

13925 Whittier Blvd. Whittier, CA 90605 Tel: (562) 696-1181 Fax: (562) 945-0663 www.arslegal.com

#### **Record Review**

Name :

Employer : Vallejo Fire Department

WCAB/ADJ # :

ARS Invoice # : 450603-01

Copy Location : Walnut Creek Orthopedics & Sports Medicine

- William B. Workman, M.D.

Date of Injury : © 2009 ARS

Date
10/05/2009 Doctor's First Report of Occupational Injury or Illness
- Jeffrey Gao, MD
HISTORY: Patient tripped and fell over uneven pavement and strained left knee.

SUBJECTIVE COMPLAINT: Knee problem.

DIAGNOSIS: Contusion of knee.

TREATMENT: Xray of knee. Ibuprofen. Neoprene. Cane.



- William B. Workman, M.D.

Date of Injury:

Date	Review
11/25/2009 Page 0024	Progress Report - Jeffrey Gao, MD SUBJECTIVE COMPLAINT: Knee problem.
	DIAGNOSES: 1. Sprain/strain, knee/left. 2. Contusion of knee.
	PLAN: PT. HEP. Ice. Heat. Follow-up.
	WORK STATUS: Modified duty.
01/07/2010 Page 0026	Progress Report - Jeffrey Gao, MD SUBJECTIVE COMPLAINT: Recheck of left knee.
	DIAGNOSES: 1. Sprain/strain, knee/left. 2. Contusion of knee.
	PLAN: HEP. Support.
	WORK STATUS: Modified work.
01/15/2010 Page 0208	Radiology - Vallejo Open MRI MRI LEFT KNEE WITHOUT CONTRAST
	<ol> <li>IMPRESSION:</li> <li>Abnormal lateral meniscus. Findings may correspond to extensive lateral meniscus tear involving the posterior and anterior horns.</li> <li>Mild sprain, medial collateral ligament.</li> <li>Tricompartmental degenerative osteoarthritis with grade 3-4 changes of chondromalacia primarily involving the anteroinferior aspect of the lateral femoral condyle and superior aspect of the lateral tibial plateau.</li> </ol>



- William B. Workman, M.D.

Date of Injury: 10/03/2009; 02/15/2014; CT: 02/15/2013 - 02/15/2014

Date	Review			
02/25/2010	Medical Report - William Workman, MD			
Page 0069	HISTORY: Patient was fitting a fire on 10/03/2009 and fell onto concrete once and then fell several more times in a hallway while trying to rescue			
	a person from home. Has been having pain in the knee.			
	•			
	IMPRESSION: Probable lateral meniscus tear.			
	PLAN: Physical therapy. Arthroscopy with partial lateral meniscectomy. Preop appointment.			
03/29/2010	Medical Report - William Workman, MD			
Page 0072	HISTORY: Patient has continued left knee pain for 6 months. Patient			
	presented for preoperative history and physical examination.			
	IMPRESSION: Left knee pain, most likely meniscus tear.			
	PLAN: Left knee arthroscopic partial lateral meniscectomy.			
03/31/2010	Operative Report - William Workman, MD			
Page 0201	PREOPERATIVE DIAGNOSIS: Left knee lateral meniscus tear.			
	POSTOPERATIVE DIAGNOSIS: Left knee lateral meniscus tear.			
	OPERATION: Left knee arthroscopy with partial lateral meniscectomy.			
04/06/2010	PT Notes - Shivani Mehta, MPT			
Page 0091	DIAGNOSIS: Tear lat menisc knee-cur.			
	HISTORY: Patient presented s/p left partial menisectomy with complaints			
	of abnormal gait pattern, limited ROM, decrease quad and hamstring			
	strength, quadriceps muscle tightness, increased edema formation, increased pain levels and inability to perform all functional and vocational			
	tasks.			



- William B. Workman, M.D.

Date of Injury: 10/03/2009; 02/15/2014; CT: 02/15/2013 - 02/15/2014

ew			
Progress Report - William Workman, MD			
SUBJECTIVE COMPLAINT: Occasional knee discomfort.			
N100=0			
SNOSES:			
JD knee. Iteral meniscus tear.			
derai meniscus tear.			
N: PT. Follow-up 6 weeks.			
ress Report - William Workman, MD			
JECTIVE COMPLAINT: S/P left knee arthroscopy.			
NOOFO			
SNOSES:			
JD knee. Iteral meniscus tear.			
iteral meniscus teal.			
N: HEP. Encouraged biking. Knee injection.			
ology - Vallejo Open MRI			
RIGHT KNEE WITHOUT CONTRAST			
RESSION:			
ap tear of the lateral meniscus.			
ocalized full-thickness cartilage wear outer third of the lateral tibial ateau with bone edema.			
gh-grade chronic cartilage wear in the femoral trochlea.			
ar peripheral small tear in the posterior horn-body junction of the			
edial meniscus with associated small perimeniscal cyst.			
nronic stress changes in the extensor mechanism.			



- William B. Workman, M.D.

Date of Injury: 10/03/2009; 02/15/2014; CT: 02/15/2013 - 02/15/2014

Date	Review				
02/21/2011	PT Notes - Ada Jaureguil, DPT				
Page 0095	DIAGNOSES:				
	<ol> <li>Following surgery, unspecified.</li> </ol>				
	<ol><li>Other tear of cartilage or meniscus knee.</li></ol>				
	CHIEF COMPLAINT: R/L knee pain.				
	PLAN: Patient education. Home exercise program. Modalities. Manual. Graston.				
02/28/2011	Operative Report - William Workman, MD				
Page 0204	PREOPERATIVE DIAGNOSIS: Right knee medial and lateral meniscus				
	tear.				
	POSTOPERATIVE DIAGNOSIS: Right knee lateral meniscus tear.				
	OPERATION: Right knee arthroscopic partial lateral meniscectomy.				
03/17/2011	PT Notes - Ada Jaureguil, DPT				
Page 0099	DIAGNOSES:				
	1. Following surgery, unspecified.				
	Other tear of cartilage or meniscus knee.				
	PLAN: Active and passive patient stretching. Gait training. Strength training. ROM. Passive or active activities. Therapeutic exercise. Ultrasound. Manual stretching. Soft tissue mobs. Cryotherapy.				



- William B. Workman, M.D.

Date of Injury: 10/03/2009; 02/15/2014; CT: 02/15/2013 - 02/15/2014

Date	Review			
04/14/2011	,			
Page 0102	DIAGNOSES: 1. Following surgery, unspecified.			
	Other tear of cartilage or meniscus knee.			
08/22/2011 Page 0058	PLAN: Active and passive patient stretching. Gait training. Strength training. ROM. Passive or active activities. Therapeutic exercise. Ultrasound. Manual stretching. Soft tissue mobs. Cryotherapy.  Permanent and Stationary Report - William Workman, MD HISTORY: Injured at work.			
	CHIEF COMPLAINT: Bilateral knee pain.			
	DIAGNOSES: 1. MMT. 2. IMT.			
	IMPAIRMENT RATING: Left med and lat 4%. Right lat 1% WPI.			
	PLAN: Physical therapy. Medications. Possible surgery.			
02/15/2014	Doctor's First Report of Occupational Injury or Illness			
<u>Page 0017</u>	<ul> <li>Jennifer Sperandio, MD</li> <li>HISTORY: While fighting fire, patient's left leg fell through a hole in a</li> </ul>			
	bedroom floor, straining left hip flexor.			
	DIAGNOSIS: Left groin muscle strain.			
	PLAN: Ice. Off work.			



- William B. Workman, M.D.

Date of Injury:

Date 02/18/2014 Page 0019	Review  Doctor's First Report of Occupational Injury or Illness - Zilue Tang, MD  HISTORY: Patient states that while fighting, left leg fell through a hole in		
	a bedroom floor, straining left hip flexor.		
	SUBJECTIVE COMPLAINT: Leg problem.		
	DIAGNOSIS: Sprain or strain of left hip.		
	TREATMENT: Physical therapy.		
	WORK STATUS: Modified work.		
03/04/2014 Page 0047	Progress Report - Zilue Tang, MD SUBJECTIVE COMPLAINT: Left inner groin area pain.		
	DIAGNOSIS: Sprain or strain of hip or left thigh.		
	PLAN: Ice. NSAID. PT. Follow-up.		
WORK STATUS: Modified work.	WORK STATUS: Modified work.		
03/18/2014 Page 0050	Progress Report - Zilue Tang, MD SUBJECTIVE COMPLAINT: Left inner groin area pain.		
	DIAGNOSIS: Sprain or strain of hip or left thigh.		
	PLAN: MRA.		
	CAUSATION: Work-related.		
	WORK STATUS: Modified work.		



- William B. Workman, M.D.

Date of Injury:

Date	Review
04/01/2014 Page 0053	Progress Report - Zilue Tang, MD SUBJECTIVE COMPLAINT: Sore lifting left leg.
	DIAGNOSIS: Sprain or strain of hip or left thigh.
	PLAN: PT. MRA.
0.4/4.5/0.04.4	WORK STATUS: Modified work.
04/15/2014 Page 0055	Progress Report - Zilue Tang, MD SUBJECTIVE COMPLAINT: Left inner groin area pain.
	DIAGNOSIS: Sprain or strain of hip or left thigh.
	PLAN: Follow-up.
	WORK STATUS: Modified work.



- William B. Workman, M.D.

Date of Injury:

Date	Review			
04/17/2014 Page 0212				
	<ol> <li>IMPRESSION:</li> <li>There is aspherical contour of the left femoral head and neck junction. There are areas of delamination of articular cartilage with subchondral cystic changes in the acetabular of the left hip in an area of greater than 9.6mm from medial to lateral. This partial junctional hyperintensity of intermediate signal consistent with degeneration of the labrum laterally.</li> <li>The articular cartilage on corresponding sagittal images shown degeneration of the acetabular roof in a greater than 2cm extent from anterior to posterior as described.</li> <li>The iliopsoas tendon is normal on corresponding sagittal images. The gluteus minimus and medius tendons are intact.</li> <li>Large field of view images show the contralateral right hip with aspherical contour.</li> </ol>			
05/22/2014 Page 0065	Consultation - William Workman, MD CHIEF COMPLAINT: Left hip pain.			
	HISTORY OF PRESENT ILLNESS: Patient injured himself on the job fighting fires and injured his left hip.			
	PLAN: Conservative care. Arthroscopic repair. Femoroplasty. Hip brace. Cold therapy. Surgery.			



Associated Reproduction Services, Inc. 13925 Whittier Blvd., Whittier, CA 90605 (562) 696-1181 FAX: (562) 945-0663

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- 3. You agree to request, use and/or disclose only the minimum necessary amount of PHI necessary to accomplish the purpose of the request, use or disclosure.
- 4. You will promptly notify ARS Legal of (i) any inappropriate use or disclosure of PHI and/or (ii) any security incident or breach which involves possible inappropriate use or disclosure of PHI. Prompt notification should occur not later than 15 days after you become aware of the inappropriate use or disclosure of PHI or a security incident or breach.

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# STATE OF CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS DIVISION OF INDUSTRIAL ACCIDENTS

ARS#: 4

### WORKERS' COMPENSATION APPEALS BOARD

	Case No.
n a la companya di santa di s	
Claimant/Applicant	SUBPOENA DUCES TECUM
vs.	(When records are mailed identify them by using above reference number of attaching a copy of subpoera)  (NO APPEARANCE NECESSARY WHEN RECORDS ARE PRODUCED BY DEPOSITION DATE)
Vallejo Fire Department  Employer/Insurance Carrier/Defendant	r
The People of the State of California Walnut Creek Orthopedics & Sports Medi	
William B. Workman, M.D.	Associated Reproduction Services at
on Jul. 08, 2014, at 9 o'clock AM., to test following described documents, papers, books and t	, CA 90605 (562)696-1181 Fax: (562)945-0663  tify in the above entitled matter and to bring with you and produce the ecords: lecords. Include records from Dr. William Workman.
applicant : DO	B: Carrier SSN: X
·	you may be deemed guilty of contempt and liable to pay to the parties aggrieved ed 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 Jun. 17, 2014	WORKERS' COMPENSATION APPEALS BOARD OF THE STATE OF CALIFORNIA
SELISATION 38	By

If no application for Adjudication of Claim has been filed, a declaration under penalty of perjury that 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, Evidence 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.	
STATE OF CALIFORNIA, County of	LOS ANGELES		
Inat he is the attorney(s) of record of representative(s) for the Applicant/Consumer in the action captioned on the reverse hereof and Associated Reproduction Services, Inc. is designated to act as his legal agent in all respects for the purposes of executing said subpoena and obtaining any records, reports, or evidence of any kind, associated with this subpoena to prove or disprove said injuries.			
described on the reverse hereof. That sollowing reason: To assist in determine physical condition; nature, extent and of the course of employment and/or necessity.	said documents are materia sing one or more of the foll duration of sickness; injury ssity of further treatment; e sure medical treatment, voc	on or under his/her control the documents all to the issues involved in the case for the lowing: To determine present and/or past disability arising out of employment & in employment occupation and duties, earnings and ational rehabilitation under Labor Code 129.5 statute of limitations.	
I declare under penalty of perjury that	the foregoing is true and co	orrect.	
Executed on Jun. 17, 2014, at White	ttier, California.		
CC: York Insurance Services	Associated Reproduction Services, Inc.		
	13925 Whittie	r Blvd., Whittier, CA 90605	
		Address	
	(562) 696-1181		
	(302) 090-1101	Telephone	
DECL	ARATION OF SERV	TCE	
STATE OF CALIFORNIA, County of	CONTRA CO	STA	
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 of service	Place	
	6.18.14	101 Ygnacio Valley Rd #400 Walnut Creek, CA 94596	
I declare under penalty of perjury that the Executed on JUNE 18			
		orthy Rhoades) Signature	

ARS#: 4

### Attachment "A" - Subpoena for Medical Records

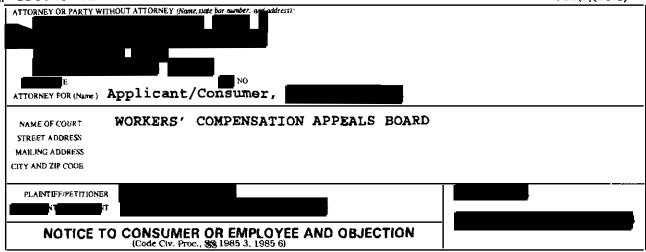
Record of: Walnut Creek Orthopedics & Sports Medicine

Any and all MEDICAL records or writings of any kind; including but not limited to: Inpatient and outpatient records, physical therapy, E/R, paramedic care, labs, tests and results, prescriptions, x-ray reports, private and industrial records pertaining to the patient.

All aforementioned records herein that are stored electronically or in digital format must be delivered electronically in a PDF or TIF format on CD, DVD or electronically transferred to ARS via internet.

If you wish to challenge any request for documents based upon privilege, we require a Privileged Log to be produced. If you challenge the subpoena for records based upon the fact that they have already been produced, we require a Certificate of Service signed under penalty of perjury that all records have been produced.

SAarsm



#### NOTICE TO CONSUMER OR EMPLOYEE

TO(name):

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

SEEKS YOUR RECORDS FOR

EXAMINATION by the parties to this action on (specific date): 07/08/2014

The records are described in the subpoena directed to witness (specify name and address of person or entity from whom records are sought): Walnut Creek Orthopedics & Sports Medicine

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.
  - a. 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.
  - b. 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.
- 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 subpeona. 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: 06/17/2014



#### **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:
- The specific grounds for my objection are as follows:

Date:

(TYPE OR PRINT NAME) (SIGNATURE)

(See reverse for proof of service)

# **DECLARATION OF CUSTODIAN OF RECORD**

Record Of:	ARS#: 4
DOB: 64 DOI:	-02/15/14
am duly authorized as Custodian of Record (or other qualified with	ness) with authority to certify records for:
n my custody have been photocopied either by a photocopy compar and control; and the copy submitted with declaration is a true copy To the best of my knowledge all records in existence referred the above named business, in the ordinary course of business, at or documents, records or other things have been withheld to prevent b	ings called for in the Subpoena Duces Tecum or Authorization which are ny or my office staff at my office, in my presence, under my direction thereof.  to above were prepared or compiled and provided by the personnel of near the time of the acts, conditions, or events recorded. No
CERTIFICATION OF NO RECORDS	
A thorough search of the business revealed no records describ  Medical/Billing/X-Ray Records  Patient never treated at this facility Records destroyed after 5 7 9 years.	Personnel/Wage/Non-Medical Records  [ ] Never Worked for this Company [ ] Records destroyed after 5 7 9 years
[ ] Records were lost / misplaced [ ] Records destroyed due to Fire Water Theft [ ] Patient has his / her records [ ] X-rays are non-existent at another facility: Name: Phone: Not kept because of prepaid Health Plan Name: Contact: Phone:	[ ] Previous owner kept original files [ ] Records kept at: Contact: Phone: Phone: [ ] Records were lost / misplaced
{ ] No records for date(s) specified { ] Other - comments:	
This certification is limited to the information provided in the attached docu	ument. Records may exist under another name, spelling or other identifying data.
Executed on Coate  Declarant  Witness	experient. atWaknut Creek
l, the undersigned hereby declare that I am an employee of Associa Renistration Number 3640, Los Angeles County. The attached cop	OF PROFESSIONAL PHOTOCOPIER ited Reproduction Services Inc., 13925 Whittier Blvd, Whittier, CA 90605, by of records produced to me by the above Custodian of Records shall be will be true copies thereof. I declare under penalty of perjury under the ct.
Executed on <u>6 - 27 - 14</u>	_at WALNUT CREEK CA.
Print Name HA7HYR HUPDES	Signature Hardy Rhoadls (State)



## **NOTIFICATION MEMO**

In order to preserve the integrity of the file copied, we have kept the pages exactly how they were provided from the location.

