional): michael@koszdin.com ATTORNEY FOR (Name): Steevio Bardadjan		313679	FOR COURT USE ONLY
SUPERIOR COURT OF CALIFORNIA, COUNTY OF Los Angeles STREET ADDRESS: 6150 Van Nuys Blvd. Rm. 105 MAILING ADDRESS: 6150 Van Nuys Blvd. Rm. 105 CITY AND ZIP CODE: Van Nuys 91401 BRANCH NAME: Workers' Compensation Appeals Board - Van Nuys			
PLAINTIFF/ PETITIONER: Steevio Bardadjan DEFENDANT/ RESPONDENT: OLIVE VIEW MEDICAL CENTER/ Subsequent Injuries Fund (SIBTF)		CASE NUMBER: SIF11540526	
NOTICE TO CONSUMER OR EMPLOYEE AND OBJECTION (Code Civ. Proc., §§ 1985.3,1985.6)			

NOTICE TO CONSUMER OR EMPLOYEE

TO (name): Steevio Bardadjan

1. PLEASE TAKE NOTICE THAT **REQUESTING PARTY (name):** Steevio Bardadjan

SEEKS YOUR RECORDS FOR EXAMINATION by the parties to this action on (*specify date*): 01/28/2025

The records are described in the subpoena directed to **witness** (*specify name and address of person or entity from whom records are sought*): Universal Pain Management GABBY / MEDICAL RECORDS 819 Auto Center Dr Palmdale CA 93551 Palmdale, CA 93551

A copy of the subpoena is attached.

2. IF YOU OBJECT to the production of these records, YOU MUST DO ONE OF THE FOLLOWING BEFORE THE DATE SPECIFIED. IN ITEM a. OR b. BELOW:
- If you are a party to the above-entitled action, you must file a motion pursuant to Code of Civil Procedure section 1987.1 to quash or modify the subpoena and give notice of that motion to the **witness** and the **deposition officer** named in the subpoena at least five days before the date set for production of the records.
 - If you are not a party to this action, you must serve on the **requesting party** and on the **witness**, before the date set for production of the records, a written objection that states the specific grounds on which production of such records should be prohibited. You may use the form below to object and state the grounds for your objection. You must complete the Proof of Service on the reverse side indicating whether you personally served or mailed the objection. The objection should **not** be filed with the court. **WARNING:** IF YOUR OBJECTION IS NOT RECEIVED BEFORE THE DATE SPECIFIED IN ITEM 1, YOUR RECORDS MAY BE PRODUCED AND MAY BE AVAILABLE TO ALL PARTIES.
3. YOU OR YOUR ATTORNEY MAY CONTACT THE UNDERSIGNED to determine whether an agreement can be reached in writing to cancel or limit the scope of the subpoena. If no such agreement is reached, and if you are not otherwise represented by an attorney in this action, YOU SHOULD CONSULT AN ATTORNEY TO ADVISE YOU OF YOUR RIGHTS OF PRIVACY.

Date: 12/19/2024

Michael Fields, Esq.

(TYPE OR PRINT NAME)

► /s/ Michael Fields

(SIGNATURE OF REQUESTING PARTY

ATTORNEY)

OBJECTION BY NON-PARTY TO PRODUCTION OF RECORDS

1. I object to the production of all of my records specified in the subpoena.

2. I object only to the production of the following specified records:

3. The specific grounds for my objection are as follows:

Date:

(TYPE OR PRINT NAME)

(Proof of service on reverse)

(SIGNATURE)

Page 1 of 2

PLAINTIFF/ PETITIONER: Steevio Bardadjan
 DEFENDANT/ RESPONDENT: OLIVE VIEW MEDICAL CENTER/ Subsequent Injuries Fund (SIBTF)

CASE NUMBER:
 SIF11540526

PROOF OF SERVICE OF NOTICE TO CONSUMER OR EMPLOYEE AND OBJECTION
 (Code Civ. Proc., §§ 1985.3,1985.6)

Personal Service Mail

1. At the time of service I was at least 18 years of age and **not a party to this legal action**.
2. I served a copy of the *Notice to Consumer or Employee and Objection* as follows (*check either a or b*):
 - a. **Personal service.** I personally delivered the *Notice to Consumer or Employee and Objection* as follows:

(1) Name of person served:	(3) Date served:
(2) Address where served:	(4) Time served:
 - b. **Mail.** I deposited the *Notice to Consumer or Employee and Objection* in the United States mail, in a sealed envelope with postage fully prepaid. The envelope was addressed as follows:

(1) Name of person served: Michael Fields, Esq.	(3) Date of mailing: 12/19/2024
(2) Address: KOSZDIN FIELDS VAN NUYS 6151 Van Nuys Blvd Van Nuys CA 91401	(4) Place of mailing (<i>city and state</i>): Rocklin, CA

 (5) I am a resident of or employed in the county where the *Notice to Consumer or Employee and Objection* was mailed.
- c. My residence or business address is (*specify*): 250 Technology Way Rocklin CA 95765
- d. My phone number is (*specify*): 877-739-7481

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date: 12/19/2024

Alain Gutierrez
 (TYPE OR PRINT NAME OF PERSON WHO SERVED)


 (SIGNATURE OF PERSON WHO SERVED)

PROOF OF SERVICE OF OBJECTION TO PRODUCTION OF RECORDS
 (Code Civ. Proc., §§ 1985.3,1985.6)

Personal Service Mail

1. At the time of service I was at least 18 years of age and **not a party to this legal action**.
2. I served a copy of the *Objection to Production of Records* as follows (*complete either a or b*):
 - a. **ON THE REQUESTING PARTY**
 - (1) **Personal service.** I personally delivered the *Objection to Production of Records* as follows:

(i) Name of person served:	(iii) Date served:
(ii) Address where served:	(iv) Time served:
 - (2) **Mail.** I deposited the *Objection to Production of Records* in the United States mail, in a sealed envelope with postage fully prepaid. The envelope was addressed as follows:

(i) Name of person served:	(iii) Date of mailing:
(ii) Address:	(iv) Place of mailing (<i>city and state</i>):

 (v) I am a resident of or employed in the county where the *Objection to Production of Records* was mailed.
 - b. **ON THE WITNESS**
 - (1) **Personal service.** I personally delivered the *Objection to Production of Records* as follows:

(i) Name of person served:	(iii) Date served:
(ii) Address where served:	(iv) Time served:
 - (2) **Mail.** I deposited the *Objection to Production of Records* in the United States mail, in a sealed envelope with postage fully prepaid. The envelope was addressed as follows:

(i) Name of person served:	(iii) Date of mailing:
(ii) Address:	(iv) Place of mailing (<i>city and state</i>):

 (v) I am a resident of or employed in the county where the *Objection to Production of Records* was mailed.
3. My residence or business address is (*specify*):
4. My phone number is (*specify*):

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

(TYPE OR PRINT NAME OF PERSON WHO SERVED)


 (SIGNATURE OF PERSON WHO SERVED)

Case No.: **SIF11540526**

Case Name: **vs. OLIVE VIEW MEDICAL CENTER**

Notice of Service

I am employed in the county of Placer. I am over the age of eighteen years and not a party to the above entitled action. My business address is 250 Technology Way Rocklin, CA 95765

Documents Served: Subpoena Duces Tecum, Declaration for Subpoena Duces Tecum, Attachment 3

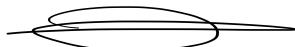
On 12/19/2024, the foregoing documents were prepared for service on each interested party in this action and addressed as follows:

Delivered to	Sent to	Method
Michael Fields, Esq.	KOSZDIN FIELDS VAN NUYS michael@koszdin.com	Email
Subsequent Injuries Fund (SIBTF)	Subsequent Injuries Fund (SIBTF) 1750 HOWE AVE SUITE 370 SACRAMENTO, CA 95825	Mail
od legal	od legal 1515 Clay Street Ste 701 Oakland, CA 94612	Mail

I am familiar with Gemini Legal Support, Inc.'s practice of collection and processing correspondence. Under that practice for mail, it will be delivered, same day, via digital delivery to our vendor Kubra who will deposit it with the U.S. Postal Service on the same day with postage thereon fully prepaid in Gardena, California, in the ordinary course of business.

I declare under the penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on 12/19/2024, at Rocklin, California.



Alain Gutierrez

000008



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSOCIATE PROFESSOR AT USC

FRANCIS X. RIEGLER, M.D.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY

RAY H d'AMOURS, M.D.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY

DANIEL ALVES, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND PM&R

KEVIN KOHAN, D.O., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND PM&R
ASSISTANT CLINICAL PROFESSOR AT USC

ARVINDER GILL, D.O., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY

ROHIT CHOUDHARY M.D., Q.M.E
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY

ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

RE: Bardakjian, Steevio

SEX: Male

DATE OF BIRTH: 05-23-1970

CHART NO: UPM49961

VISIT DATE: 08-01-2024 :

REFERRING PHYSICIAN:

Pain Management Initial Evaluation Note:

The following is an initial comprehensive pain management report performed at PALMDALE , 819 Auto Center Drive, Palmdale CA 93551 - 4599.

Current Complaints: TAIL BONE and Hip pain

History of Present Illness

Patient is a 54-year-old male with history of diabetes hypertension who presents to clinic for consultation evaluation and treatment of her right hip pain and tailbone pain. He is known to me since he has a Worker's Comp. Case for his lumbar spine he has micro disc of 4 and L4-5 and a Worker's Comp. Case has denied him for his hip and his tailbone pain and therefore he comes to us for evaluation of these parts of the body. The patient admits to progressive onset of pain that initiated in the right hip since 2018 and tailbone pain since 2022. The patient reports the pain is aching stinging soreness constant and excruciating in nature. The pain is increased with the cold weather changes and certain times of movement including sleep and walking. The pain is better with heat and lying down. The patient has Artie tried that therapies without any improvement of the pain. The patient is interested in the siphon the etiology of the pain in proceeding with potential interventions. The patient denies any bowel or bladder incontinence or perianal anesthesia.

***Initial Symptoms Scales:**

The patient reports that their pain with medications is a 3 on a scale of 0-10. The patient reports that their pain without medications is a 9 on a scale of 0-10. Pain at present is 6 on the pain scale. **Pain Descriptors:** Location of pain is at lower back, right hip pain. He has been experiencing this pain since r-hip 2018, and 2022. Patient describes his pain as aching, constant, excruciating, sore and stinging.

Current Medication

Iosartan 25 mg tablet TAKE 1 TABLET BY MOUTH ONCE DAILY for 30 Days , Prescribe 30 Each
Jardiance 10 mg tablet TAKE 1 TABLET BY MOUTH ONCE DAILY for 30 Days , Prescribe 30 Each
metformin ER 500 mg tablet,extended release 24 hr TAKE 2 TABLETS BY MOUTH TWICE DAILY WITH MEALS for 90 Days , Prescribe 360 Each
Movantik 25 mg tablet 1 Once a Day for 30 Days , Prescribe 30 Tablet
Crestor
Percocet
Zoloft

"Previous Pain Medications and Effects:"

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()
High Blood Pressure ()
Heart Disease ()
Bowel Problems ()

Social and Family History:

GENERAL: The patient has completed college.

Social History: The patient does not use tobacco. He does not drink alcohol. He does not have Medical Marijuana Card. The patient did not have problem with abusing drugs or alcohol. *There are family member(s) documented with serious illness.* Illness Description: hx of t2d and cad with older brother. Patient does not take or is not on anticoagulants. He spends his time during the day by home laying down. The patient has never been convicted for abuse/possession of narcotics. The patient is not on disability currently. He has not travelled out of country recently. The patient has not been exposed to any toxins. Marital Status: married. Patient reports that he suffered from work related injury and also had required medical care for that injury. It occurred on 07/03/2018. He reports that he did not suffer an auto accident or other injury that resulted in a personal injury lawsuit.

Review of Systems

Skin (Integumentary): Denies rash or itching.

Heme-Immuno: Denies fever, chills, easy bruising or bleeding or HIV or AIDS. There is no swollen glands or cancer.

ENT: Denies change in hearing or sore throat.

Respiratory: Denies cough, shortness of breath, bronchitis or tuberculosis. There is no coughing up blood.

Gastro-Intestinal: Denies nausea, vomiting, diarrhea, blood in stool or constipation. There is no loss of bowel control.

Neurological: Reports *numbness*.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight.

Genito-urinary: Denies blood in urine, pain on urination or loss of bladder control. There is no kidney problems.

Eyes: Denies blurry vision or loss of vision.

Musculoskeletal: Denies weakness or osteoporosis.

Endocrine: Denies diabetes or hypothyroidism.

The remainder of the review of systems is negative as described in detail in the Patient Intake Packet.

Physical Examination

Vitals:

On a scale of 1 to 10 the pain level is 8. Height (inches): 71.00 Weight (lbs): 212.00 **BP:** 155/83 mm Hg. **Pulse:** 100 per min. **SpO2:** 98.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Abdomen: The abdomen is soft, with no masses palpated, no rebound, rigidity or tenderness.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. The patient's gait appears to be antalgic.*

Neurological: Cranial nerves II to XII grossly intact.

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness in the right lower extremity*

Neurology - Sensation: UE Sensation grossly intact . LE Sensation intact except for Decreased in the right lower extremity.

Neurology - Deep Tendon Reflexes: Deep Tendon Reflexes are intact throughout.

Patient has severe tailbone pain to palpation.

There is pain with internal and external rotation of the right hip area

PAIN MANAGEMENT

- Opioid Risk Tool
- Oswestry Disability Index

Psychological testing (96130) was performed because the patient was referred for pain management

treatment and the patient demonstrated symptoms which results in the loss of function and a decrease in activities of daily living. 45 minutes were spent on the administration and interpretation of the results.

Impression:

Patient is a 54-year-old male with a history of L3 or L4-5 microdiscectomy and secondary pain in the lower extremity that developed in 2018 and 2022 in the hip and in the tailbone respectively the patient pain has been progressively getting worse difficulty with sitting and groin pain. The patient needs imaging and appropriate intervention.

Important to note that the patient has been denied for the right right hip and the tailbone pain through Worker's Comp.

ICD Codes: Coccydynia (M53.3), Right hip pain (M25.551)

Treatment Plan:

I will order MRA of the right hip as the patient has severe right hip and joint pain and also MRI of the coccyx to rule out any tumors as the patient has severe recalcitrant pain in these parts of the body and has failed conservative modes of management.

For the tailbone pain since the patient has failed multiple conservative management including therapy medications based on imaging will proceed with a ganglion impar injection

I recommended lidocaine ointment as well as diclofenac gel/lidocaine

Follow Up after: 1 Month

Encounter Addendum Notes



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 08-01-2024.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSOCIATE PROFESSOR AT USC

FRANCIS X. RIEGLER, M.D.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY

RAY H d'AMOURS, M.D.
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BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY

ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

Name: Bardakjian, Steevio
DOB: 05-23-1970
MR# UPM49961
Date of Service: 08-01-2024

Oswestry Disability Exam

Pain Intensity: 3- The pain is fairly severe at the moment.

Personal Care (eg. washing, dressing): 3 - I need some help but can manage most of my personal care.

Lifting: 4 - I can only lift very light weights.

Walking: 4 - I can only walk using a stick or crutches.

Sitting: 4 - Pain prevents me from sitting more than 10 minutes.

Standing: 4 - Pain prevents me from standing for more than 10 minutes.

Sleeping: 3 - Because of pain I have less than 4 hours sleep.

Sex Life (if applicable): 4 - My sex life is nearly absent because of pain.

Social Life: 5 - I have no social life because of pain.

Travelling: 4 - Pain restricts me to short necessary journeys under 30 minutes.

Total Score: 38.

Index For Measurement :

- 0% to 20%: Minimal disability
- 21%-40%: Moderate Disability
- 41%-60%: Severe Disability
- 61%-80%: Crippling back pain
- 81%-100%: These patients are either bed-bound or have an exaggeration of their symptoms.



Kevin Kohan D.O.

This has been electronically signed by Kevin Kohan D.O. on 08-01-2024.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

Name: Bardakjian, Steevio
DOB: 05-23-1970
MR# UPM49961
Date of Service: 08-01-2024

Opioid Risk Tool

1. Family History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
2. Personal History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
3. Age (if 16-45)		0
4. History of Preadolescent Sexual Abuse		
5. Psychological Disease	Attention Deficit Disorder	0
	Obsessive Compulsive Disorder	
	Bipolar	
	Schizophrenia	
	Depression	0
	TOTAL	0

Total Score Risk Category

Low Risk 0-3

Moderate Risk 4-7

High Risk > or equal to 8



Kevin Kohan D.O.

This has been electronically signed by Kevin Kohan D.O. on 08-01-2024.

7/23/24, 3:37 PM

XR SHOULDER LEFT 2 + VW**Bardakjian, Steevio**MRN: 20010145699, Sex Assigned at Birth: Male, 5/23/1970 (54 yrs), Outpatient
Accession #: 61823583PRV**Facey Medical Group**with  Providence**Final Result****XR SHOULDER LEFT 2 + VW**

REASON FOR EXAM: left shoulder pain M25.512: Pain in left shoulder

COMPARISON: None.

FINDINGS: The bones demonstrate normal mineralization. No acute fracture or dislocation is identified. There are no significant degenerative changes. The soft tissues are unremarkable.

Impression

IMPRESSION:

Negative exam.

Electronically signed by: Bradley Hatfield, MD on 7/9/2024 9:30 AM PDT

Signed by Bradley David Hatfield, MD on 7/9/2024 9:30 AM

Appointment Info

Exam Date

 7/9/2024

Department

PROVIDENCE FACEY VALENCIA VSC XRAY

 661-481-2400 23803 McBean Pkwy

Valencia CA 91355-2001

Reason for Exam

left shoulder pain

Providers

PCP

Sabrina Shadekamyan, MD

 661-222-2658 26357 MCBEAN PKWY

STE 205

VALENCIA CA 91355

Ordering Provider

Salf Usman, MD

 661-481-2400

000017

Jul/24/2024 2:32:01 AM

Facey 661-222-2660

14/20

7/23/24, 3:37 PM

23803 MCBEAN PKWY STE 101
VALENCIA CA 91355

000018

7/23/24, 3:37 PM

Facey Medical GroupWith  Providence**XR SHOULDER RIGHT 2 + VW****Bardakjian, Steevio**

MRN: 20010145699, Sex Assigned at Birth: Male, 5/23/1970 (54 yrs), Outpatient

Accession #: 61823582PRV

Final Result**XR SHOULDER RIGHT 2 + VW**

REASON FOR EXAM: Rt shoulder pain M25.511: Pain in right shoulder

COMPARISON: 6/24/2024

FINDINGS: The bones demonstrate normal mineralization. No acute fracture or dislocation is identified. There is glenohumeral and acromioclavicular joint space narrowing and osteophyte formation. The soft tissues are unremarkable.

Impression

IMPRESSION:

Right shoulder osteoarthritis. No acute abnormality.

Electronically signed by: Bradley Hatfield, MD on 7/9/2024 9:29 AM PDT

Signed by Bradley David Hatfield, MD on 7/9/2024 9:29 AM

Appointment Info

Exam Date

 7/9/2024

Department

PROVIDENCE FACEY VALENCIA VSC XRAY

 661-481-2400 23803 McBean Pkwy

Valencia CA 91355-2001

Reason for Exam

Rt shoulder pain

Providers

PCP

Sabrina Shadekamyan, MD

 661-222-2658 26357 MCBEAN PKWY

STE 205

VALENCIA CA 91355

Ordering Provider

Saif Usman, MD

 661-481-2400

000019

Jul/24/2024 2:32:01 AM

7/23/24, 3:37 PM

Facey 661-222-2660

16/20

📍 23803 MCBEAN PKWY STE 101
VALENCIA CA 91355

000020



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DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	EVLIN MAKHANI
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	01-03-2025

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

- | | | |
|--|--|--|
| (XX) Periodic Report | (<input type="checkbox"/>) Change in Treatment Plan | (<input type="checkbox"/>) Release from Care |
| (<input type="checkbox"/>) Change in Work Status | (<input type="checkbox"/>) Need for Referral or Consultation | (<input type="checkbox"/>) Response to Release for Information |
| (<input type="checkbox"/>) Change in Patient Condition | (<input type="checkbox"/>) Need for Surgery or Hospitalization | (<input type="checkbox"/>) Request for Authorization |
| (<input type="checkbox"/>) Other | | |

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints

Low Back Pain

History of Injury :

54-year-old male with chronic low back pain and right knee pain due to work-related injury

Patient has a history of lumbar spinal surgery with postlaminectomy syndrome

Low back pain radiates to right ankle with prolonged standing, walking or sitting. Patient has to pace himself to prevent exacerbations of pain.

He is able to perform activities of daily living independently and with less discomfort with the assistance of the medications.

Right knee pain is achy and sore with weight bearing activities. He is status post knee arthroscopic surgery for torn meniscus. Pain improved after surgery.

The patient completed physical therapy a few weeks ago and continues a home exercise program. The combination of medications, rest and therapy to keep him functional.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

ADLs/ subjective functional improvement from baseline:40 %.

Functional Objective Improvement: Patient is able to perform activities such as grooming with the aid of the medications/wife helps

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

Acupuncture

An updated pain agreement is present on file.

There is 30 % of improvement with medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

****Interval F/U***

Scales:

The patient reports that their pain with medications is a 6 on a scale of 0-10. The patient reports that their pain without medications is a 9 on a scale of 0-10. Pain at present is 7 on the pain scale.

Pain Descriptors: Location of pain is at Low back pain. Current Pain Changes : no changes. Patient describes his pain as throbbing. Following factors increase the pain: movement and walking. Following factors decrease the pain: lying down.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Other: No.

Other Studies/Recent Hospitalizations:

no er or uc visits.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

right knee surgery: 05-04-2024

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Physical Examination

NO VITALS DUE TO TELEMEDICINE

PE limited, telemed visit; Patient speaking in full clear coherent sentences and answering questions appropriately

PA-C

- UDS

Review of Medical Records:

The most recent urine drug screen was done on 11-07-2024. It is consistent with the medicines prescribed at that time, including the presence of oxycodone and/or metabolites. The CURES database was reviewed. It shows no evidence of doctor shopping. The patient is currently using THC, which is considered legal in the state of California, along with other medications. Patient was advised that combining marijuana and opioid medications has the risk to suppress the central nervous system and can result in decreased brain function, low blood pressure, extreme sedation, coma, and death. In addition, studies have shown that the use of marijuana increases the abuse potential for opioids.

Cannabinoids detected

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

The most recent urine drug screen was done on 11-07-2024. It is consistent with the medicines prescribed at that time, including the presence of oxycodone and/or metabolites. The CURES database was reviewed. It shows no evidence of doctor shopping. The patient is currently using THC, which is considered legal in the state of California, along with other medications. Patient was advised that combining marijuana and opioid medications has the risk to suppress the central nervous system and can result in decreased brain function, low blood pressure, extreme sedation, coma, and death. In addition, studies have shown that the use of marijuana increases the abuse potential for opioids.

Cannabinoids detected

Treatment Plan:

--UDS to be done prior to the next visit.

Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction, and/or other aberrant drug-related behavior, and to guide treatment. The frequency of random testing is determined by an individualized opioid risk a score which is based upon the patient's individual medical history, and the type and quantity of drugs prescribed. If the results of the definitive drug test are inconsistent, which could result in the patient being denied medication refills counseled for aberrant behavior, recommended for detoxification, or terminated from this practice.

The patient understands that the medications will not be sent next month until the patient presents for a urine drug screening prior to the next visit.

Patient wants to continue with medication management as it provides significant functional improvement.

UDS 8/24 + oxycodone and THC

Continue wtih medication management.

AME doctor ordered Dr. Lee woods - MRA of the knee done -However was negative the patient is given follow-up with orthopedic surgeon for potential hyaluronate one time Orthovisc injection

--UDS to be done prior to the next visit.

Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction, and/or other aberrant drug-related behavior, and to guide treatment. The frequency of random testing is determined by an individualized opioid risk a score which is based upon the patient's individual medical history, and the type and quantity of drugs prescribed. If the results of the definitive drug test are inconsistent, which could result in the patient being denied medication refills counseled for aberrant behavior, recommended for detoxification, or terminated from this practice.

The patient understands that the medications will not be sent next month until the patient presents for a urine drug screening prior to the next visit.

Urine drug screening 8/2024 was reviewed noted to be consistent with prescribed medication of oxycodone and THC which we do not prescribe the patient.

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring Frist in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in

the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

Chronic Pain Management and Treatment Services CPM

A comprehensive patient centered care plan is being established through this visit to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit their functional decline and improve clinical outcomes. A range of biopsychosocial factors including Numerical Rating Scale and or Visual Analog Scale, Opioid Risk Tool, and ODI (Oswestry Disability Index) will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. For crisis of care will be provided through medication and counseling support. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome. More than 30 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan, therefore we are appropriately billing a G3002.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,

Neisy Alvarez, PA-C

Shahin Sadik, M.D., Q.M.E.

DISCLOSURE:

The patient was interviewed by the above-signed Nurse Practitioner/Physician Assistant/Physician under the direction and guidance of the signing Physician. The physical examination was performed by the Nurse Practitioner/Physician under the direction and supervision of the Physician. The dictation was prepared by the Nurse Practitioner/Physician, including any and all impressions and conclusions described in the discussion,

and were discussed and reviewed with the Physician. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the above signed Nurse Practitioner/Physician under the direction and guidance of the signing physician and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Workers Compensation legislation (Labor Code 4628(j):"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 I have indicated I have received from others. As to that information, the signing Nurse Practitioner/Physician and Physician declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): "Neither the signing Physician or Nurse Practitioner/Physician have violated Labor Code section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Shahin Sadik, M.D., Q.M.E.

This has been electronically signed by Shahin Sadik, M.D., Q.M.E. on 01-03-2025.



SHAHIN A. SADIK, M.D., Q.M.E.
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DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	EVLIN MAKHANI
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	12-05-2024

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

- | | | |
|--|--|--|
| (XX) Periodic Report | (<input type="checkbox"/> Change in Treatment Plan | (<input type="checkbox"/> Release from Care |
| (<input type="checkbox"/> Change in Work Status | (<input type="checkbox"/> Need for Referral or Consultation | (<input type="checkbox"/> Response to Release for Information |
| (<input type="checkbox"/> Change in Patient Condition | (<input type="checkbox"/> Need for Surgery or Hospitalization | (<input type="checkbox"/> Request for Authorization |
| (<input type="checkbox"/> Other | | |

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints

Low back pain

History of Injury :

54 year old male presents for follow up visit of the patient for low back and knee pains. Patient was seen via telemedicine ID under visual the patient denies any changes. Patient wants to proceed with conservative modes of management at this point and tells me on a non-industrial basis seeing doctors at Casey in having a hip injection which was not successful which confirms that all the pain is stemming from the lumbar spine at this point.

The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen. Movantik medication is helping with opioid-induced constipation

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U**

Scales:

The patient reports that their pain with medications is a 6 on a scale of 0-10. The patient reports that their pain without medications is a 8 on a scale of 0-10. Pain at present is 6 on the pain scale.

Pain Descriptors: Location of pain is at Low back pain. Current Pain Changes : no changes. Patient describes his pain as constant. Following factors increase the pain: movement and walking. Following factors decrease the pain: sleep, rest and lying down.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No. Location: mri right knee (advanced imaging).

Myelogram: No.

Other: No.

Other Studies/Recent Hospitalizations:

no er or uc visits.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation

or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

NO VITALS TELEMED

General: The patient is well developed and well-nourished. Patient is alert and oriented.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

We are prescribing controlled substances. The most recent urine drug screen was done on 11-07-2024. The CURES database was reviewed. It shows no evidence of doctor shopping.

Legal Status:

Primary Treating Physician: Philip Conwissar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 11-07-2024. The CURES database was reviewed. It shows no evidence of doctor shopping.

Treatment Plan:

Patient wants to continue with medication management as it provides significant functional improvement.

UDS 8/24 + oxycodone and THC

Continue with medication management.

AME doctor ordered Dr. Lee woods - MRA of the knee done -However was negative the patient is given

follow-up with orthopedic surgeon for potential hyaluronate one time Orthovisc injection

--UDS to be done prior to the next visit.

Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction, and/or other aberrant drug-related behavior, and to guide treatment. The frequency of random testing is determined by an individualized opioid risk a score which is based upon the patient's individual medical history, and the type and quantity of drugs prescribed. If the results of the definitive drug test are inconsistent, which could result in the patient being denied medication refills counseled for aberrant behavior, recommended for detoxification, or terminated from this practice.

The patient understands that the medications will not be sent next month until the patient presents for a urine drug screening prior to the next visit.

Urine drug screening 8/2024 was reviewed noted to be consistent with prescribed medication of oxycodone and THC which we do not prescribe the patient.

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring Frist in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the

risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

Chronic Pain Management and Treatment Services CPM

A comprehensive patient centered care plan is being established through this visit to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit their functional decline and improve clinical outcomes. A range of biopsychosocial factors including Numerical Rating Scale and or Visual Analog Scale, Opioid Risk Tool, and ODI (Oswestry Disability Index) will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. For crisis of care will be provided through medication and counseling support. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome. More than 30 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan, therefore we are appropriately billing a G3002.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 90 Tablet

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed by the above-signed Nurse Practitioner/Physician Assistant/Physician under the direction and guidance of the signing Physician. The physical examination was performed by the Nurse

Practitioner/Physician under the direction and supervision of the Physician. The dictation was prepared by the Nurse Practitioner/Physician, including any and all impressions and conclusions described in the discussion, and were discussed and reviewed with the Physician. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the above signed Nurse Practitioner/Physician under the direction and guidance of the signing physician and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Workers Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, the signing Nurse Practitioner/Physician and Physician declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): "Neither the signing Physician or Nurse Practitioner/Physician have violated Labor Code section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 130975	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER SANDOVAL,RICHARD	RECEIVED DATE 11/20/2024	COLLECTION DATE 11/07/2024		REPORTED 11/21/2024 18:50 PST	
COMMENT IMMUNOASSAY SCREENING					Page 1 of 1

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Movantik, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
SPECIMEN VALIDITY TESTING (1)					
CREATININE	81		NORMAL	>=20	mg/dL
pH	5.8		NORMAL	4.7-7.8	
SPECIFIC GRAVITY	1.013		NORMAL	1.003-1.035	g/mL
OXIDANT	-4		NORMAL	<=200	ug/mL
TOXICOLOGY SCREEN (1)					
AMPHETAMINES	NEGATIVE		NORMAL	500	ng/mL
BARBITURATES	NEGATIVE		NORMAL	200	ng/mL
BENZODIAZEPINES	NEGATIVE		NORMAL	200	ng/mL
BUPRENORPHINE	NEGATIVE		NORMAL	5	ng/mL
COCAINE	NEGATIVE		NORMAL	300	ng/mL
CANNABINOIDS	POSITIVE		HIGH	50	ng/mL
ETHANOL	NEGATIVE		NORMAL	100	ng/mL
FENTANYL	NEGATIVE		NORMAL	2	ng/mL
EDDP (METHADONE METABOLITE)	NEGATIVE		NORMAL	300	ng/mL
OPIATES	NEGATIVE		NORMAL	300	ng/mL
OXYCODONE	POSITIVE		HIGH	100	ng/mL
	**See LC/MS/MS for confirmation				
PHENCYCLIDINE	NEGATIVE		NORMAL	25	ng/mL
MDMA (ECSTACY)	NEGATIVE		NORMAL	500	ng/mL
METHAMPHETAMINE	NEGATIVE		NORMAL	500	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



A Comprehensive Approach to Pain and Rehabilitation

**Summary of Findings
UNIVERSAL PAIN MANAGEMENT**

819 Auto Center Drive

Palmdale, CA 93551

Phone: (661) 267-6876 x156

Lab Director - Earl Weissman, PhD

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF # 130976	Patient ID 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER SANDOVAL,RICHARD	RECEIVED DATE 11/07/2024	COLLECTION DATE 11/07/2024	REPORTED DATE 11/25/2024 08:38	

CONSISTENT RESULTS - REPORTED MEDICATION (PARENT DRUG AND/OR METABOLITE) DETECTED

REPORTED PRESCRIPTION	ANTICIPATED POSITIVE(S)	TEST OUTCOME	DETECTION WINDOW
Percocet	OXYMORPHONE	POSITIVE	
Percocet	OXYCODONE	POSITIVE	

ADDITIONAL MEDICATIONS REPORTED BUT NOT TESTED FOR IN THIS REPORT

Crestor,Calcium,Ferrous Sulfate,Diltiazem,Vitamin D,Aspirin,Movantik

000038

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 130976	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER SANDOVAL,RICHARD	RECEIVED DATE 11/20/2024	COLLECTION DATE 11/07/2024		REPORTED 11/25/2024 08:38 PST	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening	Page 1 of 2				

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Movantik, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
ILLCIT DRUG CONFIRMATION - LC/MS/MS (1)					
6-MONOACETYL MORPHINE (Metabolite)	NEGATIVE		NORMAL	10	ng/mL
BENZOYLECGONINE	NEGATIVE		NORMAL	50	ng/mL
METHAMPHETAMINE	NEGATIVE		CONSISTENT	100	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	50	ng/mL
OPIATES/OPIOIDS CONFIRMATION - LC/MS/MS (1)					
CODEINE	NEGATIVE		CONSISTENT	50	ng/mL
MORPHINE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROMORPHONE	NEGATIVE		CONSISTENT	50	ng/mL
NORHYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
OXYCODONE	703	POSITIVE	CONSISTENT	50	ng/mL
OXYMORPHONE	459	POSITIVE	CONSISTENT	50	ng/mL
MEPERIDINE	NEGATIVE		CONSISTENT	50	ng/mL
TAPENTADOL	NEGATIVE		CONSISTENT	50	ng/mL
FENTANYL	NEGATIVE		CONSISTENT	5.0	ng/mL
O-DESMETHYL-CIS-TRAMADOL	NEGATIVE		CONSISTENT	50	ng/mL
METHADONE CONFIRMATION - LC/MS/MS (1)					
EDDP	NEGATIVE		CONSISTENT	50	ng/mL
BUPRENORPHINE CONFIRMATION - LC/MS/MS (1)					
BUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
NORBUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
BENZODIAZEPINES CONFIRMATION - LC/MS/MS (1)					
ALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
ALPHA-HYDROXYALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
7-AMINO-CLONAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
NORDIAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
OXAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
TEMAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
LORAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
PSYCHOTROPICS CONFIRMATION - LC/MS/MS (1)					
NORTRIPTYLINE	NEGATIVE		CONSISTENT	50	ng/mL
ZOLPIDEM	NEGATIVE		CONSISTENT	5.0	ng/mL
MUSCLE RELAXANTS CONFIRMATION - LC/MS/MS (1)					
MEPROBAMATE	NEGATIVE		CONSISTENT	50	ng/mL
CYCLOBENZAPRINE CONFIRMATION - LC/MS/MS (1)					
CYCLOBENZAPRINE	NEGATIVE		CONSISTENT	50	ng/mL
GABAPENTIN CONFIRMATION - LC/MS/MS (1)					
GABAPENTIN	NEGATIVE		CONSISTENT	50	ng/mL
PREGABALIN CONFIRMATION - LC/MS/MS (1)					
PREGABALIN	NEGATIVE		CONSISTENT	50	ng/mL

000039

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 130976	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER SANDOVAL,RICHARD	RECEIVED DATE 11/20/2024	COLLECTION DATE 11/07/2024		REPORTED 11/25/2024 08:38 PST	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening					Page 2 of 2

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Movantik, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
STIMULANTS CONFIRMATION - LC/MS/MS (1)					
AMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
MDMA	NEGATIVE		NORMAL	50	ng/mL
MDA	NEGATIVE		NORMAL	50	ng/mL
MDEA	NEGATIVE		NORMAL	50	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	EVLIN MAKHANI
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	11-05-2024

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

- | | | |
|--|--|--|
| (XX) Periodic Report | (<input type="checkbox"/> Change in Treatment Plan | (<input type="checkbox"/> Release from Care |
| (<input type="checkbox"/> Change in Work Status | (<input type="checkbox"/> Need for Referral or Consultation | (<input type="checkbox"/> Response to Release for Information |
| (<input type="checkbox"/> Change in Patient Condition | (<input type="checkbox"/> Need for Surgery or Hospitalization | (<input type="checkbox"/> Request for Authorization |
| (<input type="checkbox"/> Other | | |

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints

Low back pain tele

History of Injury :

This is a telemed visit done by audio/visual with patient consent.

54 year old male presents for follow up visit of the patient for low back and knee pains.

Patient reports pain remains stable and unchanged since last visit.

The patient admits the knee and low back is plateauing and there is no changes. The patient is interested mainly to continue medication management. He denies any interval changes. The patient tells me unfortunately was unable to get the medication and after researching that the patient found out that the adjuster had changed. The patient has placed the low back and mainly monitoring and medication management as he tells me he is running to some medical issues that he is taking care of.

Only lumbar spine is accepted by the port at this point. The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management. The patient reports meaningful benefit from the current pain medication regimen. He is currently taking percocet 10mg BID #60. Movantik medication is helping with opioid-induced constipation

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

ADLs/ subjective functional improvement from baseline:40 %.

Functional Objective Improvement: Patient is able to perform activities such as grooming with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER. wife helps

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

Conservative treatment has not been tried for more than 3 months.

An updated pain agreement is present on file.

There is 30 % of improvement with medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U**

Scales:

The patient reports that their pain with medications is a 6 on a scale of 0-10. The patient reports that their pain without medications is a 8 on a scale of 0-10. Pain at present is 8 on the pain scale.

Pain Descriptors: Location of pain is at Low back pain. Current Pain Changes : no changes. Patient describes his pain as constant. Following factors increase the pain: movement and walking. Following factors decrease the pain: sleep, rest and lying down.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Other: No.

Other Studies/Recent Hospitalizations:

no er or uc visits.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()
High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO
L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea or GI upset. Reports *constipation* managed with medications. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

No vitals telemed

PE limited, telemed visit; Patient speaking in full clear coherent sentences and answering questions appropriately

PAIN MANAGEMENT

- UDS

Review of Medical Records:

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. There are no signs of doctor shopping noted.

UDS 8/2024 consistent with medications prescribed of oxycodone. Positive THC which is illegal in the state of California but not prescribed from this office

We are prescribing controlled substances. The most recent urine drug screen was done on 08-14-2024. *It is consistent with the medicines prescribed at that time, including the presence of oxycodone and/or metabolites. THC is legal in the state of California but not prescribed by our clinic.* The CURES database was reviewed. It shows no evidence of doctor shopping.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwiser MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 08-14-2024. *It is consistent with the medicines prescribed at that time, including the presence of oxycodone and/or metabolites. THC is legal in the state of California but not prescribed by our clinic.* The CURES database was reviewed. It shows no evidence of doctor shopping.

Treatment Plan:

UDS 8/24 + oxycodone and THC

Continue with medication management.

Patient will follow up with Facey medical physician Dr. Lowe

Patient has had hip x-rays -+ Demonstrated the worsening joint arthritis and impingement-It was unknown if this will be added to the Worker's Comp. Case the patient was recommended to follow through with the primary insurance

AME doctor ordered Dr. Lee woods - MRA of the knee done -However was negative the patient is given follow-up with orthopedic surgeon for potential hyaluronate one time Orthovisc injection

--UDS to be done prior to the next visit.

Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction, and/or other aberrant drug-related behavior, and to guide treatment. The frequency of random testing is determined by an individualized opioid risk score which is based upon the patient's individual medical history, and the type and quantity of drugs prescribed. If the results of the definitive drug test are inconsistent, which could result in the patient being denied medication refills counseled for aberrant behavior, recommended for detoxification, or terminated from this practice.

The patient understands that the medications will not be sent next month until the patient presents for a urine drug screening prior to the next visit.

Urine drug screening 8/2024 was reviewed noted to be consistent with prescribed medication of oxycodone and THC which we do not prescribe the patient.

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the

patient is thinking of retiring Frist in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

Chronic Pain Management and Treatment Services CPM

A comprehensive patient centered care plan is being established through this visit to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit their functional decline and improve clinical outcomes. A range of biopsychosocial factors including Numerical Rating Scale and or Visual Analog Scale, Opioid Risk Tool, and ODI (Oswestry Disability Index) will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. For crisis of care will be provided through medication and counseling support. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome. More than 30 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan, therefore we are appropriately billing a G3002.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 90 Tablet

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,

Solanda Lee, PA-C



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed by the above-signed Nurse Practitioner/Physician Assistant/Physician under the direction and guidance of the signing Physician. The physical examination was performed by the Nurse Practitioner/Physician under the direction and supervision of the Physician. The dictation was prepared by the Nurse Practitioner/Physician, including any and all impressions and conclusions described in the discussion, and were discussed and reviewed with the Physician. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the above signed Nurse Practitioner/Physician under the direction and guidance of the signing physician and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Workers Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, the signing Nurse Practitioner/Physician and Physician declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): "Neither the signing Physician or Nurse Practitioner/Physician have violated Labor Code section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 11-05-2024.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSOCIATE PROFESSOR AT USC

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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	EVLIN MAKHANI
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	10-07-2024

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

- | | | |
|--|--|--|
| (XX) Periodic Report | (<input type="checkbox"/> Change in Treatment Plan | (<input type="checkbox"/> Release from Care |
| (<input type="checkbox"/> Change in Work Status | (<input type="checkbox"/> Need for Referral or Consultation | (<input type="checkbox"/> Response to Release for Information |
| (<input type="checkbox"/> Change in Patient Condition | (<input type="checkbox"/> Need for Surgery or Hospitalization | (<input type="checkbox"/> Request for Authorization |
| (<input type="checkbox"/> Other | | |

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints

Low back pain

History of Injury :

54 year old male presents for follow up visit of the patient for low back and knee pains. The patient admits the knee and low back is plateauing and there is no changes. The patient is interested mainly to continue medication management. He denies any interval changes. The patient tells me unfortunately was unable to get the medication and after researching that the patient found out that the adjuster had changed. The patient has placed the low back and mainly monitoring and medication management as he tells me he is running to some medical issues that he is taking care of.

Only lumbar spine is accepted by the port at this point. The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen. Movantik medication is helping with opioid-induced constipation

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee

surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U**

Scales: Pain at present is 8 on the pain scale.

Pain Descriptors: Location of pain is at Low back pain. Patient describes his pain as constant.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No. Location: mri right knee (advanced imaging).

Myelogram: No.

Other: No.

Other Studies/Recent Hospitalizations:

no er or uc visits.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

No vitals due to telemed

General: The patient is well developed and well-nourished. Patient is alert and oriented.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

We are prescribing controlled substances. The most recent urine drug screen was done on 08-14-2024. The CURES database was reviewed. It shows no evidence of doctor shopping.

Legal Status:

Primary Treating Physician: Philip Conwisar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 08-14-2024. The CURES database was reviewed. It shows no evidence of doctor shopping.

Treatment Plan:

UDS 8/24 + oxycodone and THC

Continue wtih medication mangaement.

Patient will follow up with Facey medical physician Dr. Lowe

Patient has had hip x-rays -+ Demonstrated the worsening joint arthritis and impingement-I was unknown if this will be added to the Worker's Comp. Case the patient was recommended to follow through with the primary insurance

AME doctor ordered Dr. Lee woods - MRA of the knee done -However was negative the patient is given follow-up with orthopedic surgeon for potential hyaluronate one time Orthovisc injection

Urine drug screening February 2024 was reviewed noted to be consistent with prescribed medication of oxycodone and THC which we do not prescribe the patient.

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring Frist in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

Chronic Pain Management and Treatment Services CPM

A comprehensive patient centered care plan is being established through this visit to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit their functional decline and improve clinical outcomes. A range of biopsychosocial factors including Numerical Rating Scale and or Visual Analog Scale, Opioid Risk Tool, and ODI (Oswestry Disability Index) will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. For crisis of care will be provided through medication and counseling support. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome. More than 30 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan, therefore we are appropriately billing a G3002.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to

continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 90 Tablet

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed by the above-signed Nurse Practitioner/Physician Assistant/Physician under the

direction and guidance of the signing Physician. The physical examination was performed by the Nurse Practitioner/Physician under the direction and supervision of the Physician. The dictation was prepared by the Nurse Practitioner/Physician, including any and all impressions and conclusions described in the discussion, and were discussed and reviewed with the Physician. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the above signed Nurse Practitioner/Physician under the direction and guidance of the signing physician and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Workers Compensation legislation (Labor Code 4628(j):"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 I have indicated I have received from others. As to that information, the signing Nurse Practitioner/Physician and Physician declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): "Neither the signing Physician or Nurse Practitioner/Physician have violated Labor Code section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

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*Signed in Los Angeles County, California
By*



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DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	09-09-2024

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

- | | | |
|--|--|--|
| (XX) Periodic Report | (<input type="checkbox"/> Change in Treatment Plan | (<input type="checkbox"/> Release from Care |
| (<input type="checkbox"/> Change in Work Status | (<input type="checkbox"/> Need for Referral or Consultation | (<input type="checkbox"/> Response to Release for Information |
| (<input type="checkbox"/> Change in Patient Condition | (<input type="checkbox"/> Need for Surgery or Hospitalization | (<input type="checkbox"/> Request for Authorization |
| (<input type="checkbox"/> Other | | |

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints

Low back pain

History of Injury :

54 year old male presents for follow up visit of the patient for low back and knee pains. The patient admits the knee and low back is plateauing and there is no changes. The patient is interested mainly to continue medication management. He denies any interval changes. He is running to some stop blocks with his Facey case. The patient tells me at this point having different cases and going with face is producing psammoma confusion the patient understands needing to proceed with injections and MRA and the patient will proceed with this after insurance is corrected.

OIC is better under control with the movantik.

Only lumbar spine is accepted by the port at this point. The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U**

Scales: Pain at present is 8 on the pain scale.

Pain Descriptors: Location of pain is at Low back and knee pain. Patient describes his pain as constant.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No. Location: mri right knee (advanced imaging).

Myelogram: No.

Other: No.

Other Studies/Recent Hospitalizations:

no er or uc visits.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal.

PAIN MANAGEMENT

- UDS

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

UDS 8/24 + oxycodone and THC

Patient will follow up with Facey medical physician Dr. Lowe

Patient has had hip x-rays -+ Demonstrated the worsening joint arthritis and impingement-I was unknown if this will be added to the Worker's Comp. Case the patient was recommended to follow through with the primary insurance

AME doctor ordered Dr. Lee woods - MRA of the knee done -However was negative the patient is given follow-up with orthopedic surgeon for potential hyaluronate one time Orthovisc injection

Urine drug screening February 2024 was reviewed noted to be consistent with prescribed medication of oxycodone and THC which we do not prescribe the patient.

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring Frist in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

Chronic Pain Management and Treatment Services CPM

A comprehensive patient centered care plan is being established through this visit to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit their functional decline and improve clinical outcomes. A range of biopsychosocial factors including Numerical Rating Scale and or Visual Analog Scale, Opioid Risk Tool, and ODI (Oswestry Disability Index) will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. For crisis of care will be provided through medication and counseling support. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome. More than 30 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan, therefore we are appropriately billing a G3002.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to

continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 90 Tablet

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed by the above-signed Nurse Practitioner/Physician Assistant/Physician under the

direction and guidance of the signing Physician. The physical examination was performed by the Nurse Practitioner/Physician under the direction and supervision of the Physician. The dictation was prepared by the Nurse Practitioner/Physician, including any and all impressions and conclusions described in the discussion, and were discussed and reviewed with the Physician. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the above signed Nurse Practitioner/Physician under the direction and guidance of the signing physician and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Workers Compensation legislation (Labor Code 4628(j):"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 I have indicated I have received from others. As to that information, the signing Nurse Practitioner/Physician and Physician declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): "Neither the signing Physician or Nurse Practitioner/Physician have violated Labor Code section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



A Comprehensive Approach to Pain and Rehabilitation

**Summary of Findings
UNIVERSAL PAIN MANAGEMENT**

819 Auto Center Drive

Palmdale, CA 93551

Phone: (661) 267-6876 x156

Lab Director - Earl Weissman, PhD

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF # 126288	Patient ID 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 08/14/2024	COLLECTION DATE 08/14/2024	REPORTED DATE 08/28/2024 07:41	

CONSISTENT RESULTS - REPORTED MEDICATION (PARENT DRUG AND/OR METABOLITE) DETECTED

REPORTED PRESCRIPTION	ANTICIPATED POSITIVE(S)	TEST OUTCOME	DETECTION WINDOW
Percocet	OXYMORPHONE	POSITIVE	
Percocet	OXYCODONE	POSITIVE	

ADDITIONAL MEDICATIONS REPORTED BUT NOT TESTED FOR IN THIS REPORT

Crestor,Calcium,Ferrous Sulfate,Diltiazem,Vitamin D,Aspirin,Movantik

000066

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 126288	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 08/26/2024	COLLECTION DATE 08/14/2024		REPORTED 08/28/2024 07:41 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening	Page 1 of 2				

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Movantik, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
ILLCIT DRUG CONFIRMATION - LC/MS/MS (1)					
6-MONOACETYL MORPHINE (Metabolite)	NEGATIVE		NORMAL	10	ng/mL
BENZOYLECGONINE	NEGATIVE		NORMAL	50	ng/mL
METHAMPHETAMINE	NEGATIVE		CONSISTENT	100	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	50	ng/mL
OPIATES/OPIOIDS CONFIRMATION - LC/MS/MS (1)					
CODEINE	NEGATIVE		CONSISTENT	50	ng/mL
MORPHINE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROMORPHONE	NEGATIVE		CONSISTENT	50	ng/mL
NORHYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
OXYCODONE	467	POSITIVE	CONSISTENT	50	ng/mL
OXYMORPHONE	779	POSITIVE	CONSISTENT	50	ng/mL
MEPERIDINE	NEGATIVE		CONSISTENT	50	ng/mL
TAPENTADOL	NEGATIVE		CONSISTENT	50	ng/mL
FENTANYL	NEGATIVE		CONSISTENT	5.0	ng/mL
O-DESMETHYL-CIS-TRAMADOL	NEGATIVE		CONSISTENT	50	ng/mL
METHADONE CONFIRMATION - LC/MS/MS (1)					
EDDP	NEGATIVE		CONSISTENT	50	ng/mL
BUPRENORPHINE CONFIRMATION - LC/MS/MS (1)					
BUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
NORBUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
BENZODIAZEPINES CONFIRMATION - LC/MS/MS (1)					
ALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
ALPHA-HYDROXYALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
7-AMINO-CLONAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
NORDIAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
OXAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
TEMAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
LORAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
PSYCHOTROPICS CONFIRMATION - LC/MS/MS (1)					
NORTRIPTYLINE	NEGATIVE		CONSISTENT	50	ng/mL
ZOLPIDEM	NEGATIVE		CONSISTENT	5.0	ng/mL
MUSCLE RELAXANTS CONFIRMATION - LC/MS/MS (1)					
MEPROBAMATE	NEGATIVE		CONSISTENT	50	ng/mL
CYCLOBENZAPRINE CONFIRMATION - LC/MS/MS (1)					
CYCLOBENZAPRINE	NEGATIVE		CONSISTENT	50	ng/mL
GABAPENTIN CONFIRMATION - LC/MS/MS (1)					
GABAPENTIN	NEGATIVE		CONSISTENT	50	ng/mL
PREGABALIN CONFIRMATION - LC/MS/MS (1)					
PREGABALIN	NEGATIVE		CONSISTENT	50	ng/mL

000067

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 126288	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 08/26/2024	COLLECTION DATE 08/14/2024		REPORTED 08/28/2024 07:41 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening					Page 2 of 2

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Movantik, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
STIMULANTS CONFIRMATION - LC/MS/MS (1)					
AMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
MDMA	NEGATIVE		NORMAL	50	ng/mL
MDA	NEGATIVE		NORMAL	50	ng/mL
MDEA	NEGATIVE		NORMAL	50	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 126287	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 08/26/2024	COLLECTION DATE 08/14/2024		REPORTED 08/27/2024 18:31 PDT	
COMMENT IMMUNOASSAY SCREENING					Page 1 of 1

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Movantik, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
SPECIMEN VALIDITY TESTING (1)					
CREATININE	96		NORMAL	>=20	mg/dL
pH	5.4		NORMAL	4.7-7.8	
SPECIFIC GRAVITY	1.015		NORMAL	1.003-1.035	g/mL
OXIDANT	-23		NORMAL	<=200	ug/mL
TOXICOLOGY SCREEN (1)					
AMPHETAMINES	NEGATIVE		NORMAL	500	ng/mL
BARBITURATES	NEGATIVE		NORMAL	200	ng/mL
BENZODIAZEPINES	NEGATIVE		NORMAL	200	ng/mL
BUPRENORPHINE	NEGATIVE		NORMAL	5	ng/mL
COCAINE	NEGATIVE		NORMAL	300	ng/mL
CANNABINOIDS	POSITIVE		HIGH	50	ng/mL
CARISOPRODOL	NEGATIVE		NORMAL	100	ng/mL
ETHANOL	NEGATIVE		NORMAL	100	ng/mL
FENTANYL	NEGATIVE		NORMAL	2	ng/mL
EDDP (METHADONE METABOLITE)	NEGATIVE		NORMAL	300	ng/mL
OPIATES	NEGATIVE		NORMAL	300	ng/mL
OXYCODONE	POSITIVE		HIGH	100	ng/mL
**See LC/MS/MS for confirmation					
PHENCYCLIDINE	NEGATIVE		NORMAL	25	ng/mL
MDMA (ECSTACY)	NEGATIVE		NORMAL	500	ng/mL
METHAMPHETAMINE	NEGATIVE		NORMAL	500	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	08-12-2024

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	() Change in Treatment Plan	() Release from Care
() Change in Work Status	() Need for Referral or Consultation	() Response to Release for Information
() Change in Patient Condition	() Need for Surgery or Hospitalization	(X) Request for Authorization
() Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

54 year old male presents for follow up visit of the patient for low back and knee pains. The patient admits the knee and low back is plateauing and there is no changes. The patient is interested mainly to continue medication management the patient reports following up with face 8 doctors in order to proceed with imaging through them.

The patient will allow have a referral with Dr. Lowell who is the pain management doctor patient has been trying to see us in the regular insurance for the hip but unfortunately been unable to be seen. He has had x-rays are really done demonstrating worsening arthritis. The patient has impingement and osteoarthritis. The patient was recommended to come into the office to be seen in the alternative insurance and the patient expresses understanding and patient will try to do this or go see Dr. Lowe.

The patient reports having MRA of the knee and reviewed it with Dr. Conwisar who has convinced the patient that the MR arthrogram did not show any significant pathology.

The patient is continuing to take care of the wife. The patient denies any side effects from the medications. AME doctor has recommended the MRA of the knee. The patient is happy with the progress that wife is having. The patient reports as far pain goes she is doing better.

He is also dealing with increased right knee pain secondary to work-related injury -The patient reports colder weather can be more painful but trying to get medication management. The patient trying to also get new insurance that has been also a very frustrating process.

OIC is better under control with the movantik.

Only lumbar spine is accepted by the port at this point. The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 6 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No. Location: mri right knee (advanced imaging).

Myelogram: No.

Other: No.

Other Studies/Recent Hospitalizations:

no er or uc visits.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO
L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

Height (inches): 71.00 Weight (lbs): 205.00 **BP:** 148/92 mm Hg. **Pulse:** 103 per min. **Sp02:** 98.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Abdomen: The abdomen is soft, with no masses palpated, no rebound, rigidity or tenderness.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. Straight leg raise on the right:: positive. Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.*

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness of the right L3-4 and L4-5*

Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: *Deep Tendon Reflexes are intact throughout except Decrease right knee reflex 1+ Pain with right hip motion*

Tenderness of the lumbar spine

PAIN MANAGEMENT

- UDS

Review of Medical Records:

We are prescribing controlled substances. The most recent urine drug screen was done on 05-31-2024. The CURES database was reviewed. It shows no evidence of doctor shopping.

Legal Status:

Primary Treating Physician: Philip Conwisar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 05-31-2024. The CURES database was reviewed. It shows no evidence of doctor shopping.

Treatment Plan:

* Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction and/or other aberrant drug-related behavior, to guide treatment. The frequency of random testing is determined by an individualized opioid risk score which is based upon the patient's individual medical history, and the type and dosage of drugs prescribed.

If the results of the definitive drug test are inconsistent, it could result in the patient being denied medication refills, counseled for aberrant behavior, recommended for detoxification or terminated from this practice.

Patient will follow up with Facey medical physician Dr. Lowe

Patient has had hip x-rays -+ Demonstrated the worsening joint arthritis and impingement-I was unknown if this will be added to the Worker's Comp. Case the patient was recommended to follow through with the primary insurance

UDS 4/24 + oxycodone and THC

AME doctor ordered Dr. Lee woods - MRA of the knee done -However was negative the patient is given follow-up with orthopedic surgeon for potential hyaluronate one time Orthovisc injection

Urine drug screening February 2024 was reviewed noted to be consistent with prescribed medication of oxycodone and THC which we do not prescribe the patient.

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring first in the future and then proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

Chronic Pain Management and Treatment Services CPM

A comprehensive patient centered care plan is being established through this visit to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit their functional decline and improve clinical outcomes. A range of biopsychosocial factors including Numerical Rating Scale and or Visual Analog Scale, Opioid Risk Tool, and ODI (Oswestry Disability Index) will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. For crisis of care will be provided through medication and counseling support. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome. More than 30 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan, therefore we are appropriately billing a G3002.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and

hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and/or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6-month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet
Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSOCIATE PROFESSOR AT USC

FRANCIS X. RIEGLER, M.D.
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RAY H d'AMOURS, M.D.
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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	07-15-2024

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

- | | | |
|--|--|--|
| (XX) Periodic Report | (<input type="checkbox"/> Change in Treatment Plan | (<input type="checkbox"/> Release from Care |
| (<input type="checkbox"/> Change in Work Status | (<input type="checkbox"/> Need for Referral or Consultation | (<input type="checkbox"/> Response to Release for Information |
| (<input type="checkbox"/> Change in Patient Condition | (<input type="checkbox"/> Need for Surgery or Hospitalization | (<input type="checkbox"/> Request for Authorization |
| (<input type="checkbox"/> Other | | |

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints

Low back and knee pain

History of Injury :

Today's visit was completed via Telemedicine Audio and or visual with the permission of the patient for low back and knee pains. The patient is a 54-year-old male who presents for low back pain and reports that the pain is about the same. The patient will allow have a referral with Dr. Lowell who is the pain management doctor patient has been trying to see us in the regular insurance for the hip but unfortunately been unable to be seen. He has had x-rays are really done demonstrating worsening arthritis. The patient has impingement and osteoarthritis. The patient was recommended to come into the office to be seen in the alternative insurance and the patient expresses understanding and patient will try to do this or go see Dr. Lowe.

The patient reports having MRA of the knee and reviewed it with Dr. Conwisar who has convinced the patient that the MR arthrogram did not show any significant pathology.

The patient is continuing to take care of the wife. The patient denies any side effects from the medications. AME doctor has recommended the MRA of the knee. The patient is happy with the progress that wife is having. The patient reports as far pain goes she is doing better.

He is also dealing with increased right knee pain secondary to work-related injury -The patient reports colder weather can be more painful but trying to get medication management. The patient trying to also get new insurance that has been also a very frustrating process.

OIC is better under control with the movantik.

Only lumbar spine is accepted by the port at this point. The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U**

Scales: Pain at present is 6 on the pain scale.

Pain Descriptors: Location of pain is at Low back and knee pain. Patient describes his pain as constant.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: Yes. Location: mri right knee (advanced imaging).

Myelogram: No.

Other: No.

Other Studies/Recent Hospitalizations:

no er or uc visits.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

No vitals due to telemed

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

We are prescribing controlled substances. The most recent urine drug screen was done on 05-31-2024. The CURES database was reviewed. It shows no evidence of doctor shopping.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 05-31-2024. The CURES database was reviewed. It shows no evidence of doctor shopping.

Treatment Plan:

Patient will follow up with Facey medical physician Dr. Lowe

Patient has had hip x-rays -+ Demonstrated the worsening joint arthritis and impingement-I was unknown if this will be added to the Worker's Comp. Case the patient was recommended to follow through with the primary insurance

UDS 4/24 + oxycodone and THC

AME doctor ordered Dr. Lee woods - MRA of the knee done -However was negative the patient is given follow-up with orthopedic surgeon for potential hyaluronate one time Orthovisc injection

Urine drug screening February 2024 was reviewed noted to be consistent with prescribed medication of oxycodone and THC which we do not prescribe the patient.

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring first in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

Long Term Goals:

This Comprehensive Chronic Care management (CCM) (Workers Compensation)

Treatment plan is being established to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit this functional decline and improve clinical outcomes. A range of biopsychosocial factors will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome.

CCM (99490)

More than 20 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan over the prior calendar month.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's

significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed by the above-signed Nurse Practitioner/Physician Assistant/Physician under the direction and guidance of the signing Physician. The physical examination was performed by the Nurse Practitioner/Physician under the direction and supervision of the Physician. The dictation was prepared by the Nurse Practitioner/Physician, including any and all impressions and conclusions described in the discussion, and were discussed and reviewed with the Physician. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the above signed Nurse Practitioner/Physician under the direction and guidance of the signing physician and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Workers Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, the signing Nurse Practitioner/Physician and Physician declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): "Neither the signing Physician or Nurse Practitioner/Physician have violated Labor Code section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California
By



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSOCIATE PROFESSOR AT USC

FRANCIS X. RIEGLER, M.D.
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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	06-14-2024

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

- | | | |
|--|--|--|
| (XX) Periodic Report | (<input type="checkbox"/>) Change in Treatment Plan | (<input type="checkbox"/>) Release from Care |
| (<input type="checkbox"/>) Change in Work Status | (<input type="checkbox"/>) Need for Referral or Consultation | (<input type="checkbox"/>) Response to Release for Information |
| (<input type="checkbox"/>) Change in Patient Condition | (<input type="checkbox"/>) Need for Surgery or Hospitalization | (<input type="checkbox"/>) Request for Authorization |
| (<input type="checkbox"/>) Other | | |

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints

Low back and knee pain

History of Injury :

Today's visit was completed via Telemedicine Audio and or visual with the permission of the patient for low back and knee pains. The patient is a 53-year-old male who presents for low back pain and reports that The pain is about the same. The patient Endorses having new x-rays of the hip by a primary treating physician who has demonstrated that the patient has worsening of arthritis over having gained osteophytes and potential impingement and osteoarthritis. However the patient has been recommended to follow through with the treatment of these problems with primary care doctor is Worker's Comp. Case likely coming 20 per patient. She admits that medications do provide for improvement in functioning. He would like to have refills today.

The patient reports having MRA of the knee and reviewed it with Dr. Conwisar who has convinced the patient that the MR arthrogram did not show any significant pathology.

The patient is continuing to take care of the wife. The patient denies any side effects from the medications. AME doctor has recommended the MRA of the knee. The patient is happy with the progress that wife is having. The patient reports as far pain goes she is doing better.

He is also dealing with increased right knee pain secondary to work-related injury -The patient reports colder weather can be more painful but trying to get medication management. The patient trying to also get new insurance that has been also a very frustrating process.

OIC is better under control with the movantik.

Only lumbar spine is accepted by the port at this point. The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U**

Scales: Pain at present is 7 on the pain scale.

Pain Descriptors: Location of pain is at Low back and knee pain. Patient describes his pain as constant.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO
L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

We are prescribing controlled substances. The most recent urine drug screen was done on 05-31-2024.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 05-31-2024.

Treatment Plan:

Patient has had hip x-rays -+ Demonstrated the worsening joint arthritis and impingement-I was unknown if this will be added to the Worker's Comp. Case the patient was recommended to follow through with the primary insurance

UDS 4/24 + oxycodone and THC

AME doctor ordered Dr. Lee woods - MRA of the knee done -However was negative the patient is given follow-up with orthopedic surgeon for potential hyaluronate one time Orthovisc injection

Urine drug screening February 2024 was reviewed noted to be consistent with prescribed medication of oxycodone and THC which we do not prescribe the patient.

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring Frist in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

Long Term Goals:

This Comprehensive Chronic Care management (CCM) (Workers Compensation)

Treatment plan is being established to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit this functional decline and improve clinical outcomes. A range of biopsychosocial factors will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome.

CCM (99490)

More than 20 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan over the prior calendar month.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 90 Tablet

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed by the above-signed Nurse Practitioner/Physician Assistant/Physician under the direction and guidance of the signing Physician. The physical examination was performed by the Nurse Practitioner/Physician under the direction and supervision of the Physician. The dictation was prepared by the Nurse Practitioner/Physician, including any and all impressions and conclusions described in the discussion, and were discussed and reviewed with the Physician. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the above signed Nurse Practitioner/Physician under the direction and guidance of the signing physician and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Workers Compensation legislation (Labor Code 4628(j):"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 I have indicated I have received from others. As to that information, the signing Nurse Practitioner/Physician and Physician declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): "Neither the signing Physician or Nurse Practitioner/Physician have violated Labor Code section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California
By

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 122491	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER ALVAREZ,NEISY	RECEIVED DATE 06/11/2024	COLLECTION DATE 05/31/2024	REPORTED 06/14/2024 10:34 PDT		
COMMENT IMMUNOASSAY SCREENING					Page 1 of 1

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Movantik, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
SPECIMEN VALIDITY TESTING (1)					
CREATININE	81	NORMAL	>=20		mg/dL
pH	5.3	NORMAL	4.7-7.8		
SPECIFIC GRAVITY	1.010	NORMAL	1.003-1.035		g/mL
OXIDANT	-12	NORMAL	<=200		ug/mL
TOXICOLOGY SCREEN (1)					
AMPHETAMINES	NEGATIVE	NORMAL	500		ng/mL
BARBITURATES	NEGATIVE	NORMAL	200		ng/mL
BENZODIAZEPINES	NEGATIVE	NORMAL	200		ng/mL
BUPRENORPHINE	NEGATIVE	NORMAL	5		ng/mL
COCAINE	NEGATIVE	NORMAL	300		ng/mL
CANNABINOIDS	POSITIVE	HIGH	50		ng/mL
CARISOPRODOL	NEGATIVE	NORMAL	100		ng/mL
ETHANOL	NEGATIVE	NORMAL	100		ng/mL
FENTANYL	NEGATIVE	NORMAL	2		ng/mL
EDDP (METHADONE METABOLITE)	NEGATIVE	NORMAL	300		ng/mL
OPIATES	NEGATIVE	NORMAL	300		ng/mL
OXYCODONE	POSITIVE	HIGH	100		ng/mL
**See LC/MS/MS for confirmation					
PHENCYCLIDINE	NEGATIVE	NORMAL	25		ng/mL
MDMA (ECSTACY)	NEGATIVE	NORMAL	500		ng/mL
METHAMPHETAMINE	NEGATIVE	NORMAL	500		ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



Summary of Findings
UNIVERSAL PAIN MANAGEMENT
819 Auto Center Drive
Palmdale, CA 93551
Phone: (661) 267-6876 x156
Lab Director - Earl Weissman, PhD

PATIENT NAME BARDAKJIAN, STEEVIO		LAB REF # 122492	Patient ID 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER ALVAREZ,NEISY	RECEIVED DATE 05/31/2024	COLLECTION DATE 05/31/2024		REPORTED DATE 06/14/2024 21:08	

CONSISTENT RESULTS - REPORTED MEDICATION (PARENT DRUG AND/OR METABOLITE) DETECTED

REPORTED PRESCRIPTION	ANTICIPATED POSITIVE(S)	TEST OUTCOME	DETECTION WINDOW
Percocet	OXYMORPHONE	POSITIVE	
Percocet	OXYCODONE	POSITIVE	

ADDITIONAL MEDICATIONS REPORTED BUT NOT TESTED FOR IN THIS REPORT

Crestor,Calcium,Ferrous Sulfate,Diltiazem,Vitamin D,Aspirin,Movantik

000096

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 122492	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER ALVAREZ, NEISY	RECEIVED DATE 06/11/2024	COLLECTION DATE 05/31/2024		REPORTED 06/14/2024 21:08 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening	Page 1 of 2				

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Movantik, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
ILLCIT DRUG CONFIRMATION - LC/MS/MS (1)					
6-MONOACETYL MORPHINE (Metabolite)	NEGATIVE		NORMAL	10	ng/mL
BENZOYLECGONINE	NEGATIVE		NORMAL	50	ng/mL
METHAMPHETAMINE	NEGATIVE		CONSISTENT	100	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	50	ng/mL
OPIATES/OPIOIDS CONFIRMATION - LC/MS/MS (1)					
CODEINE	NEGATIVE		CONSISTENT	50	ng/mL
MORPHINE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROMORPHONE	NEGATIVE		CONSISTENT	50	ng/mL
NORHYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
OXYCODONE	356	POSITIVE	CONSISTENT	50	ng/mL
OXYMORPHONE	478	POSITIVE	CONSISTENT	50	ng/mL
MEPERIDINE	NEGATIVE		CONSISTENT	50	ng/mL
TAPENTADOL	NEGATIVE		CONSISTENT	50	ng/mL
FENTANYL	NEGATIVE		CONSISTENT	5.0	ng/mL
O-DESMETHYL-CIS-TRAMADOL	NEGATIVE		CONSISTENT	50	ng/mL
METHADONE CONFIRMATION - LC/MS/MS (1)					
EDDP	NEGATIVE		CONSISTENT	50	ng/mL
BUPRENORPHINE CONFIRMATION - LC/MS/MS (1)					
BUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
NORBUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
BENZODIAZEPINES CONFIRMATION - LC/MS/MS (1)					
ALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
ALPHA-HYDROXYALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
7-AMINO-CLONAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
NORDIAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
OXAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
TEMAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
LORAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
PSYCHOTROPICS CONFIRMATION - LC/MS/MS (1)					
NORTRIPTYLINE	NEGATIVE		CONSISTENT	50	ng/mL
ZOLPIDEM	NEGATIVE		CONSISTENT	5.0	ng/mL
MUSCLE RELAXANTS CONFIRMATION - LC/MS/MS (1)					
MEPROBAMATE	NEGATIVE		CONSISTENT	50	ng/mL
CYCLOBENZAPRINE CONFIRMATION - LC/MS/MS (1)					
CYCLOBENZAPRINE	NEGATIVE		CONSISTENT	50	ng/mL
GABAPENTIN CONFIRMATION - LC/MS/MS (1)					
GABAPENTIN	NEGATIVE		CONSISTENT	50	ng/mL
PREGABALIN CONFIRMATION - LC/MS/MS (1)					
PREGABALIN	NEGATIVE		CONSISTENT	50	ng/mL

000097



A Comprehensive Approach to Pain and Rehabilitation

Final Report UNIVERSAL PAIN MANAGEMENT

819 Auto Center Drive

Palmdale, CA 93551

Phone: (661) 267-6876 x156

Lab Director - Earl Weissman PhD

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 122492	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER ALVAREZ,NEISY	RECEIVED DATE 06/11/2024	COLLECTION DATE 05/31/2024		REPORTED 06/14/2024 21:08 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening					Page 2 of 2

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Movantik, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
STIMULANTS CONFIRMATION - LC/MS/MS (1)					
AMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
MDMA	NEGATIVE		NORMAL	50	ng/mL
MDA	NEGATIVE		NORMAL	50	ng/mL
MDEA	NEGATIVE		NORMAL	50	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



Summary of Findings
UNIVERSAL PAIN MANAGEMENT
819 Auto Center Drive
Palmdale, CA 93551
Phone: (661) 267-6876 x156
Lab Director - Earl Weissman, PhD

PATIENT NAME BARDAKJIAN, STEEVIO		LAB REF # 122492	Patient ID 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER ALVAREZ,NEISY	RECEIVED DATE 05/31/2024	COLLECTION DATE 05/31/2024		REPORTED DATE 06/14/2024 21:08	

CONSISTENT RESULTS - REPORTED MEDICATION (PARENT DRUG AND/OR METABOLITE) DETECTED

REPORTED PRESCRIPTION	ANTICIPATED POSITIVE(S)	TEST OUTCOME	DETECTION WINDOW
Percocet	OXYMORPHONE	POSITIVE	
Percocet	OXYCODONE	POSITIVE	

ADDITIONAL MEDICATIONS REPORTED BUT NOT TESTED FOR IN THIS REPORT

Crestor,Calcium,Ferrous Sulfate,Diltiazem,Vitamin D,Aspirin,Movantik

000099

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 122492	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER ALVAREZ, NEISY	RECEIVED DATE 06/11/2024	COLLECTION DATE 05/31/2024		REPORTED 06/14/2024 21:08 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening	Page 1 of 2				

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Movantik, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
ILLCIT DRUG CONFIRMATION - LC/MS/MS (1)					
6-MONOACETYL MORPHINE (Metabolite)	NEGATIVE		NORMAL	10	ng/mL
BENZOYLECGONINE	NEGATIVE		NORMAL	50	ng/mL
METHAMPHETAMINE	NEGATIVE		CONSISTENT	100	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	50	ng/mL
OPIATES/OPIOIDS CONFIRMATION - LC/MS/MS (1)					
CODEINE	NEGATIVE		CONSISTENT	50	ng/mL
MORPHINE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROMORPHONE	NEGATIVE		CONSISTENT	50	ng/mL
NORHYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
OXYCODONE	356	POSITIVE	CONSISTENT	50	ng/mL
OXYMORPHONE	478	POSITIVE	CONSISTENT	50	ng/mL
MEPERIDINE	NEGATIVE		CONSISTENT	50	ng/mL
TAPENTADOL	NEGATIVE		CONSISTENT	50	ng/mL
FENTANYL	NEGATIVE		CONSISTENT	5.0	ng/mL
O-DESMETHYL-CIS-TRAMADOL	NEGATIVE		CONSISTENT	50	ng/mL
METHADONE CONFIRMATION - LC/MS/MS (1)					
EDDP	NEGATIVE		CONSISTENT	50	ng/mL
BUPRENORPHINE CONFIRMATION - LC/MS/MS (1)					
BUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
NORBUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
BENZODIAZEPINES CONFIRMATION - LC/MS/MS (1)					
ALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
ALPHA-HYDROXYALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
7-AMINO-CLONAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
NORDIAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
OXAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
TEMAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
LORAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
PSYCHOTROPICS CONFIRMATION - LC/MS/MS (1)					
NORTRIPTYLINE	NEGATIVE		CONSISTENT	50	ng/mL
ZOLPIDEM	NEGATIVE		CONSISTENT	5.0	ng/mL
MUSCLE RELAXANTS CONFIRMATION - LC/MS/MS (1)					
MEPROBAMATE	NEGATIVE		CONSISTENT	50	ng/mL
CYCLOBENZAPRINE CONFIRMATION - LC/MS/MS (1)					
CYCLOBENZAPRINE	NEGATIVE		CONSISTENT	50	ng/mL
GABAPENTIN CONFIRMATION - LC/MS/MS (1)					
GABAPENTIN	NEGATIVE		CONSISTENT	50	ng/mL
PREGABALIN CONFIRMATION - LC/MS/MS (1)					
PREGABALIN	NEGATIVE		CONSISTENT	50	ng/mL

000100

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 122492	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER ALVAREZ,NEISY	RECEIVED DATE 06/11/2024	COLLECTION DATE 05/31/2024		REPORTED 06/14/2024 21:08 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening					Page 2 of 2

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Movantik, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
STIMULANTS CONFIRMATION - LC/MS/MS (1)					
AMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
MDMA	NEGATIVE		NORMAL	50	ng/mL
MDA	NEGATIVE		NORMAL	50	ng/mL
MDEA	NEGATIVE		NORMAL	50	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	05-14-2024

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

- | | | |
|--|--|--|
| (XX) Periodic Report | (<input type="checkbox"/> Change in Treatment Plan | (<input type="checkbox"/> Release from Care |
| (<input type="checkbox"/> Change in Work Status | (<input type="checkbox"/> Need for Referral or Consultation | (<input type="checkbox"/> Response to Release for Information |
| (<input type="checkbox"/> Change in Patient Condition | (<input type="checkbox"/> Need for Surgery or Hospitalization | (<input type="checkbox"/> Request for Authorization |
| (<input type="checkbox"/> Other | | |

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints

Low back and knee pain

History of Injury :

Today's visit was completed via Telemedicine Audio and or visual with the permission of the patient for low back and knee pains. The patient is a 53-year-old male who presents for low back pain and reports that the pain is about the same. The patient is still awaiting for hip by viscous supplementation injections to be performed. The patient endorses the injection as needed been scheduled the patient continues with the same pain. X-rays of the hip were obtained the patient does not know the results.

She admits that medications do provide for improvement in functioning. He would like to have refills today.

The patient reports having MRA of the knee and reviewed it with Dr. Conwisar who has convinced the patient that the MR arthrogram did not show any significant pathology. The

The patient is continuing to take care of the wife. The patient denies any side effects from the medications. AME doctor has recommended the MRA of the knee. The patient is happy with the progress that wife is having. The patient reports as far pain goes she is doing better.

He is also dealing with increased right knee pain secondary to work-related injury -The patient reports colder weather can be more painful but trying to get medication management. The patient trying to also get new insurance that has been also a very frustrating process.

OIC is better under control with the movantik.

Only lumbar spine is accepted by the port at this point. The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U**

Scales: Pain at present is 7 on the pain scale.

Pain Descriptors: Location of pain is at Low back and knee pain. Patient describes his pain as constant.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No. Date: 02-2024. Location: RT KNEE.

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO
L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

We are prescribing controlled substances. There are no recent drug screens to review. The most recent urine drug screen was done on 02-28-2024.

Legal Status:

Primary Treating Physician: Philip Conwissar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

UDS 7/2023 + oxycodone

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. There are no recent drug screens to review. The most recent urine drug screen was done on 02-28-2024.

Treatment Plan:

Patient has had hip x-rays will follow through with the primary treating physician for the results.

* Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction and/or other aberrant drug-related behavior, to guide treatment. The frequency of random testing is determined by an individualized opioid risk score which is based upon the patient's individual medical history, and the type and dosage of drugs prescribed.

If the results of the definitive drug test are inconsistent, it could result in the patient being denied medication refills, counseled for aberrant behavior, recommended for detoxification or terminated from this practice.

AME doctor ordered Dr. Lee woods - MRA of the knee done -However was negative the patient is given follow-up with orthopedic surgeon for potential hyaluronate one time Orthovisc injection

Urine drug screening February 2024 was reviewed noted to be consistent with prescribed medication of oxycodone and THC which we do not prescribe the patient.

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring Frist in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

Long Term Goals:

This Comprehensive Chronic Care management (CCM) (Workers Compensation)

Treatment plan is being established to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit this functional decline and improve clinical outcomes. A range of biopsychosocial factors will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome.

CCM (99490)

More than 20 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan over the prior calendar month.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

- * Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.
- * The patient must follow up with primary care for preventative and maintenance healthcare.
- * Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 30 Tablet

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An

extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed by the above-signed Nurse Practitioner/Physician Assistant/Physician under the direction and guidance of the signing Physician. The physical examination was performed by the Nurse Practitioner/Physician under the direction and supervision of the Physician. The dictation was prepared by the Nurse Practitioner/Physician, including any and all impressions and conclusions described in the discussion, and were discussed and reviewed with the Physician. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the above signed Nurse Practitioner/Physician under the direction and guidance of the signing physician and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Workers Compensation legislation (Labor Code 4628(j):"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 I have indicated I have received from others. As to that information, the signing Nurse Practitioner/Physician and Physician declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): "Neither the signing Physician or Nurse Practitioner/Physician have violated Labor Code section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



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IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	04-15-2024

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	() Change in Treatment Plan	() Release from Care
() Change in Work Status	() Need for Referral or Consultation	() Response to Release for Information
() Change in Patient Condition	() Need for Surgery or Hospitalization	(X) Request for Authorization
() Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine Audio and or visual with the permission of the patient for low back and knee pains. The patient is a 53-year-old male who presents for low back pain and reports that unfortunately, his wife has had a SAH. The patient denies any interval changes. The patient tells me still waiting for Orthovisc one injection to be administered the patient tells me that it is been authorized but the waiting for the actual pharmaceutical company to send over the medication.

The patient reports having MRA of the knee and reviewed it with Dr. Conwisar who has convinced the patient that the MR arthrogram did not show any significant pathology. The

The patient is continuing to take care of the wife. The patient denies any side effects from the medications. AME doctor has recommended the MRA of the knee. The patient is happy with the progress that wife is having. The patient reports as far pain goes she is doing better.

He is also dealing with increased right knee pain secondary to work-related injury -The patient reports colder weather can be more painful but trying to get medication management. The patient trying to also get new insurance that has been also a very frustrating process.

OIC is better under control with the movantik.

Only lumbar spine is accepted by the port at this point. The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 6 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No. Date: 02-2024. Location: RT KNEE.

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

Height (inches): 71.00 Weight (lbs): 205.00

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

We are prescribing controlled substances. The most recent urine drug screen was done on 02-28-2024. The CURES database was reviewed. It shows no evidence of doctor shopping.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

UDS 7/2023 + oxycodone

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 02-28-2024. The CURES database was reviewed. It shows no evidence of doctor shopping.

Treatment Plan:

AME doctor ordered Dr. Lee woods - MRA of the knee done -However was negative the patient is given follow-up with orthopedic surgeon for potential hyaluronate one time Orthovisc injection

Urine drug screening February 2024 was reviewed noted to be consistent with prescribed medication of oxycodone and THC which we do not prescribe the patient.

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring Frist in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

Long Term Goals:

This Comprehensive Chronic Care management (CCM) (Workers Compensation)

Treatment plan is being established to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit this functional decline and improve clinical outcomes. A range of biopsychosocial factors will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome.

CCM (99490)

More than 20 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan over the prior calendar month.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of

monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and

appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 30 Tablet

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation

legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



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BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	03-18-2024

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	() Change in Treatment Plan	() Release from Care
() Change in Work Status	() Need for Referral or Consultation	() Response to Release for Information
() Change in Patient Condition	() Need for Surgery or Hospitalization	(X) Request for Authorization
() Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine Audio and or visual with the permission of the patient for low back and knee pains. The patient is a 53-year-old male who presents for low back pain and reports that unfortunately, his wife has had a SAH. The patient reports having MRA of the knee and reviewed it with Dr. Conwisar who has convinced the patient that the MR arthrogram did not show any significant pathology. The patient wants to proceed with recommendations of the orthopedic surgeon who is recommend to proceed with Orthovisc one injection

The patient is continuing to take care of the wife. The patient denies any side effects from the medications. AME doctor has recommended the MRA of the knee. The patient is happy with the progress that wife is having. The patient reports as far pain goes she is doing better.

He is also dealing with increased right knee pain secondary to work-related injury -The patient reports colder weather can be more painful but trying to get medication management. The patient trying to also get new insurance that has been also a very frustrating process.

OIC is better under control with the movantik.

Only lumbar spine is accepted by the port at this point. The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No. Date: 02-2024. Location: RT KNEE.

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

Height (inches): 71.00 Weight (lbs): 205.00

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

UDS 7/2023 + oxycodone

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

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Urine drug screening February 2024 was reviewed noted to be consistent with prescribed medication of oxycodone and THC which we do not prescribe the patient.

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring Frist in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

Long Term Goals:

This Comprehensive Chronic Care management (CCM) (Workers Compensation)

Treatment plan is being established to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit this functional decline and improve clinical outcomes. A range of biopsychosocial factors will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome.

CCM (99490)

More than 20 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan over the prior calendar month.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

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* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

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* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

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* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

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We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

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Medications prescribed:

Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 30 Tablet

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

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Signed in Los Angeles County, California

By



Kevin Kohan, D.O.

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 117581	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 03/09/2024	COLLECTION DATE 02/28/2024		REPORTED 03/13/2024 07:37 PST	
COMMENT IMMUNOASSAY SCREENING					Page 1 of 1

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Movantik, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
SPECIMEN VALIDITY TESTING (1)					
CREATININE	64		NORMAL	>=20	mg/dL
pH	5.5		NORMAL	4.7-7.8	
SPECIFIC GRAVITY	1.013		NORMAL	1.003-1.035	g/mL
OXIDANT	-8		NORMAL	<=200	ug/mL
TOXICOLOGY SCREEN (1)					
AMPHETAMINES	NEGATIVE		NORMAL	500	ng/mL
BARBITURATES	NEGATIVE		NORMAL	200	ng/mL
BENZODIAZEPINES	NEGATIVE		NORMAL	200	ng/mL
BUPRENORPHINE	NEGATIVE		NORMAL	5	ng/mL
COCAINE	NEGATIVE		NORMAL	300	ng/mL
CANNABINOIDS	POSITIVE		HIGH	50	ng/mL
CARISOPRODOL	NEGATIVE		NORMAL	100	ng/mL
ETHANOL	NEGATIVE		NORMAL	100	ng/mL
FENTANYL	NEGATIVE		NORMAL	2	ng/mL
EDDP (METHADONE METABOLITE)	NEGATIVE		NORMAL	300	ng/mL
OPIATES	NEGATIVE		NORMAL	300	ng/mL
OXYCODONE	POSITIVE		HIGH	100	ng/mL
**See LC/MS/MS for confirmation					
PHENCYCLIDINE	NEGATIVE		NORMAL	25	ng/mL
MDMA (ECSTACY)	NEGATIVE		NORMAL	500	ng/mL
METHAMPHETAMINE	NEGATIVE		NORMAL	500	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



Summary of Findings
UNIVERSAL PAIN MANAGEMENT
819 Auto Center Drive
Palmdale, CA 93551
Phone: (661) 267-6876 x156
Lab Director - Earl Weissman, PhD

PATIENT NAME BARDAKJIAN, STEEVIO		LAB REF # 117582	Patient ID 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 02/28/2024	COLLECTION DATE 02/28/2024		REPORTED DATE 03/13/2024 09:44	

CONSISTENT RESULTS - REPORTED MEDICATION (PARENT DRUG AND/OR METABOLITE) DETECTED

REPORTED PRESCRIPTION	ANTICIPATED POSITIVE(S)	TEST OUTCOME	DETECTION WINDOW
Percocet	OXYMORPHONE	POSITIVE	
Percocet	OXYCODONE	POSITIVE	

ADDITIONAL MEDICATIONS REPORTED BUT NOT TESTED FOR IN THIS REPORT

Crestor,Calcium,Ferrous Sulfate,Diltiazem,Vitamin D,Aspirin,Movantik

000127

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 117582	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 03/09/2024	COLLECTION DATE 02/28/2024		REPORTED 03/13/2024 09:44 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening	Page 1 of 2				

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Movantik, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
ILLCIT DRUG CONFIRMATION - LC/MS/MS (1)					
6-MONOACETYL MORPHINE (Metabolite)	NEGATIVE		NORMAL	10	ng/mL
BENZOYLECGONINE	NEGATIVE		NORMAL	50	ng/mL
METHAMPHETAMINE	NEGATIVE		CONSISTENT	100	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	50	ng/mL
OPIATES/OPIOIDS CONFIRMATION - LC/MS/MS (1)					
CODEINE	NEGATIVE		CONSISTENT	50	ng/mL
MORPHINE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROMORPHONE	NEGATIVE		CONSISTENT	50	ng/mL
NORHYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
OXYCODONE	380	POSITIVE	CONSISTENT	50	ng/mL
OXYMORPHONE	318	POSITIVE	CONSISTENT	50	ng/mL
MEPERIDINE	NEGATIVE		CONSISTENT	50	ng/mL
TAPENTADOL	NEGATIVE		CONSISTENT	50	ng/mL
FENTANYL	NEGATIVE		CONSISTENT	5.0	ng/mL
O-DESMETHYL-CIS-TRAMADOL	NEGATIVE		CONSISTENT	50	ng/mL
METHADONE CONFIRMATION - LC/MS/MS (1)					
EDDP	NEGATIVE		CONSISTENT	50	ng/mL
BUPRENORPHINE CONFIRMATION - LC/MS/MS (1)					
BUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
NORBUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
BENZODIAZEPINES CONFIRMATION - LC/MS/MS (1)					
ALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
ALPHA-HYDROXYALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
7-AMINO-CLONAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
NORDIAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
OXAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
TEMAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
LORAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
PSYCHOTROPICS CONFIRMATION - LC/MS/MS (1)					
NORTRIPTYLINE	NEGATIVE		CONSISTENT	50	ng/mL
ZOLPIDEM	NEGATIVE		CONSISTENT	5.0	ng/mL
MUSCLE RELAXANTS CONFIRMATION - LC/MS/MS (1)					
MEPROBAMATE	NEGATIVE		CONSISTENT	50	ng/mL
CYCLOBENZAPRINE CONFIRMATION - LC/MS/MS (1)					
CYCLOBENZAPRINE	NEGATIVE		CONSISTENT	50	ng/mL
GABAPENTIN CONFIRMATION - LC/MS/MS (1)					
GABAPENTIN	NEGATIVE		CONSISTENT	50	ng/mL
PREGABALIN CONFIRMATION - LC/MS/MS (1)					
PREGABALIN	NEGATIVE		CONSISTENT	50	ng/mL

000128

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 117582	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 03/09/2024	COLLECTION DATE 02/28/2024		REPORTED 03/13/2024 09:44 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening					Page 2 of 2

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Movantik, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
STIMULANTS CONFIRMATION - LC/MS/MS (1)					
AMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
MDMA	NEGATIVE		NORMAL	50	ng/mL
MDA	NEGATIVE		NORMAL	50	ng/mL
MDEA	NEGATIVE		NORMAL	50	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



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DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	02-16-2024

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	() Change in Treatment Plan	() Release from Care
() Change in Work Status	() Need for Referral or Consultation	() Response to Release for Information
() Change in Patient Condition	() Need for Surgery or Hospitalization	(X) Request for Authorization
() Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine Audio and or visual with the permission of the patient for low back and knee pains. The patient is a 53-year-old male who presents for low back pain and reports that unfortunately, his wife has had a SAH. The patient reports having MRA of the knee and started in PT. The patient is continuing to take care of the wife. The patient denies any side effects from the medications. AME doctor has recommended the MRA of the knee. The patient is happy with the progress that wife is having. The patient reports as far pain goes she is doing better.

He is also dealing with increased right knee pain secondary to work-related injury -The patient reports colder weather can be more painful but trying to get medication management. The patient trying to also get new insurance that has been also a very frustrating process.

OIC is better under control with the movantik.

Only lumbar spine is accepted by the port at this point. The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: Yes. Date: 02-2024. Location: RT KNEE.

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

We are prescribing controlled substances. The most recent urine drug screen was done on 07-25-2023.

Legal Status:

Primary Treating Physician: Philip Conwissar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

UDS 7/2023 + oxycodone

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 07-25-2023.

Treatment Plan:

AME doctor ordered Dr. Lee woods - MRA of the knee done but we do not have results

Patient was also given more therapy

UDS to be done before Monday 2/19

* Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction and/or other aberrant drug-related behavior, to guide treatment. The frequency of random testing is determined by an individualized opioid risk score which is based upon the patient's individual medical history, and the type and dosage of drugs prescribed.

If the results of the definitive drug test are inconsistent, it could result in the patient being denied medication refills, counseled for aberrant behavior, recommended for detoxification or terminated from this practice.

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

UDS in Jan 2024

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring Frist in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

Long Term Goals:

This Comprehensive Chronic Care management (CCM) (Workers Compensation)

Treatment plan is being established to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit this functional decline and improve clinical outcomes. A range of biopsychosocial factors will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome.

CCM (99490)

More than 20 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan over the prior calendar month.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive

for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Dept of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered

anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 30 Tablet

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I

declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



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MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	01-19-2024

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	() Change in Treatment Plan	() Release from Care
() Change in Work Status	() Need for Referral or Consultation	() Response to Release for Information
() Change in Patient Condition	() Need for Surgery or Hospitalization	(X) Request for Authorization
() Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine Audio and or visual with the permission of the patient for low back and knee pains. The patient is a 53-year-old male who presents for low back pain and reports that unfortunately, his wife has had a SAH. The patient reports that wifes function is returning. The patient is happy with the progress that wife is having. The patient reports as far pain goes she is doing better.

He is also dealing with increased right knee pain secondary to work-related injury -The patient reports colder weather can be more painful but trying to get medication management. The patient trying to also get new insurance that has been also a very frustrating process.

OIC is better under control with the movantik.

Only lumbar spine is accepted by the port at this point. The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with opioid medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No. Date: 06-01-2023. Location: Lumbar Spine (Advanced Imagine Center).

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented.

PAIN MANAGEMENT

- Opioid Risk Tool
- UDS

Review of Medical Records:

We are prescribing controlled substances. There are no recent drug screens to review. The most recent urine drug screen was done on 07-25-2023.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

UDS 7/2023 + oxycodone

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. There are no recent drug screens to review. The most recent urine drug screen was done on 07-25-2023.

Treatment Plan:

AME doctor ordered Dr. Lee woods EMG/MRI-

Patient was also given more therapy

* Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction and/or other aberrant drug-related behavior, to guide treatment. The frequency of random testing is determined by an individualized opioid risk score which is based upon the patient's individual medical history, and the type and dosage of drugs prescribed.

If the results of the definitive drug test are inconsistent, it could result in the patient being denied medication refills, counseled for aberrant behavior, recommended for detoxification or terminated from this practice.

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

UDS in Jan 2024

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring Frist in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

Long Term Goals:

This Comprehensive Chronic Care management (CCM) (Workers Compensation)

Treatment plan is being established to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit this functional decline and improve clinical outcomes. A range of biopsychosocial factors will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome.

CCM (99490)

More than 20 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan over the prior calendar month.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs

were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication

Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 30 Tablet
Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and

except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California
By

Kevin Kohan, D.O.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSOCIATE PROFESSOR AT USC

FRANCIS X. RIEGLER, M.D.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY

RAY H d'AMOURS, M.D.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY

DANIEL ALVES, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND PM&R

KEVIN KOHAN, D.O., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND PM&R
ASSISTANT CLINICAL PROFESSOR AT USC

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ROHIT CHOUDHARY M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY

ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

Name: Bardakjian, Steevio
DOB: 05-23-1970
MR# UPM31805
Date of Service: 01-19-2024

Opioid Risk Tool

1. Family History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0

2. Personal History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
3. Age (if 16-45)		0
4. History of Preadolescent Sexual Abuse		
5. Psychological Disease	Attention Deficit Disorder	0
	Obsessive Compulsive Disorder	
	Bipolar	
	Schizophrenia	
	Depression	0
	TOTAL	0
Total Score Risk Category		
Low Risk 0-3		
Moderate Risk 4-7		
High Risk > or equal to 8		



Kevin Kohan D.O.

This has been electronically signed by Kevin Kohan D.O. on 01-19-2024.



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MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	12-20-2023

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	() Change in Treatment Plan	() Release from Care
() Change in Work Status	() Need for Referral or Consultation	() Response to Release for Information
() Change in Patient Condition	() Need for Surgery or Hospitalization	(X) Request for Authorization
() Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine Audio and or visual with the permission of the patient for low back and knee pains. The patient is a 53-year-old male who presents for low back pain and reports that unfortunately, his wife has had a SAH. He reports that she is at LA county general. She is in the ICU. The patient has been going to the Hospital for everyday and this has exacerbated the pain.

He is also dealing with increased right knee pain secondary to work-related injury -The patient reports colder weather can be more painful but trying to get medication management. The patient trying to also get new insurance that has been also a very frustrating process.

OIC is better under control with the movantik.

Only lumbar spine is accepted by the port at this point. The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with opioid medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No. Date: 06-01-2023. Location: Lumbar Spine (Advanced Imagine Center).

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

On a scale of 1 to 10 the pain level is 8. TELEMED VISIT

General: The patient is well developed and well-nourished. Patient is alert and oriented.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

The most recent urine drug screen was done on 07-25-2023.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

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ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

The most recent urine drug screen was done on 07-25-2023.

Treatment Plan:

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

UDS in Jan 2024

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring first in the future and then proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

Long Term Goals:

This Comprehensive Chronic Care management (CCM) (Workers Compensation)

Treatment plan is being established to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit this functional decline and improve clinical outcomes. A range of biopsychosocial factors will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome.

CCM (99490)

More than 20 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan over the prior calendar month.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

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* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

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* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

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* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus,

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* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 30 Tablet

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



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BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSOCIATE PROFESSOR OF USC

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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	1900110B
WCAB NUMBER	:	
CURRENT EVALUATION	:	11-20-2023

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine Audio and or visual with the permission of the patient for low back and knee pains. The patient is a 53-year-old male who presents for low back pain and reports that the tailbone pain is not being treated and he is in increased pain. The patient will be seeing the orthopedic doctor but nearly two months and no auth has been generated. The patient has HMO and is awaiting to get treated.

He is also dealing with increased right knee pain secondary to work-related injury -The patient reports colder weather can be more painful but trying to get medication management. The patient trying to also get new insurance that has been also a very frustrating process.

OIC is better under control with the movantik.

Only lumbar spine is accepted by the port at this point. The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with opioid medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No. Date: 06-01-2023. Location: Lumbar Spine (Advanced Imagine Center).

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

TELEMED VISIT

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

We are prescribing controlled substances. The most recent urine drug screen was done on 07-25-2023.

Legal Status:

Primary Treating Physician: Philip Conwisor MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

UDS 7/2023 + oxycodone

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 07-25-2023.

Treatment Plan:

Continue with medication for OIC and the opioids.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

UDS in Jan 2024

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring first in the future and then proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

- * Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.
- * The patient must follow up with primary care for preventative and maintenance healthcare.
- * Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 30 Tablet
Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical

findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

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Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	10-20-2023

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints:

History of Present Illness

Today's visit was completed via Telemedicine Audio and or visual with the permission of the patient for low back and knee pains. The patient is a 52-year-old male who presents for low back pain right knee pain secondary to work-related injury -We have attempted several times to appeal the injection for the coccydynia pain that the patient is experiencing the patient has severe pain that fluctuate with intensity I have recommended the patient to proceed as soon as possible to get treatment with his private insurance as unfortunately he is not able to get any treatment through workers come for the tailbone pain it has been deemed not to be accepted by report. The patient will use private insurance.