Please note that one or more pages contained within this file may pertain to persons not associated with this case. Usually this is due to the location misfiling the records in other files. It will be the decision of the requestor to remove these pages.

The quality of the reproduction of the following documents cannot be improved if originals contain poor or illegible copies.

### INDUSTRIAL INFORMATION

Patient Name:

70

CA 94591

Phone:

Body Part(s): LEFT KNEE AND RIGHT KNEE

Authorized by:

Authorized for: RECHECK Referring Physician: NONE

Industrial Insurance: YORK RISK SERVICES GROUP

Billing Address: PO BOX 619079, ROSEVILLE, CA 95661-9079

Claim No.: CVCD-524954 Date of Injury: 10/03/09

Adjuster: MICHELLE BOK

Adjuster Phone: 209-475-3102 Adjuster Fax: 866-548-2637

UR Phone: UR Fax

**Employer: CITY OF VALLEJO** 

Nurse Case Manager: URSULA KREEGER, RN, CCN

Phone: 951-231-6855 Fax: 888-620-6919 Attorney:

#### INDUSTRIAL INFORMATION

Patient Name:		
	CA	94591
Body Part(s): LEFT KNEE		

Authorized by: SHELLY, NCM

**Authorized for:** 

Referring Physician: NONE-WAS BEING SEEN AT KAISER

Industrial Insurance: YORK INSURANCE SERVICES

Billing Address: 1390 WILLOW PASS ROAD, STE. 400, CONCORD, CA 94520

Claim No.: Date of Injury:

Adjuster: STACY MCAFEE

Adjuster Phone: 925-349-3886 Adjuster Fax: 925-609-9264

UR Phone: UR Fax

Employer: CITY OF VALLEJO

Nurse Case Manager: SHELLY JONES RN, BSN (URSULA IS TEMPORARY)

Phone: 925-349-3874 951-231-6855 Fax: 925-609-9264 951-683-3539

Attorney:

## INDUSTRIAL INFORMATION

Patient Name: Date of Birth:	
Address: Phone:	
Body Part(s): LEFT HIP	
Authorized By: ADJ. Authorized For: CONSULT/LTD. TREATMENT	
Referring Physician: NONE	
Industrial Insurance: YORK	
Billing Address: PO BOX 619079, Roseville, CA 95661-9079	
Claim No.: CVCH-546693 Date of Injury: 02/19/14	
Adjuster: Schaunna McEachron	<b>_</b> -
Adjuster Phone: 209-320-0809 Adjuster Fax:	
UR Phone: UR Fax:	
Employer@the time of injury: CITY OF VALLEJO	
Nurse Case Manager: Phone: Fax:	
Attorney:	

Notes:

# WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE PATIENT REGISTRATION FORM

(Please Print)

Date 2/25/2010

Referring Physician:			PCP:			,
,	PATIEN	IT INFORMAT	ION			
Patrick last name:	Siret	Middle:	<b>⊯</b> Mr. □ Mrs. □ Dr.	☐ Miss ☐ Ms.	Marital status (circ	de one) Div / Sep / Wid
Is this your legal name? If no	ot, what is your legal name?	(Former name):		Birth		Sex:
Street address	Other contact number: Cei	City:	<b></b> /	l <b>6</b>	Shake / Zip Code	<b></b> /
Phone number:	3 -			54	•	1
Occupation:	rer:	Address: 5	55 8411	a Ckura	amployer phone is	0.:
IF PATIENT IS A MINOR PLEASE COMPLETE:	Father: Mother	Work Work			Cell#	,
Other family members seen here:						
	INSUR/	ANCE INFORM	MATION			
		insurance card to ti		nist.)		
Person responsible for bill:	Birth date: Address (if di				Home phone no.:	
	/ /				( )	
Is this person a patient here?	□ Yes □ No					
Occupation: Employer:	Employer add	ress:			Employer phone no	0.:
					( )	
Is this patient covered by insurance	e? 🇹 Yes 🗆 No					<b></b>
Name of primary insurance:  CITY OF VALLESO	/ workers wup.	TIMINGA	rers			e service Rd Stute 400 14520
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Policy no.:		Group no.:	Co-payment:
Patient's relationship to subscriber	: 🗅 Self 🗀 Spous	e 🛭 Child	☐ Other			
Name of secondary insurance (If a	pplicable):					
Subscriber's me:					9	t: \$ 15 -
	: 🔀 Self □ Spous		☐ Other			
· .	IN CAS	E OF EMERGE	NCY			
local friend or relative:	RE,	ASON FOR VIS	SIT		32	ą.
Chief Complaint: Survivo	PAIN LEFT KUSSON	ly Part: KNご		Rigi	nt: Left:	×
Related to: Employment X	Date of Injury: 10/3/20	で9 Other_	D	ate of Incide	ent: / /	

2/7/2010

#### **WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE PATIENT REGISTRATION FORM**

	PATIE	NT REGISTR (Please Prin		ORM	Date 6	/11/2012
Referring Physician:			PCP:			······································
			TION.	<del></del> -		3.3.3
			☐ Mr.	□ Miss	Marital status (circ	de one)
			□ Mrs.	D Ms.		Div / Sep / Wid
Is this your legal pame?	wh.			Birth	date: Ane-	Cev-
	\					/
Occupation:	Employer;	Addre	,,		Employer phone p	<u> </u>
Firetighter	C /	/ 1/n/lo Addre	80, Nim	1/2 AU	(70) (()	84C7C
COMPLETE:  Other family members seen here:				T		
	· · · · · · · · · · · · · · · · · · ·	INSURANCE INF	ORMATION			
	(Please	e give your insurance car	d to the receptioni	st.)		
Person responsible for bill:	Rirth date: Ad	dress (if different):			Home phone no.:	
	/ /				( )	
Is this person a patient here?	Yes 🗆 No	<b>1</b>				
Occupation: Employer:	Em	ployer address:			Employer phone no	0.;
Is this patient covered by insurance	e? 🗆 Yes 🔥 No	<b>X</b>	$\overline{}$	• • • • • • • • • • • • • • • • • • • •	de.:	
Name of primary insurance:	TPU	100	A			
Subscriber's name:	Subscriber's S.S.	n: Brit date:	Policy no.:		Group no.:	Co-payment:
Patient's relationship to subscriber:	□ Self	Spouse Child	J □ Other			
Name of secondary Insurance (if ap	oplicable):			**************************************	and the second s	
Subscriber's name:	Subscriber's S.S. n	no.: Birth date:	Policy no.;		Group no.:	Co-payment:
						\$
Patient's relationship to subscriber:	□ Self	☐ Spouse ☐ Child	☐ Other			
	in the same	IN CASE OF EME	RGENCY		والمراجعة المراجعة ا	· · · · · · · · · · · · · · · · · · ·
Name of local friend or relative:		Relationship to pa	stient:	Home pl	hone no.: Work	phone no.:
	, 16438 °	REASON FOR	VISIT	,	· h	The same of the sa
ر بازد کا در از	ir - "i	Body Part: KA	IEFS	Righ	nt: Left:	<u></u>
Related to: Employment	Date of Injury:	0 00	ther Da	te of Incide		•

12/16/2010



# **UPDATED**

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE PATIENT REGISTRATION FORM

				(Please Print	)		Da	te 5 / d d / /
Referring Physician;				****	PCP:			
			PAT	IENT INFORM	MOTTAN			
Patient's last name:	ME IMPANTINE	Cier		Middle	₽ Mr.	□ Miss	Marital sta	tus (arde one)
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KAISER PERMANENTE

Did employee notify employer of this injury? Y

Inquiry refer to: MR 01977909

KAISER PERMANENTE Claim#2009095282 DOL'10-03-2009 Visit: 10-06-2009 13:32 ReportDote: 10-07-2009 Final; Y

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS - STATE OF CALIFORNIA

Within 5 days of your Initial examination, for every occupational injury or illness, sound two copies of this report to the employer's Workers' Compensation Insurance carrier or the sell-
Insured employer. Fallow to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnesed or suspected posticide poisoning, and it copy of this report
to Division of Labor Shelistics and Research, F.O.Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

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FOHM 5021 (REV.4.5) 1992-06. Any person who makes or squises to be made any knowingly lalse or freudulent meterial statement or material 90362 (Rev.2-83). representation for the purpose of obtaining or denying workers' comparisation banafits or payments is guilty of a felony.

V2.4

KAISER PERMANENTE Claim#2009095282 DOI:10-03-2009 Vait:10-08-2009 13:32 ReportDate:10-07-2009 Final.Y

PMR:01977909 WCAB#: FAC:VAL Contact:(707) 651-2968 LBD Carrier DOI (# averable):

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

- STATE OF CALIFORNIA Page 2

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17. History continued,

Continuation

19. Findings continued:

A. abnormal sensation or abnormal reflexes. No focal neurological findings Musculoskeletal - abnormal exam of left knee with TTP in the pop. Fossa area, no discreet cyst felt, and minimal TTP on the bilateral sides of the knee, no swelling, spasm or bruising, abnormal active range of motion of decreased by 20-30%, negative Lachman and McMurray bilateral, slow gait, squatting to 70-80% of normal Extremities - peripheral pulses normal, no pedal edema, no clubbing or syanosis. Vital Signs: BP 133/87 I Pulse 69 I Ht 5' 9" I Wt 215 ib (97.523 kg) alert, well appearing, and in no distress.

23. Treatment continued:

8.

diagnosis) Note: Will check xray to t/o bony injury, will give med as below for pain and inflammation as directed, knee support and cane given to try, PT with HEP 6 times to decrease pain and increase mobility and strength, MW for now, follow up in 2 weeks for reassessment. Plan: RADIOLOGIC EXAM, KNEE, COMPLETE, 4+ VIEW. IBUPROFEN 800 MG ORALTAB SPORT NEOPRENE KNEE SUPPORT MISC MISC CANE CONTUSION OF KNEE Note: same as above Plan: RADIOLOGIC EXAM, KNEE, COMPLETE, 4+ VIEW. IBUPROFEN 800 MG ORALTAB SPORT NEOPRENE KNEE SUPPORT MISC MISC CANE WORKERS COMPENSATION-SPECIFIC INFORMATION Chemical or toxic compounds involved? : No. Are findings/diagnosis consistent with patient's account of injury/onset of illness? (If no, explain): yes. Is there any other current condition that will impede or delay patient's recovery? (If yes, explain): no. Permanent disability expected? : No. Is there a current Worker's Compensation claim for this injury? No Chemical or toxic compounds involved?: No. Modified work 10/6/09 through 10/20/09 - not at all squat/oilmb stairs/ladders/scaffolds. No kneeling, stand and walk as tolerated, sit down work preferred. F/u appt. 10/20/09 - not at all squat/oilmb stairs/ladders/scaffolds.

000016

KNICCO	PEPMANENT	F

Did employee notily employer of this injury? Y

inquiry refer to: MR 01977909

RAISER PERMANENTE Chims: DOE02-15-2014 Vidi:02-15-2014 21:45 ReportDate:02-19-2014 Final:N DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

- STATE OF CALIFORNIA

Within 5 days of your initial examination, for every occupational injury or literal, send two copies of this report to the employer's Workers' Companies on insurance carrier or the self-
insured employer. Failure to the a timely doctor's report may result in assessment of a civil penalty, in the case of diagnoses or exemperad passicitie polerning, eard a copy of this repo
to Datelon of Labor Statistics and Research, P.O. Rox 420803. San Francisco, CA 94142-0803, and notify your local health officer by fellowhone within 24 hours.

1.	HISURER HAME AND ADD YORK INS SVCS PO BOX B		61			RECEIVED	Planes do mot use this column
2.	EMPLOYER NAME					11202.702	Case No.
3,	CITY OF VALUE STORM Address No. and Street 656 BANTA CLARA ST		City	CA	Zip 945900000	MAR 06 2014 A	Industry
4.	Nature of Business (e.g. food	menufacturing, building con	*******		(707) 648-4	OSC West	County
6.	PATIENT NAME (First	Name, Middle Initial, Last N	ame)		6. Sex	7. Date of Yr. Mo. Day Sirth	Age
Ì			A.h	<u>—</u>	Ri_	2 Poloshoo Nombou	Hazard
10,	Occupation (Specific Job Titl FIREFIGHTER ENGINEER	o)				11. Social Security No:	Disease
12.	Injured at: No. and Street STRUCTURE FIRE				County		Hospitaltzalio
13.	Date and hour of injury or onset of litness	Yr. Mo. Day 02-15-2014	Hour 09:15	PM	14. Dide s		Occupation
15.	Date and hour of first examination or treatment	Yr. Mo. Day 02-15-2014	Hour 09:43	PM		you (or your office) previously I pallent?	Ratum
17.	Patient please complete the portion shall not affect his/he Describe how the accident	r rights to workers' compare or exposure happened.	Otherwise, dock ation under the Cali (Give specific object	liomia Labor Code st, machinery or ch	emical. Use s	Inability or failure of a patient to weree side if more apace is red FLOOR; STRAINING MY LI	ulred)

- 18. Subjective Complaints (Use reverse if more space is required.): HIP PAIN Injury: Where: left upper front thigh When: pta How: during fire fighting job - on second floor - went into room with respirator and
- 19. Objective Findings (Use reverse if more apace is required.): A Physical examination: BP 151/105 | Pulse 84 | Temp(Src) 97.5 F (38.4 C) | Resp. 18 I Ht 1.753 m (5' 9.02') I Wt 95.255 kg (210 lb) I BMI 31 kg/m2 i SpO2 92-95% General - WDWN, NAD, A&O x 3, clothes smell of smoke Respiratory effort - no distress, no B: X-ray and laboratory results (State if none pending):
- 20. DIAGNOSIS (If occupational illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? · LEFT GROIN MUSCLE STRAIN

Primary ICD9 Code B43.9

Secondary ICD9 Code

21,	Are your findings and diagnosis consistent with the pattern's account of injury or onset of litness?
	If Not please explain:
22.	Is there any other current condition that will impeds or dulay patient's recovery?
	If Yes' please explain;
23.	TREATMENT RENDERED (Use reverse side if more space is required.)
	ED course - stable, concern about low p ox - asymptomatic - perhaps due to recent fire/smoke inhalation vs chronic inhalation PLACE OF INJURY,
	INDUSTRIAL PLACE Note: will on to occurred to five LEFT GROIN MUSCLE
24.	If further treatment required, aposity treatment plan, estimated duration.
	Z TANG MD. OCC HEALTH. 02/18/14
25.	If hospitalized as impatient, give hospital name and location. Date Yr.Mo.Day Estimated stay
	Admitted:
26.	Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?  Work Status - is patient able to perform usual work?
	Restrictions: SEE #23. HEVIEWED RV Modified work:
	Doctor's Stonature: CA License Number: C504480
	Doctor's Name and Degree: SPERANDIO, JENNIFER, MD TREATING MD // IRS Number:
	Address: 97\$ Sereno Drive, Vallejo, CA 94589 Telaphone Number: (707) 651-1570
	FORM 5021 (REV.4.5) 1992-05 Any person who makes or ocuses to be made any knowingly false or fraudulant material statement or eminrial
	90362 (Rev.2-93) representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

KAISER PERMANENTE CIAIMI: DOLO2-15-2014 Vialc02-15-2014 21:43 ReportDate:02-16-2014 Finath
Patient Patient Permanent P MRC1977909 WCAB#: FAC:VAL Comisct:(707) 651-1370 Carrier DOI (if available):
DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR LLNESS
Continuation

- STATE OF CALIFORNIA Page 2

- 17. History continued:
- 18. Compleints continued; through a hole in the floor with his left thigh and fell forward and now with pain when he flexes his thigh up at the crease in his groin. No h/o RAD. Fight fires for almost 30 years. Bikes 60 miles a week and does other exercise, denies SOB Exacerbated by; movement Relieved by; rest Meds tried; none ROS: Constitutional; No fever GestroIntestinal; no N/V
- A. tachypnas Skin warm, dry, no rashes Normal gait Penia, somi, neck from Ht RRR Lungs CTA bilateral Left thigh from but pain with flexion and abduction, no bruise or swelling Can bear weight on left hip independent review of xray, my read: No tx
- 23. Treatment continued:
  STRAIN Note: motrin, ice, reassured, work note for a couple days OFF WORK: 2/15/2014 through 2/17/2014. RTW-FD 02/18/14. Condition at discharge stable Return for worsening or no improvement

MAR 06 2014 A
OSC West

7076512955 >>

KAISER PERMANENTE

Old employee notify employer of this injury? Y

inquiry refer to: MR 01977909

KAISER PERMANENTE CIalmi: DCR:02-15-2014 VIsitiO2-18-2014 (5:56 ReportDate:02-19-2014 Finally

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS - STATE OF CALIFORNIA

Whith 5 days of your initial examination, for every occupational injury or litress, send two copies of this report to the employer's Workers' Compensation insurance carrier or the soliinsured employer. Feiture to tile o finally dector's report may result in assessment of a civil possity. In the case of diagnosted or suspected pecificide polecting, sond a copy of this report to Division of Labor Statistics and Responset. F.O.Box 420606. San Francisco. CA 94142-0608, and notify your local health officer by interhone within 24 hours.