Only lumbar spine is accepted by the port at this point. The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with opioid medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: Yes. Date: 06-01-2023. Location: Lumbar Spine (Advanced Imagine Center).

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

We are prescribing controlled substances. The most recent urine drug screen was done on 07-25-2023.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

UDS 8/2023 + oxycodone

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 07-25-2023.

Treatment Plan:

It has been deemed By the Worker's Compensation insurance company that the coccydynia in the tailbone pain is not part of the work-related injury and he and I have recommended the patient to proceed with this treatment through private insurance.

Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring Frist in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 30 Tablet

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	09-22-2023

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine Audio and or visual with the permission of the patient for low back and knee pains. The patient is a 52-year-old male who presents for low back pain right knee pain secondary to work-related injury -WE WILL APPEAL DENIAL FOR GANGLION IMPAR INJECTION DUE TO EXTREME CHANGE IN MEDICAL FACET AND SEVERE DIBILITATING PAIN AND INABILITY TO SIT OR PLACE PRESSUE ON THE BUTTOCK:

The patient has excruciating pain that is debilitating him and only allows him to lie and sleep on his side he cannot lie in his buttocks or tailbone. Injection has been denied therefore I will appeal it :I will appeal as the patient requires injection this is an extenuating circumstance although also it is stated in the guidelines that is generally denied this patient is only lying on the side cannot pressure on the buttocks due to the severe coccydynia that he is experiencing he cannot state he cannot lie down in order to sleep any pressure in the tailbone causes excruciating pain. There is no other therapies except an injection for the ganglion impar that is recommended for this type of pain. All conservative methods of treatment has failed. Therefore since this is an extenuating circumstance we can go outside of the guideline recommendation

The patient has severe coccydynia that is Failed therapy conservative treatment cushion and wedge cushion and donut cushion unfortunately the patient continues to have recalcitrant pain. The patient is working but cannot sit at the workstation to continue to work this is an extenuating circumstance the patient would like to proceed with a ganglion impar injection that was discussed on the last visit. Patient is to have fluoroscopy for this visit the patient can have this injection without any anesthesia. Therefore the patient is a candidate to proceed with the ganglion impar injection The patient would like to proceed with the injections of the patient's tailbone has caused significant functional deficit ability the patient has severe pain the patient tells me not able to sit down to do work and activities of daily living has become very cumbersome. The injection right now would be very much indicated given the patient's symptomatology.

The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 9 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: Yes. Date: 06-01-2023. Location: Lumbar Spine (Advanced Imagine Center).

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

NO VITALS-TELEMED

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient cannot say it is on his side has difficulty with sitting and has difficulty with sleeping severe coccyx tailbone pain point tailbone

Review of Medical Records:

The now for the injection was noted and reviewed-I will appeal as the patient requires injection this is an extenuating circumstance although also it is stated in the guidelines that is generally denied this patient is only lying on the side cannot pressure on the buttocks due to the severe coccydynia that he is experiencing he cannot state he cannot lie down in order to sleep any pressure in the tailbone causes excruciating pain. There is no other therapies except an injection for the ganglion impar that is recommended for this type of pain. All conservative methods of treatment has failed. Therefore since this is an extenuating circumstance we can go outside of the guideline recommendation

The patient has severe coccydynia that is Failed therapy conservative treatment cushion and wedge cushion and donut cushion unfortunately the patient continues to have recalcitrant pain. The patient is working but cannot sit at the workstation to continue to work this is an extenuating circumstance the patient would like to proceed with a ganglion impar injection that was discussed on the last visit. Patient is to have fluoroscopy for this visit the patient can have this injection without any anesthesia. Therefore the patient is a candidate to proceed with the ganglion impar injection

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization

Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of

non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

UDS 8/2023 + oxycodone

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

I will appeal as the patient requires injection this is an extenuating circumstance although also it is stated in the guidelines that is generally denied this patient is only lying on the side cannot pressure on the buttocks due to the severe coccydynia that he is experiencing he cannot state he cannot lie down in order to sleep any pressure in the tailbone causes excruciating pain. There is no other therapies except an injection for the ganglion impar that is recommended for this type of pain. All conservative methods of treatment has failed. Therefore since this is an extenuating circumstance we can go outside of the guideline recommendation

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Severe OIC - failed metamucil colace senna lactulose and enema and is now a candidate for Movantik 25 mg am #30

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring first in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is

becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment

modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Movantik 25 mg tablet 1 Tablet Once a Day for 30 Days , Prescribe 30 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged

to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

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*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



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OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	08-25-2023

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine with the permission of the patient for low back and knee pains. The patient is a 52-year-old male who presents for low back pain right knee pain secondary to work-related injury -The patient admits having a MRI of the lumbar spine and saw Dr. Chung. He was offered L3-S1 fusion. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

He has increased pain and is thinking of retiring in the near future. He reports that the pain is fluctuating in nature. The tail bone cushion is still there and there is continual pain and it seems to be the major issue at this point. The patient would like to proceed with the injections of the patient's tailbone has caused significant functional deficit ability the patient has severe pain the patient tells me not able to sit down to do work and activities of daily living has become very cumbersome. The injection right now would be very much indicated given the patient's symptomatology.

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with opioid medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: Yes. Date: 06-01-2023. Location: Lumbar Spine (Advanced Imagine Center).

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

No vitals due to telemedicine

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Severe tenderness to palpation over the tailbone region is noted.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

We are prescribing controlled substances. The most recent urine drug screen was done on 07-25-2023.

Legal Status:

Primary Treating Physician: Philip Conwisar MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

UDS 8/2023 + oxycodone

ICD Codes: Coccydynia (M53.3), Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 07-25-2023.

Treatment Plan:

The patient has severe coccydynia that is felt therapy conservative treatment cushion and wedge cushion and donut cushion unfortunately the patient continues to have recalcitrant pain. The patient is working but cannot sit at the workstation to continue to work this is an extenuating circumstance the patient would like to proceed with a ganglion impar injection that was discussed on the last visit. Patient is to have fluoroscopy for this visit the patient can have this injection without any anesthesia. Therefore the patient is a candidate to proceed with the ganglion impar injection

Patient was offered by Dr. Chung spine surgeon- patient is deciding on the surgery for the meanwhile the patient is thinking of retiring first in the future and than proceeding with the sx.

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is

becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment

modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 106157	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 08/07/2023	COLLECTION DATE 07/25/2023		REPORTED 08/11/2023 08:49 PDT	
COMMENT IMMUNOASSAY SCREENING					Page 1 of 1

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
SPECIMEN VALIDITY TESTING (1)					
CREATININE	87		NORMAL	>=20	mg/dL
pH	5.5		NORMAL	4.7-7.8	
SPECIFIC GRAVITY	1.014		NORMAL	1.003-1.035	g/mL
OXIDANT	-28		NORMAL	<=200	ug/mL
TOXICOLOGY SCREEN (1)					
AMPHETAMINES	NEGATIVE		NORMAL	500	ng/mL
BARBITURATES	NEGATIVE		NORMAL	200	ng/mL
BENZODIAZEPINES	NEGATIVE		NORMAL	200	ng/mL
BUPRENORPHINE	NEGATIVE		NORMAL	5	ng/mL
COCAINE	NEGATIVE		NORMAL	300	ng/mL
CANNABINOIDS	POSITIVE		HIGH	50	ng/mL
CARISOPRODOL	NEGATIVE		NORMAL	100	ng/mL
ETHANOL	NEGATIVE		NORMAL	100	ng/mL
FENTANYL	NEGATIVE		NORMAL	2	ng/mL
EDDP (METHADONE METABOLITE)	NEGATIVE		NORMAL	300	ng/mL
OPIATES	NEGATIVE		NORMAL	300	ng/mL
OXYCODONE	POSITIVE		HIGH	100	ng/mL
**See LC/MS/MS for confirmation					
PHENCYCLIDINE	NEGATIVE		NORMAL	25	ng/mL
MDMA (ECSTACY)	NEGATIVE		NORMAL	500	ng/mL
METHAMPHETAMINE	NEGATIVE		NORMAL	500	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



Summary of Findings
UNIVERSAL PAIN MANAGEMENT
819 Auto Center Drive
Palmdale, CA 93551
Phone: (661) 267-6876 x156
Lab Director - Earl Weissman, PhD

PATIENT NAME BARDAKJIAN, STEEVIO		LAB REF # 106158	Patient ID 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 07/25/2023	COLLECTION DATE 07/25/2023		REPORTED DATE 08/13/2023 09:22	

CONSISTENT RESULTS - REPORTED MEDICATION (PARENT DRUG AND/OR METABOLITE) DETECTED

REPORTED PRESCRIPTION	ANTICIPATED POSITIVE(S)	TEST OUTCOME	DETECTION WINDOW
Percocet	OXYMORPHONE	POSITIVE	
Percocet	OXYCODONE	POSITIVE	

ADDITIONAL MEDICATIONS REPORTED BUT NOT TESTED FOR IN THIS REPORT

Crestor,Calcium,Ferrous Sulfate,Diltiazem,Vitamin D,Aspirin

000185

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 106158	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 08/07/2023	COLLECTION DATE 07/25/2023		REPORTED 08/13/2023 09:22 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening	Page 1 of 2				

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
ILLCIT DRUG CONFIRMATION - LC/MS/MS (1)					
6-MONOACETYL MORPHINE (Metabolite)	NEGATIVE		NORMAL	10	ng/mL
BENZOYLECGONINE	NEGATIVE		NORMAL	50	ng/mL
METHAMPHETAMINE	NEGATIVE		CONSISTENT	100	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	50	ng/mL
OPIATES/OPIOIDS CONFIRMATION - LC/MS/MS (1)					
CODEINE	NEGATIVE		CONSISTENT	50	ng/mL
MORPHINE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROMORPHONE	NEGATIVE		CONSISTENT	50	ng/mL
NORHYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
OXYCODONE	393	POSITIVE	CONSISTENT	50	ng/mL
OXYMORPHONE	490	POSITIVE	CONSISTENT	50	ng/mL
MEPERIDINE	NEGATIVE		CONSISTENT	50	ng/mL
TAPENTADOL	NEGATIVE		CONSISTENT	50	ng/mL
FENTANYL	NEGATIVE		CONSISTENT	5.0	ng/mL
O-DESMETHYL-CIS-TRAMADOL	NEGATIVE		CONSISTENT	50	ng/mL
METHADONE CONFIRMATION - LC/MS/MS (1)					
EDDP	NEGATIVE		CONSISTENT	50	ng/mL
BUPRENORPHINE CONFIRMATION - LC/MS/MS (1)					
BUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
NORBUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
BENZODIAZEPINES CONFIRMATION - LC/MS/MS (1)					
ALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
ALPHA-HYDROXYALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
7-AMINO-CLONAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
NORDIAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
OXAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
TEMAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
LORAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
PSYCHOTROPICS CONFIRMATION - LC/MS/MS (1)					
NORTRIPTYLINE	NEGATIVE		CONSISTENT	50	ng/mL
ZOLPIDEM	NEGATIVE		CONSISTENT	5.0	ng/mL
MUSCLE RELAXANTS CONFIRMATION - LC/MS/MS (1)					
MEPROBAMATE	NEGATIVE		CONSISTENT	50	ng/mL
CYCLOBENZAPRINE CONFIRMATION - LC/MS/MS (1)					
CYCLOBENZAPRINE	NEGATIVE		CONSISTENT	50	ng/mL
GABAPENTIN CONFIRMATION - LC/MS/MS (1)					
GABAPENTIN	NEGATIVE		CONSISTENT	50	ng/mL
PREGABALIN CONFIRMATION - LC/MS/MS (1)					
PREGABALIN	NEGATIVE		CONSISTENT	50	ng/mL

000186

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 106158	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 08/07/2023	COLLECTION DATE 07/25/2023		REPORTED 08/13/2023 09:22 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening					Page 2 of 2

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
STIMULANTS CONFIRMATION - LC/MS/MS (1)					
AMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
MDMA	NEGATIVE		NORMAL	50	ng/mL
MDA	NEGATIVE		NORMAL	50	ng/mL
MDEA	NEGATIVE		NORMAL	50	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	07-23-2023

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine with the permission of the patient for low back and knee pains. The patient is a 52-year-old male who presents for low back pain right knee pain secondary to work-related injury -The patient admits having a MRI of the lumbar spine Was completed on today we reviewed it with the patient the patient is a follow-up visit with the spine surgeon Dr. Chung next month to August 2024. The patient is looking forward to that consultation and learned to proceed with potential surgical options. The patient denies any new onset of numbness weakness follow-up bladder dysfunctions

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Continues to wait to see the surgeon the patient will be in touch with orthopedic surgeon is referring the patient to Dr. Patrick Johnson.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline: 30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS

EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: Yes. Date: 2-3 weeks ago. Location: Lumbar Spine (Advanced Imagine Center).

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

No vitals telemed visit

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

Urine drug screening consistent from January 2023.

Cures is consistent with prescribed medication there is no doctor shopping for the Percocet.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization

Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

* Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction and/or other aberrant drug-related behavior, to guide treatment. The frequency of random testing is determined by an individualized opioid risk score which is based upon the patient's individual medical history, and the type and quantity of drugs prescribed.

If the results of the definitive drug test are inconsistent, it could result in the patient being denied medication refills, counseled for aberrant behavior, recommended for detoxification or terminated from this practice.

Patient to have follow-up with Dr. Chung spine surgeon on August 2024

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice

- Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	06-21-2023

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine with the permission of the patient for low back and knee pains. The patient is a 52-year-old male who presents for low back pain right knee pain secondary to work-related injury -The patient admits having a MRI of the lumbar spine about 3 weeks ago and is wanting to review the results however we do not have the results to review with the patient. The patient reports that the spine surgeon will need additional MRI in order to decipher etiology of the pain and to offer the patient's further procedures and surgeries the patient is rethinking about potential surgery. The patient denies any new onset of numbness weakness bowel or bladder changes.

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Continues to wait to see the surgeon the patient will be in touch with orthopedic surgeon is referring the patient to Dr. Patrick Johnson.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline: 30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS

EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: Yes. Date: 2-3 weeks ago. Location: Lumbar Spine (Advanced Imagine Center).

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

No vitals, telemedicine

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

Authorization for medications reviewed with the patient.

Cures reviewed and is consistent with prescribed medications.

MRI of the lumbar spine was reviewed which demonstrated worsening of central canal stenosis at L4-5 with a formal read disc bulge and abutment of the nerves at L4-5 there is also mild to moderate central canal stenosis at L3-4 with abutment of L3-4 nerves as well.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

Pending consultation with a spine surgeon for lumbar spine surgery.

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

* Urine drug screening next month

*MRI was achieved after the patient finished telemedicine and was noted to be worsening the levels of L4-5 and L3-4 with impingement of nerves.

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There

are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.

Patient Name: BARDAKJIAN, STEEVIO **DOB:** 05/23/1970
Patient Number: 43066
Date of Exam: 06/01/2023 17:00
Referring Doctor: PHILLIP CONWISAR, M.D.

MRI OF THE LUMBAR SPINE WITH AND WITHOUT GADOLINIUM CONTRAST

IMPRESSION:

1. Loss of normal lumbar lordosis is seen suggestive of paraspinal muscle spasm.
 2. L4-L5 level: 4mm posterior disc bulge is noted causing mass effect upon the thecal sac and perineural fat with associated mild bilateral facet arthropathy and ligamentum flavum thickening and prominent posterior epidural fat resulting in moderate central spinal canal stenosis, AP thecal sac measures 7 mm. Severe bilateral neuroforaminal stenosis is seen with impingement upon bilateral L4 exiting nerve roots. Partial laminectomy is noted. Minimal epidural scar noted anterolaterally on the right.
 3. L3-L4 level: 2mm posterior disc bulge is noted causing mass effect upon the thecal sac and perineural fat with moderate bilateral neuroforaminal stenosis and abutment upon bilateral L3 exiting nerve roots. There is no central spinal canal stenosis. Partial laminectomy is noted.
 4. L5-S1 level: 2 mm posterior disc bulge is noted causing mass effect upon the thecal sac and perineural fat. There is no central spinal canal stenosis or neuroforaminal narrowing.

Indications: 52 year-old male present with low back pain x 5 years s/p lifting injury. Prior L3-5 discectomy 2018.

Date of injury 07/03/2018

Technique: **AIC-VALENCIA:** Using a high-resolution GE Ovation Open MRI scanner with high-performance gradients and EXCITE technology, the following sequences were acquired: Multiplanar, multiphase MR sequences were obtained before and after administration IV gadolinium contrast. Total 20ML contrast.

Comparison: None.

FINDINGS:

Vertebral Bodies: Height and alignment: Loss of normal lumbar lordosis is seen suggestive of paraspinal muscle spasm - otherwise normal.

Marrow signal intensity: Normal

Osteophytes: present

Posterior elements: intact

IV Discs: Disc desiccation: Not present

T12-L1 level: There is no significant disc bulge, central spinal canal stenosis or neuroforaminal

000203

Patient Name: BARDAKJIAN, STEEVIO **DOB:** 05/23/1970
Patient Number: 43066
Date of Exam: 06/01/2023 17:00
Referring Doctor: PHILLIP CONWISAR, M.D.

MRI OF THE LUMBAR SPINE WITH AND WITHOUT GADOLINIUM CONTRAST

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

Pursuant to section LC5703 & 5307 "A" "I", I declare under penalty of perjury that I have not violated labor code section 139.3 and that I have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Thank you for referring this patient to **ADVANCED IMAGING CENTER**.

Electronically signed on 06/02/2023 03:56 by
Andrew McDonnell M.D.
Diplomate, American Board of Radiology
AM/DA Dictated: 06/02/2023 03:29 Transcribed: 06/02/2023 03:29



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OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	05-22-2023

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine with the permission of the patient for low back and knee pains. The patient is a 52-year-old male who presents for low back pain right knee pain secondary to work-related injury the patient is trying to work- He commutes and also trying to do alternative work. He tells me he has started CHIRO therapy with some improvement of the pain. It can be still Difficult with moving and turning and twisting symptoms. The Patient is still waiting to see the spine surgeon and will determine next step based on MRI findings .

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Continues to wait to see the surgeon the patient will be in touch with orthopedic surgeon is referring the patient to Dr. Patrick Johnson.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS

EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

***Interval F/U Scales:** Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

Height (inches): 71.00 Weight (lbs): 205.00

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

Chiro Note was reviewed and noted for: manipulation modalities PROM AROM

Urine drug screening is consistent with prescribed medications.

Case was reviewed and noted to be consistent as well.

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. There are no signs of doctor shopping noted.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwissar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

Pending consultation with a spine surgeon for lumbar spine surgery.

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

* CHIRO As help significantly the patient is trying to find more time to do it with her as a work schedule it is becoming tough. The patient admits to one session giving him some initial benefit.

Long Term Goals:

This Comprehensive Chronic Care management (CCM) (Workers Compensation)

Treatment plan is being established to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit this functional decline and improve clinical outcomes. A range of biopsychosocial factors will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome.

CCM (99490) Billing Requirements:

More than 20 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan over the prior calendar month.

Long Term Goals:

This Comprehensive Chronic Care management (CCM) (Workers Compensation)

Treatment plan is being established to coordinate the patient's physical, mental, cognitive, psychosocial and environmental function and inventory the resources available to improve these functions. Patient has been identified as having chronic conditions that place the patient at risk for functional decline. The patient will be evaluated for treatments designed to limit this functional decline and improve clinical outcomes. A range of biopsychosocial factors will be considered in the ongoing care plan, including evaluations of sleep, diet, exercise habits, function, depression, mood, anxiety and fear avoidance. The care plan will be amended ongoing at monthly intervals, as needed, to assess adherence and outcome.

CCM (99490) Billing Requirements:

More than 20 minutes of clinical staff time, under the direction of the patient's doctor, was spent establishing, implementing, revising or monitoring this care plan over the prior calendar month.

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is

made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSOCIATE PROFESSOR OF USC

FRANCIS X. RIEGLER, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	04-24-2023

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine with the permission of the patient for low back and knee pains. The patient is a 52-year-old male who presents for low back pain right knee pain secondary to work-related injury the patient is trying to work full-time from home. He tells me he has started CHIRO therapy with some improvement of the pain. It can be still Difficult with moving and turning and twisting symptoms. The patient Teldrin will continue with treatment as indicated.

The patient is awaiting for MRI of the L spine authorization to see spine surgeon meanwhile the patient is experiencing significant amount of low back pain that interferes with activities of daily living after discussion the patient recalls responding well to chiropractic therapies.

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Continues to wait to see the surgeon the patient will be in touch with orthopedic surgeon is referring the patient to Dr. Patrick Johnson.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

***Interval F/U Scales:** Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

Height (inches): 71.00 Weight (lbs): 205.00

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. There are no signs of doctor shopping noted.

AUTH for chiro noted.

CHIRO notes PROM AROM modalities and manipulation

We are prescribing controlled substances. The most recent urine drug screen was done on 01-06-2023. The CURES database was reviewed. It shows no evidence of doctor shopping.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

Pending consultation with a spine surgeon for lumbar spine surgery.

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 01-06-2023. The CURES database was reviewed. It shows no evidence of doctor shopping.

Treatment Plan:

* CHIRO AUTH and encouraged to do 6 sessions

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There

are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	04-19-2023

INITIAL CHIROPRACTIC REHABILITATION REPORT

Dear Dr. Conwisar,

Thank you for giving me the opportunity to evaluate and treat your patient, Steevio Bardakjian, in my office.

Chief Complaints:

Low back pain.

History of Present Illness

The above referenced patient is a 53-year-old male. The patient is here today for low back pain status post

industrial injury. Patient has a history of lumbar spine surgery. The patient reports overall his lower back pain and right leg radicular pain is getting progressively worse. The patient rates his pain level 7 8/10 on a scale of 0-10. The patient describes the character of the pain as dull, numbing, aching, tingling and stiffness. He indicates that pain interferes with his work, sleep, daily routine, recreational activities, sexual activities and personal hygiene. The patient reports physical activity such as sitting, standing, walking, bending, laying down are painful to perform. The patient denies fevers, chills, nausea, vomiting, bowel/bladder incontinence, saddle anesthesia, or weakness.

***Initial Symptoms**

Current Medication

aspirin

Calcium with Vitamin D

Jardiance

diltiazem HCl

ferrous sulfate

Crestor 5 mg tablet 1 Once a Day, Prescribe 1 Unspecified

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 90 Tablet

Previous Pain Medications and Effects:

lisinopril 20 mg oral tablet (07-09-2021 STOPPED)

metformin 500 mg oral tablet (07-09-2021 STOPPED)

metoprolol tartrate 25 mg oral tablet (07-09-2021 STOPPED)

Lyrica 50 mg oral capsule (05-20-2019 dc)

Allergy:

No Known Drug Allergies.

Past Medical History:

Diabetes ()

High Blood Pressure ()

Surgical History:

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems:

The entire review of systems is negative as described in the Patient Intake Packet.

Social and Family History:

GENERAL: The patient has completed college.

Social History: The patient does not use tobacco. He does not drink alcohol. He has Medical Marijuana Card. The patient did not have problem with abusing drugs or alcohol. There has been no family member with any serious illness. Patient does not take or is not on anticoagulants. He spends his time during the day by Resting, avoiding excessive movement, pt. The patient has never been convicted for abuse/possession of narcotics. *The patient is on disability currently.* He is on TTD disability. He has not travelled out of country recently. The patient has not been exposed to any toxins. Marital Status: single. Patient reports that he suffered from work related injury and also had required medical care for that injury. It occurred on 07/03/2018. He reports that he did not suffer an auto accident or other injury that resulted in a personal injury lawsuit.

Previous Injuries:

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Physical Examination:

OBSERVATIONS:

The patient is well developed, well nourished male who is dressed neatly, and appears well groomed. The patient ambulates with a limp.

BEHAVIOR:

The patient is cooperative, attentive and disclosive. There is no indication of fabrication or inconsistency.

GENERAL NEUROLOGIC:

Mental Status: The patient is alert and oriented to time, day, month and year, place, person and situation. Cranial nerves II through XII grossly intact.

LUMBAR SPINE:

Inspection: The inspection of the lumbosacral spine showed well healed scar.

Examination: The examination of the lumbosacral spine demonstrates tenderness upon palpation of the bilateral paralumbar muscles, bilateral sacroiliac joints, bilateral sciatic notches, bilateral posterior iliac crests, and bilateral gluteal muscles right greater than left side.

RANGE OF MOTION:

Forward Flexion: 20/60°

Extension: 5/25° sharp pain reported.

Right Lateral Flexion: 10/25°

Left Lateral Flexion: 10/25°

There is no area of skin discoloration, altered temperature, or edema. Sensation is grossly intact to all primary modalities.

ORTHOPEDIC TESTS

Straight Leg Raising: Positive right leg.

Heel Walking (L5): Able to perform.

Toe Walking (S1): Able to perform.

NEUROLOGICAL EXAMINATION:

Upper Extremity Deep Tendon Reflex Examination: Symmetrical at +2 at both sides.

Upper Extremity Motor Strength Testing: Motor strength in the upper extremity tested at +5 bilaterally.

Upper Extremity Sensory Examination is intact to light touch, in the right and left upper extremities.

Lower extremity deep tendon reflex examination was 1/2 over the right knee and right Achilles and 2/2 over the left knee and left Achilles.

Lower extremity motor strength testing in the muscle of lower extremity tested is +5 bilaterally.

Lower Extremity Sensory Examination decreased sensation noted at the right L3-L4, L4-L5 dermatomal level

Due to COVID-19, patients were screened upon arrival including, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Injury Date: 07-03-2018 Reason for submitting report: periodic report

WORK STATUS: as per ptp

Treatment and Plan:

Once again thank you for giving me the opportunity to evaluate and treat your patient, in my office.

THERAPY PROGRAM:

For the low back and right leg radiculopathy, the patient will undergo myofascial release, Chiro Manipulation (CMT 3-4), Electrical Muscle Stimulation , Infrared, Therapeutic ultrasound, Mechanical traction, Therapeutic exercises consisting of , PROM, AROM, Progressive Resistive Exercises, Stretching and flexibility exercises, Muscular endurance exercises and Kinetic activities, once per a week for the next 6 weeks.

(There is valid authorization on file for above-mentioned treatment plan)

Above treatment plan is structured to deliver maximal relief in pain and suffering and to restore occupational and functional capacity to the highest level possible.

REHABILITATION GOALS:

The goals intended to be achieved with the preceding treatment plans are to promote soft tissue healing, relieving pain, preventing recurrence, increasing pain free range of motion, restoring normal strength and restoring stability to the joint structure.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT:

There are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. The risk of procedure were discussed and all the questions were answered to the patients satisfaction. The patient agreed to proceed and written informed consent was obtained.

The following treatment was provided today at the same time of this examination:

1. The patient was placed in prone position, surface of skin cleaned with alcohol pad, electrodes were placed in crisscross fashion over the lumbar spine (IFC) applied at a frequency 80 to 150 Hz, 15 minutes.
2. Applied 15 minutes of Infra-red over affected area to induce vasodilatation, decrease pain, and reduce muscle spasm.
3. Therapeutic exercises in the form of LUMBAR passive range of motion (PROM) and passive stretching performed. Passive stretching is a form of therapeutic procedure in which a specific muscle or tendon (or muscle group) is deliberately flexed or stretched in order to improve the muscle's elasticity and achieve comfortable muscle tone. The result is a feeling of increased muscle control, flexibility, and range of motion. Stretching is also used therapeutically to alleviate cramps. Handheld Mechanical massager used prior to rehabilitative exercises. Mechanical massager enhances flexibility, increases range-of-motion, and reduces the risk of muscle spasms, or strains during a course of rehabilitative exercises.
4. Chiropractic manipulation therapy, This procedure helps decrease the pain-free range of motion, prevent fibrotic adhesion, decrease pain, and increased facet joint play. CMT directed to the F/D lumbar, sacrum and pelvic region.
5. Therapeutic ultrasound applied to the lumbar spine. 8 min

RECOMMENDATIONS:

1. Daily active stretching of cervical and lumbar spine.
2. Use cervical pillow for sleeping.
3. Use a lumbar spine support for activities that stress the spine.
4. Avoid soft furniture, deep sofas.
5. No repetitive bending, squatting and kneeling.

It is very important that in addition to this therapeutic modalities and exercises that were given in today's session patient continue an exercise program at home. Bearing in mind that patient education is an important part of treatment plan for management of intractable pain, instructions for outpatient use were given. These instructions can may includes education materials and discussions such as proper posture and proper body mechanism properly spanning mechanism appropriate home stretching and strengthening exercises, as well as possible safe and reasonable modifications to places that the patient spends time in.

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Treatment provided without incident. Post treatment, the patient reports relief. Patient is recommended to continue with home exercise program until the next visit.

Work Status: As per PTP

Work Restriction:

Very truly yours,



Omid Mahgerefteh, D.C.

DISCLOSURE:

In compliance with Labor Code section 4628 and the rules of Practice and Procedure, specifically 10978 and 10606, the following is supplied.

I declare under penalty of perjury that all opinions in this report are mine. I performed the evaluation and cognitive services at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084, in the County of Los Angeles and that, except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

I have complied with the Labor Code section 139.3 and I have not offered or received any commissions or inducements for this consultation. The name and contents of the report and billing are true and correct to the best of my knowledge.



Omid Mahgerefteh, D.C.



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IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	03-24-2023

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine with the permission of the patient due to the COVID-19 national emergency. The patient is a 52-year-old male who presents for low back pain right knee pain secondary to work-related injury the patient is trying to work full-time from home. The patient is awaiting authorization to see spine surgeon meanwhile the patient is experiencing significant amount of low back pain that interferes with activities of daily living after discussion the patient recalls responding well to chiropractic therapies.

CHIRO therapy - The patient has failed physical therapy for the lumbar spine the patient has increasing low back pain and exacerbation the patient now has failed a home exercise program the patient is interested in clinical trial of 6 sessions. The patient tells me having previous 6 sessions with a meaningful functional improvement subjectively and objectively. Patient has had 30% improvement with ability to be able to have increased range of motion. The patient will be utilized chiropractic therapy as adjuvant therapy for graded conditioning and strength training program. The patient requires 6 sessions for this acute exacerbation of pain

The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Continues to wait to see the surgeon the patient will be in touch with orthopedic surgeon is referring the patient to Dr. Patrick Johnson.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS

EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

***Interval F/U Scales:** Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO
L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

Authorization for medication was reviewed with the patient

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. There are no signs of doctor shopping noted.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

Pending consultation with a spine surgeon for lumbar spine surgery.

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

* CHIRO therapy - The patient has failed physical therapy for the lumbar spine the patient has increasing low back pain and exacerbation the patient now has failed a home exercise program the patient is interested in clinical trial of 6 sessions. The patient tells me having previous 6 sessions with a meaningful functional improvement subjectively and objectively. Patient has had 30% improvement with ability to be able to have increased range of motion. The patient will be utilized chiropractic therapy as adjuvant therapy for graded conditioning and strength training program. The patient requires 6 sessions for this acute exacerbation of pain

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice

- Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

Due to COVID-19, patients were screened upon arrival including taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 7.5 mg-325 mg tablet 0.5-1 Tablet Three times a Day PRN for 30 Days , Prescribe 90 Tablet

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Twice a Day PRN for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

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*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



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DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	02-20-2023

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine with the permission of the patient due to the COVID-19 national emergency. Telemedicine visits utilize audio and/or video communication.

The patient returns for medical management and treatment of ongoing pain to low back and right knee due to a work-related injury. Patient endorses going back to work full-time . The patient reports continuing to await for spine surgeon authorization which can be aggravating. The patient reports not being able to do some of the activities of daily living but is trying to do it with medication management the patient has been able to wean down on the Percocet to the Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen.

Continues to wait to see the surgeon the patient will be in touch with orthopedic surgeon is referring the patient to Dr. Patrick Johnson.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.
Sleep without medications unable to do and with medications for 3-4 hours.
Standing without medications 10 minutes and with medications more than 1 hour at a time.
Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with opioid medications.

***Interval F/U Scales:** Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

Height (inches): 71.00 Weight (lbs): 205.00

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

PAIN MANAGEMENT

- Opioid Risk Tool
- UDS

Review of Medical Records:

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. There are no signs of doctor shopping noted.

1/23 UDS + oxycodone and metabolite

We are prescribing controlled substances. There are no recent drug screens to review. The most recent urine drug screen was done on 01-06-2023. The CURES database was reviewed. It shows no evidence of doctor shopping.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

Pending consultation with a spine surgeon for lumbar spine surgery.

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. There are no recent drug screens to review. The most recent urine drug screen was done on 01-06-2023. The CURES database was reviewed. It shows no evidence of doctor shopping.

Treatment Plan:

* I will continue the patient on the current medication regimen of Percocet as it provides the patient's significant meaningful functional benefit for the knee and the low back pain. The patient is able to work full-time from home on the medication management.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS trial at this time.

- * Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.
- * Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN. We will try 5 mg next visit as he is motivated to wean down
- * The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.
- * A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.
- * I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).
- * Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.
- * Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.
- * The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.
- * A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.
- * The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.
- * Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.
- * The patient must follow up with primary care for preventative and maintenance healthcare.
- * Follow-up in one month for continued pain management.

Due to COVID-19, patients were screened upon arrival including taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 7.5 mg-325 mg tablet 0.5-1 Tablet Three times a Day PRN for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By

Kevin Kohan, D.O.



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DEBBIE CASTILLO, P.T.A.
MARC REZNICKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

Name: Bardakjian, Steevio

DOB: 05-23-1970

MR# UPM31805

Date of Service: 02-20-2023

Opioid Risk Tool

1. Family History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
2. Personal History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
3. Age (if 16-45)		0
4. History of Preadolescent Sexual Abuse		
5. Psychological Disease	Attention Deficit Disorder	0
	Obsessive Compulsive Disorder	
	Bipolar	
	Schizophrenia	
	Depression	0
	TOTAL	0

Total Score Risk Category

Low Risk 0-3

Moderate Risk 4-7

High Risk > or equal to 8



Kevin Kohan D.O.

This has been electronically signed by Kevin Kohan D.O. on 02-20-2023.



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IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	01-20-2023

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

- | | | |
|--|--|--|
| (XX) Periodic Report | (<input type="checkbox"/>) Change in Treatment Plan | (<input type="checkbox"/>) Release from Care |
| (<input type="checkbox"/>) Change in Work Status | (<input type="checkbox"/>) Need for Referral or Consultation | (<input type="checkbox"/>) Response to Release for Information |
| (<input type="checkbox"/>) Change in Patient Condition | (<input type="checkbox"/>) Need for Surgery or Hospitalization | (<input type="checkbox"/>) Request for Authorization |
| (<input type="checkbox"/>) Other | | |

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints

Low back and knee pain

History of Injury :

Today's visit was completed via Telemedicine with the permission of the patient due to the COVID-19 national emergency. Telemedicine visits utilize audio and/or video communication.

The patient returns for medical management and treatment of ongoing pain to low back and right knee due to a work-related injury. He completed physical therapy for low back and right knee pain status post right knee surgery 5/4/2022 with outside provider. He continues home exercise programs at gym twice a week. The patient is able to ambulate without a cane. He was able to wean down Percocet to 7.5/325 mg TID PRN. The patient reports meaningful benefit from the current pain medication regimen. The medications allow the patient to function and perform activities of daily living. The patient has an improved quality of life with medications and reports no distressing side effects. There is pending spine surgeon consultation with Dr. Patrick Johnson. He continues to defer a SCS trial.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to mainly right leg, numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: Physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with opioid medications.

***Interval F/U**

Scales: Pain at present is 6 on the pain scale.

Pain Descriptors: Location of pain is at Low back and knee pain. Patient describes his pain as constant.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

No vitals telemed visit

General: A&Ox3. The patient is alert and oriented. The patient is in no acute distress.

Psychiatric: Mood is euthymic. Affect is normal.

Physical exam deferred due to telemedicine visit secondary to COVID-19 Pandemic.

PAIN MANAGEMENT

- Opioid Dose Calculator
- UDS

Review of Medical Records:

The UDT on 1/4/23 is pending. The UDT from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA.

Reviewed authorization for Percocet, requests for medications, and follow up report.

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

We are prescribing controlled substances. The most recent urine drug screen was done on 01-06-2023.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisar MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

Pending consultation with a spine surgeon for lumbar spine surgery.

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 01-06-2023.

Treatment Plan:

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate. He continues to defer a SCS

trial at this time.

* Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as protocol.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation. He was able to wean down Percocet to 7.5/325 mg TID PRN.

* The UDT on 1/4/23 is pending. UDS from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

Due to COVID-19, patients were screened upon arrival including taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 7.5 mg-325 mg tablet 0.5-1 Tablet Three times a Day PRN for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Seyeon Kang, N.P.



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed by the above-signed Nurse Practitioner/Physician Assistant/Physician under the direction and guidance of the signing Physician. The physical examination was performed by the Nurse Practitioner/Physician under the direction and supervision of the Physician. The dictation was prepared by the Nurse Practitioner/Physician, including any and all impressions and conclusions described in the discussion, and were discussed and reviewed with the Physician. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the above signed Nurse Practitioner/Physician under the direction and guidance of the signing physician and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Workers Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, the signing Nurse Practitioner/Physician and Physician declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): "Neither the signing Physician or Nurse Practitioner/Physician have violated Labor Code section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 01-20-2023.



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DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

Name : Steevio Bardakjian

MR# UPM31805

Date of Operation: 01-20-2023

DOB: 05-23-1970

Opioid Dose Calculator

Category	Test	Result	Remarks
Opioid Dose Calculator			
1	Oxycodone (mg per day)	22.50	
2	Oxycodone: Morphine Equivalent	33.75	
3	Oxycodone - Total no. of pills prescribed	90	
4	Oxycodone - No. of days pills prescribed for	30	
5	Oxycodone - mg/pill	7.5	
6	Oxycodone - Med deviation	22.50	
7	Total Daily Morphine Equivalent Dose	33.75	

Combined risk category using Opioid risk tool and Opioid dose is

* Based on information published by University of California, San Francisco and University of Rochester, Dept. of Palliative Care.

A handwritten signature in black ink, appearing to read 'Seyeon Kang, N.P.'.

Seyeon Kang, N.P.

This has been electronically signed by Seyeon Kang, N.P. on 01-20-2023.

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 96863	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 01/18/2023	COLLECTION DATE 01/06/2023		REPORTED 01/20/2023 18:30 PST	
COMMENT IMMUNOASSAY SCREENING					Page 1 of 1

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
SPECIMEN VALIDITY TESTING (1)					
CREATININE	225	NORMAL		>=20	mg/dL
pH	5.6	NORMAL		4.7-7.8	
SPECIFIC GRAVITY	1.027	NORMAL		1.003-1.035	g/mL
OXIDANT	-13	NORMAL		<=200	ug/mL
TOXICOLOGY SCREEN (1)					
AMPHETAMINES	NEGATIVE	NORMAL		500	ng/mL
BARBITURATES	NEGATIVE	NORMAL		200	ng/mL
BENZODIAZEPINES	NEGATIVE	NORMAL		200	ng/mL
BUPRENORPHINE	NEGATIVE	NORMAL		5	ng/mL
COCAINE	NEGATIVE	NORMAL		300	ng/mL
CANNABINOIDS	POSITIVE	HIGH		50	ng/mL
	**See LC/MS/MS for confirmation				
CARISOPRODOL	NEGATIVE	NORMAL		100	ng/mL
ETHANOL	NEGATIVE	NORMAL		100	ng/mL
FENTANYL	NEGATIVE	NORMAL		2	ng/mL
EDDP (METHADONE METABOLITE)	NEGATIVE	NORMAL		300	ng/mL
OPIATES	NEGATIVE	NORMAL		300	ng/mL
OXYCODONE	POSITIVE	HIGH		100	ng/mL
	**See LC/MS/MS for confirmation				
PHENCYCLIDINE	NEGATIVE	NORMAL		25	ng/mL
MDMA (ECSTACY)	NEGATIVE	NORMAL		500	ng/mL
METHAMPHETAMINE	NEGATIVE	NORMAL		500	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



Summary of Findings
UNIVERSAL PAIN MANAGEMENT
819 Auto Center Drive
Palmdale, CA 93551
Phone: (661) 267-6876 x156
Lab Director - Earl Weissman, PhD

PATIENT NAME BARDAKJIAN, STEEVIO		LAB REF # 96864	Patient ID 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 01/06/2023	COLLECTION DATE 01/06/2023		REPORTED DATE 01/23/2023 20:20	

CONSISTENT RESULTS - REPORTED MEDICATION (PARENT DRUG AND/OR METABOLITE) DETECTED

REPORTED PRESCRIPTION	ANTICIPATED POSITIVE(S)	TEST OUTCOME	DETECTION WINDOW
Percocet	OXYMORPHONE	POSITIVE	
Percocet	OXYCODONE	POSITIVE	

ADDITIONAL MEDICATIONS REPORTED BUT NOT TESTED FOR IN THIS REPORT

Crestor,Calcium,Ferrous Sulfate,Diltiazem,Vitamin D,Aspirin

000251

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 96864	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 01/18/2023	COLLECTION DATE 01/06/2023		REPORTED 01/23/2023 20:20 PST	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening	Page 1 of 2				

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
ILLCIT DRUG CONFIRMATION - LC/MS/MS (1)					
6-MONOACETYL MORPHINE (Metabolite)	NEGATIVE		NORMAL	10	ng/mL
BENZOYLECGONINE	NEGATIVE		NORMAL	50	ng/mL
METHAMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	50	ng/mL
OPIATES/OPIOIDS CONFIRMATION - LC/MS/MS (1)					
CODEINE	NEGATIVE		CONSISTENT	50	ng/mL
MORPHINE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROMORPHONE	NEGATIVE		CONSISTENT	50	ng/mL
NORHYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
OXYCODONE	454	POSITIVE	CONSISTENT	50	ng/mL
OXYMORPHONE	634	POSITIVE	CONSISTENT	50	ng/mL
MEPERIDINE	NEGATIVE		CONSISTENT	50	ng/mL
TAPENTADOL	NEGATIVE		CONSISTENT	50	ng/mL
FENTANYL	NEGATIVE		CONSISTENT	5.0	ng/mL
O-DESMETHYL-CIS-TRAMADOL	NEGATIVE		CONSISTENT	50	ng/mL
METHADONE CONFIRMATION - LC/MS/MS (1)					
EDDP	NEGATIVE		CONSISTENT	50	ng/mL
BUPRENORPHINE CONFIRMATION - LC/MS/MS (1)					
BUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
NORBUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
BENZODIAZEPINES CONFIRMATION - LC/MS/MS (1)					
ALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
ALPHA-HYDROXYALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
7-AMINO-CLONAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
NORDIAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
OXAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
TEMAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
LORAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
PSYCHOTROPICS CONFIRMATION - LC/MS/MS (1)					
NORTRIPTYLINE	NEGATIVE		CONSISTENT	50	ng/mL
ZOLPIDEM	NEGATIVE		CONSISTENT	5.0	ng/mL
MUSCLE RELAXANTS CONFIRMATION - LC/MS/MS (1)					
MEPROBAMATE	NEGATIVE		CONSISTENT	50	ng/mL
CYCLOBENZAPRINE CONFIRMATION - LC/MS/MS (1)					
CYCLOBENZAPRINE	NEGATIVE		CONSISTENT	50	ng/mL
GABAPENTIN CONFIRMATION - LC/MS/MS (1)					
GABAPENTIN	NEGATIVE		CONSISTENT	50	ng/mL
PREGABALIN CONFIRMATION - LC/MS/MS (1)					
PREGABALIN	NEGATIVE		CONSISTENT	50	ng/mL

000252

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 96864	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER KOHAN,KEVIN	RECEIVED DATE 01/18/2023	COLLECTION DATE 01/06/2023		REPORTED 01/23/2023 20:20 PST	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening					Page 2 of 2

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
STIMULANTS CONFIRMATION - LC/MS/MS (1)					
AMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
MDMA	NEGATIVE		NORMAL	50	ng/mL
MDA	NEGATIVE		NORMAL	50	ng/mL
MDEA	NEGATIVE		NORMAL	50	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



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MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	12-23-2022

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

- | | | |
|--|--|--|
| (XX) Periodic Report | (<input type="checkbox"/> Change in Treatment Plan | (<input type="checkbox"/> Release from Care |
| (<input type="checkbox"/> Change in Work Status | (<input type="checkbox"/> Need for Referral or Consultation | (<input type="checkbox"/> Response to Release for Information |
| (<input type="checkbox"/> Change in Patient Condition | (<input type="checkbox"/> Need for Surgery or Hospitalization | (<input type="checkbox"/> Request for Authorization |
| (<input type="checkbox"/> Other | | |

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints

Low back and knee pain

History of Injury :

Today's visit was completed via Telemedicine with the permission of the patient due to the COVID-19 national emergency. Telemedicine visits utilize audio and/or video communication.

The patient returns for medical management and treatment of ongoing pain to low back and right knee due to a work-related injury. He endorses knee pain improved after physical therapy. He wishes to a trial of weaning down Percocet from 10/325 mg to 7.5/325 mg three times a day as needed. We will re-evaluate the pain next month. The patient continues to report low back pain. The physical therapy for low back pain mildly improved symptoms. The spine surgeon consultation with Dr. Patrick Johnson is still pending.

Lumbar spine: The pain varies in intensity but is always present. It radiates down to bilateral lower extremity with numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

Knees: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications. Status post right knee surgery 5/4/2022 improved pain.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past medical treatment for the pain: The patient continues physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain for knee pain. He has a history of lumbar spinal surgery which is not successful.

Past surgical history for the pain: status post right knee surgery 5/4/2022.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with opioid medications.

***Interval F/U**

Scales: Pain at present is 7 on the pain scale.

Pain Descriptors: Location of pain is at Low back and knee pain. Patient describes his pain as constant.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

NO VITALS TELEMED

General: A&Ox3. The patient is alert and oriented. The patient is in no acute distress.

Psychiatric: Mood is euthymic. Affect is normal.

Physical exam deferred due to telemedicine visit secondary to COVID-19 Pandemic.

PAIN MANAGEMENT

- Opioid Dose Calculator
- UDS

Review of Medical Records:

The UDT from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA.

Reviewed authorization for Percocet, requests for medications, and follow up report.

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Tear of meniscus of right knee status post recent right knee surgery May 4, 2022 which improved pain.

Pending consultation with a spine surgeon for lumbar spine surgery.

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

* Weaned down Percocet from 10/325 mg to 7.5/325 mg three times a day as needed as a trial. He endorses improvement of knee pain status post surgery. The patient continues to report low back pain. We will re-evaluate the pain next month.

* Pending consultation with a spine surgeon for lumbar spine surgery. He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

- * Consider a spinal cord stimulator trial if the patient is not a surgical candidate.
- * Follow up with Dr. Conwisar, an orthopedic surgeon status post right knee surgery as needed.
- * Continue Percocet for nociceptive pain. He is taking Metamucil for constipation.

* UDS to be done prior to the next visit. He will come on 12/27/22.

Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction, and/or other aberrant drug-related behavior, and to guide treatment. The frequency of random testing is determined by an individualized opioid risk a score which is based upon the patient's individual medical history, and the type and quantity of drugs prescribed. If the results of the definitive drug test are inconsistent, which could result in the patient being denied medication refills counseled for aberrant behavior, recommended for detoxification, or terminated from this practice.

* The UDT from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

Pharmacologic assessment and management

The patient is instructed to alert the prescribing physician to discuss any of these symptoms if they occur. The patient is instructed as to the dangers of operating a vehicle while under the influence of this medication. The patient is also aware of the synergistic effects of alcohol with this medication and to use extreme caution when operating in an automobile while under the influence of this medication.

The patient understands that this medication cannot be discontinued abruptly without professional guidance. The patient fully understands these concepts and accepts the risks. The patient understands that this medication is taken as prescribed by the prescribing physician. The patient request refills from this office only in that and understands that early requests for refills might not be honored.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

Due to COVID-19, patients were screened upon arrival including taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 7.5 mg-325 mg tablet 0.5-1 Tablet Three times a Day PRN for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Seyeon Kang, N.P.



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed by the above-signed Nurse Practitioner/Physician Assistant/Physician under the direction and guidance of the signing Physician. The physical examination was performed by the Nurse Practitioner/Physician under the direction and supervision of the Physician. The dictation was prepared by the Nurse Practitioner/Physician, including any and all impressions and conclusions described in the discussion, and were discussed and reviewed with the Physician. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the above signed Nurse Practitioner/Physician under the direction and guidance of the signing physician and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Workers Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, the signing Nurse Practitioner/Physician and Physician declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): "Neither the signing Physician or Nurse Practitioner/Physician have violated Labor Code section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California
By



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 12-23-2022.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
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DIPLIMATE, AMERICAN BOARD OF ANESTHESIOLOGY

ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

Name : Steevio Bardakjian

MR# UPM31805

Date of Operation: 12-23-2022

DOB: 05-23-1970

Opioid Dose Calculator

Category	Test	Result	Remarks
Opioid Dose Calculator			
1	Oxycodone (mg per day)	22.50	
2	Oxycodone: Morphine Equivalent	33.75	
3	Oxycodone - Total no. of pills prescribed	90	
4	Oxycodone - No. of days pills prescribed for	30	
5	Oxycodone - mg/pill	7.5	
6	Oxycodone - Med deviation	22.50	
7	Total Daily Morphine Equivalent Dose	33.75	

Combined risk category using Opioid risk tool and Opioid dose is

* Based on information published by University of California, San Francisco and University of Rochester, Dept. of Palliative Care.

A handwritten signature in black ink, appearing to read 'Seyeon Kang, N.P.'.

Seyeon Kang, N.P.

This has been electronically signed by Seyeon Kang, N.P. on 12-23-2022.



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DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	11-28-2022

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

- | | | |
|--|--|--|
| (XX) Periodic Report | (<input type="checkbox"/>) Change in Treatment Plan | (<input type="checkbox"/>) Release from Care |
| (<input type="checkbox"/>) Change in Work Status | (<input type="checkbox"/>) Need for Referral or Consultation | (<input type="checkbox"/>) Response to Release for Information |
| (<input type="checkbox"/>) Change in Patient Condition | (<input type="checkbox"/>) Need for Surgery or Hospitalization | (<input type="checkbox"/>) Request for Authorization |
| (<input type="checkbox"/>) Other | | |

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints

Low back and knee pain

History of Injury :

Today's visit was completed via Telemedicine with the permission of the patient due to the COVID-19 national emergency. Telemedicine visits utilize audio and/or video communication.

The patient returns for medical management and treatment of ongoing pain to low back and right knee due to a work-related injury. His primary complaint is low back pain. The pain varies in intensity but is always present. It radiates down to bilateral lower extremity with numbness and tingling in bilateral feet. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. Pain is aggravated by activities, such as ambulating longer distances, prolonged standing and sitting. Pain is decreased with medications. The patient denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

He has a history of lumbar spinal surgery which is not successful. A consultation with Dr. Patrick Johnson, a spine surgeon, for lumbar spine surgery is still pending at this time.

The patient continues physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain. He is able to ambulate longer distances and improve rotation movement-based activities. Knee pain improved after the procedure. The patient continues to follow up with Dr. Conwisar, an orthopedic surgeon, in December 2022.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet for nociceptive pain. He is taking Metamucil for constipation.

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.

Sleep without medications unable to do and with medications for 3-4 hours.

Standing without medications 10 minutes and with medications more than 1 hour at a time.

Range of motion is less than 30% without medications and more than 70% with medications.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

There is 30 % of improvement with opioid medications.

***Interval F/U**

Scales: Pain at present is 7 on the pain scale.

Pain Descriptors: Location of pain is at Low back and knee pain. Patient describes his pain as constant.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

Height (inches): 71.00 Weight (lbs): 205.00 No vitals telemed visit

General: A&Ox3. The patient is alert and oriented. The patient is in no acute distress.

Psychiatric: Mood is euthymic. Affect is normal.

Physical exam deferred due to telemedicine visit secondary to COVID-19 Pandemic.

PAIN MANAGEMENT

- Opioid Dose Calculator
- UDS

Review of Medical Records:

The UDT from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. No illicit drugs were noted.

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

Reviewed authorization for Percocet, follow-up report, and Second Bill Review note.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisar MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 52-year-old male status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

A history of recent right knee surgery May 4, 2022. Recovering and doing physical therapy at this time.

Pending consultation with a spine surgeon for lumbar spine surgery.

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

* Continue physical therapy for low back and right knee pain status post right knee surgery 5/4/2022. Physical therapy provides 30% of pain relief and functional gain. He is able to ambulate longer distances and improve rotation movement-based activities.

* Follow up with Dr. Conwisar, an orthopedic surgeon, in December 2022, status post right knee surgery.

* The patient to proceed with a consultation with a spine surgeon for lumbar spine surgery.

* Consider a spinal cord stimulator trial if the patient is not a surgical candidate.

* Continue Percocet for nociceptive pain. He is taking Metamucil for constipation.

* The UDT from 6/6/22 is consistent with Oxycodone and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore,

based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to the risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is instructed not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

Due to COVID-19, patients were screened upon arrival including taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets

all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Seyeon Kang, N.P.



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed by the above-signed Nurse Practitioner/Physician Assistant/Physician under the direction and guidance of the signing Physician. The physical examination was performed by the Nurse Practitioner/Physician under the direction and supervision of the Physician. The dictation was prepared by the Nurse Practitioner/Physician, including any and all impressions and conclusions described in the discussion, and were discussed and reviewed with the Physician. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the above signed Nurse Practitioner/Physician under the direction and guidance of the signing physician and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Workers Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, the signing Nurse Practitioner/Physician and Physician declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): "Neither the signing Physician or Nurse Practitioner/Physician have violated Labor Code section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California
By



Kevin Kohan, D.O.
This has been electronically signed by Kevin Kohan, D.O. on 11-28-2022.



SHAHIN A. SADIK, M.D., Q.M.E.
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MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

Name : Steevio Bardakjian

MR# UPM31805

Date of Operation: 11-28-2022

DOB: 05-23-1970

Opioid Dose Calculator

Category	Test	Result	Remarks
Opioid Dose Calculator			
1	Oxycodone (mg per day)	30	
2	Oxycodone: Morphine Equivalent	45	
3	Oxycodone - Total no. of pills prescribed	90	
4	Oxycodone - No. of days pills prescribed for	30	
5	Oxycodone - mg/pill	10	
6	Oxycodone - Med deviation	30	
7	Total Daily Morphine Equivalent Dose	45	

Combined risk category using Opioid risk tool and Opioid dose is

* Based on information published by University of California, San Francisco and University of Rochester, Dept. of Palliative Care.

A handwritten signature in black ink, appearing to read "Seyeon Kang, N.P.", is placed over a horizontal line.

Seyeon Kang, N.P.

This has been electronically signed by Seyeon Kang, N.P. on 11-28-2022.



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DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	ELAINE BARBAGALLO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	11-01-2022

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine with the permission of the patient due to the COVID-19 national emergency. Telemedicine visits utilize audio and/or video communication.

52-year-old male with low back and right knee pain due to work-related injury. Patient reports he underwent right knee surgery on 05/04/2022. The patient has been in therapy for about the knee and the low back and reports that there has been functional improvement. The patient would like to continue with conservative management of pain. The patient is happy doing therapy of both areas of the body. Meanwhile the patient admits that the spine surgery consultation has now been moved to later this month. The patient has a follow-up appointment with Dr. Patrick Johnson to work on the lumbar spine. The patient is excited to finally move forward with the lumbar spine. The patient admits also doing shoulder therapy and there nonindustrial case.

Patient admits low back pain is aching in nature and it radiates to bilateral feet. Patient reports previous lumbar spinal surgery was not very successful. He is still in process of finding a spinal specialist at Cedar Sinai.

Current medication regimen with Percocet provides 30% of pain relief and functional improvement. Patient is able to ambulate longer distances, perform hygiene duties, and perform lower extremity dressing.

Patient is able to tolerate the current regimen. He manages constipation with Metamucil.

Without medicine patient states that it would be very difficult to perform normal daily activities and would be confined to their home.

Patient denies recent hospitalizations or ER visits. Denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

Aggravating factors include excessive activity, exertion, prolonged position

Alleviating factors include rest, medication

5A's reviewed with patient:

Analgesia: Reports 30% improvement in pain with current regimen

ADL: Reports improvement in overall function was taking medication

Adverse effects: No significant effects such as respiratory depression, somnolence, etc.

Abuse: No suspicious or drug seeking behavior.

Affect: Appropriate behavior and mood

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

No vitals-telemed

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

We are prescribing controlled substances. There are no recent drug screens to review. The most recent urine drug screen was done on 06-03-2022. It is described in previous notes. The CURES database was reviewed. It shows no evidence of doctor shopping.

Legal Status:

Primary Treating Physician: Philip Conwisar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Status post right knee surgery May 4, 2022. Recovering and doing physical therapy at this time.

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 6/6/2022 report demonstrates Percocet and metabolites. It was positive for THC which we do not prescribe but are legal in CA.

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. There are no recent drug screens to review. The most recent urine drug screen was done on 06-03-2022. It is described in previous notes. The CURES database was reviewed. It shows no evidence of doctor shopping.

Treatment Plan:

--Continue with physical therapy status post right knee surgery as well as the low back

-- Proceed with consultation with Dr. Patrick Johnson

-- We discussed potential spinal cord stimulation therapy Especially if the patient is not a surgical candidate is a good idea per patient

--I am refilling medication, Percocet, today. Continue current medication regimen as it is providing significant symptomatic and functional improvement without evidence of impairment, abuse, diversion, or hoarding. Without medicine patient states that it would be very difficult to perform normal daily activities and would be confined to home.

Patient counselled regarding the medication and how to appropriately take them. Furthermore, discussion had with patient about appropriate down-titration of opioids and utilizing the lowest possible dose which provides significant relief.

Continue Metamucil to control opioid-induced constipation.

--Patient must follow-up with primary care for preventative and maintenance healthcare.

--Patient must keep medication locked safe container to prevent loss and theft.

--Encouraged the patient to continue activities as tolerated and to utilize nonpharmacological treatment modalities such as ice/hot packs as needed for flare up of symptoms.

--Follow-up in one month for continued pain management and medication refill or adjustment

Pharmacologic assessment and management

The patient's psychotropic/opiate medications were reviewed. The patient is counseled as to the benefits of this medication and potential side effects. The risks include, but are not limited to drowsiness, sedation, dependence, tolerance, and addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition and potential problems with vision including glaucoma.

The patient is instructed to alert the prescribing physician to discuss any of these symptoms if they occur. The patient is advised as to the dangers of operating a vehicle while under the influence of this medication. The patient is also aware of the synergistic effects of alcohol with this medication and to use extreme caution when operating in an automobile while under the influence of this medication.

The patient understands that this medication cannot be discontinued abruptly without professional guidance. The patient fully understands these concepts and accepts the risks. The patient understands that this medication be taken as prescribed by the prescribing physician. The patient is request refills from this office only in that and understands that early request for refills might not be honored.

Due to COVID-19, patients were screened upon arrival including taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



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BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	10-04-2022

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine with the permission of the patient due to the COVID-19 national emergency. Telemedicine visits utilize audio and/or video communication.

52-year-old male with low back and right knee pain due to work-related injury. Patient reports he underwent right knee surgery on 05/04/2022. The patient has been in therapy for about the knee and the low back and reports that there has been functional improvement. The patient would like to continue with conservative management of pain. The patient is happy doing therapy of both areas of the body. Meanwhile the patient admits that the spine surgery consultation has been pending. The patient is a follow-up visit does not know if she would like to proceed with a Baker fusion surgery as has been recommended. The patient still thinking about that the patient has several questions about a spinal cord stimulation therapy that was discussed today.

Patient admits low back pain is aching in nature and it radiates to bilateral feet. Patient reports previous lumbar spinal surgery was not very successful. He is still in process of finding a spinal specialist at Cedar Sinai.

Current medication regimen with Percocet provides 30% of pain relief and functional improvement. Patient is able to ambulate longer distances, perform hygiene duties, and perform lower extremity dressing.

Patient is able to tolerate the current regimen. He manages constipation with Metamucil.

Without medicine patient states that it would be very difficult to perform normal daily activities and would be confined to their home.

Patient denies recent hospitalizations or ER visits. Denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

Aggravating factors include excessive activity, exertion, prolonged position

Alleviating factors include rest, medication

5A's reviewed with patient:

Analgesia: Reports 30% improvement in pain with current regimen

ADL: Reports improvement in overall function was taking medication

Adverse effects: No significant effects such as respiratory depression, somnolence, etc.

Abuse: No suspicious or drug seeking behavior.

Affect: Appropriate behavior and mood

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

Height (inches): 71.00 Weight (lbs): 205.00

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

AUTH for medication noted

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. There are no signs of doctor shopping noted.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of

non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Status post right knee surgery May 4, 2022. Recovering and doing physical therapy at this time.

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 6/6/2022 report demonstrates Percocet and metabolites. It was positive for THC which we do not prescribe but are legal in CA.

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

---Continue with physical therapy status post right knee surgery As well as the low back

--- We discussed potential spinal cord stimulation therapy Especially if the patient is not a surgical candidate is a good idea per patient

---I am refilling medication, Percocet, today. Continue current medication regimen as it is providing significant symptomatic and functional improvement without evidence of impairment, abuse, diversion, or hoarding. Without medicine patient states that it would be very difficult to perform normal daily activities and would be confined to home.

Patient counselled regarding the medication and how to appropriately take them. Furthermore, discussion had with patient about appropriate down-titration of opioids and utilizing the lowest possible dose which provides significant relief.

Continue Metamucil to control opioid-induced constipation.

---Patient must follow-up with primary care for preventative and maintenance healthcare.

---Patient must keep medication locked safe container to prevent loss and theft.

---Encouraged the patient to continue activities as tolerated and to utilize nonpharmacological treatment modalities such as ice/hot packs as needed for flare up of symptoms.

---Follow-up in one month for continued pain management and medication refill or adjustment

Pharmacologic assessment and management

The patient's psychotropic/opiate medications were reviewed. The patient is counseled as to the benefits of this

medication and potential side effects. The risks include, but are not limited to drowsiness, sedation, dependence, tolerance, and addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition and potential problems with vision including glaucoma.

The patient is instructed to alert the prescribing physician to discuss any of these symptoms if they occur. The patient is advised as to the dangers of operating a vehicle while under the influence of this medication. The patient is also aware of the synergistic effects of alcohol with this medication and to use extreme caution when operating in an automobile while under the influence of this medication.

The patient understands that this medication cannot be discontinued abruptly without professional guidance. The patient fully understands these concepts and accepts the risks. The patient understands that this medication be taken as prescribed by the prescribing physician. The patient is request refills from this office only in that and understands that early request for refills might not be honored.

Due to COVID-19, patients were screened upon arrival including taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	09-01-2022

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

- | | | |
|--|--|--|
| (XX) Periodic Report | (<input type="checkbox"/>) Change in Treatment Plan | (<input type="checkbox"/>) Release from Care |
| (<input type="checkbox"/>) Change in Work Status | (<input type="checkbox"/>) Need for Referral or Consultation | (<input type="checkbox"/>) Response to Release for Information |
| (<input type="checkbox"/>) Change in Patient Condition | (<input type="checkbox"/>) Need for Surgery or Hospitalization | (<input type="checkbox"/>) Request for Authorization |
| (<input type="checkbox"/>) Other | | |

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 819 Auto Center Drive, Palmdale CA 93551 - 4599.

Current Complaints

Low back and knee pain

History of Injury :

Today's visit was completed via Telemedicine with the permission of the patient due to the COVID-19 national emergency. Telemedicine visits utilize audio and/or video communication.

The patient returns for medical management and treatment of ongoing pain to Low back and right knee due to a work related injury. The patient continues physical therapy for right knee after the surgery in May 4, 2022. A spine surgeon consultation is pending.

Lumbar spine: The pain varies in intensity but is always present. There is an underlying dull, aching pain with components that are sharp and shooting depending on the activities being performed. It intermittently radiates down to right lower extremity with numbness and tingling. Pain is aggravated by activities, such as ambulating longer distances. Pain is decreased with medications. Denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

Right knee: The pain is constant. It is a sharp, shooting pain with movement. At rest, there is an underlying dull, aching pain. Pain increases with ambulating longer distances. It decreases with the use of medications.

The patient denies recent hospitalizations, surgeries, or ER visits. There's been no increase in shootings or neurological deficits.

Current Medications for Pain: Percocet

Analgesia: The patient reports greater than 30% pain relief with the medications.

ADLs: The patient is able to perform activities such as bathing, grooming, dressing, and preparing meals with the aid of the medications.

Adverse side effects: No cognitive side effects noted. There is no respiratory depression. No somnolence was noted.

Abuse: No suspicious or drug-seeking behavior.

Associations: No associated depression or anxiety in connection with the pain.

With medications, the pain is a 5/10.

Without medications, it is a 9/10.

On average the pain level is a 6/10.

When taking the meds they take effect within 20 minutes.

Past surgical history for the pain: laminectomy in 2018

Past medications tried: gabapentin and Lyrica

Past medical treatment for the pain: TF LESI L3-4, L4-5 Right 8/8/2019 with 60% pain relief that lasted for a few days.

We discussed a spinal cord stimulator trial and the patient is interested in the procedure in the future after the spine surgeon consultation.

WCF

Pain relief with medications 30%

Walking without medications 10 yards and with medications, 50 yards.
Sleep without medications unable to do and with medications for 3-4 hours.
Standing without medications 10 minutes and with medications more than 1 hour at a time.
Range of motion is less than 30% without medications and more than 70% with medications.

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U**

Scales: Pain at present is 8 on the pain scale.

Pain Descriptors: Location of pain is at Low back and knee pain. Patient describes his pain as constant.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

Height (inches): 71.00 Weight (lbs): 205.00 No vitals telemed visit

General: A&Ox3. The patient is alert and oriented. The patient is in no acute distress.

Psychiatric: Mood is euthymic. Affect is normal.

Physical exam deferred due to telemedicine visit secondary to COVID-19 Pandemic.

PAIN MANAGEMENT

- Opioid Dose Calculator

- UDS

Review of Medical Records:

Reviewed authorization for medications, follow-up report, and Second Bill Review notes.

MRI of the lumbar spine on June 4, 2020, demonstrates multilevel disc herniation prominent at L4-L5. There is central canal stenosis at L1-L2, L2-L3, L3-L4, and L4-L5. The multilevel bilateral neural foraminal narrowing is noted from L1 to S1.

MRI of the right knee on May 28, 2020, shows an oblique tear of the posterior horn of the medial meniscus and small knee joint effusion.

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

The UDT from 6/6/22 is positive for Percocet and metabolites. It is positive for THC which we do not prescribe but is legal in CA.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

The patient is a 52-year-old male with a history of L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work-related injury. He had a right knee surgery May 4, 2022. Today recommend the following:

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

* The patient to find a new spine surgeon for second opinion for failed back surgery.

* We discussed a spinal cord stimulator trial and the patient is interested in the procedure in the future after the spine surgeon consultation. He would like to continue with current medication management at this time.

* Continue physical therapy after the right knee surgery.

* The UDT from 6/6/22 is positive for Percocet and metabolites. It is positive for THC which we do not prescribe but is legal in CA. Results were reviewed with the patient. No illicit drugs were noted. Therefore, based on the results of this urine drug test and in conjunction with other forms of monitoring I will continue to prescribe medications as noted below.

* A pain agreement is on file. The patients' sign and agree to a treatment contract that documents their understanding and willingness to abide by the expectations of opioid use. The contract outlines our patients' responsibilities with regard to their use of opioids and instructs them in the ways they are to interact with this position in their pharmacy when obtaining their medications. By signing the contract, they indicate that they understand its content and agree to abide by it.

* I have reviewed the pain medications and found no evidence of abuse, hoarding, or diversion. A complete list of medications prescribed is contained within the electronic medical records (EMR).

* Adverse effects of the medications were discussed with the patient. These include but are not limited to The risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

* Risks and side effects include but are not limited to, respiratory depression, sedation, constipation, pruritus, cognitive side effects, increased fall risk and accident risks, dependence, tolerance, addiction, and hypogonadism.

* The patient is advised not to drive or operate heavy machinery if impaired by the medications in any way. The patient is also reminded to use the medications exactly as prescribed; to never double up on doses; to never take opioids with alcohol, benzodiazepines, or other drugs that may interact with the opioids. The patient understands this. We reviewed how the medication is to be taken and this was confirmed by the patient.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

* The patient is receiving greater than 30 percent relief while on the medication. The medications are being taken as prescribed. The patient is functional and participates in daily activities and attempts at light activities within their limits. The quality of life improved since initiating opioid therapy. In addition, the patient has a pain agreement on file. The long-term goals are to keep the patient on his current level of medications.

Pharmacologic assessment and management

The patient is instructed to alert the prescribing physician to discuss any of these symptoms if they occur. The patient is advised as to the dangers of operating a vehicle while under the influence of this medication. The patient is also aware of the synergistic effects of alcohol with this medication and to use extreme caution when operating in an automobile while under the influence of this medication.

The patient understands that this medication cannot be discontinued abruptly without professional guidance. The patient fully understands these concepts and accepts the risks. The patient understands that this medication is taken as prescribed by the prescribing physician. The patient request refills from this office only in that and understands that early requests for refills might not be honored.

* Encourage the patient to continue activities as tolerated and to utilize non-pharmacological treatment modalities such as ice/hot packs as needed for the flare-up of symptoms.

* The patient must follow up with primary care for preventative and maintenance healthcare.

* Follow-up in one month for continued pain management.

Due to COVID-19, patients were screened upon arrival including taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,

Syeon Kang, N.P.



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed by the above-signed Nurse Practitioner/Physician Assistant/Physician under the direction and guidance of the signing Physician. The physical examination was performed by the Nurse Practitioner/Physician under the direction and supervision of the Physician. The dictation was prepared by the Nurse Practitioner/Physician, including any and all impressions and conclusions described in the discussion, and were discussed and reviewed with the Physician. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the above signed Nurse Practitioner/Physician under the direction and guidance of the signing physician and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Workers Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, the signing Nurse Practitioner/Physician and Physician declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): "Neither the signing Physician or Nurse Practitioner/Physician have violated Labor Code section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 09-01-2022.



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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

Name : Steevio Bardakjian

MR# UPM31805

Date of Operation: 09-01-2022

DOB: 05-23-1970

Opioid Dose Calculator

Category	Test	Result	Remarks
Opioid Dose Calculator			
1	Oxycodone (mg per day)	30	
2	Oxycodone: Morphine Equivalent	45	
3	Oxycodone - Total no. of pills prescribed	90	
4	Oxycodone - No. of days pills prescribed for	30	
5	Oxycodone - mg/pill	10	
6	Oxycodone - Med deviation	30	
7	Total Daily Morphine Equivalent Dose	45	

Combined risk category using Opioid risk tool and Opioid dose is

* Based on information published by University of California, San Francisco and University of Rochester, Dept. of Palliative Care.

Syeon Kang, N.P.

This has been electronically signed by Syeon Kang, N.P. on 09-01-2022.



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MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	08-02-2022

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

- | | | |
|--|--|--|
| (XX) Periodic Report | (<input type="checkbox"/>) Change in Treatment Plan | (<input type="checkbox"/>) Release from Care |
| (<input type="checkbox"/>) Change in Work Status | (<input type="checkbox"/>) Need for Referral or Consultation | (<input type="checkbox"/>) Response to Release for Information |
| (<input type="checkbox"/>) Change in Patient Condition | (<input type="checkbox"/>) Need for Surgery or Hospitalization | (<input type="checkbox"/>) Request for Authorization |
| (<input type="checkbox"/>) Other | | |

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints

Low back and knee pain

History of Injury :

Today's visit was completed via Telemedicine with the permission of the patient due to the COVID-19 national emergency. Telemedicine visits utilize audio and/or video communication.

The patient is 52 years old male with low back and knee pain due to work-related injuries. He recovered from COVID19 and continues with physical therapy after right knee surgery on May 4, 2022. The patient admits mild improvement with physical therapy which allows him to ambulate longer distances.

Low back pain is aching in radiates down to bilateral feet. It increases with exertion and improves with the current medication regimen. Right knee pain is aching and gets worse with the prolonged position. Alleviating factors include resting and current medication with physical therapy.

Mr. Bardakjian is in the process of finding a spinal surgeon after failed laminectomy in 2018. He had epidural injections in the past which did not help.

We discussed a spinal cord stimulator trial and the patient is interested in the procedure in the future.

The current medication regimen with Percocet provides 30% of pain relief and functional improvement. Patient is able to ambulate longer distances and perform lower extremity dressing.

Patient is able to tolerate the current regimen, and denies any side effects that include mental clouding, constipation, itching, and drowsiness. Without medicine patient states that it would be very difficult to perform normal daily activities and would be confined to their home.

He is not interested in weaning off medication at this time.

Constipation is managed with over-the-counters stool softeners as needed.

Patient denies recent hospitalizations, surgeries, or ER visits. Denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

Aggravating factors include excessive activity, exertion, prolonged position

Alleviating factors include rest, medication

5A's reviewed with patient:

Analgesia: Reports 30% improvement in pain with current regimen

ADL: Reports improvement in overall function was taking medication

Adverse effects: No significant effects such as respiratory depression, somnolence, etc.

Abuse: No suspicious or drug seeking behavior.

Affect: Appropriate behavior and mood

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.
The onset of symptom relief for their medication is 20 minutes.
Weaning has been tried but was not successful.
Conservative treatment has been tried for more than 3 months but it failed.
An updated pain agreement is present on file.
VAS (Without Meds): 10
VAS (With Meds): 7
There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U**

Scales: Pain at present is 8 on the pain scale.

Pain Descriptors: Location of pain is at Low back and knee pain. Patient describes his pain as constant.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

On a scale of 1 to 10 the pain level is 8. NO VITALS DUE TO TELEMEDICINE APPOINTMENT

General: Patient is alert and oriented. His mood and affect are normal. PE limited, telemed visit; Patient speaking in full clear coherent sentences and answering questions appropriately

PAIN MANAGEMENT

- Opioid Dose Calculator
- UDS

Review of Medical Records:

Reviewed authorization for medication and follow-up report.

MRI of the lumbar spine on June 4, 2020, demonstrates multilevel disc herniation prominent at L4-L5. There is central canal stenosis at L1-L2, L2-L3, L3-L4, and L4-L5. The multilevel bilateral neural foraminal narrowing is noted from L1 to S1.

MRI of the right knee on May 28, 2020, shows an oblique tear of the posterior horn of the medial meniscus and small knee joint effusion.

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

UDS on June 6, 2022, is consistent with Percocet and metabolites. It is positive for THC which is legal in California.

We are prescribing controlled substances. The most recent urine drug screen was done on 06-03-2022.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwissar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male with a history of L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work-related injury.

Status post right knee surgery May 4, 2022. Recovering and doing physical therapy at this time.

Mr. Bardakjian is in the process of finding a spinal surgeon after failed laminectomy in 2018. He had epidural injections in the past which did not help.

Patient reports 30% of pain improvement with Percocet. The patient is able to increase physical activity, social activities, sleep, and care for himself.

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

Urine screening from the 6/6/2022 report demonstrates Percocet and metabolites. It is also positive for THC which we do not prescribe but is legal in CA.

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic

(M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 06-03-2022.

Treatment Plan:

---We discussed a spinal cord stimulator trial and the patient is interested in the procedure in the future. He would like to continue with current medication management and follow-up with a spinal surgeon at this time. We will contact a representative to provide further information in the future if symptoms exacerbate.

---Continue physical therapy after the right knee surgery.

---The patient may benefit from the knee injection or further interventions with genicular nerve block in the future if pain persists despite knee surgery.

---Follow up with a spinal specialist.

---I am refilling medication, Percocet, today. Patient is not interested in weaning off Percocet at this time. He will consider it after completing physical therapy. Continue Metamucil to control opioid-induced constipation.

Continue current medication regimen as it is providing significant symptomatic and functional improvement without evidence of impairment, abuse, diversion, or hoarding.

Without medicine, patient states that it would be very difficult to perform normal daily activities and would be confined at home.

Patient counselled regarding the medication and how to appropriately take them. Furthermore, discussion had with patient about appropriate down-titration of opioids and utilizing the lowest possible dose which provides significant relief.

---Patient must follow up with primary care for preventative and maintenance healthcare.

---Patient must keep medication locked safe container to prevent loss and theft.

---Encouraged the patient to continue activities as tolerated and to utilize nonpharmacological treatment modalities such as ice/hot packs as needed for flare up of symptoms.

---Follow-up in one month for continued pain management and medication refill or adjustment

Pharmacologic assessment and management

The patient's psychotropic/opiate medications were reviewed. The patient is counseled as to the benefits of this medication and potential side effects. The risks include, but are not limited to drowsiness, sedation, dependence, tolerance, addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition, and potential problems with vision including glaucoma.

The patient is instructed to alert the prescribing physician to discuss any of these symptoms if they occur. The patient is advised as to the dangers of operating a vehicle while under the influence of this medication. The patient is also aware of the synergistic effects of alcohol with this medication and to use extreme caution when operating in an automobile while under the influence of this medication.

The patient understands that this medication cannot be discontinued abruptly without professional guidance.

The patient fully understands these concepts and accepts the risks. The patient understands that this medication is taken as prescribed by the prescribing physician. The patient is request refills from this office only in that and understands that early request for refills might not be honored.

Due to COVID-19, patients were screened upon arrival including taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,

Seyeon Kang, N.P.



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed by the above-signed Nurse Practitioner/Physician Assistant/Physician under the direction and guidance of the signing Physician. The physical examination was performed by the Nurse Practitioner/Physician under the direction and supervision of the Physician. The dictation was prepared by the Nurse Practitioner/Physician, including any and all impressions and conclusions described in the discussion, and were discussed and reviewed with the Physician. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the above signed Nurse Practitioner/Physician under the direction and guidance of the signing physician and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Workers Compensation legislation (Labor Code 4628(j):"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 I have indicated I have received from others. As to that information, the signing Nurse Practitioner/Physician and Physician declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): "Neither the signing Physician or Nurse Practitioner/Physician have violated Labor Code section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

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*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 08-02-2022.



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Name : Steevio Bardakjian

MR# UPM31805

Date of Operation: 08-02-2022

DOB: 05-23-1970

Opioid Dose Calculator

Category	Test	Result	Remarks
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1	Oxycodone (mg per day)	30	
2	Oxycodone: Morphine Equivalent	45	
3	Oxycodone - Total no. of pills prescribed	90	
4	Oxycodone - No. of days pills prescribed for	30	
5	Oxycodone - mg/pill	10	
6	Oxycodone - Med deviation	30	
7	Total Daily Morphine Equivalent Dose	45	

Combined risk category using Opioid risk tool and Opioid dose is

* Based on information published by University of California, San Francisco and University of Rochester, Dept. of Palliative Care.

Syeon Kang, N.P.

This has been electronically signed by Syeon Kang, N.P. on 08-02-2022.



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IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	07-05-2022

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

Today's visit was completed via Telemedicine with the permission of the patient due to the COVID-19 national emergency. Telemedicine visits utilize audio and/or video communication.

52-year-old male with low back and right knee pain due to work-related injury. Patient reports he underwent right knee surgery on 05/04/2022 and started physical therapy. Unfortunately, he got COVID19 followed by the surgery and had to be isolated for 2 weeks. Now, the patient resumed physical therapy with some improvement. Patient endorses pain is lingering but has noticed some pain relief and functional gain. He is able to ambulate longer distance and perform lower body dressing.

Patient admits low back pain is aching in nature and it radiates to bilateral feet. Patient reports previous lumbar spinal surgery was not very successful. He is still in process of finding a spinal specialist at Cedar Sinai.

Current medication regimen with Percocet provides 30% of pain relief and functional improvement. Patient is able to ambulate longer distances, perform hygiene duties, and perform lower extremity dressing.

Patient is able to tolerate the current regimen. He manages constipation with Metamucil.

Without medicine patient states that it would be very difficult to perform normal daily activities and would be confined to their home.

Patient denies recent hospitalizations or ER visits. Denies changes in bowel or bladder function. Denies signs or symptoms of saddle anesthesia.

Aggravating factors include excessive activity, exertion, prolonged position

Alleviating factors include rest, medication

5A's reviewed with patient:

Analgesia: Reports 30% improvement in pain with current regimen

ADL: Reports improvement in overall function was taking medication

Adverse effects: No significant effects such as respiratory depression, somnolence, etc.

Abuse: No suspicious or drug seeking behavior.

Affect: Appropriate behavior and mood

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate.

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at Low back and knee pain. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

Height (inches): 71.00 Weight (lbs): 205.00

General: Patient is alert and oriented. His mood and affect are normal. Patient is talkative and interactive.

Speech is clear and thoughts are coherent. Pleasant and cooperative . Rest of the physical exam deferred due to Covid -19 pandemic.

PAIN MANAGEMENT

- Opioid Dose Calculator

Review of Medical Records:

UDS on 6/6/2022 is consistent with Percocet and metabolites. It was positive for THC which we do not prescribe but are legal in CA.

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Depart of Justice - Bureau of Narcotic Enforcement was obtained. There are no signs of doctor shopping noted.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy due to work related injury.

Status post right knee surgery May 4, 2022. Recovering and doing physical therapy at this time.

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 6/6/2022 report demonstrates Percocet and metabolites. It was positive for THC which we do not prescribe but are legal in CA.

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

---Continue with physical therapy status post right knee surgery. Patient is in the process of finding a spinal specialist for low back pain.

---I am refilling medication, Percocet, today. Continue current medication regimen as it is providing significant symptomatic and functional improvement without evidence of impairment, abuse, diversion, or hoarding. Without medicine patient states that it would be very difficult to perform normal daily activities and would be confined to home.

Patient counselled regarding the medication and how to appropriately take them. Furthermore, discussion had with patient about appropriate down-titration of opioids and utilizing the lowest possible dose which provides significant relief.

Continue Metamucil to control opioid-induced constipation.

---Patient must follow-up with primary care for preventative and maintenance healthcare.

---Patient must keep medication locked safe container to prevent loss and theft.

---Encouraged the patient to continue activities as tolerated and to utilize nonpharmacological treatment modalities such as ice/hot packs as needed for flare up of symptoms.

---Follow-up in one month for continued pain management and medication refill or adjustment

Pharmacologic assessment and management

The patient's psychotropic/opiate medications were reviewed. The patient is counseled as to the benefits of this medication and potential side effects. The risks include, but are not limited to drowsiness, sedation, dependence, tolerance, and addiction, nausea, tingling in the extremities, decreased appetite, problems with cognition and potential problems with vision including glaucoma.

The patient is instructed to alert the prescribing physician to discuss any of these symptoms if they occur. The patient is advised as to the dangers of operating a vehicle while under the influence of this medication. The patient is also aware of the synergistic effects of alcohol with this medication and to use extreme caution when operating in an automobile while under the influence of this medication.

The patient understands that this medication cannot be discontinued abruptly without professional guidance. The patient fully understands these concepts and accepts the risks. The patient understands that this

medication be taken as prescribed by the prescribing physician. The patient is request refills from this office only in that and understands that early request for refills might not be honored.

Due to COVID-19, patients were screened upon arrival including taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

Name : Steevio Bardakjian

MR# UPM31805

Date of Operation: 07-05-2022

DOB: 05-23-1970

Opioid Dose Calculator

Category	Test	Result	Remarks
Opioid Dose Calculator			
1	Oxycodone (mg per day)	30	
2	Oxycodone: Morphine Equivalent	45	
3	Oxycodone - Total no. of pills prescribed	90	
4	Oxycodone - No. of days pills prescribed for	30	
5	Oxycodone - mg/pill	10	
6	Oxycodone - Med deviation	30	
7	Total Daily Morphine Equivalent Dose	45	

Combined risk category using Opioid risk tool and Opioid dose is

* Based on information published by University of California, San Francisco and University of Rochester, Dept. of Palliative Care.

Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 07-05-2022.

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 88341	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER ALVAREZ,NEISY	RECEIVED DATE 06/15/2022	COLLECTION DATE 06/06/2022		REPORTED 06/15/2022 18:09 PDT	
COMMENT IMMUNOASSAY SCREENING					Page 1 of 1

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
SPECIMEN VALIDITY TESTING (1)					
CREATININE	141		NORMAL	>=20	mg/dL
pH	5.4		NORMAL	4.7-7.8	
SPECIFIC GRAVITY	1.023		NORMAL	1.003-1.035	g/mL
OXIDANT	-18		NORMAL	<=200	ug/mL
TOXICOLOGY SCREEN (1)					
AMPHETAMINES	NEGATIVE		NORMAL	500	ng/mL
BARBITURATES	NEGATIVE		NORMAL	200	ng/mL
BENZODIAZEPINES	NEGATIVE		NORMAL	200	ng/mL
BUPRENORPHINE	NEGATIVE		NORMAL	5	ng/mL
COCAINE	NEGATIVE		NORMAL	300	ng/mL
CANNABINOIDS	POSITIVE		HIGH	50	ng/mL
	**See LC/MS/MS for confirmation				
CARISOPRODOL	NEGATIVE		NORMAL	100	ng/mL
ETHANOL	NEGATIVE		NORMAL	100	ng/mL
FENTANYL	NEGATIVE		NORMAL	2	ng/mL
EDDP (METHADONE METABOLITE)	NEGATIVE		NORMAL	300	ng/mL
OPIATES	NEGATIVE		NORMAL	300	ng/mL
OXYCODONE	POSITIVE		HIGH	100	ng/mL
	**See LC/MS/MS for confirmation				
PHENCYCLIDINE	NEGATIVE		NORMAL	25	ng/mL
MDMA (ECSTACY)	NEGATIVE		NORMAL	500	ng/mL
METHAMPHETAMINE	NEGATIVE		NORMAL	500	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



Summary of Findings
UNIVERSAL PAIN MANAGEMENT
819 Auto Center Drive
Palmdale, CA 93551
Phone: (661) 267-6876 x156
Lab Director - Earl Weissman, PhD

PATIENT NAME BARDAKJIAN, STEEVIO		LAB REF # 88342	Patient ID 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER ALVAREZ,NEISY	RECEIVED DATE 06/06/2022	COLLECTION DATE 06/06/2022		REPORTED DATE 06/16/2022 19:39	

CONSISTENT RESULTS - REPORTED MEDICATION (PARENT DRUG AND/OR METABOLITE) DETECTED

REPORTED PRESCRIPTION	ANTICIPATED POSITIVE(S)	TEST OUTCOME	DETECTION WINDOW
Percocet	OXYMORPHONE	POSITIVE	
Percocet	OXYCODONE	POSITIVE	

ADDITIONAL MEDICATIONS REPORTED BUT NOT TESTED FOR IN THIS REPORT

Crestor,Calcium,Ferrous Sulfate,Diltiazem,Vitamin D,Aspirin

000308

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 88342	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M		
ORDERING PROVIDER ALVAREZ,NEISY	RECEIVED DATE 06/15/2022	COLLECTION DATE 06/06/2022	REPORTED 06/16/2022 19:39 PDT				
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening		Page 1 of 2					
PRESCRIBED MEDICATIONS Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Percocet, Vitamin D							
TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS		
ILLCIT DRUG CONFIRMATION - LC/MS/MS (1)							
6-MONOACETYL MORPHINE (Metabolite)	NEGATIVE		NORMAL	10	ng/mL		
BENZOYLECGONINE	NEGATIVE		NORMAL	50	ng/mL		
METHAMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL		
PHENCYCLIDINE	NEGATIVE		NORMAL	50	ng/mL		
OPIATES/OPIOIDS CONFIRMATION - LC/MS/MS (1)							
CODEINE	NEGATIVE		CONSISTENT	50	ng/mL		
MORPHINE	NEGATIVE		CONSISTENT	50	ng/mL		
HYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL		
HYDROMORPHONE	NEGATIVE		CONSISTENT	50	ng/mL		
NORHYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL		
OXYCODONE	878	POSITIVE	CONSISTENT	50	ng/mL		
OXYMORPHONE	690	POSITIVE	CONSISTENT	50	ng/mL		
MEPERIDINE	NEGATIVE		CONSISTENT	50	ng/mL		
TAPENTADOL	NEGATIVE		CONSISTENT	50	ng/mL		
FENTANYL	NEGATIVE		CONSISTENT	5.0	ng/mL		
O-DESMETHYL-CIS-TRAMADOL	NEGATIVE		CONSISTENT	50	ng/mL		
METHADONE CONFIRMATION - LC/MS/MS (1)							
EDDP	NEGATIVE		CONSISTENT	50	ng/mL		
BUPRENORPHINE CONFIRMATION - LC/MS/MS (1)							
BUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL		
NORBUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL		
BENZODIAZEPINES CONFIRMATION - LC/MS/MS (1)							
ALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL		
ALPHA-HYDROXYALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL		
7-AMINO-CLONAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL		
NORDIAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL		
OXAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL		
TEMAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL		
LORAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL		
PSYCHOTROPICS CONFIRMATION - LC/MS/MS (1)							
NORTRIPTYLINE	NEGATIVE		CONSISTENT	50	ng/mL		
ZOLPIDEM	NEGATIVE		CONSISTENT	5.0	ng/mL		
MUSCLE RELAXANTS CONFIRMATION - LC/MS/MS (1)							
MEPROBAMATE	NEGATIVE		CONSISTENT	50	ng/mL		
CYCLOBENZAPRINE CONFIRMATION - LC/MS/MS (1)							
CYCLOBENZAPRINE	NEGATIVE		CONSISTENT	50	ng/mL		
GABAPENTIN CONFIRMATION - LC/MS/MS (1)							
GABAPENTIN	NEGATIVE		CONSISTENT	50	ng/mL		
PREGABALIN CONFIRMATION - LC/MS/MS (1)							
PREGABALIN	NEGATIVE		CONSISTENT	50	ng/mL		
				000309			

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 88342	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
ORDERING PROVIDER ALVAREZ,NEISY	RECEIVED DATE 06/15/2022	COLLECTION DATE 06/06/2022		REPORTED 06/16/2022 19:39 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS THC positive on screening					Page 2 of 2

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
STIMULANTS CONFIRMATION - LC/MS/MS (1)					
AMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
MDMA	NEGATIVE		NORMAL	50	ng/mL
MDA	NEGATIVE		NORMAL	50	ng/mL
MDEA	NEGATIVE		NORMAL	50	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



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MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	06-03-2022

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back and knee pain

History of Present Illness

TELEHEALTH ENCOUNTER

AUDIO AND VIDEO COMMUNICATION

COVID-19 PUBLIC HEALTH EMERGENCY

Medications reviewed and confirmed.

CURES report and UDS checked.

52-year-old male with chronic low back and right knee pain due to work-related injury. Patient reports low back pain is constant and radiating pain to bilateral lower extremity. He has a history of lumbar spinal surgery and reports that the surgery was not very successful. He is planning a consult with a spinal specialist at Cedar Sinai.

Patient had right knee surgery May 4, 2022. He reports the low back and knee pain limit his physical activity and has to pace himself to prevent exacerbations of pain. He is not working but able to perform activities of daily living with the current pain medication regimen. He has an improved quality of life with the current pain medication. No distressing side effects reported from medications.

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U**

Pain Descriptors: Patient describes his pain as constant and tight.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation

or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

TELEMED VISIT

Physical exam deferred due to telehealth

PAIN MANAGEMENT

- UDS

Review of Medical Records:

There is a urine drug screen result from sample date November 24, 2021.

Specimen tests positive for oxycodone.

There is no illicit substances detected.

There is a CURES report.

It is consistent with prescriptions we are writing.

There is no appearance of doctor shopping for controlled substances.

We are prescribing controlled substances. The most recent urine drug screen was done on 11-24-2021.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization

Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 52-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy

It is post right knee surgery May 4, 2022. Recovering and doing physical therapy at this time.

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 12/21 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 11-24-2021.

Treatment Plan:

Refill prescriptions today.

Followup in one month's time.

Continue activities as tolerated, while avoiding exacerbating factors.

I am refilling the medications as I see no evidence of abuse, diversion, hoarding, or impairment. Adverse effects of the medications were discussed with the patient. The patient is advised not to drive or operate heavy machinery if she is in anyway impaired by the medications.

Must continue to take medications as prescribed and keep them safe from theft or loss.

The patient is not to receive pain medications from any provider outside of Universal Pain Management while under our care.

Must continue to follow up with general provider for preventive and general medical care.

Due to COVID-19, patients were screened upon arrival including taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,

FRiegler MD DME

Francis Riegler, M.D.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

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Signed in Los Angeles County, California

By

FRiegler MD DME

Francis Riegler, M.D.



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IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	04-25-2022

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: low back and knee pain

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction-

51-year-old male with chronic low back and right knee pain due to work-related injury. Patient reports low back pain is constant and radiating pain to bilateral lower extremity. He has a history of lumbar spinal surgery and reports that the surgery was not very successful and bleeding symptoms. He is planning a consult with a spinal specialist at Cedar Sinai. However, patient has scheduled right knee surgery May 4, 2022. He reports the low back and knee pain limit his physical activity and has to pace himself to prevent exacerbations of pain. He is not working but able to perform activities of daily living with the current pain medication regimen. He has an improved quality of life with the current pain medication. No distressing side effects reported from medications.

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at low back and knee pain. Current Pain Changes : NO CHANGE. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Physical Examination

No vitals due to telemedicine

PA-C

- UDS

Review of Medical Records:

We are prescribing controlled substances. The most recent urine drug screen was done on 11-24-2021.

Legal Status:

Primary Treating Physician: Philip Conwisar MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy

Right knee pain/ Meniscus Tear

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 12/21 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Tear of meniscus of right knee (S83.206A), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 11-24-2021.

Treatment Plan:

* Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction and/or other aberrant drug-related behavior, to guide treatment. The frequency of random testing is determined by an individualized opioid risk score which is based upon the patient's individual medical history, and the type and quantity of drugs prescribed.

If the results of the definitive drug test are inconsistent, it could result in the patient being denied medication refills, counseled for aberrant behavior, recommended for detoxification or terminated from this practice.
Patient is scheduled for Right knee surgery May 4, 2022

He is planning to schedule a spinal surgeon consult at Cedar Sinai regarding lumbar radiculopathy

Continue activities as tolerated, while avoiding exacerbating factors.

I am refilling the medications as I see no evidence of abuse, diversion, hoarding, or impairment. Adverse effects of the medications were discussed with the patient. The patient is advised not to drive or operate heavy machinery if she is in anyway impaired by the medications.

Must continue to take medications as prescribed and keep them safe from theft or loss.

The patient is not to receive pain medications from any provider outside of Universal Pain Management while under our care.

Must continue to follow up with general provider for preventive and general medical care.

Due to COVID-19, patients were screened upon arrival including taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,

Neisy Alvarez, PA-C

DISCLOSURE:

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Signed in Los Angeles County, California

By

Neisy Alvarez, PA-C

Shahin Sadik, M.D., Q.M.E.

This has been electronically signed by Shahin Sadik, M.D., Q.M.E. on 04-25-2022.



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IN REFERENCE	:	Bardakjian, Steevio
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COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	03-28-2022

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: low back and knee pain

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient reports that medically he has been doing much better and awaiting for potential surgical intervention for the knee as well. However insurance company is not responding to the patient regarding the surgery. The patient reports awaiting for surgery and medication for the pain allowing for functional improvement- the patient is still at home and has caught up on the medication.

The patient has followed up with orthopedic surgeon and he's hoping to get the surgery soon. The patient tells me that he will need to see the orthopedic surgeon prior to having surgery as they need to be final clearance specially given his recent myocardial infarction- The cardiologist will allow him to do surgery.

He's very motivated to return to work he tells me that he still off work due to his surgery for the hard he continues to be on blood thinners and he's hoping to get off of the blood thinner to have the knee surgery. He's also hoping to take care of her low back surgery as well prior to going back to work

The patient reports Percocet is helping but the therapy can be rigorous and would like to keep it the same. 30% improvement

Due to his low back and knee pain he is taking medication and provide significant relief.

His low back pain is aching pain in nature with intermittent radiation down the leg. His pain is also aching the clinic in sounds as noted the patient notes increased pain with weightbearing activities.

He has been recommended to take off from work. He continues on the medication and denies any side effects. It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline: 30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

Opioid Risk Tool (Male): 0.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at low back and knee pain. Current Pain Changes : NO CHANGE. Patient describes his pain as constant. **Recent**

Diagnostic Studies:

CAT Scan: No.

Discogram: No
EMG: No.
MRI: No.
Myelogram: No.
Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()
High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO
L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

Height (inches): 71.00 Weight (lbs): 195.00 **BMI:** 27. height ad weight per pt

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

PAIN MANAGEMENT

- Opioid Risk Tool

Review of Medical Records:

Auth for percocet noted and reviewed

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Depart of Justice - Bureau of Narcotic Enforcement was obtained. There are no signs of doctor shopping noted.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 12/21 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

We discussed weaning of the medication post surgery and pre-planning however at this time the patient needs the knee surgery and low back pain addressed

Knee arthroscopic procedure is on hold for the time being. -Patient has been cleared however the authorization has ran out and Extension has not been obtained yet.

Continue with medications as they're provide for significant functional benefit.- 30-40% improvement of the pain.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar

knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

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Medications prescribed:

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Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

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Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



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DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

Name: Bardakjian, Steevio
DOB: 05-23-1970
MR# UPM31805
Date of Service: 03-28-2022

Opioid Risk Tool

1. Family History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
2. Personal History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
3. Age (if 16-45)		0
4. History of Preadolescent Sexual Abuse		
5. Psychological Disease	Attention Deficit Disorder	0
	Obsessive Compulsive Disorder	
	Bipolar	
	Schizophrenia	
	Depression	0
	TOTAL	0
Total Score Risk Category		
Low Risk 0-3		

Moderate Risk 4-7
High Risk > or equal to 8



Kevin Kohan D.O.