	<u>vision of Labor Statistics and E</u>			2606. CA 94142-0803. bi	JAT JAOPIJA AGITĀ JĀ	Kin upsetu otto	<u> </u>	KEEPING V	MATHER SALISMA	164	
1,	insurer name and i	-	-								Pirosa do not
	YORK INS SVCS PO B	OX 61907	'S ROSEVILLE, CA 95	<del>8</del> 61						•	use this column
2	EMPLOYER NAME										Case No.
	CITY OF VALLEJO										
1	Address No. and Street		-	City		Zlp					Industry
•	555 SANTA CLARA ST			VALLEJO	CA	94590	00000				
4.	Nature of Business (e.g.		nufacturing, building co								County
•							048-436	55			-
5.	PATIENT NAME	(First Nan	ne. Middle initial, Lest i	Marne)			Sex	7.	Date of	Yr. Mo. Day	Age
	- Hilliam I would	II kres rees.	IN THE REAL PROPERTY.	ACT INC.		M	<b></b> -	''	bear v	//· · · · · · · · · · · · · · · · · · ·	
L	Arithmes No. and Street			Cib		7h		9.	Telephor	e Number	Hazard
								-	1 4		
10.	Occupation (Specific Jo	b Tkla)		<del>.</del>				11.	Social Sc	curity No:	Disosso
	firefichter										
12		ek .				Coun	łv				Hospitalization
	STRUCTURE FIRE					SOL	•				'''
13		Of .	Yr. Mo. Day	Hout			Data lesi	,	Yr. Ma. D	) RV	Occupation
144	orsol of filmess	•	02-15-2014	09:15	PM	1	worked	•	02-15-20		0000,000
16	Date and hour of first		Yr. Ma. Day	Hour	1.199		*	LÍSE		previously	Relum
164	examination of (193) Mer	-4	02-18-2014	03:86	PM		rested o			brancasi	(MILDRI
_				***	- 110					-4liant te	
	Patient please comple						manany. m	i <b>aus</b> ii,	Ot Ishinta	oi <b>s</b> banday in	COUNTRIES THE
47	portion shell not affect to						15				الدعاد.
14.	Describe how the acci	EIO: C	xboarus uabbeued	(Give appears object	A Mechinen	OL CUBILICET	USB 79Y	900	FICO II MON	BOOCO IS TOO	utrea)
	PT STATES: WHILE	HIGHII	NG FIRE MY LEFT L	EG FELL THHOU	SH A HOLE	IN A BEUP	ROOM F	LOC	H; STHAL	NING MY L	PI MP
l	FLEXOR.										

- Subjective Completes (Use reverse if more space is required.):
   Mechanism of injury; He want into room with respirator and fell through a hole in the floor with his left thigh and fell forward and now with pain
- 19. Objective Findings (Use reverse trimore space is required.); A, Physical examination; Physical Exam; no apparent distress 8P 137/82 | Pulse 97 I SpO2 100% Galt: no antalgic Left thigh mild TTP at lateral groin area. No hernia, pain and mild reduced ROM with flexion and abduction, no bruise or swelling Can

  Et X-ray and taboratory results (State If none pending);
- 20. DIAGNOSIS (if occupational likess, specify otiologic agent and duration of exposure.) Chemical or toxic compounds Involved?

  Primary ICD9 Code

  843.9

  Secondary ICD9 Code
- 21. Are your findings and diagnosis consistent with the patient's account of injury or enset of lineas? y
- 22. Is there any other current condition that will impode or delay patient's recovery? In if "Yes" please cooksin:
- 23. TREATMENT HENDERED (Use reverse side if more space is required.)

  SPRAIN OR STRAIN OF HIP OR THIGH Note: left, source Continue loing and NSAID Physical Therapy Treatment Authorization Request Physical Therapy targeted at left hip and thigh: up to 6 visits over 4 weeks for
- 24. If further treatment regulated, specify treatment plan, estimated duration.

Z TANG MD, OCC HEALTH 03/04/14 25. It hospitalized as Inpatient, give hospital name and location. Yr.Mo.Day Estimated stay Date 26. Work Status - Is patient able to perform usual work? If 'No', dato when patient oan return to ; Regular work: Restrictions: SEE #23. Madilied work; 02-18-2014 Doctor's Signature: CA License Number: 100782A Decions Name and Dogree TANG, ZILUE, MD TREATING MD IRS Number: Tolephone Number: (707) 651-1370 Address: 975 Sereno Drive, Vallejo, CA 94589

FORM 5021 (REV.4.5) 1992-06 Any possion who makes or causes to be made any knowingly sites or fraudulent material attribution or material attribution or proposal of obtaining it danying workers' compensation benefits or payments is guilty of a follow.

v2.5

2014-02-20 13:11

KAISER PERMANENTE Claims: DOI:02-15-2014 Visit;02-18-2014 15:58 ReportDate:02-19-2014 Finalty Patient:BRUNSON, JAMES P MR:01077909 WCABE: FAC:VAL Contact(707) 651-1370 Certier DCI (il available); DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS Continuation

occmed

- STATE OF CALIFORNIA Page 2

17. History continued:

18. Complaints continued: when he flexes his thigh up at the crease in his groin. Chief Complaint; LEG PROBLEM. James P Brunson is a 49 Y male presents with left inner groin area pain. . ER visited, left hip xr negative, ibu given, Some improving, but could not climb. Prior treatment for this injury/liness: as above Current complaints: as above. Review of Systems: Constitutional: negative for fevers or chills Musculoskeletal: negative for generalized myalgias/arthralgias Sidn: negative for rash or pruritus Neurological; negative for weakness, bowel/bladder Incontinence, or clumeiness Relevant Medications; none Allergies; Review of patient's allergies inclicates no known allergies. Social History: reports that he has never smoked. He does not have any smokeless tobacco history on life. Occupational History: date last worked: 02/15/14 Relevant Past Medical/Surgical History: Patient denies prior relevant. Injuries/surgeries and Prior industrial injury/surgery - bit knee s/p surgery Relevant Family History: No relevant family history Hobbles/Leisure Activities: Patient denies any relevant recreational/lelsure activities

19. Findings continued:

 A. bear weight on left hip. Additional information Reviewed: Data Review: Reviewed radiology results: left hip no fx Reviewed other records; HC notes reviewed

В.

23. Treatment continued: Individual Instruction, home exercise program, therapeutic techniques to decrease pain and inflammation and to restore pre-injury functional status. This is consistent with ACOEM guidelines. Work Status: Modified duty 2/18/2014 through 3/4/2014 Squat/kneel, knee bending: Not at all. Climb ladders: Not at all. Use of scaffolds/work at height: Not at all. Lift/carry/push/pull no more than 10 pounds.

Return to Clinic: 3/4/2014 8:30 AM Causation: The stated mechanism is consistent with my clinical exam findings and no information has been presented that would indicate a cause other than the alleged employment avent/exposure.

000020

#### PREMIER SURGERY CENTER

2222 EAST STREET, SUITE 200 CONCORD, CALIFORNIA 94520 (925) 691-5000

PRE-OP	HISTORY and PHYSI	CAL	DA	TE OF SURGERY; 03/31/10 DATE; 03/29/2010
CHIEF COMP	PLAINT: LEFT KNEE PAIN			AGE:_ <b>45</b>
INDICATIONS	S FOR SURGERY: 45yo with	x 6months.		
		-		·
	-\.			•
PAST HISTO	RY: OPERATIONS	NEG	1271	or.
	ALLERGIES	NEG		or
	MEDICAL ILLNESS	NEG		or
	HIV/AIDS	NEG		oror
	CURRENT DRUGS	NEG		or motrin prn
	ANESTHETIC PROBLEMS	NEG		
	SIG. FAM. HISTORY	NEG	<del></del>	or
	ROS - HEENT	NEG	=	or
	GI-GU	NEG		or or
	CHEST CVS	NEG	_	
	OTHER	NEG	٠	or
				GRAVIDA PARA
EMALES	LMP	PA	P: DATE	RESULT
PHYSICAL E	XAMINATION: BP 110/80			
	EYES	WNL	<b>7</b>	or
	THROAT	WNL	7	or
	NECK	NEG	<b>▼</b>	or
	CHEST	NEG	<b>V</b>	or
	BREASTS	NEG		or <u>DEF</u>
	HEART	NEG	V	or
	ABD	NEG	<b>7</b>	or
	PELVIC	NEG		or DEF
	RECTAL	NEG		or DEF
	EXTRM	NEG		or L knee: no effusion_stable NVI
	NEURO	NEG	$\overline{\mathbf{Z}}$	or
	OTHER		_	
MPRESSION	ıs: L knee pain			
	•			
	ROPOSED: LEFT KNEE AF	RTHR	OSCOF	PY PARTIAL LATERAL MENISECTOMY.
Wilden) Fr	101 00ED			TO THE EATERNE MENIOLOTOM.
			SIGN	ED <u>William B. Workman</u> , M.D.  DOCTOR'S NAME <u>William B. Workman</u> , I
				William D. W.
PATIENT'S NA	AME			DOCTOR'S NAME WILLIAM B. WORKMAN.

#### PREMIER SURGERY CENTER

2222 EAST STREET, SUITE 200 CONCORD, CALIFORNIA 94520 (925) 691-5000

Faxed to Premier 2/17/11@2:30 pmth

PRE-OP HISTORY and PHYSICAL		DA	TE OF SURGERY: 02/18/11			
CHIEF COMPLAINT: RIGHT KNEE PAIN					AGE: 46	
NDICATIONS	S FOR SURGERY: RT. KNEE	PAIN	MED 8	LAT MENISCUS TEARS		
				·		
PAST HISTO	RY:			IT WHEELAT MENUO	FOTONY 2/40	
	OPERATIONS	NEG		or LT. KNEE LAT. MENISC		
	ALLERGIES	NEG		or	·	
	MEDICAL ILLNESS	NEG	==	or		
	HIV/AIDS	NEG	=	or		
	CURRENT DRUGS	NEG		or		
	· · · · - · · · · · · · · · · · · · · ·	NEG		or		
	SIG. FAM. HISTORY	NEG		or		
	ROS - HEENT	NEG		or		
	GI-GU	NEG		or		
	CHEST CVS	NEG	V	or		
	OTHER			000//01	NDA.	
				GRAVIDA PA		
FEMALES	LMP	_ PA	P: DATE	RESULT		
PHYSICAL E	XAMINATION: BP					
	EYES	WNL	<b>[</b> ]	or		
	THROAT	WNL	✓	or		
	NECK	NEG	✓	or		
	CHEST	NEG		or		
	BREASTS	NEG		or DEF		
	HEART	NEG	✓	or		
	ABD	NEG	abla	or		
	PELVIC	NEG		or DEF		
	RECTAL	NEG		or DEF		
	EXTRM	NEG		or DEF or OF		
	NEURO	NEG		or		
	OTHER					
MPRESSION	NS: KNEE PAIN/MENIS	CAL	TEA	RS		
SURGERY P	ROPOSED: RIGHT KNEE A	RTHRO	OSCOP	Y PARTIAL MEDIAL & LATER	RAL MENISECTOMIES.	
				A ( )		
			SIG	DOCTOR'S NAME William	Meman, M.D.	
				William	R Workman	
PATIENT'S N	AME			DOCTOR'S NAME YYIIIdii	LD. AAOLKIIISII, I	

### PREMIER SURGERY CENTER

2222 EAST STREET, SUITE 200 CONCORD, CALIFORNIA 94520 (925) 691-5000

PRE-OP HISTORY and PHYSICAL		CAL	DATE OF SURGERY: 07/09/14 DATE: 07/01/14
CHIEF COMF	PLAINT: LEFT HIP PAIN		AGE: 49
	S FOR SURGERY: LEFT HIP		· · · · · · · · · · · · · · · · · · ·
			·
PAST HISTO	RY:		
	OPERATIONS	NEG 🗌	tim telimines:
	ALLERGIES	NEG 🗌	
	MEDICAL ILLNESS	NEG 🗌	or
	HIV/AIDS	NEG 🗌	Of
	CURRENT DRUGS	NEG 🗌	or NONE LISTED
	ANESTHETIC PROBLEMS	NEG 🗌	or
	SIG. FAM. HISTORY	NEG 🗆	or
	ROS - HEENT	NEG 🗆	or
	GI-GU	NEG □	or
	CHEST CVS OTHER	NEG 🗌	or
	OTHER		GRAVIDAPARA
FEMALES	LMP	PAP: D	DATE RESULT
PHYSICAL E	EXAMINATION: BP		•
	EYES	WNL 🗆	or
	THROAT	WNL 🗆	or
	NECK	NEG 🗌	or
	CHEST	NEG 🔲	or
	BREASTS	NEG 🗌	or <u>DEF</u>
	HEART	NEG 🗌	
	ABD	NEG [	
	PELVIC	NEG [	
	RECTAL	NEG 🗌	
	EXTRM	NEG [	
	NEURO	NEG 🗌	or   Start IV in Pre-Op
	OTHER		Start IV III FIE-O
IMPRESSION	NS: LEFT HIP PAIN		
SURGERY P	ROPOSED. LEFT HIP ARTHRO	COPY WITH	H FEMOROPLASTY, ACETABULOPLASTY AND LABRAL REPAIR.
			SIGNED BUNKMAN, M.D.
DATICATIO N	IANAC		SIGNED .M.D. DOCTOR'S NAME WIlliam B. Workman, I
PATIENT'S N	IMVIE -		_ DOCTOR STANKE THINGET B. TOTALIGHT,

KAISER PERMANENTE Claisse: 2009093282 DCL:10-03-2009 Visit: 11-25-2009 11:20 Report Dote: 11-30-2009 Pinel: N
Potient: PMZ:01077909 WCABS: FAC: VAL Consou(707) 651-2969 GYE Carrier DOI (it available):

State of California Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

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

Page 1

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has

resched mortimum medical improvement), do not use this form. You m	may use DWC Form FR-3	<u>.</u>	
11. Pedent will be permanently precluded from engaging in	his/her usual and customary	occupation if any of these box	res are checked
12 Padent's condition is permanent and studenary with resi	idual disability om	you must use Wor	
13. Petient will movine forme medical care	<u>.</u>	or narrative repor	rt
14. Ciulus Administrator	Patient: 1:	16. 55N	
YORK INS SVCS	17. Name		_
	is Addres		

1390 WILLOW PASS RD, STE# 400 19 City VALLEJÓ Sure CONCORD 20. DOI 10-03-2009 21. DOS 0 22. Sex M CA 94520 23. Phone 24, Fax 25. Occupation 26. Phone (925) 349-3880 27. Fax (925) 609-9264 28. Clain 29. WCAB

30. Employer Name: CITY OF VALLEJO

31. Employer Phone (707) 648-4355

The information below must be provided. You may use this form or you may substitute or append a narrative report.

32. Subjective Complaints:

nave not changed Pain Level Current: 5/10. PT record reviewed. Constitutional: Negative Musculoskeletal: joint pain Neurological: Negative.

- 13. Objective Findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)
  Vital Signs: BP 138/83 | Pulse 86 General appearance vital signs reviewed and alert, well appearing, and in no distress
  Mental status alert, oriented to person, place, and time Neurological alert, oriented, normal speech, no abnormal sensation
  or abnormal reflexes. No focal neurological findings Museuloskeletal -patient still has left knee TTP, no swelling or spasm
  or bruising, decreased in ROM by 20%, slow gait Extremities peripheral pulses normal, no pedal edema, no clubbing or
  cyanosis. A: SPRAIN/STRAIN, KNEE-Overall no change since last visit. CONTUSION OF KNEE.
- 34. Diagnostic Studies Ordered:
- 35. Diagnoses

lat

SPRAIN/STRAIN, KNEE/Left . Primary

ICD-9 \$44.9

250

CONTUSION OF KNEE

1CD-9 924.11

- 36. Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (a.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged MWP: 11/25/09-12/10/09 SQUAT/CLIMB STAIRS OCCAS, CLIMB LADDERS/SCAFFOLDS NOT AT ALL, No kneeling, stand and walk as tolerated. meds PO PRN, PT with HEP continues til finish, then HEP continues, ice/heat PRN use, support use PRN, MW continues for now, follow up on 12/10/09 for CSI treatment.
- 37. Have there been any changes in treatment plan? X 38. If so, why?
- 39. Other Physician/Non-Physician Providers:

1 /

KAISER PREMANENTE Claim#2009095252 DCu:10-03-2009 Visit:11-25-2009 11:20 ReportDate 11-30-2009 Final:N

Festical State of California Division of Workers' Compensation

## State of California Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Page 2

40. Drugs:		
41. Physical Medical Service: 44. Hospitalization/Surgery Date 46. Consult/Other Services:	42. Times per Week 45. Hospitalization/Surgery	43. Duration:
Work Status: This patient has been instructed. I Return to full duty on with no fit 48. X Return to modified work on 11-25-2009 with 49. Limitations: SPE #36.		
50 Patient direktreed as cored (no permanent disab 51. Patient is permanently precladed from engaging are deemed permanent.	ility or need for future medical care), in his/her usual and eurhamary occupation and the ab	seve limitations/restrictions

prohibits referral to a physician or entity with whom the physician has an unlawful finan	<b>-</b>
The Fermanente Medical Group, Inc.	53. IRS Number 94-2728480
Signature	Specialty

MD

Primary Treating Physician: (original signature, do not stamp) 52. Date of exam 11-25-2009

S4. Name GAO, JEFFREY LEB

S6. Address 975 Sereno Drive Vallejo, CA 94589

Signamme Date
55 California Lie# 08092003

55 California Lie# 080920G 57. Phone (707) 651-2969

707 651 2864 JAN-11-2010 11:07 FROM: OCC MEDICINE TD: 9256899264 KAISER PERMANENTE Claims: 2009093282 DOI:10-17-2010 11:04 Rependential 08-2010 Final:N

Patient: MR:01077909 WCAD: C:VAI confidence of Rependential DOI (if available):

State of Californial Livision of Wife keeps Compensation

PRIMARY TREATING PHS SIGIAN'S PROGRESS REPORT (PR-2) Page 1

Check the box(cs) which indicate why you are submitting a report Mellik time: If the Patient is "Permanent and Stationary" (i.e., hus resched maximum medical improvement), du not use this form. You may use DWC Form PR.3

10. X Periodic Report (regular of Changla) - Interest of Change (a poor greatest of Change (a po Others

Patient will be permanently precluded from energing in his her use the particular of competion Patient's condition is permanent and stationary useful to ideal disabilities. If any of these boxes are checked you must use Form PR-3 12. ilive report tratiant will require future medical care 14. Claims Administrator Patient: 16. SSN YORK INS SVCS 17. Name 18. Address 1390 WILLOW PASS RD. STE# 400 1920 Party ASY CONCORD CA 94520 25/30公司 26. Phone (925) 349-3880 27. Fax (925) 609-9264 30. Eniployer Name: CITY OF VALLEJO 31. Employer khone (707) 648-4355 The information below must be provided. You may we this form or you may submitted or soppind a narrative report 32. Subjective Complaints: have not changed Pain Level Current: 5/10. Considerational Negation to see the selection positive for mysigian and joint pain Neurological: Negative. 33. Objective Findings: (Include significantity sicil communication in the property of the diagnostic findings.)
Vital Signs: BP 131/79 | Pulse 70 General applicance of vital significantity and light, well appearing, and in no distress
Mental status - alert, oriented to person, place, and time received of the property of the propert

joint, no swelling or spasm or bruising, decreased in ROM by 20%, slow gait, crepitus with movements Extremities perlpheral pulses normal, no pedal edema, no clubbing or cyanoxis. A: SPRAIN/STRAIN, KNEE-Overall no change since last visit. CONTUSION OF KNEE.