This has been electronically signed by Kevin Kohan D.O. on 03-28-2022.



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ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	
CLAIM NUMBER	:	
WCAB NUMBER	:	
CURRENT EVALUATION	:	03-01-2022

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: Low back & knee pain

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient reports that medically he has been doing much better and awaiting for potential surgical intervention for the knee as well. The patient reports awaiting for surgery and medication for the pain allowing for functional improvement- the patient is still at home and has caught up on the medication.

The patient has followed up with orthopedic surgeon and he's hoping to get the surgery soon. The patient tells me that he will need to see the orthopedic surgeon prior to having surgery as they need to be final clearance specially given his recent myocardial infarction- The cardiologist will allow him to do surgery.

He's very motivated to return to work he tells me that he still off work due to his surgery for the hard he continues to be on blood thinners and he's hoping to get off of the blood thinner to have the knee surgery. He's also hoping to take care of her low back surgery as well prior to going back to work

The patient reports Percocet is helping but the therapy can be rigorous and would like to keep it the same. 30% improvement

Due to his low back and knee pain he is taking medication and provide significant relief.

His low back pain is aching pain in nature with intermittent radiation down the leg. His pain is also aching the clinic in sounds as noted the patient notes increased pain with weightbearing activities.

He has been recommended to take off from work. He continues on the medication and denies any side effects. It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at Low back & knee pain. Current Pain Changes : NO CHANGE. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

Height (inches): 71.00 Weight (lbs): 192.00 **BMI:** 27.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

Auth for medication

opioid contract

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. There are no signs of doctor shopping noted.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwissar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 12/21 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Knee arthroscopic procedure is on hold for the time being. -Patient has been cleared however the authorization has ran out and Extension has not been obtained yet.

Continue with medications as they're provide for significant functional benefit.- 30-40% improvement of the pain.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar

knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

Due to COVID-19, patients were screened upon arrival including rapid antigen testing, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSOCIATE PROFESSOR OF USC

FRANCIS X. RIEGLER, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
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BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSISTANT CLINICAL PROFESSOR OF USC

DANIEL ALVES, M.D.
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ARVINDER GILL, D.O.
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ROHIT CHOUDHARY M.D.
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DIPLOMATE, AMERICAN BOARD OF ANESTHESIOLOGY

ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	12-28-2021

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

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(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: Low back & knee pain

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient reports that medically he has been doing much better and awaiting for potential surgical intervention. The patient has followed up with orthopedic surgeon and he's hoping to get the surgery likely next year. The patient tells me that he will need to see the orthopedic surgeon prior to having surgery as they need to be final clearance specially given his recent myocardial infarction.M. T

He's very motivated to return to work he tells me that he still off work due to his surgery for the hard he continues to be on blood thinners and he's hoping to get off of the blood thinner to have the knee surgery. He's also hoping to take care of her low back surgery as well prior to going back to work

The patient reports Percocet is helping but the therapy can be rigorous and would like to keep it the same. 30% improvement

Due to his low back and knee pain he is taking medication and provide significant relief.

His low back pain is aching pain in nature with intermittent radiation down the leg. His pain is also aching the clinic in sounds as noted the patient notes increased pain with weightbearing activities.

He has been recommended to take off from work. He continues on the medication and denies any side effects. It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline: 30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 500 feet with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at Low back & knee pain. Current Pain Changes : No change. Patient describes his pain as constant. **Recent Diagnostic**

Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

No vitals due to telemedicine

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 12/21 report demonstrates oxycodone consistent with prescribed medication of Percocet

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to

have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

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ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Knee arthroscopic procedure is on hold for the time being. But is awaiting clearance likely in Jan 2022

Continue with medications as they're provide for significant functional benefit.- 30-40% improvement of the pain.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar

knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

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continue opioid medications.

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We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 80489	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 12/03/2021	COLLECTION DATE 11/24/2021		REPORTED 12/03/2021 19:07 PDT	
COMMENT IMMUNOASSAY SCREENING					

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
SPECIMEN VALIDITY TESTING (1)					
CREATININE	215		NORMAL	>=20	mg/dL
pH	5.6		NORMAL	4.7-7.8	
SPECIFIC GRAVITY	1.020		NORMAL	1.003-1.035	g/mL
OXIDANT	-15		NORMAL	<=200	ug/mL
TOXICOLOGY SCREEN (1)					
AMPHETAMINES	NEGATIVE		NORMAL	500	ng/mL
BARBITURATES	NEGATIVE		NORMAL	200	ng/mL
BENZODIAZEPINES	NEGATIVE		NORMAL	200	ng/mL
BUPRENORPHINE	NEGATIVE		NORMAL	5	ng/mL
COCAINE	NEGATIVE		NORMAL	300	ng/mL
CANNABINOIDS	NEGATIVE		NORMAL	50	ng/mL
CARISOPRODOL	NEGATIVE		NORMAL	100	ng/mL
ETHANOL	NEGATIVE		NORMAL	100	ng/mL
FENTANYL	NEGATIVE		NORMAL	2	ng/mL
EDDP (METHADONE METABOLITE)	NEGATIVE		NORMAL	300	ng/mL
OPIATES	NEGATIVE		NORMAL	300	ng/mL
OXYCODONE	POSITIVE		HIGH	100	ng/mL
**See LC/MS/MS for confirmation					
PHENCYCLIDINE	NEGATIVE		NORMAL	25	ng/mL
MDMA (ECSTACY)	NEGATIVE		NORMAL	500	ng/mL
METHAMPHETAMINE	NEGATIVE		NORMAL	500	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



Summary of Findings
UNIVERSAL PAIN MANAGEMENT
819 Auto Center Drive
Palmdale, CA 93551
Phone: (661) 267-6876 x156
Lab Director - Earl Weissman, PhD

PATIENT NAME BARDAKJIAN, STEEVIO		LAB REF # 80490	Patient ID 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 11/24/2021	COLLECTION DATE 11/24/2021		REPORTED DATE 12/06/2021 20:13	

CONSISTENT RESULTS - REPORTED MEDICATION (PARENT DRUG AND/OR METABOLITE) DETECTED

REPORTED PRESCRIPTION	ANTICIPATED POSITIVE(S)	TEST OUTCOME	DETECTION WINDOW
Percocet	OXYMORPHONE	POSITIVE	
Percocet	OXYCODONE	POSITIVE	

ADDITIONAL MEDICATIONS REPORTED BUT NOT TESTED FOR IN THIS REPORT

Crestor,Calcium,Ferrous Sulfate,Diltiazem,Vitamin D,Aspirin

000342

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 80490	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 12/03/2021	COLLECTION DATE 11/24/2021		REPORTED 12/06/2021 20:13 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS	Page 1 of 2				

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
ILLCIT DRUG CONFIRMATION - LC/MS/MS (1)					
6-MONOACETYL MORPHINE (Metabolite)	NEGATIVE		NORMAL	50	ng/mL
BENZOYLECGONINE	NEGATIVE		NORMAL	50	ng/mL
METHAMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	50	ng/mL
OPIATES/OPIOIDS CONFIRMATION - LC/MS/MS (1)					
CODEINE	NEGATIVE		CONSISTENT	50	ng/mL
MORPHINE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROMORPHONE	NEGATIVE		CONSISTENT	50	ng/mL
NORHYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
OXYCODONE	3059	POSITIVE	CONSISTENT	50	ng/mL
OXYMORPHONE	2200	POSITIVE	CONSISTENT	50	ng/mL
MEPERIDINE	NEGATIVE		CONSISTENT	50	ng/mL
TAPENTADOL	NEGATIVE		CONSISTENT	50	ng/mL
FENTANYL	NEGATIVE		CONSISTENT	5.0	ng/mL
O-DESMETHYL-CIS-TRAMADOL	NEGATIVE		CONSISTENT	50	ng/mL
METHADONE CONFIRMATION - LC/MS/MS (1)					
EDDP	NEGATIVE		CONSISTENT	50	ng/mL
BUPRENORPHINE CONFIRMATION - LC/MS/MS (1)					
BUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
NORBUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
BENZODIAZEPINES CONFIRMATION - LC/MS/MS (1)					
ALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
ALPHA-HYDROXYALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
7-AMINO-CLONAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
NORDIAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
OXAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
TEMAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
LORAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
PSYCHOTROPICS CONFIRMATION - LC/MS/MS (1)					
NORTRIPTYLINE	NEGATIVE		CONSISTENT	50	ng/mL
ZOLPIDEM	NEGATIVE		CONSISTENT	5.0	ng/mL
MUSCLE RELAXANTS CONFIRMATION - LC/MS/MS (1)					
MEPROBAMATE	NEGATIVE		CONSISTENT	50	ng/mL
CYCLOBENZAPRINE CONFIRMATION - LC/MS/MS (1)					
CYCLOBENZAPRINE	NEGATIVE		CONSISTENT	50	ng/mL
GABAPENTIN CONFIRMATION - LC/MS/MS (1)					
GABAPENTIN	NEGATIVE		CONSISTENT	50	ng/mL
PREGABALIN CONFIRMATION - LC/MS/MS (1)					
PREGABALIN	NEGATIVE		CONSISTENT	50	ng/mL

000343

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 80490	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 12/03/2021	COLLECTION DATE 11/24/2021		REPORTED 12/06/2021 20:13 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS	Page 2 of 2				

PRESCRIBED MEDICATIONS

Aspirin, Calcium, Crestor, Diltiazem, Ferrous Sulfate, Percocet, Vitamin D

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
STIMULANTS CONFIRMATION - LC/MS/MS (1)					
AMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
MDMA	NEGATIVE		NORMAL	50	ng/mL
MDA	NEGATIVE		NORMAL	50	ng/mL
MDEA	NEGATIVE		NORMAL	50	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



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MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	11-30-2021

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: Low back & knee pain

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient is doing better and has reversed DM. The patient is trying to schedule knee surgery and pending. The patient has been able to do well and he's hoping to get clearance to proceed with the knee surgery as directed by the patient's orthopedic surgeon. The patient has had follow up with cardiologist and doing well with medications. Low back and leg pain is the same.

He is interested to proceed with at least a knee surgery prior to returning to work and in the future will decide upon performing even low back surgery but right now it's too early to do this combination of therapies the patient or several questions that were addressed regarding this.

The patient reports Percocet is helping but the therapy can be rigorous and would like to keep it the same. 30% improvement

Due to his low back and knee pain he is taking medication and provide significant relief.

His low back pain is aching pain in nature with intermittent radiation down the leg. His pain is also aching the clinic in sounds as noted the patient notes increased pain with weightbearing activities.

He has been recommended to take off from work. He continues on the medication and denies any side effects.

***Interval F/U Scales:** Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at Low back & knee pain. Current Pain Changes : No change. Patient describes his pain as constant. **Recent Diagnostic**

Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Other: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

No vitals due to telemedicine

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

We are prescribing controlled substances. The most recent urine drug screen was done on 11-24-2021.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 5/21 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 11-24-2021.

Treatment Plan:

Knee arthroscopic procedure is on hold for the time being. But is awaiting clearance likely in Jan 2022

Continue with medications as they're provide for significant functional benefit.- 30-40% improvement of the pain.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

Due to COVID-19, patients were screened upon arrival including rapid antigen testing, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



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MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	11-02-2021

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: Low back & knee pain

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient will have echo result and s/p open heart surgery 6/29/21 and is in cardiac rehabilitation until first week of dec 2021. The patient has been able to get off both blood thinner and diabetes medicatioin. Diet controlled foods. The patient has been able to do well and he's hoping to get clearance to proceed with the knee surgery as directed by the patient's orthopedic surgeon. The patient has had follow up with cardiologist and doing well wil medications. Low back and leg pain is the same.

He is interested to proceed with at least a knee surgery prior to returning to work and in the future will decide upon performing even low back surgery but right now it's too early to do this combination of therapies the patient or several questions that were addressed regarding this.

The patient reports Percocet is helping but the therapy can be rigorous and would like to keep it the same. 30% improvement

Due to his low back and knee pain he is taking medication and provide significant relief.

His low back pain is aching pain in nature with intermittent radiation down the leg. His pain is also aching the clinic in sounds as noted the patient notes increased pain with weightbearing activities.

He has been recommended to take off from work. He continues on the medication and denies any side effects.

***Interval F/U Scales:** Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at Low back & knee pain. Current Pain Changes : No change. Patient describes his pain as constant. **Recent Diagnostic**

Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

No vitals - telemedicine appointment.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

The most recent urine drug screen was done on 05-24-2021.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 5/21 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

The most recent urine drug screen was done on 05-24-2021.

Treatment Plan:

* Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction and/or other aberrant drug-related behavior, to guide treatment. The frequency of random

testing is determined by an individualized opioid risk score which is based upon the patient's individual medical history, and the type and quantity of drugs prescribed.

If the results of the definitive drug test are inconsistent, it could result in the patient being denied medication refills, counseled for aberrant behavior, recommended for detoxification or terminated from this practice.

Follow up with cardiologist

Patient had CABG procedure and the Knee arthroscopic procedure is on hold for the time being.

Continue with medications as they're provide for significant functional benefit.- 30-40% improvement of the pain.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar

knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

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Due to COVID-19, patients were screened upon arrival including rapid antigen testing, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

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We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6

months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6-month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

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Signed in Los Angeles County, California
By



Kevin Kohan, D.O.



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MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	10-01-2021

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: low back and knee

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient had open heart surgery 6/29/21 and is in cardiac rehabilitation and will be done at the end of month and repeat echo will be done. The patient has been able to do well and he's hoping to get clearance to proceed with the knee surgery as directed by the patient's orthopedic surgeon. The patient has had follow up with cardiologist and doing well with medications. Low back and leg pain is the same.

He is interested to proceed with at least a knee surgery prior to returning to work and in the future will decide upon performing even low back surgery but right now it's too early to do this combination of therapies the patient or several questions that were addressed regarding this.

The patient reports Percocet is helping but the therapy can be rigorous and would like to keep it the same.

Due to his low back and knee pain he is taking medication and provide significant relief.

His low back pain is aching pain in nature with intermittent radiation down the leg. His pain is also aching the clinic in sounds as noted the patient notes increased pain with weightbearing activities.

He has been recommended to take off from work. He continues on the medication and denies any side effects.

***Interval F/U Scales:** Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at low back pain/knee. Current Pain Changes : no changes. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Legal Status:

Primary Treating Physician: Philip Conwisar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 5/21 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Patient had CABG procedure and the Knee arthroscopic procedure is on hold for the time being.

Continue with medications as they're provide for significant functional benefit.- 30-40% improvement of the pain.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

Due to COVID-19, patients were screened upon arrival including rapid antigen testing, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications

and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	09-03-2021

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: low back pain/knee

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient had open heart surgery 6/29/21 and reports that HgA1c dropped to less 5.7. And the patient has been taken off of the diabetics allocation is no longer known as diabetic. The patient is very happy as he was able to beat this disease process. The patient is doing better and able to bike for now 40 minutes at a time. The patient has been able to do well and will start cardiac rehab. The patient has had follow up with cardiologist and doing well with medications. Low back and leg pain is the same.

I do patients interested to proceed with at least a knee surgery prior to returning to work and in the future will decide upon performing even low back surgery but right now it's too early to do this combination of therapies the patient or several questions that were addressed regarding this.

The patient reports Percocet is helping but the therapy can be rigorous and would like to keep it the same.

Due to his low back and knee pain he is taking medication and provide significant relief.

His low back pain is aching pain in nature with intermittent radiation down the leg. His pain is also aching the clinic in sounds as noted the patient notes increased pain with weightbearing activities.

He has been recommended to take off from work. He continues on the medication and denies any side effects. It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline: 30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing, grooming, dressing, transfers, ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 5 on the pain scale. **Pain Descriptors:** Location of pain is at low back pain /knee. Current Pain Changes : no changes. Patient describes his pain as aching and shooting. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies rash or itching.

Heme-Immuno: Denies fever, chills, easy bruising or bleeding or HIV or AIDS. There is no swollen glands or cancer.

ENT: Denies change in hearing or sore throat.

Respiratory: Denies cough, shortness of breath, bronchitis or tuberculosis. There is no coughing up blood.

Gastro-Intestinal: Denies nausea, vomiting, diarrhea, blood in stool or constipation. There is no loss of bowel control.

Neurological: Denies numbness or seizures.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight.

Genito-urinary: Denies blood in urine, pain on urination or loss of bladder control. There is no kidney problems.

Eyes: Denies blurry vision or loss of vision.

Musculoskeletal: Denies weakness or osteoporosis.

Endocrine: Denies diabetes or hypothyroidism.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

Opioid contract reviewed

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisar MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 5/21 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Patient had CABG procedure and prior to Knee arthroscopic procedure in preoperative stage the patient was cancelled.

Patient is recovering from the open heart surgery but continues to have significant low back and knee pain and requires continuation of Percocet which provided 30% improvement of the pain been able to do functional improvement and the necessary

Continue with medications as they're provide for significant functional benefit.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping.

Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

Due to COVID-19, patients were screened upon arrival including rapid antigen testing, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



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ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.Ac.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	08-06-2021

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	() Change in Treatment Plan	() Release from Care
() Change in Work Status	() Need for Referral or Consultation	() Response to Release for Information
() Change in Patient Condition	() Need for Surgery or Hospitalization	(X) Request for Authorization
() Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: back pain

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient had open heart surgery 6/29/21 and reports that HgA1c dropped to 5.7. The patient has been able to do well and will start cardiac rehab. The patient has had follow up with cardiologist and doing well with medications. Low back and leg pain is the same.

The patient reports Percocet is helping but the therapy can be rigorous and would like to keep it the same.

Due to his low back and knee pain he is taking medication and provide significant relief.

His low back pain is aching pain in nature with intermittent radiation down the leg. His pain is also aching the clinic in sounds as noted the patient notes increased pain with weightbearing activities.

He has been recommended to take off from work. He continues on the medication and denies any side effects.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline: 30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing, grooming, dressing, transfers, ambulation and preparing of meals with the aid of the medications AS

EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 5 on the pain scale. **Pain Descriptors:** Location of pain is at back pain.

Current Pain Changes : no change. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO
L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

No vitals due to telemed

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

Opioid contract reviewed

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 5/21 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Patient had CABG procedure and prior to Knee arthroscopic procedure in preoperative stage the patient was cancelled.

Patient is recovering from the open heart surgery but continues to have significant low back and knee pain and requires continuation of Percocet which provided 30% improvement of the pain been able to do functional improvement and the necessary

Continue with medications as they're provide for significant functional benefit.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

Due to COVID-19, patients were screened upon arrival including rapid antigen testing, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and

appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



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MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	07-09-2021

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/>) Change in Treatment Plan	(<input type="checkbox"/>) Release from Care
(<input type="checkbox"/>) Change in Work Status	(<input type="checkbox"/>) Need for Referral or Consultation	(<input type="checkbox"/>) Response to Release for Information
(<input type="checkbox"/>) Change in Patient Condition	(<input type="checkbox"/>) Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/>) Request for Authorization
(<input type="checkbox"/>) Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: back pain

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient had open heart surgery 6/29/21 few weeks ago as the patient was discharged. The patient is at home now. The angiogram shows that there was >70% blockage. No complication with the surgery. His Echo came back with 100% function - The incision site is fully healed. He had syncopal episode and low pressure. He has also developed anxiety and depression. He is doing better overall now.

The patient will go through cardiac rehab.

Due to his low back and knee pain he is taking medication and provide significant relief.

His low back pain is aching pain in nature with intermittent radiation down the leg. His pain is also aching the clinic in sounds as noted the patient notes increased pain with weightbearing activities.

He has been recommended to take off from work. He continues on the medication and denies any side effects. It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline: 30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 9 on the pain scale. **Pain Descriptors:** Location of pain is at back pain.

Current Pain Changes : no change. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()
High Blood Pressure ()

Surgical History

Open heart surgery: 06-29-2021 at HENRY MAYO
L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

QUAD by pass surgery last week

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination. Healed incision over the anterior chest wall secondary to the open heart surgeries noted

Review of Medical Records:

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

Opioid contract reviewed

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 60 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 5/21 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Patient had CABG procedure and prior to Knee arthroscopic procedure in preoperative stage the patient was cancelled.

Patient is recovering from the open heart surgery but continues to have significant low back and knee pain and requires continuation of Percocet which provided 30% improvement of the pain been able to do functional improvement and the necessary

Anxiety with increased blood pressure - Start buspirone 7.5 BID

Failed other medication and CBT.

Continue with medications as they're provide for significant functional benefit.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar

knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

Due to COVID-19, patients were screened upon arrival including rapid antigen testing, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was

performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

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*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



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MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	06-11-2021

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/>) Change in Treatment Plan	(<input type="checkbox"/>) Release from Care
(<input type="checkbox"/>) Change in Work Status	(<input type="checkbox"/>) Need for Referral or Consultation	(<input type="checkbox"/>) Response to Release for Information
(<input type="checkbox"/>) Change in Patient Condition	(<input type="checkbox"/>) Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/>) Request for Authorization
(<input type="checkbox"/>) Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: back pain

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient endorses as a result of the MI he is awaiting for clearance. His Echo came back with 100% function - He had syncopal episode and low pressure. He has also developed anxiety and depression. He continues to take his blood pressure but he thinks that secondary anxiety and depression is affecting the patient severely.

Due to his low back and knee pain he is taking medication and provide significant relief.

He has been recommended to take off from work. He continues on the medication and denies any side effects. It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

Opioid Risk Tool (Male): 0 .

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 9 on the pain scale. **Pain Descriptors:** Location of pain is at back pain.

Current Pain Changes : no change. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

NO VITALS DUE TO TELEMED

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

PAIN MANAGEMENT

- Opioid Dose Calculator
- Opioid Risk Tool

Review of Medical Records:

May 2021 UDS reviewed and noted for oxycodone and metabolite.

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

Opioid contract reviewed

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic

therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 11/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Patient had some sort of cardiac event and prior to Knee arthroscopic procedure in preoperative stage the patient was cancelled.

The patient has had echo with 100% function of the heart. Angiography and potential angioplasty is scheduled

Anxiety with increased blood pressure - Start buspirone 7.5 BID

Failed other medication and CBT.

Continue with medications as they're provide for significant functional benefit.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar

knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

Due to COVID-19, patients were screened upon arrival including rapid antigen testing, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

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Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation

legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

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Signed in Los Angeles County, California
By

Kevin Kohan, D.O.



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DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

Name : Steevio Bardakjian

MR# UPM31805

Date of Operation: 06-11-2021

DOB: 05-23-1970

Opioid Dose Calculator

Category	Test	Result	Remarks
Opioid Dose Calculator			
1	Oxycodone (mg per day)	30	
2	Oxycodone: Morphine Equivalent	45	
3	Oxycodone - Total no. of pills prescribed	90	
4	Oxycodone - No. of days pills prescribed for	30	
5	Oxycodone - mg/pill	10	
6	Oxycodone - Med deviation	30	
7	Total Daily Morphine Equivalent Dose	45	

Combined risk category using Opioid risk tool and Opioid dose is

* Based on information published by University of California, San Francisco and University of Rochester, Dept. of Palliative Care.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 06-11-2021.



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DOB: 05-23-1970
MR# UPM31805
Date of Service: 06-11-2021

Opioid Risk Tool

1. Family History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
2. Personal History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
3. Age (if 16-45)		0
4. History of Preadolescent Sexual Abuse		
5. Psychological Disease	Attention Deficit Disorder	0
	Obsessive Compulsive Disorder	
	Bipolar	
	Schizophrenia	
	Depression	0

TOTAL	0
--------------	---

Total Score Risk Category

Low Risk 0-3

Moderate Risk 4-7

High Risk > or equal to 8



Kevin Kohan D.O.

This has been electronically signed by Kevin Kohan D.O. on 06-11-2021.

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 73083	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 06/02/2021	COLLECTION DATE 05/24/2021		REPORTED 06/02/2021 18:17 PDT	
COMMENT IMMUNOASSAY SCREENING					

PRESCRIBED MEDICATIONS

BUSPirone, Metformin, Percocet

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
SPECIMEN VALIDITY TESTING (1)					
CREATININE	99		NORMAL	>=20	mg/dL
pH	5.4		NORMAL	4.7-7.8	
SPECIFIC GRAVITY	1.021		NORMAL	1.003-1.035	g/mL
OXIDANT	-48		NORMAL	<=200	ug/mL
TOXICOLOGY SCREEN (1)					
AMPHETAMINES	NEGATIVE		NORMAL	500	ng/mL
BARBITURATES	NEGATIVE		NORMAL	200	ng/mL
BENZODIAZEPINES	NEGATIVE		NORMAL	200	ng/mL
BUPRENORPHINE	NEGATIVE		NORMAL	5	ng/mL
COCAINE	NEGATIVE		NORMAL	300	ng/mL
CANNABINOIDS	NEGATIVE		NORMAL	50	ng/mL
CARISOPRODOL	NEGATIVE		NORMAL	100	ng/mL
ETHANOL	NEGATIVE		NORMAL	100	ng/mL
FENTANYL	NEGATIVE		NORMAL	2	ng/mL
EDDP (METHADONE METABOLITE)	NEGATIVE		NORMAL	300	ng/mL
OPIATES	NEGATIVE		NORMAL	300	ng/mL
OXYCODONE	POSITIVE		HIGH	100	ng/mL
**See LC/MS/MS for confirmation					
PHENCYCLIDINE	NEGATIVE		NORMAL	25	ng/mL
MDMA (ECSTACY)	NEGATIVE		NORMAL	500	ng/mL
METHAMPHETAMINE	NEGATIVE		NORMAL	500	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



Summary of Findings
UNIVERSAL PAIN MANAGEMENT
819 Auto Center Drive
Palmdale, CA 93551
Phone: (661) 267-6876 x156
Lab Director - Earl Weissman, PhD

PATIENT NAME BARDAKJIAN, STEEVIO		LAB REF # 73084	Patient ID 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 05/24/2021	COLLECTION DATE 05/24/2021		REPORTED DATE 06/03/2021 10:09	

CONSISTENT RESULTS - REPORTED MEDICATION (PARENT DRUG AND/OR METABOLITE) DETECTED

REPORTED PRESCRIPTION	ANTICIPATED POSITIVE(S)	TEST OUTCOME	DETECTION WINDOW
Percocet	OXYMORPHONE	POSITIVE	
Percocet	OXYCODONE	POSITIVE	

ADDITIONAL MEDICATIONS REPORTED BUT NOT TESTED FOR IN THIS REPORT

Metformin,BUSPirone

000390

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 73084	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 06/02/2021	COLLECTION DATE 05/24/2021		REPORTED 06/03/2021 10:09 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS	Page 1 of 2				

PRESCRIBED MEDICATIONS

BUSPirone, Metformin, Percocet

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
ILLCIT DRUG CONFIRMATION - LC/MS/MS (1)					
6-MONOACETYL MORPHINE (Metabolite)	NEGATIVE		NORMAL	50	ng/mL
BENZOYLECGONINE	NEGATIVE		NORMAL	50	ng/mL
METHAMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	50	ng/mL
OPIATES/OPIOIDS CONFIRMATION - LC/MS/MS (1)					
CODEINE	NEGATIVE		CONSISTENT	50	ng/mL
MORPHINE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROMORPHONE	NEGATIVE		CONSISTENT	50	ng/mL
NORHYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
OXYCODONE	1987	POSITIVE	CONSISTENT	50	ng/mL
OXYMORPHONE	1707	POSITIVE	CONSISTENT	50	ng/mL
MEPERIDINE	NEGATIVE		CONSISTENT	50	ng/mL
TAPENTADOL	NEGATIVE		CONSISTENT	50	ng/mL
FENTANYL	NEGATIVE		CONSISTENT	5.0	ng/mL
O-DESMETHYL-CIS-TRAMADOL	NEGATIVE		CONSISTENT	50	ng/mL
METHADONE CONFIRMATION - LC/MS/MS (1)					
EDDP	NEGATIVE		CONSISTENT	50	ng/mL
BUPRENORPHINE CONFIRMATION - LC/MS/MS (1)					
BUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
NORBUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
BENZODIAZEPINES CONFIRMATION - LC/MS/MS (1)					
ALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
ALPHA-HYDROXYALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
7-AMINO-CLONAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
NORDIAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
OXAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
TEMAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
LORAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
PSYCHOTROPICS CONFIRMATION - LC/MS/MS (1)					
NORTRIPTYLINE	NEGATIVE		CONSISTENT	50	ng/mL
ZOLPIDEM	NEGATIVE		CONSISTENT	5.0	ng/mL
MUSCLE RELAXANTS CONFIRMATION - LC/MS/MS (1)					
MEPROBAMATE	NEGATIVE		CONSISTENT	50	ng/mL
CYCLOBENZAPRINE CONFIRMATION - LC/MS/MS (1)					
CYCLOBENZAPRINE	NEGATIVE		CONSISTENT	50	ng/mL
GABAPENTIN CONFIRMATION - LC/MS/MS (1)					
GABAPENTIN	NEGATIVE		CONSISTENT	50	ng/mL
PREGABALIN CONFIRMATION - LC/MS/MS (1)					
PREGABALIN	NEGATIVE		CONSISTENT	50	ng/mL

000391



A Comprehensive Approach to Pain and Rehabilitation

Final Report UNIVERSAL PAIN MANAGEMENT

819 Auto Center Drive

Palmdale, CA 93551

Phone: (661) 267-6876 x156

Lab Director - Earl Weissman PhD

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 73084	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 06/02/2021	COLLECTION DATE 05/24/2021		REPORTED 06/03/2021 10:09 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS	Page 2 of 2				

PRESCRIBED MEDICATIONS

BUSPirone, Metformin, Percocet

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
STIMULANTS CONFIRMATION - LC/MS/MS (1)					
AMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
MDMA	NEGATIVE		NORMAL	50	ng/mL
MDA	NEGATIVE		NORMAL	50	ng/mL
MDEA	NEGATIVE		NORMAL	50	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



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MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	05-14-2021

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/>) Change in Treatment Plan	(<input type="checkbox"/>) Release from Care
(<input type="checkbox"/>) Change in Work Status	(<input type="checkbox"/>) Need for Referral or Consultation	(<input type="checkbox"/>) Response to Release for Information
(<input type="checkbox"/>) Change in Patient Condition	(<input type="checkbox"/>) Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/>) Request for Authorization
(<input type="checkbox"/>) Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: back pain

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient endorses as a result of the MI he is awaiting for clearance. He had syncopal episode and low pressure. He has also developed anxiety and depression. He continues to take his blood pressure but he thinks that secondary anxiety and depression is affecting the patient severely.

Due to his low back and knee pain he is taking medication and provide significant relief.

He has been recommended to take off from work. He continues on the medication and denies any side effects.

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at back pain.

Current Pain Changes : no change. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

NO VITALS DUE TO TELEMED

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect

are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

Opioid contract reviewed

We are prescribing controlled substances. There are no recent drug screens to review. The most recent urine drug screen was done on 11-04-2020. The CURES database was reviewed. It shows no evidence of doctor shopping.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwissar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 11/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. There are no recent drug screens to review. The most recent urine drug screen was done on 11-04-2020. The CURES database was reviewed. It shows no evidence of doctor shopping.

Treatment Plan:

Patient had some sort of cardiac event and prior to Knee arthroscopic procedure in preoperative stage the patient was cancelled.

Anxiety with increased blood pressure - Start buspirone 7.5 BID
Failed other medication and CBT.

Continue with medications as they're provide for significant functional benefit.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

Due to COVID-19, patients were screened upon arrival including rapid antigen testing, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of

function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6-month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California
By



Kevin Kohan, D.O.



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MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	04-16-2021

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/>) Change in Treatment Plan	(<input type="checkbox"/>) Release from Care
(<input type="checkbox"/>) Change in Work Status	(<input type="checkbox"/>) Need for Referral or Consultation	(<input type="checkbox"/>) Response to Release for Information
(<input type="checkbox"/>) Change in Patient Condition	(<input type="checkbox"/>) Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/>) Request for Authorization
(<input type="checkbox"/>) Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: back pain

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient endorses that during the pre-operative. He was told he has had heart attack few months ago. He also has had abnormal labs and thallium test which he had reaction. He had syncopal episode and low pressure. He has also developed anxiety and depression. He continues to take his blood pressure but he thinks that secondary anxiety and depression is affecting the patient severely.

Due to his low back and

He has been recommended to take off from work. He continues on the medication and denies any side effects. It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

Opioid Risk Tool (Male): 0 .

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:**

The patient reports that their pain with medications is a 0 on a scale of 0-10. Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at back pain. Current Pain Changes : no change. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()
High Blood Pressure ()

Surgical History

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

NO VITALS DUE TO TELEMED

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

PAIN MANAGEMENT

- Opioid Dose Calculator
- Opioid Risk Tool

Review of Medical Records:

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

Opioid contract reviewed

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwissar MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to

have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 11/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Patient had some sort of cardiac event and prior to Knee arthroscopic procedure in preoperative stage the patient was cancelled.

Anxiety with increased blood pressure - Start buspirone 7.5 BID
Failed other medication and CBT.

Continue with medications as they're provide for significant functional benefit.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

Due to COVID-19, patients were screened upon arrival including rapid antigen testing, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet
buspirone 7.5 mg tablet 1 Tablet Twice a Day for 30 Days , Prescribe 60 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all

impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*

Kevin Kohan, D.O.



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BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
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DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

Name: Bardakjian, Steevio
DOB: 05-23-1970

MR# UPM31805

Date of Service: 04-16-2021

Opioid Risk Tool

1. Family History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
2. Personal History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
3. Age (if 16-45)		0
4. History of Preadolescent Sexual Abuse		
5. Psychological Disease	Attention Deficit Disorder	0
	Obsessive Compulsive Disorder	
	Bipolar	
	Schizophrenia	
	Depression	0
	TOTAL	0
Total Score Risk Category		
Low Risk 0-3		
Moderate Risk 4-7		
High Risk > or equal to 8		



Kevin Kohan D.O.

This has been electronically signed by Kevin Kohan D.O. on 04-16-2021.



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MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

Name : Steevio Bardakjian

MR# UPM31805

Date of Operation: 04-16-2021

DOB: 05-23-1970

Opioid Dose Calculator

Category	Test	Result	Remarks
Opioid Dose Calculator			
1	Oxycodone (mg per day)	30	
2	Oxycodone: Morphine Equivalent	45	
3	Oxycodone - Total no. of pills prescribed	90	
4	Oxycodone - No. of days pills prescribed for	30	
5	Oxycodone - mg/pill	10	
6	Oxycodone - Med deviation	30	
7	Total Daily Morphine Equivalent Dose	45	

Combined risk category using Opioid risk tool and Opioid dose is

* Based on information published by University of California, San Francisco and University of Rochester, Dept. of Palliative Care.

A handwritten signature in black ink, appearing to read 'Bardakjian' or a similar name.

Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 04-16-2021.



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MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	
CLAIM NUMBER	:	
WCAB NUMBER	:	
CURRENT EVALUATION	:	03-19-2021

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/>) Change in Treatment Plan	(<input type="checkbox"/>) Release from Care
(<input type="checkbox"/>) Change in Work Status	(<input type="checkbox"/>) Need for Referral or Consultation	(<input type="checkbox"/>) Response to Release for Information
(<input type="checkbox"/>) Change in Patient Condition	(<input type="checkbox"/>) Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/>) Request for Authorization
(<input type="checkbox"/>) Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: back pain

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient endorses that he is scheduled for the knee arthroscopic procedure next week. He is also weaning down on the opioids as. I recommended to be able to control post pain. He's excited about getting some relief as far as the knee pain goes. He denies any new onset of numbness or weakness.

He has been recommended to take off from work. He continues on the medication and denies any side effects. It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:**

The patient reports that their pain with medications is a 0 on a scale of 0-10. Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at back pain. Current Pain Changes : no change. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

NO VITALS DUE TO TELEMED

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

UDS reviewed and consistent with the medication

* A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. This is a prescription drug monitoring program (PDMP). There are no signs of doctor shopping noted.

Opioid contract reviewed

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization

Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwissar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 11/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome

(M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Knee arthroscopic procedure scheduled March 26- recommended to wean off opioids prior to the procedure.

Continue with medications as they're provide for significant functional benefit.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

Due to COVID-19, patients were screened upon arrival including rapid antigen testing, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is

made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



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MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	02-23-2021

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/>) Change in Treatment Plan	(<input type="checkbox"/>) Release from Care
(<input type="checkbox"/>) Change in Work Status	(<input type="checkbox"/>) Need for Referral or Consultation	(<input type="checkbox"/>) Response to Release for Information
(<input type="checkbox"/>) Change in Patient Condition	(<input type="checkbox"/>) Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/>) Request for Authorization
(<input type="checkbox"/>) Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: back pain

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient endorses that he is scheduled for the knee arthroscopic procedure end of March 2021. He's excited about getting some relief as far as the knee pain goes. He denies any new onset of numbness or weakness. The patient is able to continue to work and only means that he has to continue to work is the medication he reports that the medication provides for significant pain relief for the patient is able to do activities of daily living and work full-time.

He continues to work with that medication combination. The patient has followup with orthopedic surgeon Reportedly originally thought that there was an authorization but then has come out and said that there is no authorization. Patient denies any new onset of numbness or weakness.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:**

The patient reports that their pain with medications is a 0 on a scale of 0-10. Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at back pain. Current Pain Changes : no change. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

No vitals due to telemed

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. There are no signs of doctor shopping noted.

Auth for medication

uds 11/20 cw medication Percocet

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 11/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Knee arthroscopic procedure scheduled March 26- recommended to wean off opioids prior to the procedure.

Continue with medications as they're provide for significant functional benefit.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

Due to COVID-19, patients were screened upon arrival including rapid antigen testing, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication

Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation

legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



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MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	
CLAIM NUMBER	:	
WCAB NUMBER	:	
CURRENT EVALUATION	:	01-26-2021

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/>) Change in Treatment Plan	(<input type="checkbox"/>) Release from Care
(<input type="checkbox"/>) Change in Work Status	(<input type="checkbox"/>) Need for Referral or Consultation	(<input type="checkbox"/>) Response to Release for Information
(<input type="checkbox"/>) Change in Patient Condition	(<input type="checkbox"/>) Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/>) Request for Authorization
(<input type="checkbox"/>) Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: back pain

History of Present Illness

The patient was seen via telemedicine audio and visual due to COVID restriction- The patient is holding off any type of surgery till post epidemic, however admits that he got the second vaccine and will likely try to have surgery by end of March 2021. The patient is able to continue to work and only means that he has to continue to work is the medication he reports that the medication provides for significant pain relief for the patient is able to do activities of daily living and work full-time.

He continues to work with that medication combination. The patient has followup with orthopedic surgeon. Reportedly originally thought that there was an authorization but then has come out and said that there is no authorization. Patient denies any new onset of numbness or weakness.

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:**

The patient reports that their pain with medications is a 0 on a scale of 0-10. Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at back pain. Current Pain Changes : no changes. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 11/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisar MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 11/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Continue with medications as they're provide for significant functional benefit.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar

knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

Due to COVID-19, patients were screened upon arrival including rapid antigen testing, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

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Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



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MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	12-29-2020

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/>) Change in Treatment Plan	(<input type="checkbox"/>) Release from Care
(<input type="checkbox"/>) Change in Work Status	(<input type="checkbox"/>) Need for Referral or Consultation	(<input type="checkbox"/>) Response to Release for Information
(<input type="checkbox"/>) Change in Patient Condition	(<input type="checkbox"/>) Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/>) Request for Authorization
(<input type="checkbox"/>) Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: back pain

History of Present Illness

The patient was seen via telemedicine audio and visual - The patient is holding off any type of surgery till post epidemic, however admits that he got the vaccine and will likely try to have surgery by end of Feb 2021. The patient is able to continue to work and only means that he has to continue to work as the medication he reports that the medication provides for significant pain relief for the patient is able to do activities of daily living and work full-time. He continues to work with that medication combination. The patient has followup with orthopedic surgeon Reportedly originally thought that there was an authorization but then has come out and said that there is no authorization. Patient denies any new onset of numbness or weakness.

The patient continues with medications to alleviate the pain the patient denies any side effects the patient reports that there is functional improvement or the patient is able to work

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:**

The patient reports that their pain with medications is a 0 on a scale of 0-10. Pain at present is 8 on the pain scale. **Pain Descriptors:** Location of pain is at back pain. Current Pain Changes : no changes. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

PAIN MANAGEMENT

- UDS

Review of Medical Records:

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. There are no signs of doctor shopping noted.

We are prescribing controlled substances. There are no recent drug screens to review. The most recent urine drug screen was done on 11-04-2020. The CURES database was reviewed. It shows no evidence of doctor shopping.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 11/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. There are no recent drug screens to review. The most recent urine drug screen was done on 11-04-2020. The CURES database was reviewed. It shows no evidence of doctor shopping.

Treatment Plan:

Continue with medications as they're provide for significant functional benefit.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

Due to COVID-19, patients were screened upon arrival including rapid antigen testing, taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

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Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

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*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	
CLAIM NUMBER	:	
WCAB NUMBER	:	
CURRENT EVALUATION	:	11-30-2020

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: back pain

History of Present Illness

The patient was seen via telemedicine audio and visual - The patient is holding off any type of surgery till post epidemic. The patient is able to continue to work and only means that he has to continue to work as the medication he reports that the medication provides for significant pain relief for the patient is able to do activities of daily living and work full-time. He continues to work with that medication combination. The patient has followup with orthopedic surgeon Reportedly originally thought that there was an authorization but then has come out and said that there is no authorization. Patient denies any new onset of numbness or weakness. The patient continues with medications to alleviate the pain the patient denies any side effects the patient reports that there is functional improvement or the patient is able to work

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:**

The patient reports that their pain with medications is a 0 on a scale of 0-10. Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at back pain. Current Pain Changes : no change. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 11/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 11/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Continue with medications as they're provide for significant functional benefit.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar

knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

Due to COVID-19, patients were screened upon arrival including taking temperatures, asking if patient are experiencing COVID-19 symptoms, providing distancing instructions while in the office. Increased sanitation measures to prevent COVID-19 have been implemented which include calling patient, consent for treatment, taking temperature, hand sanitizer, and disinfecting wipes.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 65663	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 11/12/2020	COLLECTION DATE 11/04/2020		REPORTED 11/12/2020 22:53 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS	Page 1 of 1				

PRESCRIBED MEDICATIONS

Metformin, Percocet, Vistaril

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
SPECIMEN VALIDITY TESTING (1)					
CREATININE	29		NORMAL	>=20	mg/dL
pH	7.2		NORMAL	4.7-7.8	
SPECIFIC GRAVITY	1.011		NORMAL	1.003-1.035	g/mL
OXIDANT	-12		NORMAL	<=200	ug/mL
TOXICOLOGY SCREEN (1)					
AMPHETAMINES	NEGATIVE		NORMAL	500	ng/mL
BARBITURATES	NEGATIVE		NORMAL	200	ng/mL
BENZODIAZEPINES	NEGATIVE		NORMAL	200	ng/mL
BUPRENORPHINE	NEGATIVE		NORMAL	5	ng/mL
COCAINE	NEGATIVE		NORMAL	300	ng/mL
CANNABINOIDS	NEGATIVE		NORMAL	50	ng/mL
CARISOPRODOL	NEGATIVE		NORMAL	100	ng/mL
ETHANOL	NEGATIVE		NORMAL	100	ng/mL
FENTANYL	NEGATIVE		NORMAL	2	ng/mL
EDDP (METHADONE METABOLITE)	NEGATIVE		NORMAL	300	ng/mL
OPIATES	NEGATIVE		NORMAL	300	ng/mL
OXYCODONE	POSITIVE		HIGH	100	ng/mL
**See LC/MS/MS for confirmation					
PHENCYCLIDINE	NEGATIVE		NORMAL	25	ng/mL
MDMA (ECSTACY)	NEGATIVE		NORMAL	500	ng/mL
METHAMPHETAMINE	NEGATIVE		NORMAL	500	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



Summary of Findings
UNIVERSAL PAIN MANAGEMENT
819 Auto Center Drive
Palmdale, CA 93551
Phone: (661) 267-6876 x156
Lab Director - Earl Weissman, PhD

PATIENT NAME BARDAKJIAN, STEEVIO		LAB REF # 65664	Patient ID 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 11/04/2020	COLLECTION DATE 11/04/2020		REPORTED DATE 11/14/2020 09:07	

CONSISTENT RESULTS - REPORTED MEDICATION (PARENT DRUG AND/OR METABOLITE) DETECTED

REPORTED PRESCRIPTION	ANTICIPATED POSITIVE(S)	TEST OUTCOME	DETECTION WINDOW
Percocet	OXYMORPHONE	POSITIVE	
Percocet	OXYCODONE	POSITIVE	

ADDITIONAL MEDICATIONS REPORTED BUT NOT TESTED FOR IN THIS REPORT

Metformin,Vistaril

000437

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 65664	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 11/12/2020	COLLECTION DATE 11/04/2020		REPORTED 11/14/2020 09:07 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS	Page 1 of 2				

PRESCRIBED MEDICATIONS

Metformin, Percocet, Vistaril

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
ILLCIT DRUG CONFIRMATION - LC/MS/MS (1)					
6-MONOACETYL MORPHINE (Metabolite)	NEGATIVE		NORMAL	50	ng/mL
BENZOYLECGONINE	NEGATIVE		NORMAL	50	ng/mL
METHAMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	50	ng/mL
OPIATES/OPIOIDS CONFIRMATION - LC/MS/MS (1)					
CODEINE	NEGATIVE		CONSISTENT	50	ng/mL
MORPHINE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROMORPHONE	NEGATIVE		CONSISTENT	50	ng/mL
NORHYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
OXYCODONE	197	POSITIVE	CONSISTENT	50	ng/mL
OXYMORPHONE	218	POSITIVE	CONSISTENT	50	ng/mL
MEPERIDINE	NEGATIVE		CONSISTENT	50	ng/mL
TAPENTADOL	NEGATIVE		CONSISTENT	50	ng/mL
FENTANYL	NEGATIVE		CONSISTENT	5.0	ng/mL
O-DESMETHYL-CIS-TRAMADOL	NEGATIVE		CONSISTENT	50	ng/mL
METHADONE CONFIRMATION - LC/MS/MS (1)					
EDDP	NEGATIVE		CONSISTENT	50	ng/mL
BUPRENORPHINE CONFIRMATION - LC/MS/MS (1)					
BUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
NORBUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
BENZODIAZEPINES CONFIRMATION - LC/MS/MS (1)					
ALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
ALPHA-HYDROXYALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
7-AMINO-CLONAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
NORDIAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
OXAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
TEMAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
LORAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
PSYCHOTROPICS CONFIRMATION - LC/MS/MS (1)					
NORTRIPTYLINE	NEGATIVE		CONSISTENT	50	ng/mL
ZOLPIDEM	NEGATIVE		CONSISTENT	5.0	ng/mL
MUSCLE RELAXANTS CONFIRMATION - LC/MS/MS (1)					
MEPROBAMATE	NEGATIVE		CONSISTENT	50	ng/mL
CYCLOBENZAPRINE CONFIRMATION - LC/MS/MS (1)					
CYCLOBENZAPRINE	NEGATIVE		CONSISTENT	50	ng/mL
GABAPENTIN CONFIRMATION - LC/MS/MS (1)					
GABAPENTIN	NEGATIVE		CONSISTENT	50	ng/mL
PREGABALIN CONFIRMATION - LC/MS/MS (1)					
PREGABALIN	NEGATIVE		CONSISTENT	50	ng/mL

000438

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 65664	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 11/12/2020	COLLECTION DATE 11/04/2020		REPORTED 11/14/2020 09:07 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS	Page 2 of 2				

PRESCRIBED MEDICATIONS

Metformin, Percocet, Vistaril

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
STIMULANTS CONFIRMATION - LC/MS/MS (1)					
AMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
MDMA	NEGATIVE		NORMAL	50	ng/mL
MDA	NEGATIVE		NORMAL	50	ng/mL
MDEA	NEGATIVE		NORMAL	50	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	11-03-2020

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: Back pain

History of Present Illness

The patient was seen via telemedicine audio and visual - was frustrated as insurance company is not approving much services. The patient is able to continue to work and only means that he has to continue to work as the medication he reports that the medication provides for significant pain relief for the patient is able to do activities of daily living and work full-time. He continues to work with that medication combination. The patient has followup with orthopedic surgeon. Originally thought that there was an authorization but then has come out and said that there is no authorization. The patient is a little bit frustrated as far as the insurance company goes.

Patient denies any new onset of numbness or weakness.

The patient continues with medications to alleviate the pain the patient denies any side effects the patient reports that there is functional improvement or the patient is able to work

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:**

The patient reports that their pain with medications is a 0 on a scale of 0-10. Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at Back pain. Current Pain Changes : no. Patient describes his pain as aching and shooting. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies rash or itching.

Heme-Immuno: Denies fever, chills, easy bruising or bleeding or HIV or AIDS. There is no swollen glands or cancer.

ENT: Denies change in hearing or sore throat.

Respiratory: Denies cough, shortness of breath, bronchitis or tuberculosis. There is no coughing up blood.

Gastro-Intestinal: Denies nausea, vomiting, diarrhea, blood in stool or constipation. There is no loss of bowel control.

Neurological: Denies numbness or seizures.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight.

Genito-urinary: Denies blood in urine, pain on urination or loss of bladder control. There is no kidney problems.

Eyes: Denies blurry vision or loss of vision.

Musculoskeletal: Denies weakness or osteoporosis.

Endocrine: Denies diabetes or hypothyroidism.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. There are no signs of doctor shopping noted.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 5/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

* Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction and/or other aberrant drug-related behavior, to guide treatment. The frequency of random testing is determined by an individualized opioid risk score which is based upon the patient's individual medical history, and the type and quantity of drugs prescribed.

If the results of the definitive drug test are inconsistent, it could result in the patient being denied medication refills, counseled for aberrant behavior, recommended for detoxification or terminated from this practice. We will obtain a urine drug screen today as per our narcotic contract. Patient understands that this test does not necessarily mean that there is a suspicion of drug abuse. This test is designed to improve patient compliance. It helps us in identification of possible dangerous drug interactions and identifies possible recreational drug use.

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	10-06-2020

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 4599.

Current Complaints: low back pain and knee

History of Present Illness

The patient was seen via telemedicine audio and visual -Saw QME dr. Woods and was frustrated as insurance company is not approving much services. Knee pain has increased and surgery denied. He continues to work with that medication combination. The patient has followup with orthopedic surgeon Reportedly originally thought that there was an authorization but then has come out and said that there is no authorization. The patient is a little bit frustrated as far as the insurance company goes.

Patient denies any new onset of numbness or weakness.

The patient continues with medications to alleviate the pain the patient denies any side effects the patient reports that there is functional improvement or the patient is able to work

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS

EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include;

none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at low back pain and knee. Current Pain Changes : no change. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

On a scale of 1 to 10 the pain level is 8.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

A CURES (Controlled Substance Utilization Review and Evaluation System) report from the Department of Justice - Bureau of Narcotic Enforcement was obtained. There are no signs of doctor shopping noted.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisar MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 5/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

The patient is interested in braces for that knee pain and recommended to try over-the-counter initially and if not helpful the patient can come to the office to attempt sizing of braces

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup regarding authorization for a neurosurgeon at Cedar Sinai Hospital

UDS next visit

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar

knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California
By



Kevin Kohan, D.O.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	09-01-2020

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: low back and knee

History of Present Illness

The patient was seen via telemedicine audio and visual -He continues to work with that medication combination. The patient has followup with orthopedic surgeon who has recommended a knee surgery Which has been proven the patient is awaiting to have the surgery done likely next year. The patient has also been recommended to followup with a neurosurgeon at Cedars Sinai Hospital.

Patient denies any new onset of numbness or weakness.

The patient continues with medications to alleviate the pain the patient denies any side effects the patient reports that there is functional improvement or the patient is able to work

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at low back and knee. Current Pain Changes : fluctuates in intensity. Patient describes his pain as constant. **Recent**

Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization

Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of

non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 5/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup colostomy in regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I

declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 09-01-2020.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	08-04-2020

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: low back pain and knee

History of Present Illness

The patient was seen via telemedicine audio and visual -He continues to work with that medication combination. The patient has followup with orthopedic surgeon who has recommended a knee surgery and is awaiting for authorization. There is also a pending authorization for the patient to see the neurosurgeons at Cedars Sinai Hospital.

The patient continues with medications to alleviate the pain the patient denies any side effects the patient reports that there is functional improvement or the patient is able to work

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.
Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

Opioid Risk Tool (Male): 0 .

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Scales:** Pain at present is 7 on the pain scale. **Pain Descriptors:** Location of pain is at low back pain and knee. Current Pain Changes : fluctuates in intensity. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

PAIN MANAGEMENT

- Opioid Dose Calculator
- Opioid Risk Tool

Review of Medical Records:

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 5/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery/The patient was recommended to followup colostomy in regarding authorization for a neurosurgeon at Cedar Sinai Hospital

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar

knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

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We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation

legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

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Signed in Los Angeles County, California
By

Kevin Kohan, D.O.

Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 08-04-2020.

Name: Bardakjian, Steevio
DOB: 05-23-1970
MR# UPM31805
Date of Service: 08-04-2020

Opioid Risk Tool

1. Family History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
2. Personal History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
3. Age (if 16-45)		0
4. History of Preadolescent Sexual Abuse		
5. Psychological Disease	Attention Deficit Disorder	0

Obsessive Compulsive Disorder
Bipolar
Schizophrenia

Depression 0

TOTAL 0

Total Score Risk Category

Low Risk 0-3

Moderate Risk 4-7

High Risk > or equal to 8



Kevin Kohan D.O.

This has been electronically signed by Kevin Kohan D.O. on 08-04-2020.

Name : Steevio Bardakjian

MR# UPM31805

Date of Operation: 08-04-2020

DOB: 05-23-1970

Opioid Dose Calculator

Category	Test	Result	Remarks
Opioid Dose Calculator			
1	Oxycodone (mg per day)	30	
2	Oxycodone: Morphine Equivalent	45	
3	Oxycodone - Total no. of pills prescribed	90	
4	Oxycodone - No. of days pills prescribed for	30	
5	Oxycodone - mg/pill	10	
6	Oxycodone - Med deviation	30	
7	Total Daily Morphine Equivalent Dose	45	

Combined risk category using Opioid risk tool and Opioid dose is

* Based on information published by University of California, San Francisco and University of Rochester, Dept. of Palliative Care.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 08-04-2020.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	06-29-2020

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints: low back pain and knee

History of Present Illness

The patient was seen via telemedicine audio and visual -He continues to work with that medication combination. The patient Like to review the MRI of the knee and the lumbar spine. The patient reports that knee is enlarged and the swelling is causing increasing pain. The patient would like to review the MRI the patient is concerned with the median potential need for surgical interventions.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Pain Descriptors:** Location of pain is at low back pain and knee. Current Pain Changes :

fluctuate in intensity. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

L3-L5 Disectomy: 08/2018

Review of Systems

Skin (Integumentary): Denies itching.

Gastro-Intestinal: Denies nausea, constipation or GI upset. There is no loss of bowel control.

Neurological: There is no focal neurologic changes.

Constitutional: Denies sweats, dizziness or unusual loss or gain of weight. Sweats. There is no over sedation or dysphoria.

Genito-urinary: Denies loss of bladder control.

Physical Examination

On a scale of 1 to 10 the pain level is 6.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Review of Medical Records:

MRI of the knee demonstrates the oblique meniscus tear

MRI of the lumbar spine demonstrates 3 mm disc Dominantly at L4-5 with neural foraminal stenosis

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization

Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwiser MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 5/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

The patient was recommended to proceed with the orthopedic surgeon for potential knee surgery

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet
Vistaril 25 mg capsule 1 Capsule Twice a Day PRN for 30 Days , Prescribe 60 Capsule

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I

declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 06-29-2020.



TOTAL IMAGING & OPEN MRI

18560 Via Princessa Suite #120, Santa Clarita, CA 91387
Tel: (661) 250-4611 Fax: (661) 250-9356

REFERRING PHYSICIAN: DR. CONWISAR, PHILIP

DIAGNOSTIC IMAGING REPORT

Patient Name: BARDAKJAN, STEEVIO
Exam Date: 06/04/2020 09:20:52

Sex: M
Patient DOB: 05/23/1970

STUDY: MRI OF THE LUMBAR SPINE WITH AND WITHOUT CONTRAST

HISTORY: Injured at work.

TECHNIQUE: Multiplanar and multi-echo MRI of the lumbar spine was performed before and after administration of intravenous contrast.

FINDINGS:

There is scoliosis of the lumbar vertebral column with concavity to the right.

Multilevel facet arthropathy, ligamentum flavum thickening and prominent posterior epidural fat noted.

On post contrast images no enhancement seen.

There is no acute or sub-acute observed vertebral fracture or wedging at this time. No evidence of posterior longitudinal ligament or interspinous ligament tear. The complete lower visualized disc is considered to be L5-S1.

Disc Spaces:

L1-L2: 1.12 mm disc herniation which indents the thecal sac which results in central canal stenosis with central canal AP diameter measuring 10.07 mm. The disc herniation also causes bilateral neural foraminal narrowing. No annular disc tear.

L2-L3: 1.34 mm disc herniation which indents the thecal sac which results in central canal stenosis with central canal AP diameter measuring 9.15 mm. The disc herniation also causes bilateral neural foraminal narrowing. No annular disc tear.

L3-L4: 2.98 mm diffuse disc herniation which indents the thecal sac which results in central canal stenosis with central canal AP diameter measuring 9.02 mm. The disc herniation also causes bilateral neural foraminal narrowing. No annular disc tear.

L4-L5: 3.84 mm diffuse disc herniation which indents the thecal sac which results in central canal stenosis with central canal AP diameter measuring 6.79 mm. The disc herniation also causes bilateral neural foraminal narrowing. No annular disc tear.

Electronically Signed By: Norman Pennington on 06/05/2020 07:01:57 AM
Board Certified Radiologist



TOTAL IMAGING & OPEN MRI

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REFERRING PHYSICIAN: DR. CONWISAR, PHILIP

DIAGNOSTIC IMAGING REPORT

Patient Name: BARDAKJAN,STEEVIO

Sex: M

Exam Date: 06/04/2020 09:20:52

Patient DOB: 05/23/1970

L5-S1: 1.32 mm diffuse disc herniation which indents the thecal sac. The disc herniation also causes bilateral neural foraminal narrowing. No annular disc tear. Central canal is patent.

Spinal cord and thecal sac:

There is no significant cauda equina compression. The lower thoracic cord is normal. The conus medullaris ends at L1 and reveals normal signal intensity.

Paravertebral soft tissue is unremarkable.

IMPRESSION:

- 1. L1-L2: 1.12 mm disc herniation which indents the thecal sac which results in central canal stenosis with central canal AP diameter measuring 10.07 mm. The disc herniation also causes bilateral neural foraminal narrowing. No annular disc tear.**
- 2. L2-L3: 1.34 mm disc herniation which indents the thecal sac which results in central canal stenosis with central canal AP diameter measuring 9.15 mm. The disc herniation also causes bilateral neural foraminal narrowing. No annular disc tear.**
- 3. L3-L4: 2.98 mm diffuse disc herniation which indents the thecal sac which results in central canal stenosis with central canal AP diameter measuring 9.02 mm. The disc herniation also causes bilateral neural foraminal narrowing. No annular disc tear.**
- 4. L4-L5: 3.84 mm diffuse disc herniation which indents the thecal sac which results in central canal stenosis with central canal AP diameter measuring 6.79 mm. The disc herniation also causes bilateral neural foraminal narrowing. No annular disc tear.**
- 5. L5-S1: 1.32 mm diffuse disc herniation which indents the thecal sac. The disc herniation also causes bilateral neural foraminal narrowing. No annular disc tear. Central canal is patent.**

Electronically Signed By: Norman Pennington on 06/05/2020 07:01:57 AM
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REFERRING PHYSICIAN: DR. CONWISAR, PHILIP

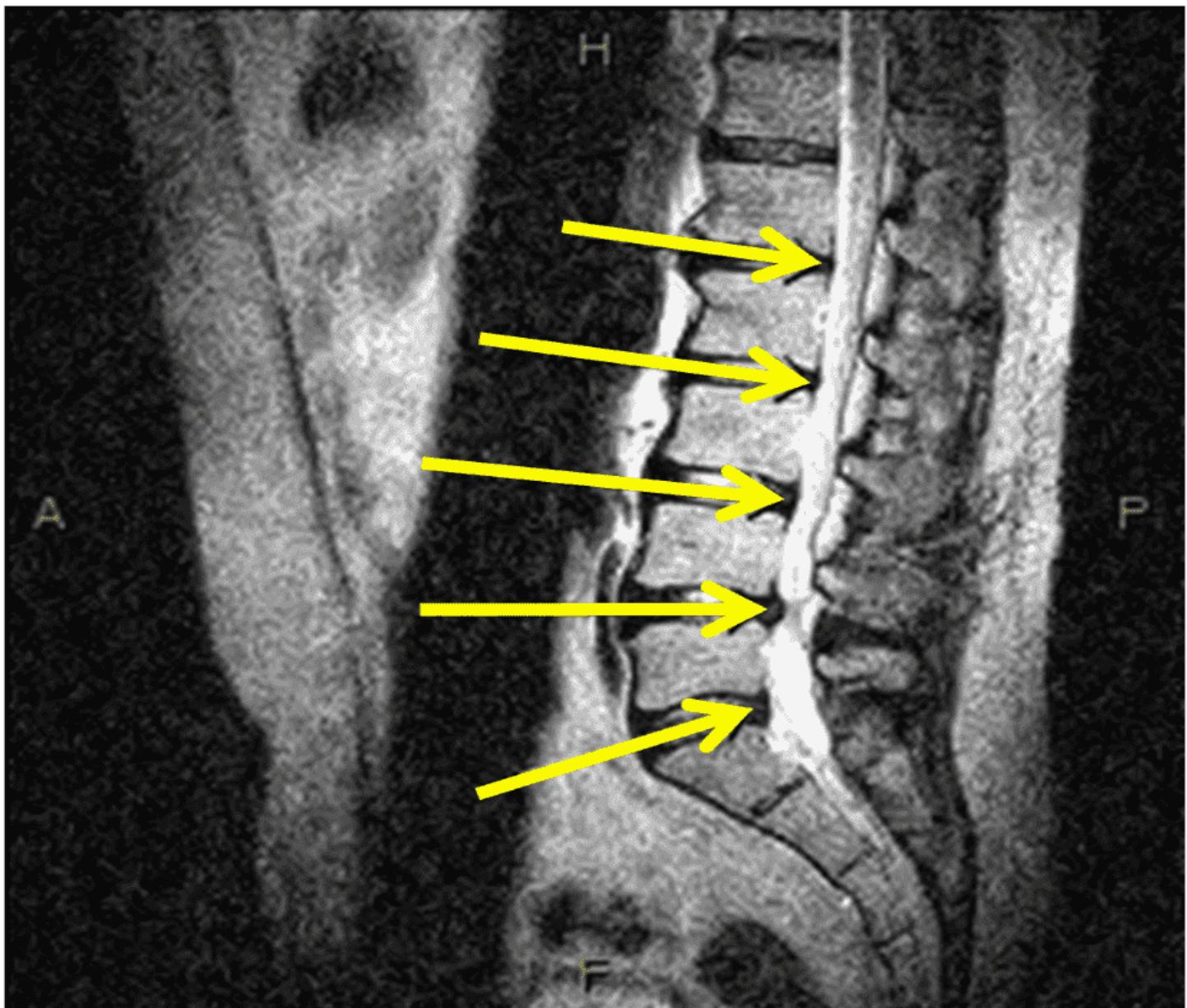
DIAGNOSTIC IMAGING REPORT

Patient Name: **BARDAKJAN,STEEVIO**

Exam Date: **06/04/2020 09:20:52**

Sex: **M**

Patient DOB: **05/23/1970**



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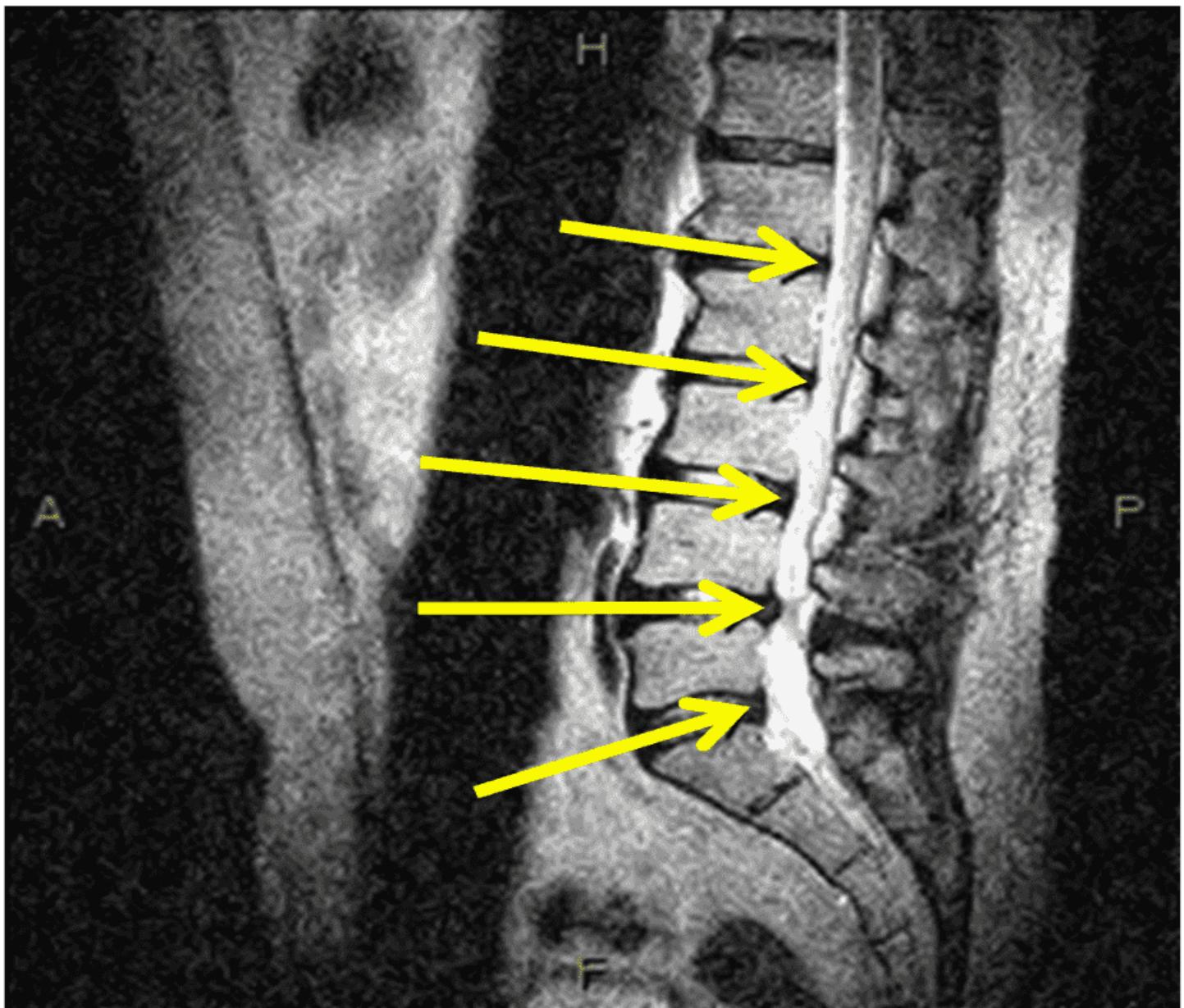
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Patient Name: **BARDAKJAN,STEEVIO**

Exam Date: **06/04/2020 09:20:52**

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Patient DOB: **05/23/1970**





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REFERRING PHYSICIAN: DR. CONWISAR, PHILIP PHILIP

DIAGNOSTIC IMAGING REPORT

Patient Name: BARDAKJIAN,STEEVIO

Sex: M

Exam Date: 05/28/2020 13:26:19

Patient DOB: 05/23/1970

STUDY: MRI OF THE RIGHT KNEE WITHOUT CONTRAST

HISTORY: Injured at work.

TECHNIQUE: Multiplanar multisequence MR images of the right knee were obtained without the administration of intravenous contrast.

FINDINGS:

Cruciate ligament:

Anterior cruciate ligament and posterior cruciate ligaments are normal in size and signal intensity.

Menisci:

There is an oblique tear of the posterior horn of medial meniscus. Rest of the menisci are unremarkable.

Collateral ligaments:

The lateral collateral ligament and medial collateral ligaments are intact and show normal signal intensity.

Joint capsule:

Patellofemoral ligaments are normal. Medial and Lateral patellar retinaculum are normal. Surrounding soft tissue shows no abnormality. Observation is made of small knee joint effusion. Baker's cyst observed.

Bones and articular cartilage:

Alignment of tibia, femur as well maintained. The patella is normally positioned within the femoral groove.

Femoral condyles and visible bones appear normal in signal intensity. The femoral, tibial, and patellar articular cartilage appear normal. No fracture, stress reaction, or osseous lesion is seen.

Muscles, tendons and postero-lateral complex:

No hyaline cartilaginous disease in patellofemoral, medial and lateral compartments. The distal quadriceps and patellar tendons are intact. The biceps femoris tendon and ilio-tibial tract are normal. The quadriceps and patellar tendons are normal. The popliteal vessels are normal. Hoffa's fat pad is normal. The muscles surrounding the knee joint are normal. No evidence of obvious loose bodies.

Electronically Signed By: Norman Pennington on 05/29/2020 06:22:55 AM
Board Certified Radiologist



TOTAL IMAGING & OPEN MRI

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REFERRING PHYSICIAN: DR. CONWISAR, PHILIP PHILIP

DIAGNOSTIC IMAGING REPORT

Patient Name: BARDAKJIAN,STEEVIO

Sex: M

Exam Date: 05/28/2020 13:26:19

Patient DOB: 05/23/1970

IMPRESSION:

1. Oblique tear of the posterior horn of medial meniscus.
2. Small knee joint effusion.

Electronically Signed By: Norman Pennington on 05/29/2020 06:22:55 AM
Board Certified Radiologist



TOTAL IMAGING & OPEN MRI

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DIAGNOSTIC IMAGING REPORT

Patient Name: **BARDAKJIAN,STEEVIO**

Exam Date: **05/28/2020 13:26:19**

Sex: **M**

Patient DOB: **05/23/1970**



Electronically Signed By: Norman Pennington on 05/29/2020 06:22:55 AM
Board Certified Radiologist

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	06-01-2020

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints:

low back pain and knee

History of Present Illness

The patient was seen via telemedicine audio and visual -He continues to work with that medication combination. The patient send for MRI of the knee and lumbar. MRI of the knee was done few days ago- He denies any side effects and reports that the Vistaril due to patient's significant improvement in anxiety The patient endorses that the low back pain is under control with the Percocet and the elective surgery is on hold right now.-patient is getting 30% improvement of function with a combination of medications denies any side effects reports a dysfunctional improvement.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include;

none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Pain Descriptors:** Location of pain is at Back pain, rle. Current Pain Changes : same. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Review of Systems

Neurological: Reports *numbness*.

Constitutional: Reports *sweats*.

Musculoskeletal: Reports *weakness*.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination. Uses a cane

Review of Medical Records:

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. The urine screening May 2020 wasn't reviewed noted to be consistent with prescribed medications of Oxycodone

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization

Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 50-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 5/20 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

The patient has had MRI of that knee and will have the MRI of the lumbar spine we will try to get that images on the next office visit to review with patient the patient may be a candidate for surgical intervention

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar

knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and

aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Vistaril 25 mg capsule 1 Capsule Twice a Day PRN for 30 Days , Prescribe 60 Capsule

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

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*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 06-01-2020.

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 57491	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 05/12/2020	COLLECTION DATE 05/04/2020		REPORTED 05/12/2020 19:11 PDT	
COMMENT IMMUNOASSAY SCREENING	Page 1 of 1				

PRESCRIBED MEDICATIONS

Metformin, Percocet, Vistaril

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
SPECIMEN VALIDITY TESTING (1)					
CREATININE	79		NORMAL	>=20	mg/dL
pH	5.9		NORMAL	4.7-7.8	
SPECIFIC GRAVITY	1.009		NORMAL	1.003-1.035	g/mL
OXIDANT	-14		NORMAL	<=200	ug/mL
TOXICOLOGY SCREEN (1)					
AMPHETAMINES	NEGATIVE		NORMAL	500	ng/mL
BARBITURATES	NEGATIVE		NORMAL	200	ng/mL
BENZODIAZEPINES	NEGATIVE		NORMAL	200	ng/mL
BUPRENORPHINE	NEGATIVE		NORMAL	5	ng/mL
COCAINE	NEGATIVE		NORMAL	300	ng/mL
CANNABINOIDS	NEGATIVE		NORMAL	50	ng/mL
CARISOPRODOL	NEGATIVE		NORMAL	100	ng/mL
ETHANOL	NEGATIVE		NORMAL	100	ng/mL
FENTANYL	NEGATIVE		NORMAL	2	ng/mL
EDDP (METHADONE METABOLITE)	NEGATIVE		NORMAL	300	ng/mL
OPIATES	NEGATIVE		NORMAL	300	ng/mL
OXYCODONE	POSITIVE		HIGH **See LC/MS/MS for confirmation	100	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	25	ng/mL
MDMA (ECSTACY)	NEGATIVE		NORMAL	500	ng/mL
METHAMPHETAMINE	NEGATIVE		NORMAL	500	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



Summary of Findings
UNIVERSAL PAIN MANAGEMENT
819 Auto Center Drive
Palmdale, CA 93551
Phone: (661) 267-6876 x156
Lab Director - Earl Weissman, PhD

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF # 57492	Patient ID 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 05/04/2020	COLLECTION DATE 05/04/2020	REPORTED DATE 05/14/2020 19:31	

CONSISTENT RESULTS - REPORTED MEDICATION (PARENT DRUG AND/OR METABOLITE) DETECTED

REPORTED PRESCRIPTION	ANTICIPATED POSITIVE(S)	TEST OUTCOME	DETECTION WINDOW
Percocet	OXYMORPHONE	POSITIVE	
Percocet	OXYCODONE	POSITIVE	

ADDITIONAL MEDICATIONS REPORTED BUT NOT TESTED FOR IN THIS REPORT

Metformin,Vistaril

000480

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 57492	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 05/12/2020	COLLECTION DATE 05/04/2020		REPORTED 05/14/2020 19:31 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS	Page 1 of 2				

PRESCRIBED MEDICATIONS

Metformin, Percocet, Vistaril

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
ILLCIT DRUG CONFIRMATION - LC/MS/MS (1)					
6-MONOACETYL MORPHINE (Metabolite)	NEGATIVE		NORMAL	50	ng/mL
BENZOYLECGONINE	NEGATIVE		NORMAL	50	ng/mL
METHAMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	50	ng/mL
OPIATES/OPIOIDS CONFIRMATION - LC/MS/MS (1)					
CODEINE	NEGATIVE		CONSISTENT	50	ng/mL
MORPHINE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROMORPHONE	NEGATIVE		CONSISTENT	50	ng/mL
NORHYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
OXYCODONE	312	POSITIVE	CONSISTENT	50	ng/mL
OXYMORPHONE	591	POSITIVE	CONSISTENT	50	ng/mL
MEPERIDINE	NEGATIVE		CONSISTENT	50	ng/mL
TAPENTADOL	NEGATIVE		CONSISTENT	50	ng/mL
FENTANYL	NEGATIVE		CONSISTENT	5.0	ng/mL
O-DESMETHYL-CIS-TRAMADOL	NEGATIVE		CONSISTENT	50	ng/mL
METHADONE CONFIRMATION - LC/MS/MS (1)					
EDDP	NEGATIVE		CONSISTENT	50	ng/mL
BUPRENORPHINE CONFIRMATION - LC/MS/MS (1)					
BUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
NORBUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
BENZODIAZEPINES CONFIRMATION - LC/MS/MS (1)					
ALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
ALPHA-HYDROXYALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
7-AMINO-CLONAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
NORDIAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
OXAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
TEMAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
LORAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
PSYCHOTROPICS CONFIRMATION - LC/MS/MS (1)					
NORTRIPTYLINE	NEGATIVE		CONSISTENT	50	ng/mL
ZOLPIDEM	NEGATIVE		CONSISTENT	5.0	ng/mL
MUSCLE RELAXANTS CONFIRMATION - LC/MS/MS (1)					
MEPROBAMATE	NEGATIVE		CONSISTENT	50	ng/mL
CYCLOBENZAPRINE CONFIRMATION - LC/MS/MS (1)					
CYCLOBENZAPRINE	NEGATIVE		CONSISTENT	50	ng/mL
GABAPENTIN CONFIRMATION - LC/MS/MS (1)					
GABAPENTIN	NEGATIVE		CONSISTENT	50	ng/mL
PREGABALIN CONFIRMATION - LC/MS/MS (1)					
PREGABALIN	NEGATIVE		CONSISTENT	50	ng/mL

000481

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 57492	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 05/12/2020	COLLECTION DATE 05/04/2020		REPORTED 05/14/2020 19:31 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS	Page 2 of 2				

PRESCRIBED MEDICATIONS

Metformin, Percocet, Vistaril

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
STIMULANTS CONFIRMATION - LC/MS/MS (1)					
AMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
MDMA	NEGATIVE		NORMAL	50	ng/mL
MDA	NEGATIVE		NORMAL	50	ng/mL
MDEA	NEGATIVE		NORMAL	50	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	05-04-2020

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints:

back pain

History of Present Illness

The patient was seen via telemedicine audio and visual -He continues to work with that medication combination. He denies any side effects and reports that the Vistaril due to patient's significant improvement in anxiety The patient endorses that the low back pain is under control with the Percocet and the elective surgery is on hold right now.-patient is getting 30% improvement of function with a combination of medications denies any side effects reports a dysfunctional improvement.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Pain Descriptors:** Location of pain is at back pain. Current Pain Changes : fluctuates in intensity.

Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Review of Systems

Neurological: Reports *numbness*.

Constitutional: Reports *sweats*.

Musculoskeletal: Reports *weakness*.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination. Uses a cane

Review of Medical Records:

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization

Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 49-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Urine drug screening necessary on next visit

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar

knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6

months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6-month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Vistaril 25 mg capsule 1 Capsule Twice a Day PRN for 30 Days , Prescribe 60 Capsule

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of

errors."

Signed in Los Angeles County, California
By



Kevin Kohan, D.O.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 05-04-2020.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	XXX-XX-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	03-31-2020

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, SUITE 155, Valencia CA 91355 - 5084.

Current Complaints:

Back pain

History of Present Illness

The patient was seen via telemedicine audio and visual for approximately 15 minutes. The patient endorses that the low back pain is under control with the Percocet and the elective surgery is on hold right now.-Vision is getting 30% improvement of function with a combination of medications denies any side effects reports a dysfunctional improvement.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 3 blocks with the medications, an improvement from baseline.

***Interval F/U Pain Descriptors:** Location of pain is at back pain. Current Pain Changes : fluctuates in intensity.

Patient describes his pain as aching. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Review of Systems

Neurological: Reports *numbness*.

Constitutional: Reports *sweats*.

Musculoskeletal: Reports *weakness*.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination. Uses a cane

Review of Medical Records:

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Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 49-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy

with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

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ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Urine drug screening necessary on next visit

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

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function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6-month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet
Vistaril 25 mg capsule 1 Capsule Twice a Day PRN for 30 Days , Prescribe 60 Capsule

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

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*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 03-31-2020.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSISTANT CLINICAL PROFESSOR OF USC

FRANCIS X. RIEGLER, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSISTANT CLINICAL PROFESSOR OF USC

RAY H. d'AMOURS, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSISTANT CLINICAL PROFESSOR OF USC

DANIEL ALVES, M.D.
BOARD CERTIFIED-PAIN MANAGEMENT AND PM&R

ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNICKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	03-03-2020

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084.

Current Complaints:

Back pain

History of Present Illness

The patient returns to clinic for interval followup visit of low back pain and endorses that the combination of medications are working go well to alleviate the pain the patient has a followup with a neurosurgeon to be evaluated. The patient denies any side effects the patient is able to work with the medication combination with

30% improvement of ability to move around and uses a cane in order to be built and ambulates
It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline: 30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

***Interval F/U Pain Descriptors:** Location of pain is at Back pain. Current Pain Changes : fluctuates in intensity.

Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Review of Systems

Neurological: Reports *numbness*.

Constitutional: Reports *sweats*.

Musculoskeletal: Reports *weakness*.

Physical Examination

Height (inches): 71.00 **BP:** 184/107 mm Hg. **Pulse:** 107 per min. **Sp02:** 96.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Abdomen: The abdomen is soft, with no masses palpated, no rebound, rigidity or tenderness.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. Straight leg raise on the right:: positive. Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.*

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness of the right L3-4 and L4-5*

Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: *Deep Tendon Reflexes are intact throughout except Decrease right knee reflex 1+ Pain with right hip motion-Is pain noted with internal rotation and external rotation of the hip*

Tenderness of the lumbar spine

Review of Medical Records:

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping.

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwiser MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 49-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Urine drug screening necessary on next visit

Continue medications as the patient is Able to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 03-03-2020.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSISTANT CLINICAL PROFESSOR OF USC

FRANCIS X. RIEGLER, M.D., Q.M.E.
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DEBBIE CASTILLO, P.T.A.
MARC REZNICKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	02-04-2020

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084.

Current Complaints:

Back pain

History of Present Illness

The patient returns to clinic for interval followup visit of low back pain secondary to work-related injury the patient endorses the combination of medications allow for functional improvement the patient denies any side effects the patient is awaiting for MRI and potential surgical intervention by orthopedic surgeon to be

recommended.

Meds allow the patient to work.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline: 30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 3

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

***Interval F/U Pain Descriptors:** Location of pain is at Low back pain. Current Pain Changes : fluctuates in intensity. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Review of Systems

Neurological: Reports *numbness*.

Constitutional: Reports *sweats*.

Musculoskeletal: Reports *weakness*.

Physical Examination

On a scale of 1 to 10 the pain level is 5. Height (inches): 71.00 Weight (lbs): 220.00 **BP:** 190/100 mm Hg. **Pulse:** 105 per min. **SpO2:** 99. **BMI:** 31.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Abdomen: The abdomen is soft, with no masses palpated, no rebound, rigidity or tenderness.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. Straight leg raise on the right:: positive. Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.*

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness of the right L3-4 and L4-5*

Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: Deep Tendon Reflexes are intact throughout except Decrease right knee reflex 1+ Pain with right hip motion-Is pain noted with internal rotation and external rotation of the hip
Tenderness of the lumbar spine

Review of Medical Records:

Review of medical records and/or consultation between treating physicians and/or discussion of Utilization Review and/or planning and/or creation of RFAs, and/or preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwisor MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 49-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Continue medications as of the lobe the patient to function and work full-time. The patient is awaiting for further surgery recommendations

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California
By



Kevin Kohan, D.O.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 02-04-2020.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
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DEBBIE CASTILLO, P.T.A.
MARC REZNICKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	Sedgwick
ADDRESS	:	PO BOX 11028, Orange CA 92856
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	01-07-2020

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

- | | | |
|--|--|--|
| (XX) Periodic Report | (<input type="checkbox"/> Change in Treatment Plan | (<input type="checkbox"/> Release from Care |
| (<input type="checkbox"/> Change in Work Status | (<input type="checkbox"/> Need for Referral or Consultation | (<input type="checkbox"/> Response to Release for Information |
| (<input type="checkbox"/> Change in Patient Condition | (<input type="checkbox"/> Need for Surgery or Hospitalization | (<input type="checkbox"/> Request for Authorization |
| (<input type="checkbox"/> Other | | |

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084.

Current Complaints

Low back pain

History of Injury :

Patient returns to clinic for low back pain and right leg pain the patient has followed up with the qualified medical provider who has recommended that me to be part of the case the patient continues to have right leg

pain which interferes with activities of daily living however the patient reports that the Percocet that the patient can function and work with the medication—that the medication the patient is essentially bedbound.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline: 30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS

EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

***Interval F/U**

Pain Descriptors: Location of pain is at low back and right leg pain. Current Pain Changes : same.

Review of Systems

Neurological: Reports *numbness*.

Constitutional: Reports *sweats*.

Musculoskeletal: Reports *weakness*.

Physical Examination

On a scale of 1 to 10 the pain level is 7. Height (inches): 71.00 Weight (lbs): 215.00 **BP:** 166/103 mm Hg. **Pulse:** 103 per min. **SpO2:** 94. **BMI:** 30.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Abdomen: The abdomen is soft, with no masses palpated, no rebound, rigidity or tenderness.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. Straight leg raise on the right:: positive. Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.*

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness of the right L3-4 and L4-5*

Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: *Deep Tendon Reflexes are intact throughout except Decrease right knee reflex 1+ Pain with right hip motion-Is pain noted with internal rotation and external rotation of the hip Tenderness of the lumbar spine*

PAIN MANAGEMENT

- Opioid Risk Tool

Review of Medical Records:

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping.

This patient treatment conference was required for multidisciplinary chronic pain management and ongoing patient care planning. Review of medical records, consultation between treating physicians, discussion of Utilization Review, planning and creation of RFAs, and preparation of this report totaled 35 minutes of non-face-to-face patient care time, justifying CPT code 99358. I am billing appropriately.

Legal Status:

Primary Treating Physician: Philip Conwissar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 49-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

The patient would like to discuss findings with orthopedic surgeon the patient may need surgery of the lumbar knee is apparently part of the case and the patient is interested in further imaging

Knee with medications as they allow the patient to function and be able to work

Hip joint injection has been approved however the patient would like to hold off on any intervention

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping.

Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed by the above-signed Nurse Practitioner/Physician Assistant/Physician under the direction and guidance of the signing Physician. The physical examination was performed by the Nurse Practitioner/Physician under the direction and supervision of the Physician. The dictation was prepared by the Nurse Practitioner/Physician, including any and all impressions and conclusions described in the discussion, and were discussed and reviewed with the Physician. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the above signed Nurse Practitioner/Physician under the direction and guidance of the signing physician and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Workers Compensation legislation (Labor Code 4628(j):"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 I have indicated I have received from others. As to that information, the signing Nurse Practitioner/Physician and Physician declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): "Neither the signing Physician or Nurse Practitioner/Physician have violated Labor Code section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California
By



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSISTANT CLINICAL PROFESSOR OF USC

FRANCIS X. RIEGLER, M.D., Q.M.E.
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ASSISTANT CLINICAL PROFESSOR OF USC

DANIEL ALVES, M.D.
BOARD CERTIFIED-PAIN MANAGEMENT AND PM&R
ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

Name: Bardakjian, Steevio
DOB: 05-23-1970
MR# UPM31805
Date of Service: 01-07-2020

Opioid Risk Tool

1. Family History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
2. Personal History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
3. Age (if 16-45)		0
4. History of Preadolescent Sexual Abuse		
5. Psychological Disease	Attention Deficit Disorder	0
	Obsessive Compulsive Disorder	
	Bipolar	
	Schizophrenia	
	Depression	0
	TOTAL	0
Total Score Risk Category		
Low Risk 0-3		
Moderate Risk 4-7		
High Risk > or equal to 8		



Kevin Kohan D.O.

This has been electronically signed by Kevin Kohan D.O. on 01-07-2020.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSISTANT CLINICAL PROFESSOR OF USC

FRANCIS X. RIEGLER, M.D., Q.M.E.
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RAY H. d'AMOURS, M.D., Q.M.E.
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OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	TRISTRAR RISK MANAGEMENT
ADDRESS	:	PO BOX 11967, SANTA ANA CA 92711 - 1967
ADJUSTOR	:	VIRIDIANA MALDONADO
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	12-02-2019

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084.

Current Complaints:

low back and right leg pain

History of Present Illness

Patient returns to clinic for interval followup visit of low back pain and right hip joint pain the patient endorses following up with the neurosurgeon was recommended for better evaluation of the right hip the patient's primary orthopedic surgeon has obtained x-rays of the hip the patient has had those completed and comes in today desiring to review them. The MRI and x-rays were reviewed with the patient the patient has new onset of joint

pain that interferes with activities of daily living the patient has failed conservative therapies including physical therapy and medication management the patient is a good candidate to proceed with intra-articular hip joint injections for hip joint osteoarthritis.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

***Interval F/U Pain Descriptors:** Location of pain is at low back and right leg pain. Current Pain Changes : fluctuates in intensity. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Review of Systems

Neurological: Reports *numbness*.

Constitutional: Reports *sweats*.

Musculoskeletal: Reports *weakness*.

Physical Examination

Height (inches): 71.00 Weight (lbs): 215.00 **BP:** 169/91 mm Hg. **Pulse:** 105 per min. **SpO2:** 98. **BMI:** 30.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Abdomen: The abdomen is soft, with no masses palpated, no rebound, rigidity or tenderness.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. Straight leg raise on the right:: positive. Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.*

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness of the right L3-4 and L4-5*

Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: *Deep Tendon Reflexes are intact throughout except Decrease right knee*

reflex 1+ Pain with right hip motion-Is pain noted with internal rotation and external rotation of the hip
Tenderness of the lumbar spine

Review of Medical Records:

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. The patient's x-rays of the pelvis and the head was reviewed and noted to be consistent with degenerative changes

MRI of the lumbar spine was also reviewed which showed significant changes at a 45 where there is severe canal stenosis did 2 epidural lipomatosis facet arthropathy and disc herniation.

35 minutes

Legal Status:

Primary Treating Physician: Philip Conwisor MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 49-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

The patient is a candidate for right hip joint injection intra-articular as there are x-rays noted to be consistent with degenerative changes of the hip

Patient requires fluoroscopy for this injection

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By

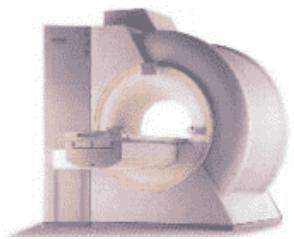
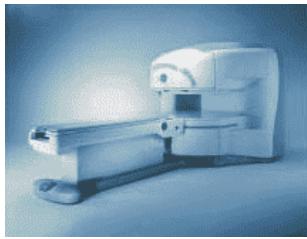


Kevin Kohan, D.O.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 12-02-2019.



Accredited by the American College of Radiology

Patient Name: BARDAKJIAN, STEEVIO
Patient Number: 43066
Date of Exam: 10-07-19 09:45
Referring Doctor: PHILLIP CONWISAR, M.D.

DOB: 05-23-1970

MRI OF THE LUMBAR SPINE WITH AND WITHOUT GADOLINIUM CONTRAST

IMPRESSION:

1. Loss of normal lumbar lordosis is seen suggestive of paraspinal muscle spasm.
2. L4-L5 level: 4mm posterior disc bulge is noted causing mass effect upon the thecal sac and perineural fat with associated mild bilateral facet arthropathy and ligamentum flavum thickening and epidural lipomatosis resulting in severe central spinal canal stenosis, AP thecal sac measures 7 mm. Moderate bilateral neuroforaminal stenosis is seen with abutment upon bilateral L4 exiting nerve roots.
3. L3-L4 level: 1mm posterior disc bulge is noted causing mass effect upon the thecal sac and perineural fat with mild bilateral neuroforaminal narrowing. There is no central spinal canal stenosis.
4. L5-S1 level: 2 mm posterior disc bulge is noted causing mass effect upon the thecal sac and perineural fat. There is no central spinal canal stenosis or neuroforaminal narrowing.

Indications: 49 year-old male presents with an injury from work on 7/2018. Patient complains of lower back pain that is constant. Hx Sx, ambulates with a cane.

Dx: Lumbar radiculopathy. Date of injury 07-03-18.

Technique: **AIC-VALENCIA:** Using a high-resolution GE Ovation Open MRI scanner with high-performance gradients and EXCITE technology, the following sequences were acquired: Multiplanar, multiphase MR sequences were obtained before and after administration IV gadolinium contrast. Total 20ML contrast.

Comparison: None.

FINDINGS:

Vertebral Bodies: Height and alignment: Loss of normal lumbar lordosis is seen suggestive of paraspinal muscle spasm, otherwise normal.

Marrow signal intensity: Normal.

Osteophytes: present.

Posterior elements: intact.

IV Discs: Disc desiccation: Not present.

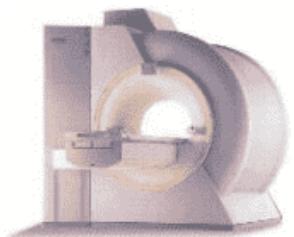
T12-L1 level: There is no significant disc bulge, central spinal canal stenosis or neuroforaminal narrowing.

L1-L2 level: There is no significant disc bulge, central spinal canal stenosis or neuroforaminal narrowing.



aic
ADVANCED IMAGING CENTER
Valencia

Accredited by the American College of Radiology



Patient Name: BARDAKJIAN, STEEVIO
Patient Number: 43066
Date of Exam: 10-07-19 09:45
Referring Doctor: PHILLIP CONWISAR, M.D.

DOB: 05-23-1970

MRI OF THE LUMBAR SPINE WITH AND WITHOUT GADOLINIUM CONTRAST

L2-L3 level: There is no significant disc bulge, central spinal canal stenosis or neuroforaminal narrowing.

L3-L4 level: 1mm posterior disc bulge is noted causing mass effect upon the thecal sac and perineural fat with mild bilateral neuroforaminal narrowing. There is no central spinal canal stenosis.

L4-L5 level: 4mm posterior disc bulge is noted causing mass effect upon the thecal sac and perineural fat with associated mild bilateral facet arthropathy and ligamentum flavum thickening and epidural lipomatosis resulting in severe central spinal canal stenosis, AP thecal sac measures 7 mm. Moderate bilateral neuroforaminal stenosis is seen with abutment upon bilateral L4 exiting nerve roots.

L5-S1 level: 2 mm posterior disc bulge is noted causing mass effect upon the thecal sac and perineural fat. There is no central spinal canal stenosis or neuroforaminal narrowing.

Thecal Sac and Cord: Thecal sac: Reduced at L4-L5.

Epidural spaces and fat: normal.

Spinal Cord: normal. Conus and cauda equina: normal.

No abnormal postcontrast enhancement.

Anterior and posterior longitudinal ligaments: intact.

Pre and paravertebral muscles and soft tissues: normal.

Bilateral sacroiliac joint: normal.

Other findings:

Abdominal aorta: non aneurysmal

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

Pursuant to section LC5703 & 5307 "A" "1", I declare under penalty of perjury that I have not violated labor code section 139.3 and that I have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Thank you for referring this patient to **ADVANCED IMAGING CENTER**.

Electronically signed on 10/08/19 16:16 by

Andrew McDonnell M.D.

Diplomate, American Board of Radiology

AM/DA

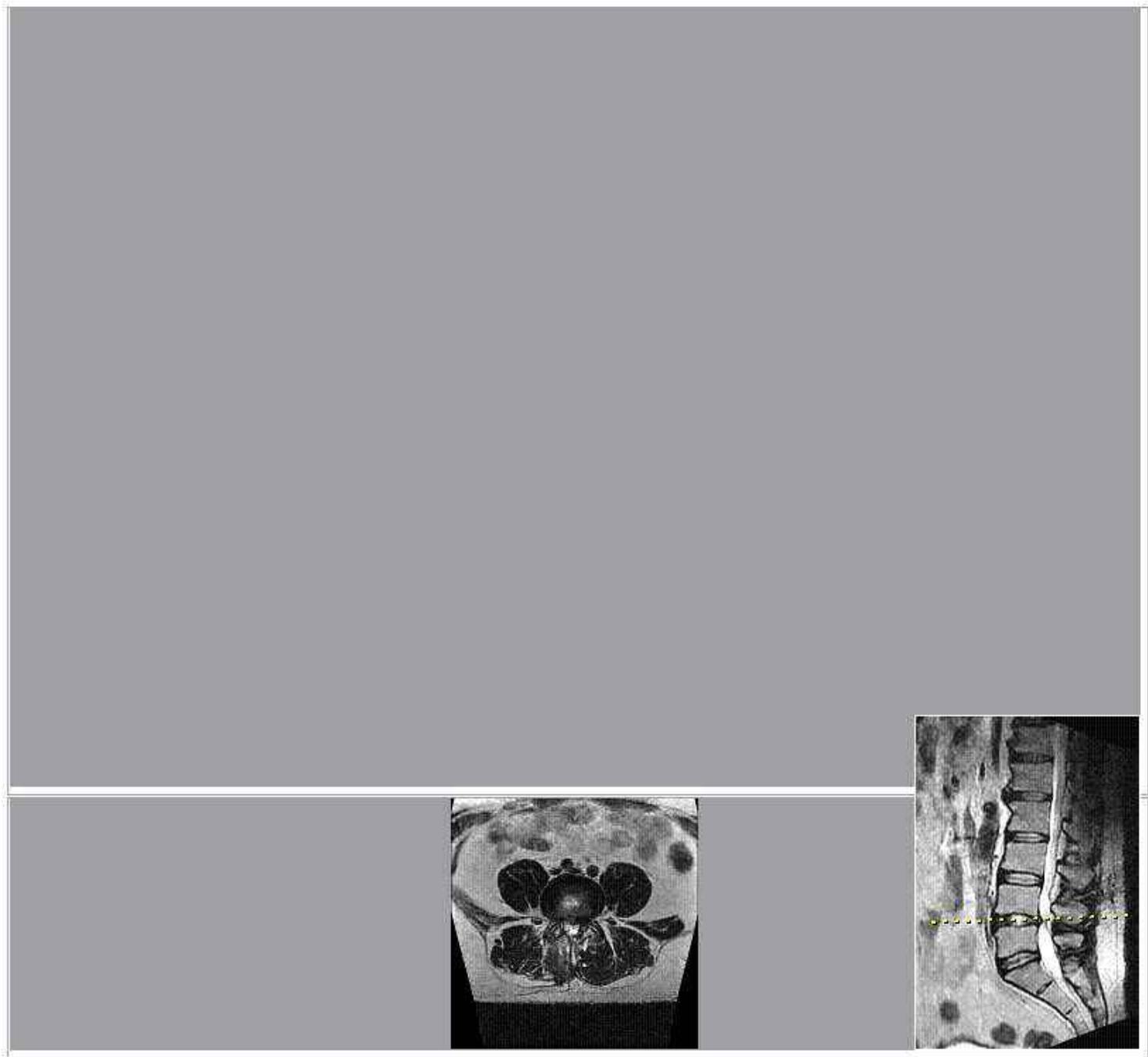
Dictated: 10-08-19 03:58

Transcribed: 10-08-19 03:58

(Page 2 of 2)

Patient Name: BARDAKJIAN, STEEVIO
Patient ID: 43066
Patient D.O.B.: May 23, 1970 M049Y

Exam Name: MRI Spine - Lumbar W A
Exam Date: Mon Oct 7, 2019
Referring Dr: CONWISAR P

**Comments:**

Loss of normal lumbar lordosis is seen suggestive of paraspinal muscle spasm.