34. Diagnostie Studies Ordered:

35. Diagnoses

SPRAIN/STRAIN, KNEE/Left . Primary

2nd CONTUSION OF KNEE



ICD-9 844.9

ICD-9 924.11

36. Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. The property and non-particle and non-particle and the property and duration of physical medicine services (e.g., physical parallel physician and non-particle and non-particle and the property and duration of physical medicine services (e.g., physical parallel physical medicine services (e.g., physical parallel physical physical medicine services (e.g., physical parallel physical physical

37. Have there been my changes in treatment planting 38. If 50, why?

39. Other Physician/Non-Physician Providers:



40. Drugs:

Page 2

- 41. Physical Medical Service:
- 44. Hospitalization/Surgery Date
- 46. Consult/Other Services:



43. Duration:

Work Status: This pat	fcut mas ocen	Instructed	w:
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47. Return to full duty on with no limitations or restrictions.

48. Esturn to modified work on 01-07-2010 with the sail point limitations or restrictions.

49. Linutrations:

SEE #36.

50. Patient discharged as cured (no permanent disability or need for future medical care).

51. Patient is persuantly produced from engaging in his/her usual and customary occupation and the above limitations/restrictions.

are deemed perananent.



Primary Treating Physician: (original signature de not stamp) . Dale of exam 01-07-2010

I declare under penalty of perjury that this report is true the complete best of the best of the declared that I have not violated labor code 139.3 which prohibits referral to a physician or entity with whom the passet of the best of the prohibits referral to a physician or entity with whom the passet of the best of

The Permanente Medical Group, Inc.

53. 1RS Number 94-2728480

Signatura			Specialty		
Executed at	<del></del>		Signature Date		
54. Name	GAO, JEFFREY LES 975 Sareno Drive Vallelo, CA 94589	Bo	Signature Date  15. California Lic#  27. Pinke	080920G (707) 651-2969	

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary"

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Occupation	SS#		hone:	
Claims Administrator: Name YORK INSURANCE SERVICES		Claim Number		
	City	_ Claim Number State	Zir	<u> </u>
AddressPhone	_ City	Fax 925-609-9264		<b>'</b>
I none	_	1 ax 310-003-3104		
Employer name: CITY OF VALLEJO		Employer phone		
The information below must be provided. You may	use this form or y		ppend a narra	tive report.
Subjective complaints:	-	-		-
45yo M f/u L knee arthroscopic partial lateral menisced	tomy x 5-6wks. Re	sponding well to water l	PT. Some cont	occasional knee discomfo
with increased activity, kneeling.				
Objective findings:				
L knee: Incisions well healed. FROM. No effusion. Stre	ngth intact. Tender	r around incisions.		
<b>Diagnosis:</b> (Please indicate right or left)				
1, 715.16 - DJD knee		ICI	<b>)-</b> 9	
2, 836.1 - Lat. Meniscus tear		ICI	<b>)-</b> 9	
3.		ICI		
Treatment Plan: (Include treatment rendered to d	ate. List methods	. frequency and duration	n of planned	treatment(s).
Specify consultation/referral, surgery, and hospitaliz				
type, frequency and duration of physical medicine so				
Use of CPT codes is encouraged. Have there been a			y?	
1. cont with PT for conditioning, pt responding well to	aqua PT, cont to a	dvance		
2. f/u 6wks				

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\$120 P. C. C. C. A.	

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

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

Signature:

Date: 05/10/2010

Name: William B. Workman, MD

Address: 301 Lennon Lane, Ste. 100, Walnut Creek, CA 94598

California License No.: <u>A72343</u> Specialty: Orthopedic Surgeon

Phone: (925) 944-0110 Fax: (925) 944000028

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum improvement), do not use this form. You may use DWC Forms PR-3 or PR-4. Afrancilla Kapert (ragined 45 days after lesi (4. 401) — C. Craspa, residuent plant. C. Helekset, Sumpara Bolten i verterne Boerforefriet-ramagene Boerfore Brigger Bother i verterne Boerfore Boerfore Brigger, ethagesternoù bere betreit de beginn be Patient: First JAMES Sex Last M.I. City VALLEJO State CA Zip 94591 Address 2 Date of Injury 10/03/2009 Date o Occupation SS# 5 Phone: Claims Administrator: Name YORK INSURANCE SERVICES Claim Number City Address Phone Employer name: CITY OF VALLEJO Employer phone The information below must be provided. You may use this form or you may substitute or append a narrative report. Subjective complaints: Has had two. 5 translet mus of though . Has been vide, but me how the **Diagnosis:** (Please indicate right or left) 1, 715.16 - DJD knee ICD-9 2, 836.1 - Lat. Meniscus tear ICD-9 ICD-9 Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Em manage Next Appointment <u>07/29/10</u> Date of exam: 06/21/2010 Primary Treating Physician: (original signature, do not stamp) I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3. Date: 06/21/2010 Signature: California License No.: A72343 Executed at: Contra Costa County, CA

Specialty: Orthopedic Surgeon

Phone: (925) 944-0110 Fax: (925) 944006029

William B. Workman, MD

301 Lennon Lane, Ste. 100, Walnut Creek, CA 94598

Name:

Address:

Check the boxes which indicate why you are submitting a report at this time. If the natient is "Permanent and Stationary"

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type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?

- 1. cont recommendation for advancement of HEP, encouraged biking
- 2. consider knee injection coming moths if no further improvement.

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Next Appointment: <u>54/kB</u> Date of exam: 07/29/2010 Primary Treating Physician: (original signature, do not stamp) I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Rock Marie Signature: Date: 07/29/2010 California License No.: A72343 Executed at: Contra Costa County, CA

William B. Workman, MD Name: 301 Lennon Lane, Ste. 100, Walnut Creek, CA 94598 Address:

Specialty: Orthopedic Surgeon

Phone: (925) 944-0110 Fax: (925) 944**00960**30

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Address		State Zip
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Primary Treating Physician: (orig		ate of exam: 09/09/2010
declare under penalty of perjury that the	has report is true and correct to the best of	my knowledge and that I have not
violated Labor Code 139.7.	t / /X	

Name: William B. Workman, MD
Address: 301 Lennon Lane, Ste. 100, Walnut Creek, CA 94598

Signature:

Executed at: Contra Costa County, CA

Specialty: Orthopedic Surgeon Phone: (925) 944-0110 Fax: (925) 944**9060**31

California License No.: A72343

Date: 09/09/2010

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Next Appointment: Date of exam: 10/21/2010 Primary Treating Physician: (original signature, do not stamp) I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not

violated Labor Code/139, Signature:

Executed at: Contra Costa County, CA Name: William B. Workman, MD

Address: 301 Lennon Lane, Ste. 100, Walnut Creek, CA 94598 Date: 10/21/2010

California License No.: A72343 Specialty: Orthopedic Surgeon

Phone: (925) 944-0110 Fax: (925) 944**90960**32

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California License No.: A72343

Phone: (925) 944-0110 Fax: (925) 944000033

Specialty: Orthopedic Surgeon

Name: William B. Workman, MD
Address: 301 Lennon Lane, Ste. 100, Walnut Creek, CA 94598

Executed at: Contra Costa County, CA

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Signature:\_

Name:

Address:

Executed at: Contra Costa County, CA

William B. Workman, MD

301 Lennon Lane, Ste. 100, Walnut Creek, CA 94598

Date: 01/06/2011

California License No.: A72343 Specialty: Orthopedic Surgeon

Phone: (925) 944-0110 Fax: (925) 9440096034

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" Iran coached maximum improvement), do not use this form. You may use DWC Forms PR-3 or PR-4 ika Basaka jira ilija <mark>1866 di</mark> esti ja subtra estika j<mark>a 1</mark>8 maa kina firma mandali ja ja e 🗝 📜 Naga kaleng papah didaga an Masara 🗖 Palasa Patient: Last M.I. Sex M Address City VALLEJO State CA Zip 94591 Date of Injury 10/03/2009 Date d Phone: 707-333-9258 Occupation SS# 5 Claims Administrator: Name YORK INSURANCE SERVICES Claim Number Address City State Phone Fax Employer name: CITY OF VALLEJO Employer phone The information below must be provided. You may use this form or you may substitute or append a narrative report. Subjective complaints: 1st post op right knee. Objective findings: **Diagnosis:** (Please indicate right or left) 1,836.1 - Lat. Meniscus tear ICD-9 2, 836.0 - Med. Meniscus Tear ICD-9 ICD-9 Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Next Appointment: Date of exam: 02/28/2011 Primary Treating Physician: (original signature, do not stamp) I declare under penalty of portions that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 189.30 Date: 02/28/2011 Signature: California License No.: A72343 Executed at: Contra Costa County, CA William B. Workman, MD Specialty: Orthopedic Surgeon Name:

101 Ygnacio Valley Road, Suite 400, Walnut Creek, CA 94596 Phone: (925) 944-0110 Fax: (925) 944**00003**5

Address:

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum improvement), do not use this form. You may use DWC France PR-I or PR-4. Chenkalistische von Heine der Streit aus revist. Die sanise in palmenische Diagonale Arthicere De papier von streit der Chen der einstelle sanisitie der Egyppische der Busie unter Eine Geschausten palitik von der Streit der Streit der Streit der der sanis Deutsche der Witselfer der Witselfer de Patient: Last First M.I. Sex M City VALLEJO State CA Zip 94591 Address Date o Date of Injury 10/03/2009 SS# 5 Phone: 707-333-9258 Occupation Claims Administrator: Name YORK INSURANCE SERVICES Claim Number Address \_\_\_\_\_ City State \_\_\_\_ Phone Fax 888-620-6919 Employer name: CITY OF VALLEJO Employer phone The information below must be provided. You may use this form or you may substitute or append a narrative report. Subjective complaints: Doing well. LOM is hold had a built of pan on medial sub Objective findings: **Diagnosis:** (Please indicate right or left) I. 836.1 - Lat. Meniscus tear ICD-9 2, 836.0 - Med. Meniscus Tear ICD-9 ICD-9 Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? well. in managest - CONTINUE PHYSICAL THERAPY 2X5 WEEKS to right knee Next Appointment: Date of exam: 03/21/2011 Primary Treating Physician: (original signature, do not stamp) I declare under penalty of perjury that this propert is true an correct to the best of my knowledge and that I have not violated Labor Code 139.3/./ Signature: Date: 03/21/2011

Name: William B. Workman, MD Specialty: Orthopedic Surgeon
Address: 101 Ygnacio Valley Road, Suite 400, Walnut Creek, CA 94596 Phone: (925) 944-0110 Fax: (925) 944000036

California License No.: A72343

Executed at: Contra Costa County, CA

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached massimum improvement), do not use this form. You may use DWC Forms PR-3 or PR-4. Company (span) interior of Section of Company (Company) is a supplied to the Company of the Company of Company The Company of Company The Company of Company Patient: Last First Sex M Address City VALLEJO State CA Zip 94591 Date of Injury 10/03/2009 Date d SS# 5 Occupation Phone: Claims Administrator: Claim Number Name City Address State Phone Fax Employer name: CITY OF VALLEJO Employer phone The information below must be provided. You may use this form or you may substitute or append a narrative report. Subjective complaints: 5 crylet **Objective findings:** MI do (1) **Diagnosis:** (Please indicate right or left) 1,836.1 - Lat. Meniscus tear ICD-9 2. 836.0 - Med. Meniscus Tear ICD-9 ICD-9 Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Next Appointment: Date of exam: 05/23/2011 Primary Treating Physician: (original signature, do not stamp) I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139 8. Date: 05/23/2011 Signature: Executed at: Contra Costa County, CA California License No.: A72343

Name:

Address:

William B. Workman, MD

Specialty: Orthopedic Surgeon

101 Ygnacio Valley Road, Suite 400, Walnut Creek, CA 94596 Phone: (925) 944-0110 Fax: (925) 944-0100 Fax: (925) 944-0110 Fax:

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(i.e., has reached macdanian improvement), do not use this form. You may use DWC Forms PK-3 or PR-4. effectivents in an initialist and respect to the contract of t Patient: Last First M.I. Sex M City VALLEJO State CA Address Zip 94591 Date of Injury 10/03/2009 Date of Occupation SS# 54 Phone: Claims Administrator: Name YORK INSURANCE SERVICES Claim Number City Address State Phone Employer name: CITY OF VALLEJO Employer phone The information below must be provided. You may use this form or you may substitute or append a narrative report. Subjective complaints: Objective findings: Diagnosis: (Please indicate right 1, 836.1 - Lat. Meniscus tear ICD-9 2, 836.0 - Med. Meniscus Tear ICD-9 ICD-9 Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? Matanii Matanii amatanii Afrika (1972) Next Appointment:\_ Primary Treating Physician: (original signature, do not stamp) Date of exam: 08/22/2011 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 139/8 Signature: Date: 08/22/2011 Executed at: Contra Costa County, CA California License No.: A72343 William B. Workman, MD Specialty: Orthopedic Surgeon Name: 191 Ygnacio Valley Road, Suite 400, Walnut Creek, CA 94596 Phone: (925) 944-0110 Fax: (925) 9440096039 Address:

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Signature:		Date: 04/28/2011
Executed at: Contra Costa Count		California License No.: A72343
Name: William B. Workma	n, MD	Specialty: Orthopedic Surgeon

101 Ygnacio Valley Road, Suite 400, Walnut Creek, CA 94596 Phone: (925) 944-0110 Fax: (925) 9440000040

Address:

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" discultural reactived reaccionare intercoverements do not use this form. You may use DWC Forms PR-3 or PR-4. Patient: Last First M.I. Sex M City VALLEJO State CA Zip 94591 Address | Date of Injury 10/03/2009 Date of SS# Phone: Occupation Claims Administrator: Name YORK INSURANCE Claim Number Address City Phone Fax Employer name: Employer phone The information below must be provided. You may use this form or you may substitute or append a narrative report. Subjective complaints: Knles skom & strength Objective findings: **Diagnosis:** (Please indicate right or left) 1,836.1 - Lat. Meniscus tear ICD-9 2, 836.0 - Med. Meniscus Tear ICD-9 3, 715.16 - DJD knee ICD-9 Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? sonefut from water therape n jura diugiar Next Appointment. Date of exam: 04/30/2012 Primary Treating Physician: (original signature, do not stamp) I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3 Date: 04/30/2012 Signature: Executed at: Contra Costa County, CA California License No.: A72343 Specialty: Orthopedic Surgeon Name: William B. Workman, MD

101 Ygnacio Valley Road, Suite 400, Walnut Creek, CA 94596 Phone: (925) 944-0110 Fax: (925) 9440000041

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me: William B. Workman, MD		Specialty: Orthopedic Surgeon
Idress: 101 Ygnacio Valley Road, Suite 400, Wa	alnut Creek, CA 9	94596 Phone: (925) 944-0110 Fax: (925) 944000

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary"

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Next Appointment. Date of exam: 10/30/2012 Primary Treating Physician: (original signature, do not stamp) I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not

violated Labor Code 179.3 eman, Signature:

Executed at: Contra Costa County, CA Name:

Specialty: Orthopedic Surgeon William B. Workman, MD

Date: 10/30/2012

California License No.: A72343

101 Ygnacio Valley Road, Suite 400, Walnut Creek, CA 94596 Phone: (925) 944-0110 Fax: (925) 941000044 Address:

Check the I	boxes which	indicate wh	ıy you are su	bmitting a	report at th	nis time.	If the pa	tient is "P	ermanent	and Stationary"
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	in keiluset tiid Kalkaristikusta
Patient:	M.I. Sex M
Address First City VALLEJO	M.I. Sex M State CA Zip 94591
Date of Injury 10/03/2009 Date of	State State Dip State
Occupation SS# 5	Phone:
	aim Numbe
Address City	StateZip
Phone 209-475-3102 Fa	x <u>866-548-2637</u>
Employer name: CITY OF VALLEJO  The information below must be provided. You may use this form or you not subjective complaints:	nployer phonenay substitute or append a narrative report.
Objective findings:  Now U-120°  MX UAD	
Diagnosis: (Please indicate right or left)	
1, 836.1 - Lat. Meniscus tear	ICD-9
2. 836.0 - Med. Meniscus Tear	ICD-9
3, 715.16 - DJD knee	ICD-9
Treatment Plan: (Include treatment rendered to date. List methods, free Specify consultation/referral, surgery, and hospitalization. Identify each pitype, frequency and duration of physical medicine services (e.g., physical to Use of CPT codes is encouraged. Have there been any changes in treatment with the company of the code o	hysician and non-physician provider. Specify therapy, manipulation, acupuncture).
	Next Appointment:
Primary Treating Physician: (original signature, do not stamp) 1 declare under penalty of perjury that this report is true and correct to the violated Labor Code 139.3.	Date of exam: 03/05/2013 best of my knowledge and that I have not
Signature: ///	Date: 03/05/2013
Executed at: Contra Costa County, CA Name: William B. Workman, MD	California License No.: <u>A72343</u> Specialty: Orthopedic Surgeon
Address: 101 Ygnacio Valley Road, Suite 400, Walnut Creek, CA 945	

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached manimum improvement), do not use this form. You may use DWC Forms PR-3 or PR-4. It specificates a distribute of the control of beauty of the rate of realistic stands. Will be the control of and an income programme of the contract of the Patient. Last M.I. Sex First City VALLEJO State CA Zip 94591 Address I Date of Injury 10/03/2009 Date d Occupation SS# Phone: Claims Administrator: Name york Claim Numbe Address City State \_ Phone 209-475-3102 Fax 866-548-2637 Employer name: Employer phone The information below must be provided. You may use this form or you may substitute or append a narrative report. Subjective complaints: Objective findings: **Diagnosis:** (Please indicate right or left) I . 836.1 - Lat. Meniscus tear ICD-9 2, 836.0 - Med. Meniscus Tear ICD-9 3. 715.16 - DJD knee ICD-9 Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why? vacilistemes en spinistres de la distinción de in the factor that which the firefall **# 1997 1997 1998 1999 1999** Control Problems and American Control of the Contro discrepenting a design of the speciment of the second seco Next Appointment: Date of exam: 11/04/2013 Primary Treating Physician: (original signature, do not stamp) I declare under penalty of porjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3 Date: 11/04/2013 Signature: Executed at: Contra Costa County, CA California License No.: A72343

Name:

Address:

William B. Workman, MD

Specialty: Orthopedic Surgeon

101 Ygnacio Valley Road, Suite 400, Walnut Creek, CA 94596 Phone: (925) 944-0110 Fax: (925) 9440000046

KAISER PERMANENTE Claim#:CVCH-546693 DOI:02:15-2014 Visit:03-04-2014 08:37 ReportDate:03-05-2014 Final:N P MR:01977909 WCABR: FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available): State of California Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2) Page 1
Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical (suprovement), do not use this form. You may use DWC Form PR-3

Patient will be permanently precluded from engaging it.     Patient's condition is permanent and stationary with re-     Patient will require future medical care.	in his/her usual sidual disabilit	and customary occupa on:	you must	these bostef are checked use Form PR-3 ive report.
14. Claims Administrator	Patient:	15. MR (		16. S
YORK INS SVCS	17. Name	MINICIPAL PAR		
PO BOX 619079	19. City V	ALLEIO	42	Zip 945918322
ROSEVILLE	20. DOI	21, DOB		22. Sex M
CA 95661	23. Phone			24. Fax
	25. Occu			
26. Phone (800) 422-7244 27; Fax (866) 548-2637	28. Clain		29, WCAB	

30. Employer Name: CITY OF VALLEJO

31, Employer Phone (707) 648-4355.

The information below must be provided. You may use this form or you may substitute or append a nametive report.

32. Subjective Complaints:

is a 49 Y male presents with left inner groin area pain.

Some improving, but still could not climb. PT once so far.

Prior treatment for this injury/liness: as above

Current complaints: as aboyé.

Review of Systems:

Constitutional: negative for fevers or chills

Musculoskeletal: negative for generalized myalglas/arthralgias

Skin: hegative for rash or pruritus

Neurological: negative for weakness, bowel/bladder incontinence, or

clumainess

Relevant Medications: none

Allergies: Review of patient's allergies indicates no known allergies. Social History: reports that he has never smoked. He does not have any

smokeless tobacco history on file.

Occupational History: date last worked: 02/15/14

Relevant Part Medical/Surgical History: Patient denies prior relevant injuries/surgeries and Prior industrial injury/surgery - bil knee-s/p

surgery

Relevant Family History: No relevant family history Hobbies/Leisure Activities: Patient denies any relevant

recreational/léisure activities

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

Physical Exam: no apparent distress

Gait: no antalgic

Left thigh - mild TTP at lateral groin area. No hernia, mild reduced ROM

with flexion and abduction, no brulse or swelling.

Can bear weight on left hip.

Additional Information Reviewed

Data Review: Reviewed radiology results: left hip no fx

Reviewed other records: HC notes reviewed

34. Diagnostic Studies Ordered:

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KAISER PERMANENTE-Claim#:CVCH-546693 DOI:02-15-2014 Visit:03-04-2014 08:37 ReportDate:03-05-2014 Final:N-P MR:01977909 WCAB#: FAC:VAL Contact:(707) 651-(370 Carrier DOI (if available): State of California Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2) Page 2 35. Diagnoses ICD-9 843.9 SPRAIN OR:STRAIN OP HIP OR THIGH (L) ICD-9 36. Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. SPRAIN OR STRAIN OF HIP OR THIGH Note: left, acute, improving Plan: Continue icing and NSAID I certify the medical necessity of the care and have reviewed and approve the Plan of Care. Continue PT Work Status: Modified duty advanced 3/4/2014 through 3/18/2014 Squat/kneel, knee bending: Not at all. Climb ladders; Not at all. Use of scaffolds/work at height; Not at all. Lift/carry/push/pull no more than 20 pounds. Return to Clinic: 3/18/2014 8:50 AM Causation: The stated mechanism is consistent with my clinical exam findings and no information has been presented that would indicate a cause other than the alleged employment event/exposure. 37, Have there been any changes in treatment plan? 38. If so, why 7 39. Other Physician/Non-Physician Providers: 40, Drugs; 41, Physical Medical Setvice: 42. Times per Week 43. Duration: 44. Hospitalization/Surgery Date 45, Hospitalization/Surgery 46. Consult/Other Services: Work Status: This patient has been instructed to: 47. Return to field duty on with no limitations or restrictions.
48. Return to medified work on 03-04-20|4 with the following limitations or restrictions. SEE #36. 50: 🔲 Patient discharged as cured (no permanent disability or need for faturé medical care). Patient is permanently precluded from engaging in his/fer usual and customery occupation and the above limitations/restrictions are deemed permianent.

KAISER PERMANENTE Claimé:CVCH-546693 DOI:02-15-2014 Visit:03-04-2014 08:37 ReportDate:03-05-2014 Final:NPatient P MR:01977909 WCAB#: FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available):
State of California Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Page 3

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L declare unde	reating Physician; (original si f penalty of perjury that this report is true tal to a physician or entity with whom the	and correct to th	a best-of my k	owledge and that I have	e not violated labor code 139:3 which
The Persone	nte Medical Group, Inc.			53. IRS Number 9	<del>4:</del> 2728480
Signature				Specialty	KOJ Occupational Health
Executed at	·-··	7		Signature Date	MAR 0 5 2014
54. Name	TANG, ZILUE	-	MD	55. California Lic#	100782A.
56. Addréss	975 Scieno Drive, Vallejo, CA, 94589	•		57. Phone	(707) (Validio Facility
					-7 a

KAISER PERMANENTE Claims: CVCH-546693 DOI:02-15-2014 Visic03-18-2014 08:53 ReportDate:03-19-2014 Final:N

P MR:01977909 WCAB#: FAC:VAL Contact:(707) 651-1370 Carrier DOJ (if available):

State of California Division of Workers' Compensation

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

Page 1

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum enedical improvement), do not use this form. You may use DWC Form PR-3

Patient will be permanently precluded from engaging i     Patient's condition is permanent and stationary with re     Patient will require future medical care	in his/her arust and customs	ry occupation If any of these boxes are checked you must use Form PR-3 or narrative report.
14. Claims Administrator	Patient:	15 3/P 01977909 16.
YORK INS SVCS	17. Name	
	18. Address so parcer.	VII DIRITO
PO BOX 619079	19. City VALLEJO	State CA Zip 945918322
ROSEVILLE	20. DOI 02-15-2014	21. DO 22. Sex M
CA 95661	23. Phone	24. Pax
	25. Occu	-
26. Phone (800) 422-7244 27. Fax (866) 548-2637	28. Claim	29. WCAB

30. Employer Name: CITY OF VALLEJO

31. Employer Phone (707) 648-4355

The information below must be provided. You may use this form or you may substitute or append a narrative report.

32. Subjective Complaints:

n is a 49 Y male presents with left inner groin area pain. Some improving, but still could not climb. PT 6x. Still sore with lifting left leg. Could not stretch the thigh out.

Prior treatment for this injury/illness: as above

Current complaints: as above.

Review of Systems:

Constitutional: negative for fevers or chills

Musculoskeletal: negative for generalized myalgisa/arthralgias

Skin: negative for rash or pruritus

Neurological: negative for weakness, bowel/bladder incontinence, or

clumainess

Relevant Medications: none

Allergies: Review of patient's allergies indicates no known allergies. Social History: reports that he has never smoked. He does not have any smokeless tobacco history on file.

Relevant Past Medical/Surgical History: Patient denies prior relevant injuries/surgeries and Prior industrial injury/surgery - bil knee s/p surgery

Relevant Family History: No relevant family history Hobbles/Leisure Activities: Patient denies any relevant

recreational/leisure activities

33. Objective Findings: (include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Physical Exam: no apparent distress BP 149/80 | Pulse 70 | SpO2 97%

Gait: no antalgic

Left thigh - mild TTP at lateral groin area. No hernia. mild reduced ROM

with flexion and abduction, no bruise or swelling.

Can bear weight on left hip.

Additional Information Reviewed

Data Review: Reviewed radiology results: left hip no fx

Reviewed other records: HC notes reviewed

34. Diagnostic Studies Ordered:

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# KAISER PERMANENTE Claim#:CVCH-546693 DOI:02-15-2014 Visici03-18-2014 08:53 ReportDate:03-19-2014 Final:N P MR:01977909 WCAB#: FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available): State of California Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Page 2

35. Diagnoses		
1st SPRAIN OF STRAIN OF HIP OR THIGH (L)		ICD-9 843.9
2nd		ICD-9
	•	
36. Treatment Plan: (Include treatment rendered to a consultation/referral, surgery, and hospitalization. Identification of physical medicine astrices (e.g., physical the SPRAIN OR STRAIN OF HIP OR THIGH Note: left, acute, r/o labrum tear Plan: MRA	fy each physician and non-physician provider. S	pecify type, frequency and
I have reviewed the Physical Therapy progress note	s. The patient has shown	
functional gains from therapy, specifically improved improvement in activities of daily living and reducti		
restrictions. I am requesting authorization for an add		
physical therapy over 3 weeks.  Work Status: Modified duty advanced 3/18/2014 th	maigh 4/1/2014 Smiat/knest, knes hending:	Not at all.
Climb ladders: Not at all.	torgi a mora calone suport mas entering.	
Use of scaffolds/work at height: Not at all.		
Lift/carry/push/pull no more than 20 pounds.  Return to Clinic: 4/1/2014 1:50 PM		
Causation: The stated mechanism is consistent with findings and no information has been presented that other than the alleged employment event/exposure.		44.000
37. Have there been any changes to treatment plan?	38. If so, why ?	
39. Other Physician/Non-Physician Providers:		
40. Drugs:		
41. Physical Medical Service:	42. Times per Week	43. Duration:
44. Hospitalization/Surgery Date 46. Consult/Other Services:	45. Hospitalization/Surgery	
Work Status: This patient has been instructed		*
47. Return to full disty on with no limit 48. X Return to modified work on 03-18-2014 with the	tations or restrictions. • following limitations or restrictions.	
49. Limitations:		,
see #36.		
50. Patient discharged as cared (no permanent disability	ty or need for future medical care).	hove ilmitations/restrictions

are degred permanent

# KAISER PERMANENTE Claim#:CVCH-546693 DOI:02-15-2014 Visit:03-18-2014 08:53 ReportDate:03-19-2014 Final:N P MR:01977909 WCAB#: FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available): State of California Division of Workers' Compensation

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

Page 3

## RECEIVED APR 01 2014.V **OSC West**

Primary Treating Physician: (original si	gnature, do not stamp	) 52. Date of exam 03-18-2014
I declare under penalty of perjury that this report is true a prohibits referral to a physician or entity with whom the		nowledge and that I have not violated labor code 139.3 which arcial interest.
The Permanente Medical Group, Inc.		53. IRS Number 94-2728480 KOJ Occupational Health
Signature	<del></del>	Specialty
Executed at		Signature Date
54. Name TANG, ZILUE 56. Address 975 Sereno Drive, Vallejo, CA, 94589	MD	55. California Lic# 100782A 57. Phone (7078/68-1)6399acHity

KAISÉR PER (ANENTE ChimitoCyCH: 546693 DOI:02-15-2014 Virk:04-01-2014 13:59 ReportDate:04-02-2014 Final:N P MR:01977909 WCAB#: FAC:VAL Comact:(707) 651-1370 Carrier DOI (If available): State of California Division of Workers' Compensation PRIMARY. TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Page 1

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement); do not use this form: You may use DWC Point PR-3. Partient will be permanently precluded from englighing in his/her using and customary occupation. If any of facts boxes are checked you wast use Form PR-J Patient's condition is permanent and stationary with residual disability on: 13. Patient will require future medical tare or narrative rep 14. Claims Administrator Patient 16. SSF YORK INS SYCS 17. Name 18. Addres PO BOX 619079 19. City VALLEJO 20. DOI 02-15-2014 21. State CA Zip 945918322 ROSEVILLE 22: Sex M CA-95661 23. Phon 24. Pax 25, Occo 26. Phone (800) 422-7244 27. Fax (866) 548-2637 28. Clain 29. WCAB 30. Employer Name: CITY OF VALLEJO 31. Employer Phone (707) 648-4355 The information below must be provided. You may use this form or you may substitute or append a narrative report. 32. Subjective Complaints: a 49 Y. male presents with left inner groin area pain. PT 8x. Still sore with lifting left leg. Could not stretch the thigh out. Overall symptoms no sig improving.

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Review of Systems:

Constitutional: negative for fevers or chills

Prior treatment for this injury/illnest: as above

Musculoskeletal: negative for generalized myalgias/arthralgias

Skin: negative for resh or prigritus

Current complaints: as above.

Neurological: negative for weakness, bowel/bladder incontinence; or

chimsiness

Relévant Medications: none

Aftergies: Review of patient's altergies indicates no known aftergies. Social History: reports that he has never smoked. He does not have any

amokeless tobacco history on file.

Relevant Past Medical/Surgical History: Patient denies prior relevant injuries/surgeries and Prior industrial injury/surgery - bil knee s/p surgery

Relevant Family History: No relevant family history Hobblet/Leisure Activities: Patient denies any relevant

recreational/leisure activities

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

Physical Exam: no apparent distress BP 129/68 | Pulse 89 | SpO2 98%

Gait: no antaigic

Left thigh - mild TIP at lateral groin area, No hernia, mild reduced RQM

with flexion and abduction, no bruise or swelling.

Can bear weight on left hip.