L4-L5 level: 4mm posterior disc bulge is noted causing mass effect upon the thecal sac and perineural fat with associated mild bilateral facet arthropathy and ligamentum flavum thickening and epidural lipomatosis resulting in severe central spinal canal stenosis, AP thecal sac measures 7 mm. Moderate bilateral neuroforaminal stenosis is seen with abutment upon bilateral L4 exiting nerve roots.

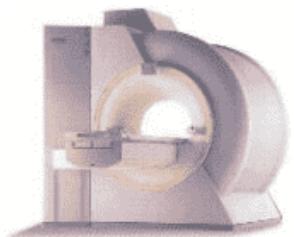
L3-L4 level: 1mm posterior disc bulge is noted causing mass effect upon the thecal sac and perineural fat with mild bilateral neuroforaminal narrowing. There is no central spinal canal stenosis.

L5-S1 level: 2 mm posterior disc bulge is noted causing mass effect upon the thecal sac and perineural fat. There is no central spinal canal stenosis or neuroforaminal narrowing.

Preliminary Only. Final to Follow. Summary prepared by _____



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Valencia



Accredited by the American College of Radiology

Patient Name: BARDAKJIAN, STEEVIO **DOB:** 05/23/1970
Patient Number: 43066
Date of Exam: 11/25/19 14:10
Referring Doctor: PHILLIP CONWISAR, M.D.

XRAYS OF PELVIS (ONE OR TWO VIEWS)

IMPRESSION:

1. No evidence of acute osseous abnormality or fracture seen.
2. Degenerative joint disease both hips.

Indications: 49 year-old male presents with right hip pain and pelvic pain, limited ROM without pain meds. Pt sustained a fall down the stairs a 2 weeks after back surgery on 8/2018. Has pinched nerves, trying to R/o right acetabulum. Date of injury 07/03/18.

Technique: **AIC-VALENCIA:** Utilizing a Carestream Computerized Radiography (**CR Digital X-ray**) scanner, the following views were obtained: AP.

Comparison: «None.»

FINDINGS:

The pelvic skeleton presents an anatomically normal and symmetrical shape. Normal bone mineralization. No evidence of acute fracture. The cortical margins and trabecular markings of the osseous structures are unremarkable. The sacroiliac joint and symphysis pubis are of normal width. The sacrum and imaged portions of the lumbar spine are unremarkable.

Marginal joint line osteophytes are seen at both acetabuli. Femoro-acetabular joint spaces are intact bilaterally. There are no intra-articular or periarticular calcifications. .

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

Pursuant to section LC5703 & 5307 "A" "1", I declare under penalty of perjury that I have not violated labor code section 139.3 and that I have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Thank you for referring this patient to **ADVANCED IMAGING CENTER**.

Electronically signed on 11/25/19 14:44 by

Amjad Safvi, M.D.

Diplomate, American Board of Radiology

AS/S11

Dictated: 11/25/19 14:44

Transcribed: 11/25/19 14:44

(Page 1 of 1)

aic Advanced Imaging Center

Patient Name: BARDAKJIAN^STEEVIO

Patient ID: 43066

Patient D.O.B.: May 23, 1970 M49Y

Exam Name: XRAY PELVIS Xray Pelvis; 1 or 2

Exam Date: Mon Nov 25, 2019

Referring Dr: CONWISAR^P

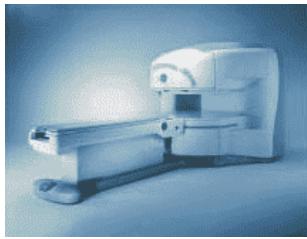


Comments:

No evidence of acute osseous abnormality or fracture seen.

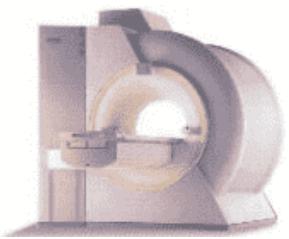
Degenerative joint disease both hips.

Preliminary Only. Final to Follow. Summary prepared by _____



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ADVANCED IMAGING CENTER
Valencia

Accredited by the American College of Radiology



Patient Name: BARDAKJIAN, STEEVIO **DOB:** 05/23/1970
Patient Number: 43066
Date of Exam: 11/25/19 14:00
Referring Doctor: PHILLIP CONWISAR, M.D.

X-RAYS OF THE RIGHT HIP (UNILAT/COMPLETE, TWO+ VIEWS)

IMPRESSION:

1. No acute osseous abnormality or fracture seen.
2. Degenerative joint disease right hip.

Indications: 49 year-old male presents with right hip pain and pelvic pain, limited ROM without pain meds. Pt sustained a fall down the stairs a 2 weeks after back surgery on 8/2018. Has pinched nerves, trying to R/o right acetabulum. Date of injury 07/03/18.

Technique: **AIC-VALENCIA:** Utilizing a Carestream Computerized Radiography (**CR Digital X-ray**) scanner, the following views were obtained: AP and lateral.

Comparison: «None.»

FINDINGS:

Normal bone mineralization. Cortical margins of the osseous structures are within normal limits. There is no evidence of acute fracture or dislocation. There is no lytic or sclerotic lesion. Osteoarthritic changes are seen in right hip joint depicted by marginal osteophyte of acetabulum with sclerosis. Right femoro-acetabular joint space is intact. Soft tissues appear normal without evidence of calcifications.

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

Pursuant to section LC5703 & 5307 "A" "1", I declare under penalty of perjury that I have not violated labor code section 139.3 and that I have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

Thank you for referring this patient to **ADVANCED IMAGING CENTER**.

Electronically signed on 11/25/19 14:49 by

Amjad Safvi, M.D.

Diplomate, American Board of Radiology

AS/S11

Dictated: 11/25/19 14:49 Transcribed: 11/25/19 14:49

(Page 1 of 1)

Patient Name: BARDAKJIAN^STEEVIO
Patient ID: 43066
Patient D.O.B.: May 23, 1970 M49Y

Exam Name: XRAY HIP Xray Hip, Right; Unit:
Exam Date: Mon Nov 25, 2019
Referring Dr: CONWISAR^P

**Comments:**

No acute osseous abnormality or fracture seen.
Degenerative joint disease right hip.
Preliminary Only. Final to Follow. Summary prepared by _____



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSISTANT CLINICAL PROFESSOR OF USC

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OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	TRISTRAR RISK MANAGEMENT
ADDRESS	:	PO BOX 11967, SANTA ANA CA 92711 - 1967
ADJUSTOR	:	Regina Diaz
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	11-04-2019

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084.

Current Complaints:

Low back and right leg pain

History of Present Illness

Returns to clinic for internal followup visit of low back pain versus accommodation medications are working well denies any side effects the patient reports that the medications allows functional improvement and ability to work

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are

relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline: 30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS

EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

***Interval F/U Pain Descriptors:** Location of pain is at Low back and right leg pain. Current Pain Changes :

fluctuates in intensity. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Review of Systems

Neurological: Reports *numbness*.

Constitutional: Reports *sweats*.

Musculoskeletal: Reports *weakness*.

Physical Examination

On a scale of 1 to 10 the pain level is 7. Height (inches): 71.00 Weight (lbs): 215.00 **BP:** 158/93 mm Hg. **Pulse:** 104 per min. **SpO2:** 96. **BMI:** 30.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Abdomen: The abdomen is soft, with no masses palpated, no rebound, rigidity or tenderness.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. Straight leg raise on the right:: positive. Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.*

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness of the right L3-4 and L4-5*

Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: *Deep Tendon Reflexes are intact throughout except Decrease right knee reflex 1+ Pain with right hip motion*

Tenderness of the lumbar spine

PAIN MANAGEMENT

- UDS

Review of Medical Records:

Oxycodone on 10/2019 UDS results noted.

We are prescribing controlled substances. The most recent urine drug screen was done on 10-08-2019.
35 minutes

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 49-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

We are prescribing controlled substances. The most recent urine drug screen was done on 10-08-2019.

Treatment Plan:

Recommended the patient to follow up with neurosx/spine surgeon.

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from 10/ 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California
By



Kevin Kohan, D.O.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 11-04-2019.

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 49109	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 10/15/2019	COLLECTION DATE 10/08/2019		REPORTED 10/16/2019 18:01 PDT	
COMMENT IMMUNOASSAY SCREENING					Page 1 of 1

PRESCRIBED MEDICATIONS

Metformin, Percocet

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
SPECIMEN VALIDITY TESTING (1)					
CREATININE	86		NORMAL	>=20	mg/dL
pH	5.3		NORMAL	4.7-7.8	
SPECIFIC GRAVITY	1.016		NORMAL	1.003-1.035	g/mL
OXIDANT	-10		NORMAL	<=200	ug/mL
TOXICOLOGY SCREEN (1)					
AMPHETAMINES	NEGATIVE		NORMAL	500	ng/mL
BARBITURATES	NEGATIVE		NORMAL	200	ng/mL
BENZODIAZEPINES	NEGATIVE		NORMAL	200	ng/mL
BUPRENORPHINE	NEGATIVE		NORMAL	5	ng/mL
COCAINE	NEGATIVE		NORMAL	300	ng/mL
CANNABINOIDS	NEGATIVE		NORMAL	50	ng/mL
CARISOPRODOL	NEGATIVE		NORMAL	100	ng/mL
ETHANOL	NEGATIVE		NORMAL	100	ng/mL
FENTANYL	NEGATIVE		NORMAL	2	ng/mL
EDDP (METHADONE METABOLITE)	NEGATIVE		NORMAL	300	ng/mL
OPIATES	NEGATIVE		NORMAL	300	ng/mL
OXYCODONE	POSITIVE		HIGH	100	ng/mL
**See LC/MS/MS for confirmation					
PHENCYCLIDINE	NEGATIVE		NORMAL	25	ng/mL
MDMA (ECSTACY)	NEGATIVE		NORMAL	500	ng/mL
METHAMPHETAMINE	NEGATIVE		NORMAL	500	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



Summary of Findings
UNIVERSAL PAIN MANAGEMENT
819 Auto Center Drive
Palmdale, CA 93551
Phone: (661) 267-6876 x156
Lab Director - Earl Weissman, PhD

PATIENT NAME BARDAKJIAN, STEEVIO		LAB REF # 49110	Patient ID 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 10/08/2019	COLLECTION DATE 10/08/2019		REPORTED DATE 10/17/2019 17:20	

CONSISTENT RESULTS - REPORTED MEDICATION (PARENT DRUG AND/OR METABOLITE) DETECTED

REPORTED PRESCRIPTION	ANTICIPATED POSITIVE(S)	TEST OUTCOME	DETECTION WINDOW
Percocet	OXYMORPHONE	POSITIVE	
Percocet	OXYCODONE	POSITIVE	

ADDITIONAL MEDICATIONS REPORTED BUT NOT TESTED FOR IN THIS REPORT

Metformin

000527

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 49110	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 10/15/2019	COLLECTION DATE 10/08/2019		REPORTED 10/17/2019 17:20 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS	Page 1 of 2				

PRESCRIBED MEDICATIONS

Metformin, Percocet

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
OPIATES/OPIOIDS CONFIRMATION - LC/MS/MS (1)					
CODEINE	NEGATIVE		CONSISTENT	50	ng/mL
MORPHINE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROMORPHONE	NEGATIVE		CONSISTENT	50	ng/mL
NORHYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
OXYCODONE	532	POSITIVE	CONSISTENT	50	ng/mL
OXYMORPHONE	484	POSITIVE	CONSISTENT	50	ng/mL
MEPERIDINE	NEGATIVE		CONSISTENT	50	ng/mL
TAPENTADOL	NEGATIVE		CONSISTENT	50	ng/mL
FENTANYL	NEGATIVE		CONSISTENT	5.0	ng/mL
O-DESMETHYL-CIS-TRAMADOL	NEGATIVE		CONSISTENT	50	ng/mL
METHADONE CONFIRMATION - LC/MS/MS (1)					
EDDP	NEGATIVE		CONSISTENT	50	ng/mL
BUPRENORPHINE CONFIRMATION - LC/MS/MS (1)					
BUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
NORBUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
BENZODIAZEPINES CONFIRMATION - LC/MS/MS (1)					
ALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
ALPHA-HYDROXYALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
7-AMINO-CLONAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
NORDIAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
OXAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
TEMAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
LORAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
PSYCHOTROPICS CONFIRMATION - LC/MS/MS (1)					
NORTRIPTYLINE	NEGATIVE		CONSISTENT	50	ng/mL
ZOLPIDEM	NEGATIVE		CONSISTENT	5.0	ng/mL
MUSCLE RELAXANTS CONFIRMATION - LC/MS/MS (1)					
MEPROBAMATE	NEGATIVE		CONSISTENT	50	ng/mL
CYCLOBENZAPRINE CONFIRMATION - LC/MS/MS (1)					
CYCLOBENZAPRINE	NEGATIVE		CONSISTENT	50	ng/mL
GABAPENTIN CONFIRMATION - LC/MS/MS (1)					
GABAPENTIN	NEGATIVE		CONSISTENT	50	ng/mL
PREGABALIN CONFIRMATION - LC/MS/MS (1)					
PREGABALIN	NEGATIVE		CONSISTENT	50	ng/mL
STIMULANTS CONFIRMATION - LC/MS/MS (1)					
AMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
MDMA	NEGATIVE		NORMAL	50	ng/mL
MDA	NEGATIVE		NORMAL	50	ng/mL
MDEA	NEGATIVE		NORMAL	50	ng/mL

000528

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 49110	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 10/15/2019	COLLECTION DATE 10/08/2019		REPORTED 10/17/2019 17:20 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS	Page 2 of 2				

PRESCRIBED MEDICATIONS

Metformin, Percocet

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
ILLCIT DRUG CONFIRMATION - LC/MS/MS (1)					
6-MONOACETYL MORPHINE (Metabolite)	NEGATIVE		NORMAL	50	ng/mL
BENZOYLECGONINE	NEGATIVE		NORMAL	50	ng/mL
METHAMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	50	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



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MARC REZNICKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	TRISTRAR RISK MANAGEMENT
ADDRESS	:	PO BOX 11967, SANTA ANA CA 92711 - 1967
ADJUSTOR	:	Regina Diaz
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	10-08-2019

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 4835 Van Nuys Blvd, 210, Sherman Oaks CA 91403 - 2109.

Current Complaints:

low back and right leg pain

History of Present Illness

The patient returns to clinic for general followup visit of low back pain and right leg pain the patient endorses that new imaging is pending and the patient will likely require new follow up visit with surgeon.

Meanwhile the patient is taking Percocet up to 3 times a day which allows him to work he gets 30% improvement of function ability to do his activities of daily living and work full-time. He denies any side effects

and reports that there is functional improvement .

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

***Interval F/U Pain Descriptors:** Location of pain is at low back and right leg pain. Current Pain Changes : same. Patient describes his pain as constant. **Recent Diagnostic Studies:**

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Review of Systems

Neurological: Reports *numbness*.

Constitutional: Reports *sweats*.

Musculoskeletal: Reports *weakness*.

Physical Examination

On a scale of 1 to 10 the pain level is 4. Height (inches): 71.00 Weight (lbs): 215.00 **BP:** 190/98 mm Hg. **Pulse:** 97 per min. **SpO2:** 106. **BMI:** 30.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Abdomen: The abdomen is soft, with no masses palpated, no rebound, rigidity or tenderness.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. Straight leg raise on the right:: positive. Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.*

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness of the right L3-4 and L4-5*

Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: *Deep Tendon Reflexes are intact throughout except Decrease right knee reflex 1+ Pain with right hip motion*

Tenderness of the lumbar spine

Review of Medical Records:

CURES reviewed and is consistent with prescribed medications.

35 minutes

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 49-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

* Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction and/or other aberrant drug-related behavior, to guide treatment. The frequency of random testing is determined by an individualized opioid risk score which is based upon the patient's individual medical history, and the type and quantity of drugs prescribed.

If the results of the definitive drug test are inconsistent, it could result in the patient being denied medication refills, counseled for aberrant behavior, recommended for detoxification or terminated from this practice. Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping.

Urine screening from April 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California
By



Kevin Kohan, D.O.



Kevin Kohan, D.O.
This has been electronically signed by Kevin Kohan, D.O. on 10-08-2019.



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OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	TRISTRAR RISK MANAGEMENT
ADDRESS	:	PO BOX 11967, SANTA ANA CA 92711 - 1967
ADJUSTOR	:	Regina Diaz
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	09-03-2019

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084.

Current Complaints:

low back and right leg pain

History of Present Illness

The patient returns to clinic for general followup visit of low back pain and right leg pain the patient endorses that the epidural injection gave approximately 5 days of pain relief 400% this was the patient's first epidural injection and the diagnostic phase was consistent however the patient would like to hold off on still doing the therapeutic phase where the patient would get another epidural injection the patient reports that she would like

to wait neurosurgeon's recommendations

Meanwhile the patient is taking Percocet up to 3 times a day which allows him to work he gets 30% improvement of function ability to do his activities of daily living and work full-time.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline: 30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing, grooming, dressing, transfers, ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 8

VAS (With Meds): 5

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

***Interval F/U**

Pain Descriptors: Location of pain is at low back and right leg pain. Current Pain Changes : fluctuates in intensity. Patient describes his pain as constant.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Review of Systems

Neurological: Reports **numbness**.

Constitutional: Reports **sweats**.

Musculoskeletal: Reports **weakness**.

Physical Examination

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Abdomen: The abdomen is soft, with no masses palpated, no rebound, rigidity or tenderness.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. Straight leg raise on the right:: positive. Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.*

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness of the right L3-4 and L4-5*

Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: *Deep Tendon Reflexes are intact throughout except Decrease right knee reflex 1+*

Pain with right hip motion

Tenderness of the lumbar spine

PAIN MANAGEMENT

- Opioid Dose Calculator

Review of Medical Records:

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping.
Epidural procedure report was reviewed

35 minutes

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 49-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Treatment Plan:

Patient Receive significant pain relief from the epidural injection and the diagnostic phase was consistent however the patient would like to hold off on therapeutic phase of the epidurals fail he has his followup by neurosurgeon

Urine screening at the next office visit

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from April 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

we'll consider the patient for epidural injection if the above felt epidural injection but likely involve

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 09-03-2019.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSISTANT CLINICAL PROFESSOR OF USC

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DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

Name : Steevio Bardakjian

MR# UPM31805

Date of Operation: 09-03-2019

DOB: 05-23-1970

Opioid Dose Calculator

Category	Test	Result	Remarks
Opioid Dose Calculator			
1	Oxycodone (mg per day)	30	
2	Oxycodone: Morphine Equivalent	45	
3	Oxycodone - Total no. of pills prescribed	90	
4	Oxycodone - No. of days pills prescribed for	30	
5	Oxycodone - mg/pill	10	
6	Oxycodone - Med deviation	30	
7	Total Daily Morphine Equivalent Dose	45	

Combined risk category using Opioid risk tool and Opioid dose is Low

* Based on information published by University of California, San Francisco and University of Rochester, Dept. of Palliative Care.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 09-03-2019.



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OMID MAHGEREFTEH, D.C.

Name : Steevio Bardakjian

MR# UPM31805

Date of Operation: 08-08-2019

DOB: 05-23-1970

Clinic Location: VALENCIA

Lumbar Transforaminal Injection

Pre-operative Diagnosis: Lumbar radiculopathy - M54.16

Post-operative Diagnosis: Lumbar radiculopathy - M54.16

Procedure Title(s):

1. Lumbar transforaminal injection

Side: Right

Procedure Level: L4-5 and L3-4

Surgeon: Kevin Kohan, D.O.

Anesthesia: Local

Indications: The patient is a 49 year-old male with a diagnosis of Lumbar radiculopathy - M54.16. The risks, benefits and alternatives to the procedure were discussed and all questions were answered to the patient's satisfaction. The patient agreed to proceed and written informed consent was obtained.

Anesthesia: Local. The patient's medical condition and the nature of this procedure requires the presence of a qualified anesthesia provider to administer sedation and to manage the airway and vital signs and to continually assess the patient for clinical problems and treat appropriately to ensure patient safety and comfort.

Procedure in Detail:- An intravenous line was started while the patient was in the preoperative holding area.

The patient was brought into the procedure room and placed in the prone position on the fluoroscopy table. Standard monitors were placed and vital signs were observed throughout the procedure. The area of the lumbar spine was prepped with Betadine times three and draped in a sterile manner. The L4-L5 interspace was identified with AP fluoroscopy. An oblique view to the right was obtained to better visualize the inferior junction of the pedicle and transverse process. The 6 o' clock position of the pedicle was marked and identified. The skin and subcutaneous tissues in the area were anesthetized with 1% lidocaine. A 22-gauge, 3 and 1/2 inch needle was directed towards the targeted point under fluoroscopy until bone was contacted. . The needle was then walked inferiorly until the neural foramen was entered. A lateral fluoroscopic view was then used to adjust the final position of the needle tip within the foramen. The same procedure was repeated at L3-L4 levels.

Negative aspiration was confirmed for blood and CSF and 0.5 ml isovue -m 300 contrast was injected at each level. Appropriate neurograms were observed under AP fluoroscopy. Then after negative aspiration, a solution consisting of 3cc of 6 cc solution 10 mg dexamethasone + 0.125% bupivacaine was easily injected at each level. The needles were removed. The patient's back was cleaned and a bandage was placed over the needle insertion points.

Disposition: The patient tolerated the procedure well and there were no complications. Vital signs remained stable throughout the procedure. The patient was taken to the recovery area where written discharge instructions for the procedure were given.

The patient was discharged in good condition.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 08-08-2019.



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MARC REZNICKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	TRISTRAR RISK MANAGEMENT
ADDRESS	:	PO BOX 11967, SANTA ANA CA 92711 - 1967
ADJUSTOR	:	Regina Diaz
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	07-23-2019

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084.

Current Complaints:

low back and right leg pain

History of Present Illness

The patient returns to clinic for interval followup visit of low back pain and leg pain the patient endorses to increasing pain in the low back and the legs however the medications the patient to function and perform activities of daily living the patient is waiting for epidural injection to be completed.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are

relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS

EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

***Interval F/U**

Pain Descriptors: Location of pain is at low back and right leg pain. Current Pain Changes : fluctuates in intensity. Patient describes his pain as constant.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Review of Systems

Neurological: Reports **numbness**.

Constitutional: Reports **sweats**.

Musculoskeletal: Reports **weakness**.

Physical Examination

On a scale of 1 to 10 the pain level is 6. Height (inches): 71.00 Weight (lbs): 215.00 **BP:** 147/86 mm Hg. **Pulse:** 97 per min. **SpO2:** 97.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Abdomen: The abdomen is soft, with no masses palpated, no rebound, rigidity or tenderness.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. Straight leg raise on the right:: positive. Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.*

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness of the right L3-4 and L4-5*

Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: *Deep Tendon Reflexes are intact throughout except Decrease right knee reflex 1+ Pain with right hip motion
Tenderness of the lumbar spine*

Review of Medical Records:

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Electrodiagnostic examination reviewed which demonstrates L4-L5 bilateral neuropathy as well as polyneuropathy

35 minutes

Legal Status:

Primary Treating Physician: Philip Conwisor MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Impression:

This patient is a 48-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate.

The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications. Without medications, the patient is able to ambulate 50 feet as baseline. With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

Injury Date: 07-03-2018 Reason for submitting report: periodic report

WORK STATUS: as per ptpt

Treatment Plan:

Patient is to continue with the epidural injection as it has been approved and the electrodiagnostic examination is consistent with the patient's symptomatology

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from April 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

we'll consider the patient for epidural injection if the above felt epidural injection but likely involve

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

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Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 07-23-2019.



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OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	TRISTRAR RISK MANAGEMENT
ADDRESS	:	PO BOX 11967, SANTA ANA CA 92711 - 1967
ADJUSTOR	:	Regina Diaz
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	07-01-2019

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084.

Current Complaints:

low back and right leg pain

History of Present Illness

The patient returns clinic for interval follow-up visit up low back pain and endorses To increasing pain. The patient has had increased pain down the leg despite acu and and HEP. The patient would like to proceed with epidural injection. The patient endorses numbness and weakness in the right leg unit dermatomal fashion of L3-4 and L45 consistent with MRI. The patient would like to stop the opioids wean them down and stop the

opioids and continued to work full-time- He is having trouble finishing the day although the opioids help its not sufficient.

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline: 30 %.

Functional Objective Improvement: Patient is able to perform activities such as

bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS

EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

***Interval F/U**

Pain Descriptors: Location of pain is at Back pain. Current Pain Changes : fluctuates in intensity. Patient describes his pain as constant.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Review of Systems

Neurological: Reports **numbness**.

Constitutional: Reports **sweats**.

Musculoskeletal: Reports **weakness**.

Physical Examination

Height (inches): 71.00 Weight (lbs): 215.00 **BP:** 158/78 mm Hg. **Pulse:** 100 per min. **Sp02:** 96. **BMI:** 30.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Abdomen: The abdomen is soft, with no masses palpated, no rebound, rigidity or tenderness.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. Straight leg raise on the right:: positive. Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.*

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness of the right L3-4 and*

L4-5

Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: *Deep Tendon Reflexes are intact throughout except Decrease right*

knee reflex 1+ Pain with right hip motion

Tenderness of the lumbar spine

Review of Medical Records:

CURES reviewed and is consistent

ACU notes reviewed noted for electroacu, patch placement and cupping

35 minutes

Legal Status:

Primary Treating Physician: Philip Conwisar MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 48-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate.

The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications. Without medications, the patient is able to ambulate 50 feet as baseline. With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

Injury Date: 07-03-2018 Reason for submitting report: periodic report

WORK STATUS: as per ptpt

Treatment Plan:

Patient has failed both chiro and acu and is a candidate for epidural injection - He is doing HEP and is in rehab program. He is working and it is very tough for him to finish the day and he is taking opioids and would like to wean down -He is a candidate for L3-4 and L4-5 levels on the right side with fluro and mac anesthesia due to severe anxiety.

Continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from April 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

we'll consider the patient for epidural injection if the above felt epidural injection but likely involve

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means

of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

Signed in Los Angeles County, California

By



Kevin Kohan, D.O.



SHAHIN A. SADIK, M.D., Q.M.E.
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MARC REZNICKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	TRISTRAR RISK MANAGEMENT
ADDRESS	:	PO BOX 11967, SANTA ANA CA 92711 - 1967
ADJUSTOR	:	Regina Diaz
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	06-10-2019

ACUPUNCTURE FOLLOW-UP REHABILITATION REPORT (PR-2)

(XX) Periodic Report	() Change in Treatment Plan	() Release from Care
() Change in Work Status	() Need for Referral or Consultation	() Response to Release for Information
() Change in Patient Condition	() Need for Surgery or Hospitalization	() Request for Authorization
() Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

Dear Dr. Conwisar,

Thank you for giving me the opportunity to re-evaluate and treat your patient, Steevio Bardakjian, in my office.

Chief Complaints:

Right hip pain

Presenting Complaints:

Mr. Bardakjian is here today seeking relief from his right hip pain.

This is due to a work-related injury that occurred on July 3, 2018.

He again reports good pain relief for a couple days after his last acupuncture treatment.

Today he reports low back pain with pain into his right hip and down the outside part of his leg to his mid calf.

Patient tells me that he was a nurse/ IT manager working for the LA County Department of Health,

Where he had worked for approximately 20 years when the injury occurred.

The patient tells me he was Looking for a cable under the desk and when he got up he felt his back pop.

This injury necessitated low back surgery which was performed by Dr. Barcohana on August 4, 2018.

The patient tells me that the surgery was not successful and has been in a lot of pain since that time.

Mr. Bardakjian is looking forward to pain relief with acupuncture today.

Acupuncture Intake FollowUp

Patient Condition: Reason for visit: Right hip pain. Describes his pain as sharp, throbbing, numbness, aching, shooting, cramps and stiffness type. Frequency of pain is Daily. Constant. Pain does interfere with his Work^Sleep^Daily Routine^Recreation. Reports that activities such as Sitting^Standing^Walking^Bending are painful to perform.

Health History: Patient has already undergone medication regime, palliative surgery, physical therapy and chiropractic services for his condition.

Allergy:

No Known Drug Allergies.

Past Medical History:

Diabetes ()

High Blood Pressure ()

Surgical History:

L3-L5 Disectomy: 08/2018

Review of Systems:

Neurological: Reports **numbness** RLE.

Constitutional: Reports **sweats**.

Musculoskeletal: Reports **weakness** RLE.

The remainder of the review of systems is negative as described in detail in the Patient Intake Packet.

Social and Family History:

GENERAL: The patient has completed college.

Social History: The patient does not use tobacco. He does not drink alcohol. He has Medical Marijuana Card.

The patient did not have problem with abusing drugs or alcohol. There has been no family member with any

serious illness. Patient does not take or is not on anticoagulants. He spends his time during the day by Resting, avoiding excessive movement, pt. The patient has never been convicted for abuse/possession of narcotics. **The patient is on disability currently.** He is on TTD disability. He has not travelled out of country recently. The patient has not been exposed to any toxins. Marital Status: single. Patient reports that he suffered from work related injury and also had required medical care for that injury. It occurred on 07/03/2018. He reports that he did not suffer an auto accident or other injury that resulted in a personal injury lawsuit.

Previous Injuries:

Legal Status:

Primary Treating Physician: Philip Conwisar MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. 2 inch Straight leg raise on the right:: positive. Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.*

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness of the right L3-4 and L4-5*

Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: *Deep Tendon Reflexes are intact throughout except Decrease right knee reflex 1+*

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Injury Date: 07-03-2018 Reason for submitting report: periodic report

WORK STATUS: as per ptp

Treatment Plan:

Electro Acupuncture to UB 25,28,31-34,40,57 ST 40

GB 29,30,31,34 Ashi Rt hip X 5

HJJ PTS: L1-L5

Cupping

Myofascial Release

Far-Infrared Heat

Herbal pain patches x7

Continue treatment plan 1x6 to decrease pain, increase function/ROM, decrease the need for increased medications, and

Improve activities of daily living.

Work Status: As per PTP

Work Restriction:

Required evaluation services to meet the reporting requirements set forth in Title 8, California Code of Regulations Section §9785(c): New Reg. §9785(f)(8), and CCR8 §§ 9792.20 - 9792.26 Medical Treatment Utilization Schedule. Acupuncture treatment requested: combine electro-acupuncture, heat, Myofascial release, etc. (passive care) with an exercise program (active care) as needed, to avoid de-conditioning and dependency on the use of passive modalities.

Be aware of the CA UR regulations and penalties: If more information is needed-requested, the physician to be contacted should be the one providing-requesting the acupuncture services (requesting physician) and not the referring physician (PTP). §9792.9(1) If reasonable information is requested, it should be within 5 working days (prospective-concurrent reviews) and 30 days (retrospective reviews). Some others: §9792. 6(q), (s), §9792.7(b)(1), (2), §9792.8(a) (1), §9792.9(3), (4), (c); (f), (1), §9792. 10 (1), (2).

Very truly yours,



Marc Reznikoff, L. Ac



Kevin Kohan, D.O.

DISCLOSURE:

In compliance with Labor Code section 4628 and the rules of Practice and Procedure, specifically 10978 and 10606, the following is supplied.

I declare under penalty of perjury that all opinions in this report are mine. I performed the evaluation and cognitive services at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084, in the County of Los Angeles and that, except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

I have complied with the Labor Code section 139.3 and I have not offered or received any commissions or inducements for this consultation. The name and contents of the report and billing are true and correct to the best of my knowledge.



Marc Reznikoff, L. Ac



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 06-10-2019.



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MARC REZNICKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

RE: Bardakjian, Steevio

SEX: Male

DATE OF BIRTH: 05-23-1970

CHART NO: UPM31805

VISIT DATE: 06-05-2019 :

REFERRING PHYSICIAN: Philip Conwisor MD

CHIROPRACTIC DAILY SOAP NOTE

Subjective Complaints:

History of Present Illness

Chiro Intake

Accident Information: Patient relates his current condition to a previous accident. The accident occurred at work place.

Patient Condition: Reason for visit: Low back pain. Describes his pain as aching and stiffness type.

Objective Findings:

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. Palpation of lumbar paraspinal muscles: tender. The patient's gait appears to be antalgic.*

Assessment:

Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Injury Date: 07-03-2018 Reason for submitting report: periodic report

WORK STATUS: as per ptpt

Plan

1. The patient was placed in prone position, surface of skin cleaned with alcohol pad, electrodes were placed in crisscross fashion over the lumbar spine (IFC) applied at a frequency 80 to 150 Hz, 15 minutes over the lumbar spine.
2. Therapeutic ultrasound therapy applied to the lumbar spine at constant setting at 1.6 watts per square centimeters over 8 minutes with analgesic coupling agent over the lumbar spine. Ultrasound causes the resolution inflammatory exudates and increases blood flow.
3. Mechanical massager applied to loosen up the spine paravertebral musculature prior to L/S PROM and Passive stretching. Passive stretching is a form of therapeutic procedure in which a specific muscle or tendon (or muscle group) is deliberately flexed or stretched in order to improve the muscle's elasticity and achieve comfortable muscle tone. The result is a feeling of increased muscle control, flexibility, and range of motion. Stretching is also used therapeutically to alleviate cramps.
4. CHIROPRACTIC manipulation: This procedure helps decrease the pain-free range of motion, prevent fibrotic adhesion, decrease pain, and increased facet joint play. Chiropractic manipulation performed over F/D lumbar, sacrum and pelvic region.

Approximately total of 45 minutes spent to provide above-mentioned treatments.

Treatment provided without incident. Post treatment, the patient reports relief. The patient is recommended to continue with home exercise program until the next visit. To continue with home exercise program until the next visit.



Omid Mahgerefteh, D.C.

This has been electronically signed by Omid Mahgerefteh, D.C. on 06-05-2019.



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OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	TRISTRAR RISK MANAGEMENT
ADDRESS	:	PO BOX 11967, SANTA ANA CA 92711 - 1967
ADJUSTOR	:	Regina Diaz
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	06-03-2019

ACUPUNCTURE FOLLOW-UP REHABILITATION REPORT (PR-2)

(XX) Periodic Report	(<input type="checkbox"/>) Change in Treatment Plan	(<input type="checkbox"/>) Release from Care
(<input type="checkbox"/>) Change in Work Status	(<input type="checkbox"/>) Need for Referral or Consultation	(<input type="checkbox"/>) Response to Release for Information
(<input type="checkbox"/>) Change in Patient Condition	(<input type="checkbox"/>) Need for Surgery or Hospitalization	(<input type="checkbox"/>) Request for Authorization
(<input type="checkbox"/>) Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

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Right hip pain

Presenting Complaints:

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This is due to a work-related injury that occurred on July 3, 2018.

He reports good pain relief for a couple days after his last acupuncture treatment.

Today he reports pain from his low back into his right hip and down his leg to his mid calf.

Patient tells me that he was a nurse/ IT manager working for the LA County Department of Health,

Where he had worked for approximately 20 years when the injury occurred.

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This injury necessitated low back surgery which was performed by Dr. Barcohana on August 4, 2018.

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Mr. Bardakjian is looking forward to pain relief with acupuncture today.

Acupuncture Intake FollowUp

Patient Condition: Reason for visit: Right hip pain. Describes his pain as sharp, throbbing, numbness, aching, shooting, cramps and stiffness type. Frequency of pain is Daily. Constant. Pain does interfere with his Work^Sleep^Daily Routine^Recreation. Reports that activities such as Sitting^Standing^Walking^Bending are painful to perform.

Health History: Patient has already undergone medication regime, palliative surgery, physical therapy and chiropractic services for his condition.

Allergy:

No Known Drug Allergies.

Past Medical History:

Diabetes ()

High Blood Pressure ()

Surgical History:

L3-L5 Disectomy: 08/2018

Review of Systems:

Neurological: Reports **numbness** RLE.

Constitutional: Reports **sweats**.

Musculoskeletal: Reports **weakness** RLE.

The remainder of the review of systems is negative as described in detail in the Patient Intake Packet.

Social and Family History:

GENERAL: The patient has completed college.

Social History: The patient does not use tobacco. He does not drink alcohol. He has Medical Marijuana Card.

The patient did not have problem with abusing drugs or alcohol. There has been no family member with any

serious illness. Patient does not take or is not on anticoagulants. He spends his time during the day by Resting, avoiding excessive movement, pt. The patient has never been convicted for abuse/possession of narcotics. **The patient is on disability currently.** He is on TTD disability. He has not travelled out of country recently. The patient has not been exposed to any toxins. Marital Status: single. Patient reports that he suffered from work related injury and also had required medical care for that injury. It occurred on 07/03/2018. He reports that he did not suffer an auto accident or other injury that resulted in a personal injury lawsuit.

Previous Injuries:

Legal Status:

Primary Treating Physician: Philip Conwisar MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

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Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: *Deep Tendon Reflexes are intact throughout except Decrease right knee reflex 1+*

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Injury Date: 07-03-2018 Reason for submitting report: periodic report

WORK STATUS: as per ptp

Treatment Plan:

Electro Acupuncture to UB 25,28,31-34,40,57 ST 40

GB 29,30,31,34 Ashi Rt hip X 5

HJJ PTS: L1-L5

Cupping

Myofascial Release

Far-Infrared Heat

Herbal pain patches x7

Continue treatment plan 1x6 to decrease pain, increase function/ROM, decrease the need for increased medications, and

Improve activities of daily living.

Work Status: As per PTP

Work Restriction:

Required evaluation services to meet the reporting requirements set forth in Title 8, California Code of Regulations Section §9785(c): New Reg. §9785(f)(8), and CCR8 §§ 9792.20 - 9792.26 Medical Treatment Utilization Schedule. Acupuncture treatment requested: combine electro-acupuncture, heat, Myofascial release, etc. (passive care) with an exercise program (active care) as needed, to avoid de-conditioning and dependency on the use of passive modalities.

Be aware of the CA UR regulations and penalties: If more information is needed-requested, the physician to be contacted should be the one providing-requesting the acupuncture services (requesting physician) and not the referring physician (PTP). §9792.9(1) If reasonable information is requested, it should be within 5 working days (prospective-concurrent reviews) and 30 days (retrospective reviews). Some others: §9792. 6(q), (s), §9792.7(b)(1), (2), §9792.8(a) (1), §9792.9(3), (4), (c); (f), (1), §9792. 10 (1), (2).

Very truly yours,



Marc Reznikoff, L. Ac



Kevin Kohan, D.O.

DISCLOSURE:

In compliance with Labor Code section 4628 and the rules of Practice and Procedure, specifically 10978 and 10606, the following is supplied.

I declare under penalty of perjury that all opinions in this report are mine. I performed the evaluation and cognitive services at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084, in the County of Los Angeles and that, except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

I have complied with the Labor Code section 139.3 and I have not offered or received any commissions or inducements for this consultation. The name and contents of the report and billing are true and correct to the best of my knowledge.



Marc Reznikoff, L. Ac



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 06-03-2019.



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BOARD CERTIFIED-PAIN MANAGEMENT AND PM&R

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DEBBIE CASTILLO, P.T.A.
MARC REZNICKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	TRISTRAR RISK MANAGEMENT
ADDRESS	:	PO BOX 11967, SANTA ANA CA 92711 - 1967
ADJUSTOR	:	Regina Diaz
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	05-20-2019

SUPPLEMENTAL REPORT ON PAIN MANAGEMENT PROGRESS (PR-2)

(XX) Periodic Report	(<input type="checkbox"/> Change in Treatment Plan	(<input type="checkbox"/> Release from Care
(<input type="checkbox"/> Change in Work Status	(<input type="checkbox"/> Need for Referral or Consultation	(<input type="checkbox"/> Response to Release for Information
(<input type="checkbox"/> Change in Patient Condition	(<input type="checkbox"/> Need for Surgery or Hospitalization	(<input checked="" type="checkbox"/> Request for Authorization
(<input type="checkbox"/> Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is a report on pain management progress performed at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084.

Current Complaints:

Back pain

History of Present Illness

The patient returns to clinic for followup visit of low back pain and right leg pain. The patient endorses to that Percocet and the combination of acupuncture and chiropractic therapy the patient has been having courage and strength to return to work. The patient endorses that the Percocet helps significantly with the pain where the patient gets 30% improvement of the pain. The combination of chiropractic and active puncture can help

30% as well to alleviate the pain. The patient denies side effects the patient endorses that the pregabalin dosage may have given the patient increased dizziness-however the patient is going to give it a try. It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.
ADLs/ subjective functional improvement from baseline: 30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.
Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

***Interval F/U**

Pain Descriptors: Location of pain is at Low back and right leg and hip pain. Current Pain Changes : fluctuates in intensity. Patient describes his pain as constant.

Recent Diagnostic Studies:

CAT Scan: No.

Discogram: No

EMG: No.

MRI: No.

Myelogram: No.

Review of Systems

Neurological: Reports **numbness**.

Constitutional: Reports **sweats**.

Musculoskeletal: Reports **weakness**.

Physical Examination

Height (inches): 71.00 Weight (lbs): 213.00 **BP:** 144/90 mm Hg. **Pulse:** 101 per min. **SpO2:** 99. **BMI:** 30.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Abdomen: The abdomen is soft, with no masses palpated, no rebound, rigidity or tenderness.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. Straight leg raise on the right:: positive. Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.*

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness of the right L3-4 and*

L4-5

Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: *Deep Tendon Reflexes are intact throughout except Decrease right*

knee reflex 1+ Pain with right hip motion

Tenderness of the lumbar spine

Review of Medical Records:

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping.

Urine screening at April 2019 visit was consistent with prescribed medication of oxycodone

Acupuncture notes and chiropractic notes were reviewed and noted for cupping electro-acupuncture range of motion strengthening and modalities.

35 minutes

Legal Status:

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Impression:

This patient is a 48-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries -patient is doing well with conservative therapies of acupuncture chiropractic therapies as well as medication management with Percocet

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate.

The patient has failed prior medications which include; none.

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications. Without medications, the patient is able to ambulate 50 feet as baseline. With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

Injury Date: 07-03-2018 Reason for submitting report: periodic report

WORK STATUS: as per ptp

Treatment Plan:

Continue combination of chiropractic and acupuncture

continue Percocet up to 3 times a day

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping. Urine screening from April 2019 report demonstrates oxycodone consistent with prescribed medication of Percocet

we'll consider the patient for epidural injection if the above felt epidural injection but likely involve L3-4 and L4-5 levels on the right side

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER. An opioid contract is on file. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b)): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j)): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

*Signed in Los Angeles County, California
By*



Kevin Kohan, D.O.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 05-20-2019.



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IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
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EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	TRISTRAR RISK MANAGEMENT
ADDRESS	:	PO BOX 11967, SANTA ANA CA 92711 - 1967
ADJUSTOR	:	Regina Diaz
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	05-13-2019

ACUPUNCTURE FOLLOW-UP REHABILITATION REPORT (PR-2)

(XX) Periodic Report	(<input type="checkbox"/>) Change in Treatment Plan	(<input type="checkbox"/>) Release from Care
(<input type="checkbox"/>) Change in Work Status	(<input type="checkbox"/>) Need for Referral or Consultation	(<input type="checkbox"/>) Response to Release for Information
(<input type="checkbox"/>) Change in Patient Condition	(<input type="checkbox"/>) Need for Surgery or Hospitalization	(<input type="checkbox"/>) Request for Authorization
(<input type="checkbox"/>) Other		

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

Dear Dr. Conwisar,

Thank you for giving me the opportunity to re-evaluate and treat your patient, Steevio Bardakjian, in my office.

Chief Complaints:

Right hip pain

Presenting Complaints:

Mr. Bardakjian is here today seeking relief from his right hip pain.

This is due to a work-related injury that occurred on July 3, 2018.

He reports feeling very relaxed and getting good sleep after his first acupuncture treatment last week.

"It's hard to tell how much it helped after the first treatment".

Today he reports pain shooting from his low back into his right hip and down his leg to his mid calf.

Patient tells me that he was a nurse/ IT manager working for the LA County Department of Health,

Where he had worked for approximately 20 years when the injury occurred.

The patient tells me he was Looking for a cable under the desk and when he got up he felt his back pop.

This injury necessitated low back surgery which was performed by Dr. Barcohana on August 4, 2018.

The patient tells me that the surgery was not successful and has been in a lot of pain since that time.

Mr. Bardakjian is looking forward to pain relief with acupuncture today.

Acupuncture Intake FollowUp

Patient Condition: Reason for visit: Right hip pain. Describes his pain as sharp, throbbing, numbness, aching, shooting, cramps and stiffness type. Frequency of pain is Daily. Constant. Pain does interfere with his Work^Sleep^Daily Routine^Recreation. Reports that activities such as Sitting^Standing^Walking^Bending are painful to perform.

Health History: Patient has already undergone medication regime, palliative surgery, physical therapy and chiropractic services for his condition.

Allergy:

No Known Drug Allergies.

Past Medical History:

Diabetes ()

High Blood Pressure ()

Surgical History:

L3-L5 Disectomy: 08/2018

Review of Systems:

Neurological: Reports **numbness** RLE.

Constitutional: Reports **sweats**.

Musculoskeletal: Reports **weakness** RLE.

The remainder of the review of systems is negative as described in detail in the Patient Intake Packet.

Social and Family History:

GENERAL: The patient has completed college.

Social History: The patient does not use tobacco. He does not drink alcohol. He has Medical Marijuana Card. The patient did not have problem with abusing drugs or alcohol. There has been no family member with any serious illness. Patient does not take or is not on anticoagulants. He spends his time during the day by Resting, avoiding excessive movement, pt. The patient has never been convicted for abuse/possession of narcotics. **The patient is on disability currently.** He is on TTD disability. He has not travelled out of country recently. The patient has not been exposed to any toxins. Marital Status: single. Patient reports that he suffered from work related injury and also had required medical care for that injury. It occurred on 07/03/2018. He reports that he did not suffer an auto accident or other injury that resulted in a personal injury lawsuit.

Previous Injuries:

Legal Status:

Primary Treating Physician: Philip Conwisor MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. 2 inch Straight leg raise on the right:: positive. Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.*

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness of the right L3-4 and L4-5*

Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: *Deep Tendon Reflexes are intact throughout except Decrease right knee reflex 1+*

ICD Codes: Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

There is 30 % of improvement with opioid medications. Without medications, the patient is able to ambulate 50 feet as baseline. With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

Injury Date: 07-03-2018 Reason for submitting report: periodic report

WORK STATUS: as per pt

Treatment Plan:

Electro Acupuncture to UB 25,28,31-34,40,57 ST 40

GB 29,30,31,34 Ashi Rt hip X 5

HJJ PTS: L1-L5

Cupping

Myofascial Release

Neuro re-ed

Far-Infrared Heat

Herbal pain patches x6

Continue treatment plan 1x6 to decrease pain, increase function/ROM, decrease the need for increased medications, and

Improve activities of daily living.

Work Status: As per PTP

Work Restriction:

Required evaluation services to meet the reporting requirements set forth in Title 8, California Code of Regulations Section §9785(c): New Reg. §9785(f)(8), and CCR8 §§ 9792.20 - 9792.26 Medical Treatment Utilization Schedule. Acupuncture treatment requested: combine electro-acupuncture, heat, Myofascial release, etc. (passive care) with an exercise program (active care) as needed, to avoid de-conditioning and dependency on the use of passive modalities.

Be aware of the CA UR regulations and penalties: If more information is needed-requested, the physician to be contacted should be the one providing-requesting the acupuncture services (requesting physician) and not the referring physician (PTP). §9792.9(1) If reasonable information is requested, it should be within 5 working days (prospective-concurrent reviews) and 30 days (retrospective reviews). Some others: §9792. 6(q), (s), §9792.7(b)(1), (2), §9792.8(a) (1), §9792.9(3), (4), (c); (f), (1), §9792. 10 (1), (2).

Very truly yours,

Marc Reznikoff, L. Ac

Kevin Kohan, D.O.

DISCLOSURE:

In compliance with Labor Code section 4628 and the rules of Practice and Procedure, specifically 10978 and 10606, the following is supplied.