Additional Information Reviewed

Data Review: Reviewed radiology results: left hip no fx

Reviewed other records: HC notes reviewed

34. Diagnostic Studies Ordered:

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# KAISER PERMANENTE Claims: CVCH-546693, DOI:02-15-2014 Visit:04-01-2014 13:59 ReportDate:04-02-2014 Final:N Patient FMR:01977909 WCABs: FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available); State of California Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Page 2

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SPRAIN OR STRAIN OF HIP OR THIGH (L)	APR 15 2014 A		·
₽nd	OSC West		ICD-9
•	OCC WEST		
36. Treatment Plan: (Include treatment rendered to consultation/referral, surgery, and hospitalization. Ident furation of physical medicine services (e.g., physical the SPRAIN OR STRAIN OF HIP OR THIGH Note: left, acute, wo labrum tear	tify each physician and non-physi	cian provider. Spe	olfy type, frequency and
•			
MRA requested. Walting for appt: I certify the medical necessity of the care and have he Plan of Care. Continue PT	reviewed and approve		
Work Status: Modified duty if available 4/1/2014	through 4/15/2014 Squat/knee	, knee bending:	Not at all.
Climb ladders: Not at all.  Use of scaffolds/work at height: Not at all.			
Lift/carry/push/pull no more than 20 pounds.			
Return to Clinic: 4/15/2014 2:30 PM			
37. Have there been any changes in treatment plan?	? 38. If so, why ?		
39. Other Physician/Non-Physician Providers:	· -		
40. Drags:			
	, 15 TS-1	Work	43. Duration:
44. Hospitalization/Surgery Date	45. Hospitalization/	Surgary	
41. Physical Medical Service: 44. Hospitalization/Surgery Date 46. Consult/Other Services: Work Status: This patient has been instruct	45. Hospitalization/	Surgary	•
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44. Hospitalization/Surgery Date 46. Consult/Other Services:  Work Status: This patient has been instructed.  47. Return to full duty on with no lim 48. M Esturn to smolitted work on 04-01-2014 with the services.  SRE #36.  50. Patient discharged so cured (no permanent disability).  Patient is permanently precluded from engaging in are domest permanent.  Treating Physiciant: (original signal lare under penalty of perjury that this report is true and	45. Hospitalization/ ed to: justions or restrictions. he following limitations or restrictions tity or need for future medical curve in his/her usual and customary occu- nature, do not stamp) 52. correct to the best of my knowled	pation and the about Date of examing and that I have	04-01-2014
44. Hospitalization/Surgery Date 46. Consult/Other Services:  Work Status: This patient has been instructed. 47. Return to full duty on with as lim 48. X Esturn to sandified work on 04-01-2014 with it 49. Linitations: SEE #36.  50. Patient discharged as cured (as permanent disable of patient is permanently precluded from engaging in are deemed permanent.  mary Treating Physician: (original signal are under penalty of perjury that this report is true and libits referral to a physician or entity with whom the phy	45. Hospitalization/ ed to: justions or restrictions. he following Basitations or restricts tity or need for future medical curve n his/her usual and customary occu- esterre, do not stamp) 52. correct to the best of my knowled- rician has an unlawful financial	pation and the above Date of exame igo and that I have	04-01:-2014 not violated labor code 139.3 which
44. Hospitalization/Surgery Date 46. Consult/Other Services:  Work Status: This patient has been instructed.  47. Return to full duty on with no lim 48. X Esturn to smolified work on 04-01-2014 with it 49. Limitations:  SEE #36.  50. Patient discharged so cured (no permanent disability).  The patient is permanently precluded from engaging has are deemed permanent.  Interv Treating Physician: (original signal lare under penalty of perjury that this report is true and libits referral to a physician or entity with whom the phy Permanente Medical Group, Inc.	45. Hospitalization/ ed to: juitions or restrictions. he following finitations or restricts tity or need for future medical curve n his/her usual and customary occu- esterre, do not stamp) 52. correct to the best of my knowled- relcian has an unlawful financial 53.	pation and the above Date of exams the and that I have necest.	04-01-2014 not violated labor code 139.3 which KOJ Occupational Health
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44. Hospitalization/Surgery Date 46. Consult/Other Services:  Work Status: This patient has been instructed.  47. Return to full duty on with as lim 48. M Esturn to smolitted work on 04-01-2014 with the state of the services.  SRE #36.  50. Patient discharged as cured (no permanent disability).  The patient is permanently precluded from engaging have deemed permanent.  Interry Treating Physiciant: (original significare under penalty of perjury that this report is true and ibita referral to a physician or entity with whom the phy Permanente Medical Group, Inc.  Saure TANG, ZILUE	45. Hospitalization/ ed to: justions or restrictions. he following limitations or restricts  tity or need for future medical curve in his/her usual and customary occu- atture, do not stamp) 52. correct to the best of my knowled- relcian has an unlawful financial   53.  Spe  Sig MD 55	Date of examing and the short of examing and that I have necest.  (R.S. Number ciality	04-01-2014 not violated labor code 139.3 which will be to the labor co
44. Hospitalization/Surgery Date 46. Consult/Other Services:  Work Status: This patient has been instructed.  47. Return to full duty on with no lim 48. X Raturn to smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the state of the smodified work on 04-01-2014 with the	45. Hospitalization/ ed to: justions or restrictions. he following limitations or restricts  tity or need for future medical curve in his/her usual and customary occu- atture, do not stamp) 52. correct to the best of my knowled- relcian has an unlawful financial   53.  Spe  Sig MD 55	Date of examing and that I have need to the contract.  (RS Number contract)	04-01-2014 not violated labor code 139.3 which will be to the labor co

KAISER PERMANENTE Claim#:CVCH-546693 D&:02-15-2014 Patient: D1977909 WCAB#: FAC:VAL	4 Visit:04-15-2014 14:32 Re Contract:(707) 551-1320 (	sportDate:04-16-2014 Final;	Y
	Division of Worker		
PRIMARY TREATING PHY	SICIAN'S PROGR	ESS REPORT (PR	2) Page 1
Check the box(es) which indicate why you are submitti reached maximum medical improvement), do not use this form. Yo	u may use DWC Form PR-3	•	
01. X Periodic Report (required 45 days after last report	rt) 02. Change in tre	atment plan 03.   R	eleased from care
04. Change in work status 05. Need for referral o 07. Change in patient's condition 8. Need for surge			
10. Other:	ry or mospitalization	as:  wedgest for white	or madein
11. Patient will be permanently precluded from engaging			y of these boxes are checked
12. Patient's condition is permanent and stationary with r 13. Patient will require future medical care	esidual disability on:	•	must use Form PR-3 arrative report
14. Claims Administrator	Patient:	15. MR 01977909	16. SSN
YORK INS SVCS	17. Name		
DO POY 610000	18. Address 19. City V		Zip 945918322
PO BOX 619079 · ROSEVILLE	20. DOI 0		22. Sex M
CA 95661	23. Phone (		24. Fax
	25. Occupat		
26. Phone (800) 422-7244 27. Fax (866) 548-2637	28. Claim C		
30, Employer Name: CITY OF VALLEJO		Phone (707) 648-4355	•
The information below must be provided. You may use this	form or you may substitu	ite or append a narrative r	eport,
32. Subjective Complaints:			
is a 49 Y male presents with left inne			
FT 10x. Still sore with lifting left leg. Could not stretch			
Pain level is much less. MRA scheduled on 04/17/14 or	utside of kaiser		
Prior treatment for this injury/illness: as above .  Current complaints: as above.	,	•	
Allergies: Review of patient's allergies indicates no know	own allergies.		
Social History: reports that he has never smoked. He do			
smakeless tobacco history on file.	•	•	•
Relevant Past Medical/Surgical History: Patient denies			
injuries/surgeries and Prior industrial injury/surgery - b	il knee s/p		
surgery			
Relevant Family History: No relevant family history			
Hobbies/Leisure Activities: Patient denies any relevant recreations/leisure activities			
Lectesmona tereate sed Autres			
•		•	
33. Objective Findings: (include significant physica	l examination, laboratory	, imaging, or other diagn	ostic findings.)
Physical Exam: no apparent distress			
BP 145/80   Pulse 74   SpO2 98%		•	
Gait; no antalgic	nild sodneed POM		
Left thigh - mild TTP at lateral groin area. No hernia. r with flexion and abduction, no bruise or swelling.	IIIIQ ICQUÇEU KOM		•
Can bear weight on left hip.			
Additional Information Reviewed			
Data Review: Reviewed radiology results: left hip no f	x		
Reviewed other records: HC notes reviewed			
		•	
34, Diagnostic Studies Ordered:			
· · · · · · · · · · · · · · · · · · ·			
25 Diamoses	•		
35. <u>Diagnoses</u>		·	ICD-9 843.9
SPRAIN OR STRAIN OF HIP OR THIGH (L)			
			1CD-9
2nd			/

#### State of California Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Page 2

36. T	resiment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify
consul	tation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and
duratio	on of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged.
SPRA	IN OR STRAIN OF HIP OR THIGH (primary encounter diagnosis)
Note:	left, acute, r/o labrum tear
Pian:	PHYSICIANS REPORT, PR-2 TREATING PHYSICIAN'S PROGRESS REPORT

MRA 04/17/14 Work Status: Modified duty if available. Return to Clinic: 1 week to review MRI results.

The total visit time face to face with the patient was 15 min. I spent greater than 50% of this time counseling and in discussion with the patient. We reviewed injury, exam findings, pathogenesis, prognosis, work and medications.

MWP: 4/15-4/23/14: Squat/kneel, knee bending: Not at all.

Climb ladders: Not at all.

Use of scaffolds/work at height: Not at all.

Lift/carry/push/pull no more than 20 pounds.

F/U APPT ON 4/23/14 @ 4:30PM.

- 38, If so, why ? 37. Have there been any changes in treatment plan?
- 39. Other Physician/Non-Physician Providers:
- 40. Drugs:
- 41. Physical Medical Service:
- 44. Hospitalization/Surgery Date

42. Times per Week 45. Hospitalization/ Surgery 43. Duration:

46. Consult/Other Services:
Work Status: This patient has been instructed to:  47. Return to full duty on with no limitations or restrictions.  48. Return to modified work on 04-15-20 t4 with the following limitations or restrictions.  49. Limitations:  SEE #36
50. Patient discharged as cured (no permanent disability or need for future medical care). 51. Patient is permanently precluded from engaging in his/her usual and customary occupation and the above limitations/restrictions

KAISER PERMANENTE Claim#:CVCH-546693 DG:02-15-2014 Visic04-15-2014 14:32 ReportDate:04-16-2014 Final:Y
Patient PMR:01977909 WCAB#: FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available):
State of California Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Page 3

RECEIVED

APR 2 4 2014 A

OSC West

Primary 7	reating Physician: (original signature	e, do not stamp	52. Date of exam 04-15-2014		
	r penalty of perjury that this report is true and corrected to a physician or entity with whom the physician		owledge and that I have not violated labor code 139.3 which noted interest.		
The Permanente Medical Group, Inc.			53. IRS Number		
Signature _	· .		Specialty		
Executed at			Signature Date		
54. Name	TANG, ZILUE	MD	55. California Lic# 100782A -		
56. Address	975 Sereno Drive, Vallejo, CA, 94589	-	57. Phone (707) 651-1370		

v2.9

# STATE OF CALIFORNIA Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

and standard on the <b>Hillian Continue</b> the beautiful to t	Karandesia da Azada, aren 1 186 - Arrando di Arada, erren 1 Sentego 1881 - Espelo Arada	t applications on the Anti-Alemania and the Anti-Alemania (Anti-Alemania)				and Survey
	guis-rechinem.		Hall of the last		esta di de	
atient:						
Last Name	_ Middle Initial _	First Name	ALLEJO	Sex <u>M</u> [	ate of Birt	h 94591
AddressOccupation	Soc	City Cial Security Number	het		CA Zip	34001
Claims Administrator/Insure		our occurry raine		1	110110 110.	
Name YORK INSURANC	•	/#: 200909528	2	Phone Number	F:925-60	9-9264
Name Address						
		City				
mployer: Name CITY OF VALLE	IO					
		Ci.				
Address		City		State	Z.ip	·
Name Willam B. Workn	nan, MD			Phone Number	925 944-	0110
Name Willam B. Workn Address 101 Ygnacio Va	alley Road, Ste 400		alnut Creek	State	CA_Zip	94596
MANANAMAN CONTRACTOR MOST INTERPRETATION THE PRODUCT		HINIMATELLA MELLE MENTON MINERIO			HIN HANGHI KARN	
			State of the state			
10/03/2009				RIEGATEMENTING   FRANCISCO	0/22/44	A STATE OF THE STA
ate of Injury 10/03/2009  Date	Last date worked	Permanent & _ \cdot Stationary	5/ <b>22/11</b> Date	Date of current _	Date	
		•				
lescription of how injury/illn go to asbestos):	ess occurred (e.g. Hand	caught in punch	press; fell fron	height onto bac	k; exposed	25 years
njured at work						
atient's Complaints:						
oilateral knee pain						

## STATE OF CALIFORNIA Division of Workers' Compensation

#### PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

Relevant Medical History:

none

#### **Objective Findings:**

**Physical Examination:** Describe all relevant findings as required by the AMA Guides, 5<sup>th</sup> Edition. Include any specific measurements indicating atrophy, range of motion, strength, etc. Include bilateral measurements - injured/uninjured - for injuries of the extremities.

0-120 degrees ROM bilaterally medial and lateral joint line tenderness

Diagnostic tests results (X-ray/Imaging/Laboratory/etc.)

MRI shows lat men tear on right knee and med/lat meniscus tear on left

Diagnoses (List each diagnosis; ICD-9 code must be included)	ICD-9
I. mmt	836.0
2. Imt	836.1
3.	
4	

#### Impairment Rating:

Report the whole person impairment (WPI) rating for each impairment using the AMA Guides, 5<sup>th</sup> Edition, and explain how the rating was derived. List tables used and page numbers.

Impairment left med and lat	WPI% <b>4</b>	Table #(s). 17-33 p546	Page #(s)
Explanation			
Impairment right lat	<sub>WPI%</sub> 1	Table #(s). 17-33 p546	Page #(s)
Explanation			
Impairment	WPI%	Table #(s).	Page #(s)
Explanation			
Impairment	WPI%	Table #(s).	Page #(s)
Explanation			

#### STATE OF CALIFORNIA

#### Division of Workers' Compensation

#### PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

#### Pain assessment:

If the burden of the worker's condition has been increased by pain-related impairment in excess of the pain component already incorporated in the WPI rating under Chapters 3-17 of the AMA Guides, 5<sup>th</sup> Edition, specify the additional whole person impairment rating (0% up to 3% WPI) attributable to such pain. For excess pain involving multiple impairments, attribute the pain in whole number increments to the appropriate impairments. The sum of all pain impairment ratings may not exceed 3% for a single injury.

#### Apportionment.

Effective April 19, 2004, apportionment of permanent disability shall be based on causation. Furthermore, any physician who prepares a report addressing permanent disability due to a claimed industrial injury is required to address the issue of causation of the permanent disability, and in order for a permanent disability report to be complete, the report must include an apportionment determination. This determination shall be made pursuant to Labor Code Sections 4663 and 4664 set forth below:

Labor Code section 4663. Apportionment of permanent disability; Causation as basis; Physician's report; Apportionment determination; Disclosure by employee

- (a) Apportionment of permanent disability shall be based on causation.
- (b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.
- (c) In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.
- (d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments.

Labor Code section 4664. Liability of employer for percentage of permanent disability directly caused by injury; Conclusive presumption from prior award of permanent disability; Accumulation of permanent disability awards

- (a) The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.
- (b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden of proof.
- (c)(1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. As used in this section, the regions of the body are the following:
- A) Hearing
- (B) Vision.

## STATE OF CALIFORNIA

## Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

(C) Mental and behavioral disorders.				
(D) The spine.				
(E) The upper extremities, including the shoulders.				
(F) The lower extremities, including the hip joints.				
(G) The head, face, cardiovascular system, respiratory system, and all other systems or rein subparagraphs (A) to (F), inclusive.	egions of the body	not listed		
(2) Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100 percent.				
	Yes	No		
Is the permanent disability	ies	110		
directly caused, by an injury				
or illness arising out of and in the course of employment?	Ø			
Is the permanent disability caused, in whole or in part,				
by other factors besides this industrial injury or illness,				
including any prior industrial injury or illness?		☑		
If the answer to the second question is "yes," provide below: (1) the approximate p disability that is due to factors other than the injury or illness arising out of and in the co a complete narrative description of the basis for your apportionment finding. If yo apportionment determination in your report, state the specific reasons why you could r You may attach your findings and explanation on a separate sheet.	urse of employmen u are unable to ir	nt; and (2) nclude an		

**DWC Form PR-4** (Rev. 06-05)

## STATE OF CALIFORNIA Division of Workers' Compensation

#### PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT(PR-4)

Future Medical Treatment: Describe any continuing medical treatment related to this injury that you believe must be provided to the patient. ("Continuing medical treatment" is defined as occurring or presently planned treatment.) And describe any medical treatment the patient may require in the future. ("Future medical treatment" is defined as treatment which is anticipated at some time in the future to cure or relieve the employee from the effects of the injury) Include medications, surgery, physical medicine services, durable equipment, etc.

Comments: may need future MD visits, Physical Therapy, medications, and possible surgery.
Functional Capacity Assessment:
Note: The following assessment of functional capacity is to be prepared by the treating physician, solely for the purpose of determining a claimant's ability to return to his or her usual and customary occupation, and will not to be considered in the permanent impairment rating.
Limited, but retains MAXIMUM capacities to LIFT (including upward pulling) and/or CARRY:
[ ] 10 lbs. [ ] 20 lbs. [ ] 30 lbs. [ ] 40 lbs. [ ] 50 or more lbs.
FREQUENTLY LIFT and/or CARRY:
[ ] 10 lbs. [ ] 20 lbs. [ ] 30 lbs. [ ] 40 lbs. [ ] 50 or more lbs.
OCCASIONALLY LIFT and/or CARRY:
[ ] 10 lbs. [ ] 20 lbs. [ ] 30 lbs. [ ] 40 lbs. [ ] 50 or more lbs.
STAND and/or WALK a total of:
[ 1 Less than 2 HOURS per 8 hour day [ ] Less than 4 HOURS per 8 hour day [ ] Less than 6 HOURS per 8 hour day [ ] Less than 8 HOURS per 8 hour day
SIT a total of:
[   Less than 2 HOURS per 8 hour day

PUSH and/or PULL (including hand or foot controls):

[ ] UNLIMITED

[ ] Less than 4 HOURS per 8 hour day [ ] Less than 6 HOURS per 8 hour day [ ] Less than 8 HOURS per 8 hour day

[ ] LIMITED (Describe degree of limitation)

# STATE OF CALIFORNIA Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

#### ACTIVITIES ALLOWED.

Climbing Balancing Stooping Kneeling Crouching Crawling Twisting	Frequently [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	Occasionally [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	Never [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]	
Reaching Handling Fingering Feeling Seeing Hearing Speaking	[ ] [ ] [ ] [ ]			
Describe in what way <b>none</b>	s the impaired activities	s are limited:		
Environmental restric	tions (e.g. heights, mac	hinery, temperature e	xtremes, dust, fumes, humidity, vibration etc.)	
Can this patient now return to his/her usual occupation?			Yes ☑	No
List information you r Medical Reco patients chart		his report, or relied uj	oon for the formulation of your medical opinions:	
Written Job I				

# STATE OF CALIFORNIA Division of Workers' Compensation

#### PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT(PR-4)

Other.

verbal job description

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

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

Signature: WKWn leman, MD

(County and State)

Cal. Lic. #: **A72343** 

Executed at: Contra Costa, CA

Date: 08/26/2011

Name (Printed): William B. Workman, MD

Specialty Orthopedic Surgeon



#### William B. Workman, M.D.

101 Ygnacio Valley Road • Suite 400 • Walnut Creek, CA 94596 • Phone: 925.944.0110 • Fax: 925.944.0960 • www.calsportsdoc.com

May 22, 2014

York Insurance P.O. Box 619079 Roseville, CA 95661-9079

Date of Injury: 02/19/2014

Orthopedic Consultation

Dear Claims Adjustor,

CHIEF COMPLAINT

Left hip pain.

#### HISTORY OF PRESENT ILLNESS

Left hip - This is a 49-year-old firefighter who injured himself on the job fighting fires and injured his left hip. It has been very painful since then. He had an arthrogram MRI of his left hip on 04/17/2014, which shows a labral tear and cartilage tearing in his left hip. He has undergone physical therapy which hasn't helped and he is continuing to have pain.

#### PAST MEDICAL HISTORY

Detailed elsewhere in the chart.

#### PHYSICAL EXAMINATION

- 1. This individual exhibits symptoms of femoral acetabular impingement syndrome, including hip pain, which is primarily in the groin and interferes with activities of daily living.
- 2. The patient's radiographs confirm the diagnosis of femoral acetabular impingement syndrome (FAIS), with evidence of Cam impingement (with an alpha angle greater than 50 degrees), and/or pincer impingement (acetabular retroversion or coxa profunda).

The individual has failed conservative therapy for duration of at least six months, including (A) Activity modification with restriction of athletic pursuits if





- 3. any that include avoidance of symptomatic movements and (B) Treatment with NSAIDs or acetaminophen.
- 4. The etiology of the hip pain was confirmed by relief after injection of local anesthetic into the joint or the signs and symptoms of FAIS were so obvious that the injection was not performed due to the desire to avoid risk of injection in the presence of very obvious findings of FAIS.
- 5. The individual has minimal degenerative changes of the hip joint (Tonnis grade 1 or less and/or joint space of greater than 2 mm.
- 6. The individual has had no prior hip surgery or arthroscopy. If the patient has had prior hip surgery or arthroscopy, the surgery was not sufficient to remove all of the abnormalities associated with the FAI and needs to have further surgery to complete the job.
- 7. As an orthopedic surgeon who is double-board certified in Orthopedic Surgery and Orthopedic Sports Medicine including membership in the International Society of Hip Arthroscopy, it is my medical determination that the surgery is necessary for this patient.

He has pain with flexion and internal rotation of his hip. He has 5/5 strength in his lower extremities. His knee has full range of motion without instability. He is neurovascularly intact distally.

At this point the patient has failed conservative care for a hip labral tear injury. He will do best at this point with an arthroscopic repair, which will include a femoroplasty, acetabuloplasty, and labral repair. We will get this authorized and scheduled. He will require a hip brace, cold therapy, 24 visits of physical therapy. Once all this is authorized, we will proceed with the surgery.

Sincerely,

illiam B. Workman, M.D.

WBW/msh

# MD NOTE

Walnut Creek Orthopedics & Sports Medicine

Patient Name:			Date: _	05/22/2014
Birthdate:				
	5 — (L) lup 1	labul tea		

# WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

Name _	
Date 2/05/2010	
CHIEF COMPLAINT: (Please present complaints in patient's own words.)	
SWELLING & SEVERE PAIN OF LEFT KNEE MAINLY BEHIND THE KNEE	
DATE OF ONSET/INJURY: $10/8/2009$	
CAUSE: (If injury, please explain.)  WHILE WORKING ON AN ACTIVE FIRE, TRIP AND  SEKERAL TIMES WHILE RESCUING VICTIM TRAPP  IN FIRE	FEU ED
X-rays or MRI's brought to today's appointment.	
☐ X-rays or MRI's exist but not brought to today's appointment.	
□ No previous imaging done.	



### WILLIAM B. WORKMAN, M.D.

# Orthopedic Team Physician University of California Golden Bears

February 25, 2010

York Insurance Services 1390 Willow Pass Road, Suite 400 Concord, CA 94520

Re:	
Claim#:	
Date of Injury: '	10/03/09

Dear Claims Examiner:

who, as you know, is a 45-year-old firefighter who was fitting a fire on 10/03/09 and fell on to concrete once and then fell several more times in a hallway while trying to rescue a person from the home. He has been having pain in the knee since then. He does cycle which does not bother it but lateral movement is a considerable problem. He has had no other injuries to the knee.

#### PAST MEDICAL HISTORY

Past medical history is detailed as per in the chart.

#### PHYSICAL EXAMINATION

On physical examination, he is a well developed and well nourished gentleman in no acute distress. The skin over his bilateral lower extremities is intact. He is neurovascularly intact distally. The rest of the exam is per his chart.

KNEE	RIGHT	LEFT
Alignment	Neutral	Neutral
Effusion	None	None
PFC	None	None
Atrophy	None	None
Extension	0	0 with pain
Flexion	120	120 with pain
Lachman	Negative	Negative
Pivot shift	Negative	Negative
Posterior drawer	Negative	Negative
Valgus at 30 degrees	Negative	Negative
Varus at 30 degrees	Negative	Negative

#### February 25, 2010

Page 2

Tenderness		
Medial joint line	Negative	Negative
Lateral joint line	Negative	Positive
Inferior pole	Negative	Negative

#### **IMPRESSION**

Probable lateral meniscus tear.

#### **IMAGING STUDIES**

An MRI, which was done on 01/15/10, shows a probable extensive lateral meniscus tear involving the posterior and anterior horn.

#### **DISCUSSION**

Given the fact that this patient has not ever had surgery on his knee, he has lateral pain after his work-related injury and an MRI showing a lateral meniscus tear, I think he is a candidate for arthroscopy with partial lateral meniscectomy. We will get authorization for this procedure plus 24 visits of postop physical therapy. Once this is authorized, we will see him again for a preop appointment.

Thanks for including me in the care of this pleasant gentleman. Please contact me if any questions,

Sincerely Yours,

DICTATED BUT NOT READ

William B. Workman, M.D.

WBW/ssa

# **KNEE**

NAME		DATE: 02/25/2010
MECHANISM OF INJURY/COMPLAINT:		DOI:
PREVIOUS TREATMENT:		
		n /2 /09
RIGHT	LEFT	70/3/09
Alignment		
Effusion		Legating fine
PFC		fell on to
Atrophy		Concrete.
Extension		_
Flexion		Then fell in hallway
Lachman		tunce vescue
Pivot Shift		
Posterior Drawer		Eycly duennt
Valgus at 30 degrees		Eycly duennt bath it
Varus at 30 degrees		,
Tenderness		lateral moment ni
medial joint line	<u>-</u>	a resolution
lateral joint line		
inferior pole	<u> </u>	<u></u>
X-RAYS: Lut cung	0A m	offer sother upin
MRI:	Ju	les Ø
IMPRESSION:		
DI ANI		
PLAN:		

James T. Quintella, PA-C

William B. Workman MP

### PATIENT:

**DATE:** March 29, 2010

#### HISTORY OF PRESENT ILLNESS

This is a 45-year-old male with continued left knee pain x6 months. The patient presents for preoperative history and physical examination for his knee arthroscopy procedure scheduled for 03/31/2010. The patient states he has been in his normal state of good health with no problems.

#### PHYSICAL EXAMINATION

On physical examination, he is a well-nourished well-dressed 45-year-old male who looks stated age in no apparent distress. Left knee exam shows no gross deformity, discoloration, or open wound. The patient is with full range of motion of the left knee. No palpable effusion. There is tenderness to palpation in the lateral joint line. No gross instability. Left lower extremity is neurovascularly intact.

#### **IMPRESSION**

Left knee pain, most likely meniscus tear.

#### **PLAN**

- 1. Risks versus benefits were explained for left knee arthroscopic partial lateral meniscectomy. No guarantees were given. All questions were answered. The patient was in agreement. Consent was obtained.
- 2. I spent over 25 minutes in discussion with the patient in regards to preoperative, intraoperative, and postoperative care.

William B. Workman, M.D.

3. Preoperative history and physical paperwork was completed.

James Quintella, PA-C

JQ/av

### KNEE

NAME		DATE: 04/05/2010
MECHANISM OF INJURY/COMPLAINT:		DOI:
PREVIOUS TREATMENT.		
RIGHT /	LEFT 5:	
Alignment		
Effusion	truce 5 mg/	_
PFC		
Atrophy		<b>'</b> ,
Extension	o better t	ha
Flexion	0 better t	44.
Lachman	- Lynes	
Pivot Shift		
Posterior Drawer		
Valgus at 30 degrees		
Varus at 30 degrees		
Tenderness		
medial joint line		
lateral joint line inferior pole	<del>()</del>	
X-RAYS:		
MRI:		
IMPRESSION: (-duz un	el	
PLAN: (. PT stang	temmu @ Ben	cein Buy
7- F/V one		
	L.	William B. Workman MD
James T. Quintella, PA-C		vviniam B. Workman 1413

#### Services Include:

- Back + Neck Pain
- Sports + Work Injuries
- **Auto Injuries**
- **Arthritis**
- Knee Pain



- Ankle/Foot + Shoulder Pain
- Post Surgical Rehab
- Aqua + Alter G Antigravity Treadmills
- Performance Care

# **Patient Results Form**

ON FIRST VIST MY ROM WAS VERY ShORT AND my good, Glute STRENT WAS very weak. I felt myself getting stranger After every vist, my cardio also improved. I feel 5-8 more vists would improve my overAll leg strength & Fittness

Name:	
<b>—</b>	

 $\frac{115}{115}$  Ok to publish with initials only.

Date:

Therapist/Trainer:

SOL Physical Therapy Sports + Orthopedic Leaders

MD: Dr. William

Sports + Orthopedic Leaders

Sports + Orthopedic Rehabilitation • Active Release Technique® Providers • Manual Therapy Techniques • Pilates • Personal and Peak Performance Training

Two locations to serve you

5297-A College Avenue Oakland, California 94618 P 510.547.1630 F 510.923 1944 www.solpt.com 1510 Seabright Avenue Santa Cruz, California 95062 P 831.425.3588 F 831.425.3538

## WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

# MEDICAL HISTORY FORM

Patient	Name:						Па	te: 6	11/12
L		ATTONC.						~·· <del>/</del>	
-	KEU	ATIONS:							
Rejetic	>n	Age (if ilv	ring)		If deceased	, cause of death		Age at d	eath
Father Mother						4CT		76	
Brother:					75FK	AIN ClOT		2/3	
Sisters	3				730	"		7,	
Spouse					••				
Children	1								Ì
II. Have yo		NESSES: our relations	had any o	of the fo	llowing? (Spe	ecify <b>if you or your</b> relation	)		
ILLNES	SS		YES	NO	WHO	ILLNESS	YES	NO	LWHO
Rheuma		er	<del>-</del>		1	Hepatitis		ستن ا	
Glaucon	na			<u></u>	-	Asthma		•	SONT ZAUGAKI
Epilepsy	7			~		Kidney Stone			JAUGINER
Cancer				<u></u>		Gout	<i>'</i>	· _	FATHER
Heart D				<u></u>		Sickle Cell Anemia		V	<u> </u>
Tubercu				<del>                                     </del>	<u> </u>	Diabetes	_	10	
High Blo	ood Pres	ssure				Aliergies			
Have yo	u had a	RATIONS:	treatmen	ts or ope	erations? YE	55 NO	' UI	FIR	el/isrus.
Have yo	ou had a	any surgical and give γι	treatmen our age al	ts or ope	erations? YE	1: 472 46	47	frif	eviscus.
Have you	ou had a describe	any surgical and give you	our age al	: which t	hey occurred	: <u>49e 46</u>	47	Psp	eviscus.
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If yes, o	ou had a describe INJU	any surgical and give you  JRIES:	our age al	: which t	hey occurred	: <u>49e 46</u>	•		
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# WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

## MEDICAL HISTORY FORM

Page 2 of 2

v 11 48 4 v)	YES		l Y
gitalls (for heart)	1.55	Insulin	<del>- '</del>
ticoagulants (blood thinner)		Cortisone	
uretics (to remove fluid)		Sleeping Pills	
ugs to lower high blood pressure		Tranquilizers	
yrold		Asplrin	
rrent Medications (Please list dosage and frequ	iency):	N/A	
Frequent Headaches	have any of	the following? (Check only those which pertain  Vomiting of blood	
Frequent or severe dizziness		Vomiting of material resembling coffee of	rounds
Fainting or blackouts		Frequent vomiting	
Impaired Hearing		Recurring burning In stomach	
Worn/wear a hearing aid		Yellow jaundice	
Hay fever		Frequent diarrhea	
Frequent nose bleeds		Frequent constipation	
Impaired vision not corrected by glasses		Red blood in bowel movement	
Worn/wear glasses		Black, tarry bowel movements	
Pain or difficulty in swallowing		Hemorrholds (plies or rectal disease)	
Frequent hoarseness Lived with anyone with tuberculosis		Hernia	
i ived with anvoke with timerclings		Blood in urine Frequent or painful urination	
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Freduent sweating at night Chronic cough		Trouble starting or stopping urine	
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# WALNUT CREEK ORTHOPEDIO

				ם חבע ב	<u>1 of</u> 2			
					_			122/14
Patient Name	e: <sub>1</sub>					Dat	e: <b>5</b> /	122/14
I. RI	ELATIONS:						•	
Relation	Age (if liv	ing)	1		ause of death	A	ge at d	eath
<u>Father</u>				f/ea	<i>~</i> {		6'	7
<u>Mother</u> Brothers								
Sisters								
Spouse								
Children								
	LNESSES:	had any o	if the foi	linwing? (Specifi	y if you or your relation)	1		
	your resources						1 210	1100
<b>ILLNESS</b> Rheumatic F	On /Or	YES	NO NO	MHO _	ILLNESS Hepatitis	YES	NO NO	WHO
kneumatic r Glaucoma	CACI	+	*		Asthma	<b>Y</b>	<del>                                     </del>	SON/DANG
Epilepsy		1	~		Kidney Stone	<del>/~</del>	1	DALENTO
Cancer			<b>X</b>		Gout			
Heart Diseas		K		FATher	Sickle Ceil Anemia		1/2	
Tuberculosis		1	<u>~</u>		Diabetes		7	
High Blood F	ressure	İ	1	<u> </u>	Allergles		- to	
Have you ha			s or ope	erations? YES	<b>★</b> NO	- Z	₽ ₽	KNEES
Have you ha	d any surgical	treatment	s or ope	erations? YES		- L	‡ R	KNEES
Have you ha	d any surgical	treatment	s or ope	erations? YES	<b>★</b> NO	- L	‡ R	KNEES
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Have you ha  If yes, descr  IV. If	d any surgical libe and give you give y	treatment our age at accidents o	s or ope which t	erations? YES _	<u> №                                    </u>	- 4	<u></u> ‡ R	KNEES
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Please list other drug allergles \_\_\_

# WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

# MEDICAL HISTORY FORM

Page 2 of 2

	YES			YE
Digitalis (for heart)		Insu	in .	
Inticoagulants (blood thinner)		Corti		
Huretics (to remove fluid)			oing Pills	
Orugs to lower high blood pressure			quilizers	
Thyrold		Aspir	in	
Current Medications (Please list dosage and f	requency):		e Pamero en	
Have you ever had or do you curre	ently have any of	f the fo	ollowing? (Check only those which pertain	to you.)
Frequent or severe dizziness			Vomiting of material resembling coffee of	arounds
Fainting or blackouts			Frequent vomiting	<i>-</i>
Impaired Hearing			Recurring burning in stomach	
Worn/wear a hearing aid			Yellow jaundice	
Hay fever			Frequent diarrhea	
Frequent nose bleeds			Frequent constipation	
Impaired vision not corrected by glasse	S .		Red blood in bowel movement	
Worn/wear glasses			Black, tarry bowel movements	
Pain or difficulty in swallowing			Hemorrhoids (piles or rectal disease)	
Frequent hoarseness			Hernla	
Lived with anyone with tuberculosis			Blood in urine	
Frequent sweating at night			Frequent or painful urination	
1 1			Trouble starting or stopping urine	
Chronic cough			Urinate more than once at night	
Coughed up blood				
Coughed up blood Severe or recurrent chest pain			Prostate trouble	
Coughed up blood Severe or recurrent chest pain Pneumonia			Disabiling back pain	
Coughed up blood Severe or recurrent chest pain Pneumonia High blood pressure			Disabling back pain Worn a back brace	
Coughed up blood Severe or recurrent chest pain Pneumonia High blood pressure Heart murmur		<b>X</b>	Disabling back pain Worn a back brace Foot trouble	
Coughed up blood Severe or recurrent chest pain Pneumonia High blood pressure Heart murmur Shortness of breath on climbing stairs		××	Disabling back pain Worn a back brace Foot trouble Trick or locked knee	
Coughed up blood Severe or recurrent chest pain Pneumonia High blood pressure Heart murmur Shortness of breath on climbing stairs Pressure or tightness in chest		XX	Disabling back pain  Worn a back brace Foot trouble  Trick or locked knee  Painful or trick shoulder or elbow	
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Coughed up blood Severe or recurrent chest pain Pneumonia High blood pressure Heart murmur Shortness of breath on climbing stairs Pressure or tightness in chest Pain or cramps in legs with waiking Irregular heart beat		XX	Disabling back pain  Worn a back brace Foot trouble  Trick or locked knee Painful or trick shoulder or elbow Blood disorder  Tendency to bleed	
Coughed up blood Severe or recurrent chest pain Pneumonia High blood pressure Heart murmur Shortness of breath on climbing stairs Pressure or tightness in chest Rain or cramps in legs with walking		X	Disabling back pain  Worn a back brace Foot trouble  Trick or locked knee Painful or trick shoulder or elbow Blood disorder	



# WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

Name	
Date _	5/22/2014

CHIEF COMPLAINT: (Please present complaints in patient's own words.)