I declare under penalty of perjury that all opinions in this report are mine. I performed the evaluation and cognitive services at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084, in the County of Los Angeles and that, except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

I have complied with the Labor Code section 139.3 and I have not offered or received any commissions or inducements for this consultation. The name and contents of the report and billing are true and correct to the best of my knowledge.



Marc Reznikoff, L. Ac



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 05-13-2019.



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MARC REZNICKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

RE: Bardakjian, Steevio

SEX: Male

DATE OF BIRTH: 05-23-1970

CHART NO: UPM31805

VISIT DATE: 05-08-2019 :

REFERRING PHYSICIAN: Philip Conwisor MD

CHIROPRACTIC DAILY SOAP NOTE

Subjective Complaints:

History of Present Illness

Chiro Intake

Accident Information: Patient relates his current condition to a previous accident. The accident occurred at work place.

Patient Condition: Reason for visit: Back pain. Describes his pain as aching and stiffness type.

Objective Findings:

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

Lumbar Spine: *Palpation of lumbar paraspinal muscles: tender. The patient's gait appears to be antalgic. He requires a cane for ambulation.*

Assessment:

Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

There is 30 % of improvement with opioid medications. Without medications, the patient is able to ambulate 50 feet as baseline. With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

Injury Date: 07-03-2018 Reason for submitting report: periodic report

WORK STATUS: as per ptp

Plan

1. The patient was placed in prone position, surface of skin cleaned with alcohol pad, electrodes were placed in crisscross fashion over the lumbar spine (IFC) applied at a frequency 80 to 150 Hz, 15 minutes over the lumbar spine.
2. Therapeutic ultrasound therapy applied to the lumbar spine at constant setting at 1.6 watts per square centimeters over 8 minutes with analgesic coupling agent over the lumbar spine. Ultrasound causes the resolution inflammatory exudates and increases blood flow.
3. Mechanical massager applied to loosen up the spine paravertebral musculature prior to L/S PROM and Passive stretching. Passive stretching is a form of therapeutic procedure in which a specific muscle or tendon (or muscle group) is deliberately flexed or stretched in order to improve the muscle's elasticity and achieve comfortable muscle tone. The result is a feeling of increased muscle control, flexibility, and range of motion. Stretching is also used therapeutically to alleviate cramps.
4. CHIROPRACTIC manipulation: This procedure helps decrease the pain-free range of motion, prevent fibrotic adhesion, decrease pain, and increased facet joint play. Chiropractic manipulation performed over instrument assisted manipulation directed to the thoracic, lumbar, sacrum and pelvic region.

Approximately total of 45 minutes spent to provide above-mentioned treatments.

Treatment provided without incident. Post treatment, the patient reports relief. The patient is recommended to continue with home exercise program until the next visit. To continue with home exercise program until the next visit.



Omid Mahgerefteh, D.C.

This has been electronically signed by Omid Mahgerefteh, D.C. on 05-08-2019.



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IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	TRISTRAR RISK MANAGEMENT
ADDRESS	:	PO BOX 11967, SANTA ANA CA 92711 - 1967
ADJUSTOR	:	Regina Diaz
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	05-06-2019

INITIAL ACUPUNCTURE REHABILITATION REPORT

Dear Dr. Conwisar,

Thank you for giving me the opportunity to evaluate and treat your patient, Steevio Bardakjian, in my office.

Chief Complaints:

Right hip pain

History of Present Illness

Mr. Bardakjian is here today seeking relief from his right hip pain.

This is due to a work-related injury that occurred on July 3, 2018.

Patient tells me that he was a nurse/ IT manager working for the LA County Department of Health,

Where he had worked for approximately 20 years when the injury occurred.

The patient tells me he was Looking for a cable under the desk and when he got up he felt his back pop.

This injury necessitated low back surgery which was performed by Dr. Barcohana on August 4, 2018.

The patient tells me that the surgery was not successful and has been in a lot of pain since that time.

He reports pain shooting from his low back into his hip and down his leg to his mid calf.

Mr. Bardakjian has never attempted acupuncture and is looking forward to pain relief today.

Acupuncture Intake

Accident Information: Patient relates his current condition to a previous accident. The accident occurred on 07/03/2018. The accident occurred at work place. He reported the accident to worker comp.

Patient Condition: Reason for visit: Right hip pain. Reports that his symptoms appeared 07/03/2018. Rates the sensitivity of pain as 7-10/10 on the pain scale. Describes his pain as sharp, throbbing, numbness, aching, shooting, cramps and stiffness type. Frequency of pain is daily. Constant. Pain does interfere with his Work^Sleep^Daily Routine^Recreation. Reports that activities such as Sitting^Standing^Walking^Bending are painful to perform.

Health History: Patient has already undergone medication regime, palliative surgery and physical therapy for his condition.

Allergy:

No Known Drug Allergies.

Past Medical History:

Diabetes ()

High Blood Pressure ()

Surgical History:

L3-L5 Disectomy: 08/2018

Review of Systems:

Neurological: Reports ***numbness*** RLE.

Constitutional: Reports ***sweats***.

Musculoskeletal: Reports ***weakness*** RLE.

The remainder of the review of systems is negative as described in detail in the Patient Intake Packet.

Social and Family History:

GENERAL: The patient has completed college.

Social History: The patient does not use tobacco. He does not drink alcohol. He has Medical Marijuana Card. The patient did not have problem with abusing drugs or alcohol. There has been no family member with any serious illness. Patient does not take or is not on anticoagulants. He spends his time during the day by Resting, avoiding excessive movement, pt. The patient has never been convicted for abuse/possession of narcotics. ***The patient is on disability currently.*** He is on TTD disability. He has not travelled out of country recently. The patient has not been exposed to any toxins. Marital Status: single. Patient reports that he suffered from work related injury and also had required medical care for that injury. It occurred on 07/03/2018. He reports that he did not suffer an auto accident or other injury that resulted in a personal injury lawsuit.

Previous Injuries:

Legal Status:

Primary Treating Physician: Philip Conwisor MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

On a scale of 1 to 10 the pain level is 7. Height (inches): 71.00 Weight (lbs): 215.00

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Lumbar Spine: *Inspection of the lumbar spine reveals a scar. 2 inch Straight leg raise on the right:: positive. Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.*

Neurology - Motor Strength: *Motor strength is grossly normal except Weakness of the right L3-4 and L4-5*

Neurology - Sensation: *LE Sensation intact except for Decreased L3-4 and L4-5 right side.*

Neurology - Deep Tendon Reflexes: *Deep Tendon Reflexes are intact throughout except Decrease right knee reflex 1+*

Impression:

Hip pain (M25.559), Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Long term (current) use of opiate analgesic (Z79.891)

There is 30 % of improvement with opioid medications. Without medications, the patient is able to ambulate 50 feet as baseline. With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

Injury Date: 07-03-2018 Reason for submitting report: periodic report

WORK STATUS: as per ptpt

Treatment and Plan:

Electro Acupuncture to UB 25,28,31-34,40,57 ST 40

GB 29,30,31,34 Ashi Rt hip X 3

HJJ PTS: L1-L5

Cupping

Myofascial Release

Far-Infrared Heat

Herbal pain patches x7

Continue treatment plan 1x6 to decrease pain, increase function/ROM, decrease the need for increased medications, and

Improve activities of daily living.

Work Status: As per PTP

Work Restriction:

Very truly yours,



Marc Reznikoff, L. Ac



Kevin Kohan, D.O.

DISCLOSURE:

In compliance with Labor Code section 4628 and the rules of Practice and Procedure, specifically 10978 and 10606, the following is supplied.

I declare under penalty of perjury that all opinions in this report are mine. I performed the evaluation and cognitive services at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084, in the County of Los Angeles and that, except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

I have complied with the Labor Code section 139.3 and I have not offered or received any commissions or inducements for this consultation. The name and contents of the report and billing are true and correct to the best of my knowledge.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 05-06-2019.

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 42313	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 04/24/2019	COLLECTION DATE 04/16/2019		REPORTED 04/24/2019 17:51 PDT	
COMMENT IMMUNOASSAY SCREENING	Page 1 of 1				

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
SPECIMEN VALIDITY TESTING (1)					
CREATININE	90		NORMAL	>=20	mg/dL
pH	5.4		NORMAL	4.7-7.8	
SPECIFIC GRAVITY	1.013		NORMAL	1.003-1.035	g/mL
OXIDANT	-7		NORMAL	<=200	ug/mL
TOXICOLOGY SCREEN (1)					
AMPHETAMINES	NEGATIVE		NORMAL	500	ng/mL
BARBITURATES	NEGATIVE		NORMAL	200	ng/mL
BENZODIAZEPINES	NEGATIVE		NORMAL	200	ng/mL
BUPRENORPHINE	NEGATIVE		NORMAL	5	ng/mL
COCAINE	NEGATIVE		NORMAL	300	ng/mL
CANNABINOIDS	NEGATIVE		NORMAL	50	ng/mL
CARISOPRODOL	NEGATIVE		NORMAL	100	ng/mL
ETHANOL	NEGATIVE		NORMAL	100	ng/mL
FENTANYL	NEGATIVE		NORMAL	2	ng/mL
EDDP (METHADONE METABOLITE)	NEGATIVE		NORMAL	300	ng/mL
OPIATES	NEGATIVE		NORMAL	300	ng/mL
OXYCODONE	POSITIVE		HIGH <small>**See LC/MS/MS for confirmation</small>	100	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	25	ng/mL
MDMA (ECSTACY)	NEGATIVE		NORMAL	500	ng/mL
METHAMPHETAMINE	NEGATIVE		NORMAL	500	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



Summary of Findings
UNIVERSAL PAIN MANAGEMENT
819 Auto Center Drive
Palmdale, CA 93551
Phone: (661) 267-6876 x156
Lab Director - Earl Weissman, PhD

PATIENT NAME BARDAKJIAN, STEEVIO		LAB REF # 42314	Patient ID 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 04/16/2019	COLLECTION DATE 04/16/2019		REPORTED DATE 04/25/2019 19:04	

INCONSISTENT RESULTS - ANALYTE DETECTED BUT NO CORRESPONDING PRESCRIPTION REPORTED

DETECTED ANALYTE	ILLICIT	MEASURED RESULT	CUTOFF	TEST OUTCOME	DETECTION WINDOW
OXYMORPHONE		554 ng/mL	50	POSITIVE	
OXYCODONE		919 ng/mL	50	POSITIVE	

000585

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 42314	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 04/24/2019	COLLECTION DATE 04/16/2019		REPORTED 04/25/2019 19:04 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS	Page 1 of 2				

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
OPIATES/OPIOIDS CONFIRMATION - LC/MS/MS (1)					
CODEINE	NEGATIVE		CONSISTENT	50	ng/mL
MORPHINE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
HYDROMORPHONE	NEGATIVE		CONSISTENT	50	ng/mL
NORHYDROCODONE	NEGATIVE		CONSISTENT	50	ng/mL
OXYCODONE	919	POSITIVE	INCONSISTENT	50	ng/mL
OXYMORPHONE	554	POSITIVE	INCONSISTENT	50	ng/mL
MEPERIDINE	NEGATIVE		CONSISTENT	50	ng/mL
TAPENTADOL	NEGATIVE		CONSISTENT	50	ng/mL
FENTANYL	NEGATIVE		CONSISTENT	5.0	ng/mL
O-DESMETHYL-CIS-TRAMADOL	NEGATIVE		CONSISTENT	50	ng/mL
METHADONE CONFIRMATION - LC/MS/MS (1)					
EDDP	NEGATIVE		CONSISTENT	50	ng/mL
BUPRENORPHINE CONFIRMATION - LC/MS/MS (1)					
BUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
NORBUPRENORPHINE	NEGATIVE		CONSISTENT	5.0	ng/mL
BENZODIAZEPINES CONFIRMATION - LC/MS/MS (1)					
ALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
ALPHA-HYDROXYALPRAZOLAM	NEGATIVE		CONSISTENT	50	ng/mL
7-AMINO-CLONAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
NORDIAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
OXAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
TEMAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
LORAZEPAM	NEGATIVE		CONSISTENT	50	ng/mL
PSYCHOTROPICS CONFIRMATION - LC/MS/MS (1)					
NORTRIPTYLINE	NEGATIVE		CONSISTENT	50	ng/mL
ZOLPIDEM	NEGATIVE		CONSISTENT	5.0	ng/mL
MUSCLE RELAXANTS CONFIRMATION - LC/MS/MS (1)					
MEPROBAMATE	NEGATIVE		CONSISTENT	50	ng/mL
CYCLOBENZAPRINE CONFIRMATION - LC/MS/MS (1)					
CYCLOBENZAPRINE	NEGATIVE		CONSISTENT	50	ng/mL
GABAPENTIN CONFIRMATION - LC/MS/MS (1)					
GABAPENTIN	NEGATIVE		CONSISTENT	50	ng/mL
PREGABALIN CONFIRMATION - LC/MS/MS (1)					
PREGABALIN	NEGATIVE		CONSISTENT	50	ng/mL
STIMULANTS CONFIRMATION - LC/MS/MS (1)					
AMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
MDMA	NEGATIVE		NORMAL	50	ng/mL
MDA	NEGATIVE		NORMAL	50	ng/mL
MDEA	NEGATIVE		NORMAL	50	ng/mL
ILICIT DRUG CONFIRMATION - LC/MS/MS (1)					
6-MONOACETYL MORPHINE (Metabolite)	NEGATIVE		NORMAL	50	ng/mL
BENZOYLECGONINE	NEGATIVE		NORMAL	50	ng/mL

000586



A Comprehensive Approach to Pain and Rehabilitation

Final Report

UNIVERSAL PAIN MANAGEMENT

819 Auto Center Drive

Palmdale, CA 93551

Phone: (661) 267-6876 x156

Lab Director - Earl Weissman PhD

PATIENT NAME BARDAKJIAN, STEEVIO	LAB REF. # 42314	Requesting Site: PALMDALE	Patient Account 31805	DOB 05/23/1970	SEX M
PHYSICIAN KOHAN,KEVIN	RECEIVED DATE 04/24/2019	COLLECTION DATE 04/16/2019		REPORTED 04/25/2019 19:04 PDT	
COMMENT CONFIRMATION BY LCMS/MS - QUANTITATIVE ANALYSIS	Page 2 of 2				

TEST	RESULTS	OUTCOME	INTERPRETATION	CUT OFF / REF RANGE	UNITS
METHAMPHETAMINE	NEGATIVE		CONSISTENT	50	ng/mL
PHENCYCLIDINE	NEGATIVE		NORMAL	50	ng/mL

1. Universal Pain Management, 819 Auto Center Drive, Palmdale, CA, 93551. Ph: (661) 267-6876.



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MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	TRISTRAR RISK MANAGEMENT
ADDRESS	:	PO BOX 11967, SANTA ANA CA 92711 - 1967
ADJUSTOR	:	Regina Diaz
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	04-24-2019

INITIAL CHIROPRACTIC REHABILITATION REPORT

Dear Dr. Conwisar,

Thank you for giving me the opportunity to evaluate and treat your patient, Steevio Bardakjian, in my office.

Chief Complaints:

Low back pain and right hip pain.

History of Present Illness

The above referenced patient was seen today for initial chiropractic evaluation and treatment for his low back and right hip the patient is a 48-year-old male status post lumbar spine L3-L5 microdiscectomy.

CURRENT COMPLAINTS:

The patient complains of persistent back pain with radiation of the pain to the right lower extremity. Symptoms increase sharply with bending, stooping, and attempts at lifting. He reports numbness and tingling sensations in his right foot. Pain interferes with his work, sleep, pivoting, regression activities, sexual activity as, possible

shorts and personal hygiene. Patient denies bladder dysfunction.

***Initial Symptoms**

Current Medication

metformin 500 mg tablet 1 Twice a Day for 30 Days , Prescribe 60 Unspecified
Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet
Lyrica 50 mg capsule 1 Capsule Three times a Day 1 Capsule fpr 5 nights, then increase to 1 cap QAM and
QHS fpr 5 nights, and then increase to 3 caps TID for 30 Days , Prescribe 90 Capsule, Refills 1

Previous Pain Medications and Effects:

Allergy:

No Known Drug Allergies.

Past Medical History:

Diabetes ()
High Blood Pressure ()

Surgical History:

L3-L5 Disectomy: 08/2018

Review of Systems:

The entire review of systems is negative as described in the Patient Intake Packet.

Social and Family History:

GENERAL: The patient has completed college.

Social History: The patient does not use tobacco. He does not drink alcohol. He has Medical Marijuana Card. The patient did not have problem with abusing drugs or alcohol. There has been no family member with any serious illness. Patient does not take or is not on anticoagulants. He spends his time during the day by Resting, avoiding excessive movement, pt. The patient has never been convicted for abuse/possession of narcotics. ***The patient is on disability currently.*** He is on TTD disability. He has not travelled out of country recently. The patient has not been exposed to any toxins. Marital Status: single. Patient reports that he suffered from work related injury and also had required medical care for that injury. It occurred on 07/03/2018. He reports that he did not suffer an auto accident or other injury that resulted in a personal injury lawsuit.

Previous Injuries:

Legal Status:

Primary Treating Physician: Philip Conwisar MD
Attorney: KOSZDIN, FIELDS, SHERRY & KATZ
P & S Status:

Physical Examination:

Height (inches): 71.00 Weight (lbs): 216.00

OBSERVATIONS:

The patient is well developed, well nourished male who is dressed neatly, and appears well groomed. The patient ambulates with a limp. He is using cane for ambulation.

BEHAVIOR:

The patient is cooperative, attentive and disclosive. There is no indication of fabrication or inconsistency.

GENERAL NEUROLOGIC:

Mental Status: The patient is alert and oriented to time, day, month and year, place, person and situation. Cranial nerves II through XII grossly intact.

LUMBAR SPINE:

Inspection: The inspection of the lumbosacral spine showed well healed scar.

Examination: The examination of the lumbosacral spine demonstrates tenderness upon palpation of the bilateral paralumbar muscles, bilateral sacroiliac joints, bilateral sciatic notches, bilateral posterior iliac crests, and bilateral gluteal muscles right greater than left side.

RANGE OF MOTION:

Forward Flexion: 20/60°

Extension: 5/25° sharp pain reported.

Right Lateral Flexion: 10/25°

Left Lateral Flexion: 10/25°

There is no area of skin discoloration, altered temperature, or edema. Sensation is grossly intact to all primary modalities.

ORTHOPEDIC TESTS

Straight Leg Raising: Positive right leg.

Heel Walking (L5): Able to perform.

Toe Walking (S1): Able to perform.

NEUROLOGICAL EXAMINATION:

Upper Extremity Deep Tendon Reflex Examination: Symmetrical at +2 at both sides.

Upper Extremity Motor Strength Testing: Motor strength in the upper extremity tested at +5 bilaterally.

Upper Extremity Sensory Examination is intact to light touch, in the right and left upper extremities.

Lower extremity deep tendon reflex examination was 1/2 over the right knee and right Achilles and 2/2 over the left knee and left Achilles.

Lower extremity motor strength testing in the muscle of lower extremity tested is +5 bilaterally.

Lower Extremity Sensory Examination decreased sensation noted at the right L3-L4, L4-L5 dermatomal level

ICD Codes: Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Hip pain (M25.559), Long term (current) use of opiate analgesic (Z79.891)

There is 30 % of improvement with opioid medications. Without medications, the patient is able to ambulate 50 feet as baseline. With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

Injury Date: 07-03-2018

WORK STATUS: as per ptp

Treatment and Plan:

Once again thank you for giving me the opportunity to evaluate and treat your patient, in my office.

THERAPY PROGRAM:

For the low back and right leg radiculopathy, the patient will undergo myofascial release, Chiro Manipulation (CMT 3-4), Electrical Muscle Stimulation , Infrared, Therapeutic ultrasound, Mechanical traction, Therapeutic exercises consisting of , PROM, AROM, Progressive Resistive Exercises, Stretching and flexibility exercises, Muscular endurance exercises and Kinetic activities, once per a week for the next 6 weeks.

(There is valid authorization on file for above-mentioned treatment plan)

Above treatment plan is structured to deliver maximal relief in pain and suffering and to restore occupational and functional capacity to the highest level possible.

REHABILITATION GOALS:

The goals intended to be achieved with the preceding treatment plans are to promote soft tissue healing, relieving pain, preventing recurrence, increasing pain free range of motion, restoring normal strength and restoring stability to the joint structure.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT:

There are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. The risk of procedure were discussed and all the questions were answered to the patients satisfaction. The patient agreed to proceed and written informed consent was obtained.

The following treatment was provided today at the same time of this examination:

1. The patient was placed in prone position, surface of skin cleaned with alcohol pad, electrodes were placed in crisscross fashion over the lumbar spine (IFC) applied at a frequency 80 to 150 Hz, 15 minutes.

2. Applied 15 minutes of Infra-red over affected area to induce vasodilatation, decrease pain, and reduce muscle spasm.

3. Therapeutic exercises in the form of LUMBAR passive range of motion (PROM) and passive stretching performed. Passive stretching is a form of therapeutic procedure in which a specific muscle or tendon (or muscle group) is deliberately flexed or stretched in order to improve the muscle's elasticity and achieve comfortable muscle tone. The result is a feeling of increased muscle control, flexibility, and range of motion. Stretching is also used therapeutically to alleviate cramps. Handheld Mechanical massager used prior to rehabilitative exercises. Mechanical massager enhances flexibility, increases range-of-motion, and reduces the risk of muscle spasms, or strains during a course of rehabilitative exercises.

4. Chiropractic manipulation therapy, This procedure helps decrease the pain-free range of motion, prevent fibrotic adhesion, decrease pain, and increased facet joint play. CMT directed to the F/D lumbar, sacrum and pelvic region.

RECOMMENDATIONS:

1. Daily active stretching of cervical and lumbar spine.
2. Use cervical pillow for sleeping.
3. Use a lumbar spine support for activities that stress the spine.
4. Avoid soft furniture, deep sofas.
5. No repetitive bending, squatting and kneeling.

It is very important that in addition to this therapeutic modalities and exercises that were given in today's session patient continue an exercise program at home. Bearing in mind that patient education is an important part of treatment plan for management of intractable pain, instructions for outpatient use were given. These instructions can may includes education materials and discussions such as proper posture and proper body mechanism properly spanning mechanism appropriate home stretching and strengthening exercises, as well as possible safe and reasonable modifications to places that the patient spends time in.

Dragon medical software was used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors.

Treatment provided without incident. Post treatment, the patient reports relief. Patient is recommended to continue with home exercise program until the next visit.

Work Status: As per PTP

Work Restriction:

Very truly yours,



Omid Mahgerefteh, D.C.

DISCLOSURE:

In compliance with Labor Code section 4628 and the rules of Practice and Procedure, specifically 10978 and 10606, the following is supplied.

I declare under penalty of perjury that all opinions in this report are mine. I performed the evaluation and cognitive services at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084, in the County of Los Angeles and that, except as otherwise stated herein, the evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code.

I have complied with the Labor Code section 139.3 and I have not offered or received any commissions or inducements for this consultation. The name and contents of the report and billing are true and correct to the best of my knowledge.



Omid Mahgerefteh, D.C.



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OMID MAHGEREFTEH, D.C.

IN REFERENCE	:	Bardakjian, Steevio
DATE OF BIRTH	:	05-23-1970
SSN	:	554-81-2130
EMPLOYER	:	OLIVE VIEW MEDICAL CENTER
INJURY DATE	:	07-03-2018
COMPENSATION CARRIER	:	TRISTRAR RISK MANAGEMENT
ADDRESS	:	PO BOX 11967, SANTA ANA CA 92711 - 1967
ADJUSTOR	:	Regina Diaz
CLAIM NUMBER	:	219-00110-B
WCAB NUMBER	:	
CURRENT EVALUATION	:	04-16-2019

INITIAL COMPREHENSIVE PAIN MANAGEMENT REPORT

This is a consultation report in accordance with the State of California Workers' Compensation Official Medical Fee Schedule effective April 1, 1999, Reports Section, C, Consultation Report.

The following is an initial comprehensive pain management report performed at 28212 Kelly Johnson Parkway, Suite 155, Valencia CA 91355 - 5084

Chief Complaints :

Low back and right leg and hip pain

History of Present Illness

This patient is a 48-year-old male with a history of Diabetes and hypertension presents to clinic for consultation evaluation and treatment of low back pain and hip pain that occurred on July 3, 2018. The patient reports being a nurse manager working for the Los Angeles County Department of health services and on day indicated date the patient to went down and underneath the table in order to fix some wires and felt a big pop on the back upon rising from a flexion to an extension the patient noticed 10 minutes later that he could not move the right lower extremity the patient's pain the following day was excruciating. The patient went to the urgent care and that was referred to the hospital where the patient had the MRI images which demonstrated a large disc at the L3-4 and L4-5. The patient was then referred to a spine surgeon and underwent a laminectomy discectomy from L3-L5 in August 2018. The patient reports that the surgery was not successful and the patient noticed increasing pain over a period of time the patient got another MRI as recommended by

the spine surgeon which demonstrated that the reoccurrence of the disc and severe pain down the right leg the patient also had actual fee of the right quadriceps on the right lower extremity where the patient was unable to walk the patient was placed on Percocet the patient failed gabapentin and anti-inflammatory medication the patient has slowly been able to walk now with a cane.

The patient reports never attempting chiropractic therapy or acupuncture. The patient has failed gabapentin and has never attempted pre-gabalin -Since the patient has failed gabapentin and amitriptyline he is a candidate to proceed with Pregabalin (Lyrica) 50 mg TID -I will initiate this medication for the patient to alleviate his numbness in his burning pain down the right lower extremity. The patient denies any bowel or bladder dysfunctions the patient denies any perianal anesthesia

It is the practice of Universal Pain Management to periodically review the 5 domains (The 5 As) which are relevant for ongoing monitoring of chronic pain patient on opioids.

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate. The patient has failed prior medications which include; none.

Opioid Risk Tool (Male): 0 .

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications.

Without medications, the patient is able to ambulate 50 feet as baseline.

With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

***Initial Symptoms**

Scales:

The patient reports that their pain with medications is a 3 on a scale of 0-10. The patient reports that their pain without medications is a 9 on a scale of 0-10. Pain at present is 6 on the pain scale.

Pain Descriptors: Location of pain is at Low back and right leg pain. He has been experiencing this pain since 07/0/2018. Patient describes his pain as aching, cramping, excruciating, intense, numb, radiating, shooting, tight and severe. Following factors increase the pain: physical activity, movement, sitting, walking, sexual intercourse and tension or stress. Following factors decrease the pain: sleep, rest and lying down. Following factors have no change in pain: liquor, coffee, eating, heat, cold, dampness, weather changes, massage, distraction (tv etc), urination, bowel movement, bright lights, loud noises and fatigue.

Treatment History:

TENS Unit: Yes Date of treatment: 2018.

Physical Therapy: Yes Date of treatment: 2018.

Recent Diagnostic Studies:

MRI: Yes. Date: 2018. Location: L-SPINE.

Allergy

No Known Drug Allergies.

Past Medical History

Diabetes ()

High Blood Pressure ()

Surgical History

L3-L5 Disectomy: 08/2018

Review of Systems

Neurological: Reports ***numbness***.

Constitutional: Reports ***sweats***.

Musculoskeletal: Reports ***weakness***.

The remainder of the review of systems is negative as described in detail in the Patient Intake Packet.

Social and Family History

GENERAL: The patient has completed college.

Social History: The patient does not use tobacco. He does not drink alcohol. He has Medical Marijuana Card. The patient did not have problem with abusing drugs or alcohol. There has been no family member with any serious illness. Patient does not take or is not on anticoagulants. He spends his time during the day by Resting, avoiding excessive movement, pt. The patient has never been convicted for abuse/possession of narcotics. ***The patient is on disability currently.*** He is on TTD disability. He has not travelled out of country recently. The patient has not been exposed to any toxins. Marital Status: single. Patient reports that he suffered from work related injury and also had required medical care for that injury. It occurred on 07/03/2018. He reports that he did not suffer an auto accident or other injury that resulted in a personal injury lawsuit.

Previous Injuries

Legal Status

Primary Treating Physician: Philip Conwisor MD

Attorney: KOSZDIN, FIELDS, SHERRY & KATZ

P & S Status:

Physical Examination

Height (inches): 71.00 Weight (lbs): 216.00 **BP:** 157/89 mm Hg. **Pulse:** 102 per min. **Sp02:** 98. **BMI:** 30.

General: The patient is well developed and well-nourished. Patient is alert and oriented. His mood and affect are normal. Patient is in no acute distress. Patient has good hygiene. There is no apparent loss of coordination.

HEENT: Normocephalic: Normal. Atraumatic: Normal. Extraocular muscles: Normal.

Respiratory: Breath sounds are equal bilaterally. There is no wheezing.

Cardio: Rate and rhythm is regular.

Abdomen: The abdomen is soft, with no masses palpated, no rebound, rigidity or tenderness.

Lumbar Spine: ***Inspection of the lumbar spine reveals a scar. Straight leg raise on the right:: positive.***

Palpation of the lumbar facet reveals pain on both the sides at L3-S1 region. Palpable twitch positive trigger points are noted in the lumbar paraspinous muscles. Anterior lumbar flexion causes pain. There is pain noted with lumbar extension.

Neurology - Motor Strength: ***Motor strength is grossly normal except Weakness of the right L3-4 and L4-5***

Neurology - Sensation: ***LE Sensation intact except for Decreased L3-4 and L4-5 right side.***

Neurology - Deep Tendon Reflexes: ***Deep Tendon Reflexes are intact throughout except Decrease***

right knee reflex 1+ Pain with right hip motion

Tenderness of the lumbar spine

PAIN MANAGEMENT

- Opioid Risk Tool
- Oswestry Disability Index

Review of Medical Records

Dr. Barcohana notes for diagnosis of lumbar radiculopathy s/p Lumbar laminectomy was reviewed

Dr. Conwisar notes for hip pain and lumbar radiculopathy was reviewed

MRI of the lumbar spine demonstrated a meniscectomy defect at L3-4 and L4-5 with impingement of nerves due to disc bulge

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping.

I have spent a total of 35 minutes reviewing these records. I am billing appropriately.

Psychological testing (96101) was performed because the patient was referred for pain management treatment and the patient demonstrated symptoms which results in the loss of function and a decrease in activities of daily living.

Impression

This patient is a 48-year-old male with a history of diabetes and hypertension status post L3-L5 laminectomy with significant radiculopathy on the right side and postlaminectomy syndrome with lumbar radiculopathy. He has been recommended to have a fusion surgery by a spine surgeon however the patient does not want to have any further surgeries As he has not attempted a course of conservative therapies yet he has not yet attempted any acupuncture chiropractic therapy medication management with opioids and or epidural injection

ICD Codes:

Lumbar radiculopathy, chronic (M54.16), Lumbar postlaminectomy syndrome (M96.1), Hip pain (M25.559)

Analgesia: The patient reports greater than 30 % pain relief while taking medications, including opioids.

ADLs/ subjective functional improvement from baseline:30 %.

Functional Objective Improvement: Patient is able to perform activities such as bathing,grooming,dressing,transfers,ambulation and preparing of meals with the aid of the medications AS EVIDENCED IN THE PERSONAL MEDICATION STATEMENTS PROVIDED UNDER SEPARATE COVER.

Adverse side effects : no side effects noted.

Abuse: the patient is compliant with the pain management agreement.

Affect: the patient's behavior and mood are appropriate.

The patient has failed prior medications which include; none.

Opioid Risk Tool (Male): 0 .

The duration that the opioid medication lasts is 6 hours.

The onset of symptom relief for their medication is 20 minutes.

Weaning has been tried but was not successful.

Conservative treatment has been tried for more than 3 months but it failed.

An updated pain agreement is present on file.

VAS (Without Meds): 7

VAS (With Meds): 4

There is 30 % of improvement with opioid medications. Without medications, the patient is able to ambulate 50 feet as baseline. With the medications patient able to ambulate 1 block with the medications, an improvement from baseline.

Injury Date: 07-03-2018

0 0 0 0 0 0 0 ORT Score : 0.

Pain Intensity: 4- The pain is very severe at the moment.

Personal Care (eg. Washing, dressing): 3 - I need some help but can manage most of my personalcare.

Lifting: 4 - I can only lift very light weights.

Walking: 4 - I can only walk using a stick or crutches.

Sitting: 3 - Pain prevents me from sitting more than 30 minutes.

Standing: 4 - Pain prevents me from standing for more than 10 minutes.

Sleeping: 3 - Because of pain I have less than 4 hours sleep.

Sex Life (if applicable): 4 - My sex life is nearly absent because of pain.

Social Life: 4 - Pain has restricted my social life to my home.

Travelling: 4 - Pain restricts me to short necessary journeys under 30 minutes.

Total Score: 37.

Total Percentage: 74 %.

Total Score in Percentage: 61%-80%: crippling back pain.

One (1) hour was spent on the processing and interpretation of the psychological testing examination

WORK STATUS: as per ptpt

Treatment Plan:

The patient is a candidate for chiropractic therapy for the lumbar spine-she has failed physical therapy, aerobic conditioning and home exercise program. The patient is a candidate for clinical trial of 6 sessions of chiropractic therapy

The patient is also a candidate for acupuncture for the thighs and hips and they are very painful. The patient has failed physical therapy aerobic conditioning and home exercise program the patient is a candidate for clinical trial of 6 acupuncture sessions

The patient has failed anti-inflammatory medications muscle relaxants and gabapentin. The patient is a candidate to be on opioid therapy-Were placed the patient on Percocet 10 325 up to maximum of 3 times a day this has also been recommended by the patient's orthopedic surgeon as well as primary care doctor. The patient has a pain contract that was signed and reviewed today. The patient is a lower risk and is taking less than 50 morphine equivalence C. The patient gets functional improvement that is meaningful with that medication combination of Percocet

Since the patient has failed gabapentin and amitriptyline he is a candidate to proceed with Pregabalin (Lyrica) 50 mg TID -I will initiate this medication for the patient to alleviate his numbness in his burning pain down the right lower extremity.

An online pharmacy report, CURES report, was obtained today and it shows no evidence of doctor shopping.

* Today I am ordering a urine drug test. Urine drug testing (UDT) is used to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances--v58.69), to diagnose substance misuse (abuse), addiction and/or other aberrant drug-related behavior, to guide treatment. The frequency of random testing is determined by an individualized opioid risk score which is based upon the patient's individual medical history, and the type and quantity of drugs prescribed.

If the results of the definitive drug test are inconsistent, it could result in the patient being denied medication refills, counseled for aberrant behavior, recommended for detoxification or terminated from this practice.

The patient has interval subjective and objective functional improvement with the medications as documented from BASELINE. The patient has been WEANED to the lowest possible dose. Any further weaning will result in the patient being bedbound and or going to the ER and increasing the cost of workers compensation. UDS is consistent, there are no side effects, opioid contract is on file and presented with this report, and there are no signs of abuse. Therefore the patient meets all the guidelines criteria of ODG, CMS and CAMTUS guidelines that are utilized in the state of California to continue opioid medications.

Based on the patient questionnaires and time spent face to face with the patient the following treatment is recommended: One (1) hour was spent on the administration and interpretation of the psychological testing.

We are a multidisciplinary pain clinic as noted on page 78 of the CAMTUS guidelines. This is to be considered anytime the patient's symptoms do not improve on opioids in 3 months. We utilize a combination of Medication Management, Biofeedback, Physical Therapy, Chiropractic, Acupuncture, Psychological intervention and appropriate Interventional Techniques. We assess the patient on a routine basis.

We monitor the 4 A's for ongoing monitoring: Analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. For monitoring patients for long-term use of opioids we also utilize recommendations as noted on page 88 of the CAMTUS. These are patients who are on opioids greater than 6 months. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. We make every effort to assess the pain at every visit, and functioning is measured at 6- month intervals as recommended by the guidelines. For maintenance of the patient's medications we do not lower if the current medication is working as noted on page 89 of the CAMTUS guidelines. All our patients sign a pain agreement and is kept on file. We monitor patient compliance by means of CURES reports and Urine Drug Screening.

Included with this report is a handwritten attestation by the patient documenting pain relief and improvement in functional activity before and after taking their prescribed medications. Any utilization review of these medications that does not specifically comment on the handwritten attestation, when provided, is invalid and non-compliant.

Medications prescribed:

Percocet 10 mg-325 mg tablet 0.5-1 Tablet Three times a Day for 30 Days , Prescribe 90 Tablet
Lyrica 50 mg capsule 1 Capsule Three times a Day 1 Capsule fpr 5 nights, then increase to 1 cap QAM and QHS fpr 5 nights, and then increase to 3 caps TID for 30 Days , Prescribe 90 Capsule, Refills 1

Work Status: As per PTP

Work Restriction:

Due to the complexities involved with management and close monitoring of this patient's current medications and treatment, it is my opinion that the patient follow up with our office on a regimen of at least every 30 to 45 days to properly assess and treat the patient's condition. The patient's questions were answered in detail. An extended period of time was spent with the patient explaining test results, diagnostic impressions, physical findings, and further plans and alternatives. Should there be any additional questions; the patient is encouraged to contact our office.

Sincerely,



Kevin Kohan, D.O.

DISCLOSURE:

The patient was interviewed regarding the undersigned regarding the history. The physical examination was performed entirely by the undersigned physician. The dictation was prepared by myself, including any and all impressions and conclusions described in the discussion. In compliance with the recent Workers Compensation legislation (Labor Code Section 4628 (b): "I declare that the above evaluation was performed by the undersigned and was in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (j) of Section 139.2." In compliance with recent Worker's Compensation legislation (Labor Code 4628(j): "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 I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true." In compliance with the recent Workers Compensation legislation (Labor Code Section 5703 under AB 1300): 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. This statement is made under penalty of perjury.

Signed in Los Angeles County, California.

"Dragon medical software may have been used to dictate this note. On occasion errors can occur in the content, grammar, and punctuation. We retain the right to modify this information without notice in the event of errors."

By



Kevin Kohan, D.O.



Kevin Kohan, D.O.

This has been electronically signed by Kevin Kohan, D.O. on 04-16-2019.



SHAHIN A. SADIK, M.D., Q.M.E.
BOARD CERTIFIED-PAIN MANAGEMENT AND ANESTHESIOLOGY
ASSISTANT CLINICAL PROFESSOR OF USC

FRANCIS X. RIEGLER, M.D., Q.M.E.
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RAY H. d'AMOURS, M.D., Q.M.E.
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DANIEL ALVES, M.D.
BOARD CERTIFIED-PAIN MANAGEMENT AND PM&R
ANNA KRZYSIAK, P.T.
DEBBIE CASTILLO, P.T.A.
MARC REZNIKOFF, L.A.C., Q.M.E.
OMID MAHGEREFTEH, D.C.

Name: Bardakjian, Steevio
DOB: 05-23-1970
MR# UPM31805
Date of Service: 04-16-2019

Oswestry Disability Exam

Pain Intensity: 4- The pain is very severe at the moment.

Personal Care (eg. washing, dressing): 3 - I need some help but can manage most of my personalcare.

Lifting: 4 - I can only lift very light weights.

Walking: 4 - I can only walk using a stick or crutches.

Sitting: 3 - Pain prevents me from sitting more than 30 minutes.

Standing: 4 - Pain prevents me from standing for more than 10 minutes.

Sleeping: 3 - Because of pain I have less than 4 hours sleep.

Sex Life (if applicable): 4 - My sex life is nearly absent because of pain.

Social Life: 4 - Pain has restricted my social life to my home.

Travelling: 4 - Pain restricts me to short necessary journeys under 30 minutes.

Total Score: 37.

Total Percentage: 74 %.

Total Score in Percentage: 61%-80%: crippling back pain.

One (1) hour was spent on the processing and interpretation of the psychological testing examination

Index For Measurement :

- 0% to 20%: Minimal disability
- 21%-40%: Moderate Disability
- 41%-60%: Severe Disability
- 61%-80%: Crippling back pain
- 81%-100%: These patients are either bed-bound or have an exaggeration of their symptoms.

A handwritten signature in black ink, appearing to read "Bardakjian".

Kevin Kohan D.O.

This has been electronically signed by Kevin Kohan D.O. on 04-16-2019.



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Name: Bardakjian, Steevio
DOB: 05-23-1970
MR# UPM31805
Date of Service: 04-16-2019

Opioid Risk Tool

1. Family History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
2. Personal History of Substance Abuse	Alcohol	0
	Illegal Drugs	0
	Prescription Drugs	0
3. Age (if 16-45)		0
4. History of Preadolescent Sexual Abuse		
5. Psychological Disease	Attention Deficit Disorder	0
	Obsessive Compulsive Disorder	
	Bipolar	
	Schizophrenia	
	Depression	0
	TOTAL	0

Total Score Risk Category

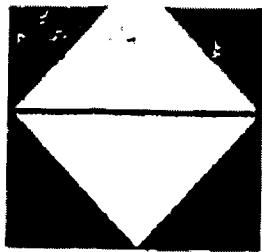
Low Risk 0-3

Moderate Risk 4-7

High Risk > or equal to 8

Kevin Kohan D.O.

This has been electronically signed by Kevin Kohan D.O. on 04-16-2019.



Center For MRI and CT

Southern California Orthopedic Institute

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2400 Bahamas Dr., Bakersfield, CA 93309 • Tel: (661) 328-5565 • Fax (818) 901-4529

PATIENT: BARDAKJIAN, STEEVIO

DATE OF BIRTH: 05/23/1970

ACCOUNT #: 286721

11/8/18

DATE OF EXAMINATION: 11/08/2018

REFERRING PHYSICIAN: BABAK BARCOHANA MD

MRI EVALUATION OF THE LUMBAR SPINE WITH AND WITHOUT DOTAREM:

HISTORY: Low back pain radiating down right leg with numbness and tingling.

COMPARISON: Comparison is made to the previous study dated 07/10/2018.

PROTOCOL: MRI was performed on a newer short bore 1.5 Tesla GE multichannel scanner utilizing an 8-channel dedicated phased-array spine coil. A coronal single shot T2W breath-hold localizer was obtained. Sagittal T1 and dual spin echo sequences in the sagittal and axial planes utilizing fast spin echo were then obtained prior to gadolinium. T1W sagittal and T1W axial images were obtained following the uneventful intravenous administration of dotarem, 20/20 cc.

FINDINGS: The alignment is anatomic although there is slight loss of the normal lumbar lordosis. There is underlying congenital spinal stenosis due to short pedicles and there is a component of epidural lipomatosis within the lumbar spine compressing the theca. The bone marrow signal intensity is normal except for Modic type I degenerative endplate changes at L4-5. There are no compression fractures.

T12-L1: There is no loss of disc height or signal intensity. There is no bulge or protrusion, facet arthropathy, canal or foraminal stenosis or focal nerve root impingement.

L1-2: There is no loss of disc height or signal intensity. There is no bulge or protrusion, facet arthropathy, canal or foraminal stenosis or focal nerve root impingement.

L2-3: There is mild loss of disc signal with 1 mm disc bulge and slight facet hypertrophy without canal or foraminal stenosis.

L3-4: There is mild loss of disc signal with a 3 mm disc bulge. There has been a right hemilaminectomy. There is enhancing granulation tissue within the lateral canal and hemilaminectomy site. There is mild residual canal stenosis. Right-sided disc bulge mild to moderately narrows the right and mildly narrows the left neural foramen.

L4-5: There is mild loss of disc signal with a 4 mm central extrusion which mildly flattens the thecal sac. There is enhancing granulation tissue within the right hemilaminectomy site within the posterior canal and within the right lateral recess without obvious nerve root impingement. Disc bulge extending into the right neural foramen moderate to severely narrows the right neural foramen impinging the right L4 nerve root, progressive since the previous. There is no recurrent disc herniation within the right lateral recess. Left-sided disc bulge extending to the left neural foramen with facet hypertrophy moderate to severely narrows the left neural foramen impinging the left L4 nerve root, similar to previous. There is mild underlying congenital spinal stenosis.

LS-S1: There is mild loss of disc signal with 1-2 mm disc bulge, right side greater than left, which with facet hypertrophy mildly narrows the right and left-sided disc bulge with facet hypertrophy mildly narrows the left neural foramen, similar to previous.

IMPRESSION:

1. L4-5: There is a 4 mm central extrusion which mildly flattens the thecal sac. There is enhancing granulation tissue within the right hemilaminectomy site within the posterior canal and within the right lateral recess without obvious nerve root impingement. Disc bulge extending into the right neural foramen moderate to severely narrows the right neural foramen impinging the right L4 nerve root, progressive since the previous. There is no recurrent disc herniation within the right lateral recess. Left-sided disc bulge extending to the left neural foramen with facet hypertrophy moderate to severely narrows the left neural foramen impinging the left L4 nerve root, similar to previous. There is mild underlying congenital spinal stenosis.
2. L3-4: There is a 3 mm disc bulge. There has been a right hemilaminectomy. There is enhancing granulation tissue within the lateral canal and hemilaminectomy site. There is mild residual canal stenosis. Right-sided disc bulge mild to moderately narrows the right and mildly narrows the left neural foramen.
3. L2-3: There is a 1 mm disc bulge and slight facet hypertrophy

RE: BARDAKJIAN, STEFY
Page 3 of 3

without canal or foraminal stenosis.

4. Underlying congenital spinal stenosis.

ELECTRONICALLY SIGNED BY LAURA APPLEGATE MD at 11/12/2018 10:51:32 AM

J: 181902765 D: 11/09/18 T: 11/10/18

000606



 Henry Mayo
Newhall Hospital

23845 McBean Parkway Valencia California 91355

Printed on:

Name: BARDAKIAN,STEEVIO Ord Dr: Casey,Robert J M.D.
Pt #: V00017273001 Adm Dr:
MR #: M000748903
Age: 48 Sex: M Room#: ED
DOB: 05/23/1970
Procedure Location: MRI
Date Procedure Ordered: 07/10/18 Order#: 0710-0020 Report#: 0710-02

Signed

7/10/18

MR LUMBAR SPINE WITHOUT CONTRAST

EXAMINATION DATE AND TIME: 7/10/2018 3:30 PM

COMPARISON: MR lumbar spine dated 1/21/2014

REASON FOR STUDY: low back pain, numbness, weakness R side

PROTOCOL: Using a 3.0 tesla Siemens MRI system, coronal and axial T1, axial T2, sagittal T1, sagittal T2 and STIR sagittal scans were performed. A myelogram effect coronal turbo spin echo image was also done. There is some motion artifact which degrades images somewhat.

FINDINGS.

T12-L1: There is a congenitally small central spinal canal. There is no central spinal stenosis, disc extrusion or change from previously.

L1-L2: There is a congenitally small central spinal canal. There is no central spinal stenosis, disc extrusion or change from previously.

L2-L3: There is a congenitally small central spinal canal. There is unchanged mild central spinal stenosis secondary to disc bulging.

L3-L4: There is an unchanged congenitally small central spinal canal. There is a 3 mm bilateral disc bulge that flattens the ventral thecal sac and causes unchanged moderate central spinal stenosis. There is mild bilateral and recess and inferior foraminal narrowing.

Richard Goldman MD, Medical Director • Bruce Yawitz, MD
Gerald Roth, MD • Ted Hittle, MD • Daniel Kirsch, MD • Ira Smalberg, MD • David Tran, MD
John Gonzales, MD • Srinivas Peddi, MD • Joshua Hanelin, MD • Simon Garbiel, MD • James Hill, MD
Anjali Date, MD • Ravi Sharma, MD • Ian Levin, MD • John Rhee, MD • Vicki Schiller, MD

Page 1

**Henry Mayo Newhall Hospital
23845 McBean Parkway Valencia California 91355**

Printed on:

Name: BARDAKJIAN,STEEVIO	Ord Dr: Casey,Robert J M.D.
Pt #: V00017273001	Adm Dr:
MR #: M000748903	
Age: 48	Sex: M
DOB: 05/23/1970	Room#: ED
Procedure Location: MRI	
Date Procedure Ordered: 07/10/18	Order#: 0710-0020 Report#: 0710-0258

L4-L5: There is a congenitally small central spinal canal and a minimally larger bilateral 5 mm disc bulge that results in moderately severe central spinal stenosis. The thecal sac measures 7 mm in AP diameter. There is bilateral lateral recess and inferior foraminal narrowing from the disc bulging, facet and ligamentum flavum hypertrophy.

L5-S1: There is no central spinal stenosis, disc extrusion or change. There is unchanged mild facet hypertrophy.

The conus medullaris ends at T12-L1. The vertebral body bone marrow signal, height and alignment are normal.

IMPRESSION:

There is been slight progression at L4-5 which now includes a 5 mm disc bulge resulting in moderately severe central spinal stenosis.

There is a congenitally small central spinal canal that results in unchanged moderate L3-L4 central spinal stenosis.

Richard L. Goldman M.D./TR: Date:07/10/18 Time:1534

Richard Goldman MD, Medical Director • Bruce Yawitz, MD
Gerald Roth, MD • Ted Hirtle, MD • Daniel Kirsch, MD • Ira Smalberg, MD • David Tran, MD
John Gonzales, MD • Srinivas Peddi, MD • Joshua Hanelin, MD • Simon Garbiel, MD • James Hill, MD
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