PAIN IN LEFT HIP Flexor

DATE OF ONSET/INJURY: 2/15/2014

**CAUSE:** (If injury, please explain.)

while fighting a Bedroom fire I Fell Through
A second STORY Floor, STRAINING MY LOFT Hip
Flexor

X-rays or MRI's brought to today's appointment. SENT by PORK INSURANCE

- ☐ X-rays or MRI's exist but not brought to today's appointment.
- ☐ No previous imaging done.



#### CITY OF VALLEJO Workers' Compensation Management Program INITIAL INJURY PACKET



								LE STATUS REPUR IDENTIAL INFORMATIO	
EMDI OALL NAME		DATE	OF INJURY			A	PPT, DATE:	TIME IN: TIME OUT.	
			10-	· 3~C	9	1	10-21-10	1315 1345	
1 PROORD #		DATE	OF BIRTH:		Ī	N.	EXT APPT. DATE:	INJURY TYPE:  Recordable First Aid	
Dr. Initial: "Yes, I have rev	iewed the	Employ	ee's Usu	al & Cus	tomary	job desci	ription prior t	o addressing work status."	
INJURY/TREAT	MENT					W	ORK STATU	S	
TYPE OF INJURY:				A. RELEA	SED TO U	SUAL & CU	STOMARY ON (Da	le):	
PHYSICAL THERAPY:			図	B. RELEA	SED TO R	ESTRICTED	DUTY ON (Date):	10/21/10	
sessions per week for v	veeke		<del> </del>	C. TOTAL	TEMPOR	ARY DISABI	LITY EFFECTIVE	. , .	
SURGERY SCHEDULED?:			<del></del>	D DEEDA	4 > 170 > 171 9 37	DICADII ED	EDOM:		
□NO □YES, DATE: □ D. PERMANENTLY DISABILED FROM USUAL & CUSTOMARY EFFECTIVE (Date):									
ī			337	ODV AD	TT TEST	<b>C</b>			
	Marino	um hou		ORK AE			tivity per day	•	
	No	6	4	2	1	0	tivity per day		
Sitting	restriction	hours	hours	hours	hour	houre		COMMENTS	
Standing/Walking				H	H				
Kneeling/Crawling/ Squatting	õ					≅'			
Climbing									
Laying Back/Stomach	9 <b>2</b> 3′								
Bending			□						
Twisting Pushing/Pulling			H				Wainha limitati	lana.	
	<u>L.J</u>			ئيا			Weight limitati	ions.	
HAND/ARM USE:	67								
Reaching Overhead Reaching Above Shoulder	H	H	片	님	H	Ħ			
Fine Manipulation	H	H	H	H	H	H			
Keyboard/Mouse Use	計	Ħ	Ħ	Ħ	Ħ	Ħ			
Simple Grasping	Ħ	♬			<u> </u>				
Power Grasping	<u></u>								
LIFTING/ CARRYING:							Specify height	limitations for each restriction:	
0-10 lbs.				□					
11-25 lbs.				₩					
26-50 lbs.	님	님	님	片	님				
51-75 lbs. 76+ lbs.	H	H	H	H	H	H			
Can Employee work entire shi	<del></del>				 ≹Yee □	 ]No If n	o, how many hou	ra?	
Does Employee need periodic a						No If y	es, how often?	every 2 hrs.	
Can Employee operate/work a		equipm	ent?			<b>-</b>			
Can Employee work at beights Is Employee on any medication		work shi	lien?	_		No If y	es, explain:		
16 Employee on any medication	I mar anects	WOLK AD	шьу;	<u> </u>	1166 7	y No 11 y	es, explail.		
I declare under penalty of perjury that to	the best of my i	oformation e	PHYSIC and belief I have	e not violated	California L	abor Code Becti	ion 189.5 and have not	offered, delivered, received or accepted any	
rebate, refund, commission, preference.	al Therapy		; or other cons ther:	instantin in s	mà Latellat IO	r exermiterion	or eastrained by 2 byla		
NAME			SIGNAT	VIII	<i>.</i>	ħ.	DAT	<u> </u>	
THEPHONE WY - OCH	<u>nan,s</u>	νι <u>]</u>	1 (11)	<u>1240</u> 25- 9	44-1	2960	E-M	10/21/10 vii:	

If you have any questions about this form or comments regarding the employee's work status, contact the City of Vallejo, Risk Management Division at (707) 648-4355.

AND give completed original to Employee to return to Department Workers' Compensation Contact.

Initial Distribution: Treating Physician Envelope

PHYSICIAN: Fax to City of Vallejo, Risk Management Division at (707) 649-5443

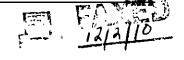
From: 707 6485289

CITYOFVALLE			ompens	BATION I	Managi	EMENT	Program		PHYSICIAN COMPLETS				
;							EMPLOYE						
BMPLÖYRE NAME:	•	DATE	OF INJUR	(: /		_	APPT. DATE:	TIMEDI:	NFORMATION TIME OUT:   1600				
MEDICAL RECORD #		DATE	10-3-09										
De lattic "Yes, I have revi	lewed th	Employ	ee's Usu	al & Cu	stomary	Job des	cription prior to	ddressing	work status."				
injury/treati	MENT				_		WORK STATUS						
TYPE OF INJURY TOEN L M	enisc	do _					UBTOMARY ON (Deta):		"				
PHYSICAL THERAPY:			B. RELEASED TO RESTRICTED DUTY ON (Dote): //- 24-/0										
ATTRIBUTE OF HEIGHT BIDS			C. TOTAL TEMPORARY DISABILITY EFFECTIVE (Date):										
DNO DATES, DATE. 3/3	///0		D. PERMANENTLY DISABILED FROM USUAL & CUSTOMARY SPECITIVE (Dose):										
WORK ABILITIES													
	Maxi No	num hou	rs Emplo	yes can	perfort	n esch s	ctivity per day	*					
Sitting	restrictio	g hours	hours	Lours	hour	hours		COMMENTS					
Standing/Wolking Knocling/Oraw)ing/ Squatting Climbing	00-,		مممد	וםססנ									
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PHYSICIAN: Fax to City of AND size come	HYSICIAN: Fox to City of Vallejo, Risk Management Division at (707) 649-5448  AND size completed critical to Employee to return to Department Workors' Compensation Contact.												

If you have any questions about this form or comments regarding the employee's work status, contact this City of Vallejo, Risk Management Division at (707) 848-4855.

Initial Distribution: Treating Physician Revelops

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F4 707-648-5289 Dets: 11/30/2010 9:05:00 AM From: 707 6485289 Page: 1/1

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This fax was recieved by Stryker's OrthoPed softwere, www.stryker.com

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From: 707 6485289

# CITY OF VALLEJO WORKERS' COMPENSATION MANAGEMENT PROGRAM

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PHYSICIAN: Fax to City of Vallei AND give completed or	o, Risk Manage		(707) 649-5	448	pensation Contag	<u> </u>	
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# CITY OF VALLEJO WORKERS' COMPENSATION MANAGEMENT PROGRAM INITIAL INJURY PACKET



EMPLOYEE STATUS REPORT

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contact the City of Vallejo, Risk Management Division at (707) 648-4855.

Initial Distribution: Treating Physician Envisions

PAGE



# CITY OF VALLEJO WORKERS' COMPENSATION MANAGEMENT PROGRAM

PHYSICIAN

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PHYSICIAN: Fax to City of Vallojo, Risk Management Division at (707) 649-5448

AND give completed original to Employee to return to Department Workors' Compensation Contact. If you have any questions about this form or comments regarding the employee's work status, contact the Dity of Vallejo, Risk Management Division at (707) 648-4255.

Initial Distribution: Treating Physician Brusiope

PACE 3

# CITY OF VALLE TO WORKERS' COMPENSATION MANAGEMENT PROGRAM INITIAL INJURY PACKET



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If you have any questions about this form or comments regarding the employee's work status, contact the Dity of Vallejo, Rick Management Division at (707) 648-4856.

Initial Distribution: Treating Physician Bayespe

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Initial Distribution: Treating Physicism Envelops

PAGE 5

Initial Evaluation

Patient:

Exam Date: 4/6/2010

Visits for problem: 1

Date of b

# Sex: M York 1390

ID: 554806211

10. 00400021

Group: 2009095282
Problem: S/P L Knee Partial Lateral menisectomy

Diagnosis: 836.1 Tear lat menisc knee-cur

Referred by: William Workman, M.D.

Phone: (925) 944-0110 Fax: (925) 944-0960

Physician Summary for

Benicia Bay Phyliscal Therapy

560 First Street Ste C 103

Benicia, CA 945103266

Phone: (707) 747-9977

Fax: (707) 747-9477

presents today s/p L partial menisectomy with complaints of abnormal gait pattern, limited ROM, decrease quad and hamstring strength, quadriceps muscle tightness,increased edema formation, increased pain levels and inability to perform all functional and vocational tasks without the presence of pain. I would like to see 2-3x/week for the next 4 weeks to address these impairments and prepare him for return to work and physical activity.

### **Subjective**

#### Case History

**Date of Surgery:** 3/31/10 pt had partial menisectomy of i., knee • **Onset Due To:** pt has been having pain in his L knee since an injury on the job in October of 2009 • **Surgery:** No unusual problems post op.

#### **Current Complaints**

Activities Aggravating Pain: sharp cutting, squatting and descending stairs • Pain Frequency: Intermittent, Daily • Pain Intensity at Worst; 5/10: Moderate Pain. • Pain Localization: Patient complains of pain in the following areas: over teh distal aspect of the quadriceps

#### Vocational

Current Status: Unable to work.

### **Objective**

#### Observation

Gait

Abnormality: Antalgic L. LE

Structural

Deformity: Swelling: +1 cm L vs R when measured at the superior pole of the patella

**Treatment Tolerance** 

Symptom Response to Today's Treatment: Good symptom relief - pt complains of less knee

stiffness post treatment

Page 1 of 2 Printed on: 4/7/2010 From: 7077479477 Page 3/3 Date: 4/7/2010 9:39:10 AM

# initial Evaluation for

4/6/2010

Referred by: William Workman, M.D.

Measurements 8	& Goals			
Left Knee		Measurements	Short Term Go	al Long Term Goal
Manuai Muscle	Hamstrings	4 /5	5 /5	5 /5
Test				
	Quadriceps	4 /5	5 /5	5 / <b>5</b>
ROM-Passive	Knee Extension	-5 degrees	0 degrees	0 degrees
		with pain at end range		
	Knee Flexion	110 degrees	130 degrees	130 degrees
			with p	pain at end range

#### Assessment & Plan

Care Plan: Short Term Clinical Goals

Manual Muscle Test: As stated in clinical measurements. • Pain at End Range: Improve pain at end range of all motions. • Range of Motion: As stated in clinical measurements. •

Tenderness: Eliminate all described tendemess.

Care Plan: Long Term Clinical Goals

Gait: Eliminate all documented gait abnormalities. • Manual Muscle Test: As stated in clinical measurements. • Pain at End Range: Eliminate pain at end range of all motions. • Range of Motion: As stated in clinical measurements. • Tenderness: Eliminate all described tenderness.

Thank you for the opportunity of working with your patient.

Shivani Mehta MPT
Signed 4/6/2010 4:14 PM
License # PT 25851

Signed 4/6/2010 2:59 PM

Page 2 of 2 Printed on: 4/7/2010 11

Phone: (707)447-8462 Fax: (707)447-8463

# "The Next Step" Physical Repair and Conditioning

PROGRESS REPORT / /
PATIENT NAME: DATE: 5/10/10
DOCTOR: Dr. CLAIM #
PRESCRIPTION: (2) Knee - worker therapy progress to came as followers
RECOMMENDATION: progues to com
NOTES: HAS 1657 complete his 10th sission in wester the raply
(WKS). HE HAS for POM in Both Leg oxforsion & Flexion Bot
continues to HAVE some swelling + pain whim the D Knee it
he postes too HAM. Standing in one place. I pain & swelling the most.
It is apparent that were use out ours mass + strength when
ampores to his Deg-He exhibited a mis Antaigic gait when
storting water Therapy that is now seas noticenede. The compensation
BEHOVIORS be HAN From his D KNE injury Are now CAOSINg his
P) Hip Plexor pain. Water Horapy was seen iseas for as
all of his LE issues are being appressed at The same tire -
We are encouraging to begin more land Loading activities
as to cerated to agin to suppose him for his RTW paties
Thank you for your referral; He HAS BEEN A PLEASANT AND
Thank you for your referral; He HAS BEEN A pleasant AND Kathel fring "Highly motivated Client.
Next Step Stape

Vacaville Phone: (707)446-2350 Fax: (707)446-3814



# "The Next Step" Physical Repair and Conditioning

PROGRESS REPORT / /
PATIENT NAME: DATE: 7/2/10
DOCTOR: WORKMAND CLAIM#_
PRESCRIPTION Ree
RECOMMENDATION: Progress to LAND -> WORK HOMENING FOR RTW 60.
NOTES: West completed another Hukes of water therapy
WIT LAND functional Training as forerated. Excessive LOADITY Stice
1 pain on @ Knee AND CAUSES swelling. We Apapted to
a 3xlock water program a ACANCED WIT A stationary DIKE.
2x last on mun tension for 30 min. This program HAS sollowed
to progress ranfortably and consistently the steer experiences
some (B) Hip pain from compensating remained but this is
Aeso 1 improving. HAS four floring mans extension, HAS
I his notregic gait Ann HAS I OWAD/HAM Strength, His
DUMO . 15 Still weak so we are Apping mai interse squatting
V Longing to P Piring - sis a "highly motivated
Client Ann A joy to work with - He Hopes to return to
Thank you for your referral; full puty status by August.
1 And On a Stage
Wielder



Sports + Orthopedic Leaders Physical Therapy, Inc. 5297A College Ave Oakland, CA 94618
P 510.547.1630 F 510.923.1944

#### Initial Evaluation

Patient Name: Referring Physician: Diagnosis:

William Workman, MD V67.00 Following

Following surgery, unspecifie d

836.2 Other

tear of cartilage or meniscus Date Seen: Patient ID: Date of Birth 2/21/2011 9241

Time in:

12:00 AM

Time Out:

12:00 AM

#### **Subjective**

#### **Current Condition**

#### Detalls

Chief Complaint: Pt notes long standing R/L knee pain for greater than 20 years. L knee; 3/2010 required medial and lateral meniscal repair. Currently pt is 4 days post-op R knee medial and lateral menisectomy,reports minimal pain during the day worse at night and responds well to pain medication. Pt goal to have Improved balance and strength in LE to resume athletic goals ( century rides, wind sprints)

Onset Date: 2/18/2011

Type of Injury: Workers compensation

Specific Injury: Chronic knee issues for 20 years. No true mechanism of Injury. Cumulative injuries while fighting

fires.

Surgery Date: 02/18/2011

Type of Surgery, Medial and lateral menisectomy

Occupation: Fire Fighter/Not full-duty

#### **Functional Status**

Functional Activity	Statu <b>s</b>	Level
Walk	Moderate Limitation	Current
Stairs	Moderate Limitation	Current
Running	Unable to Perform	Current
Recreational Sports	Unable to Perform	Current

Currently Working: No

#### Medical History

Surgery	Date Outco	me
R knee Medial/lateral	2/18/2011 Improv	red .
menisectomy		
L knee Medial/lateral	3/2010 Improv	/ed
menisectomy	-	

### **Objective**



Sports + Orthopedic Leaders Physical Therapy, Inc. 5297A College Ave Oakland, CA 94618
P 510.547.1630 F 510.923.1944

#### Observation

Patient noted to have decreased ability to WB fully through R LE d/t pain. Limited heel to toe contact, more of a foot flat contact with decreased WB time on R LE. Pt able to perform slt <>stand with fair glut/ham/quad control, however weight shift to L noted. Able to perform 1/4-1/2 squat (SBA, high low table in pt's reach)No steri strips, 2 incision sites clean. Swellling noted greatest on L incision site.

#### Knee

#### Knee - Active Range Of Motion

Motion	Right	Left
Flexion	100 Degrees	120 Degrees
Extension	-5 Degrees	0 Degrees

#### Knee - Passive Range Of Motion

<u>Measurement</u>	Right
Flexion	110 Degrees
Extension	0 Degrees

Tight end feel into flexion, pain reported popliteal fossa. Mild swelling noted in this areaincreased tension noted along semi ten and semi mem tendons -Popliteal bursa

#### Knee - Girth

Measurem <b>ent</b>	Right	
4 cm above joint line	43 cm	-
4 cm below joint line	39 cm	

#### Knee - Muscle Testing

Measurement	Right Strength	Left Strength
Gastrocnemius	4+/5 ( \$L calf	5/5 ( SL calf
	raise)	raise)
Hamstring	5-/5	5/5
Quadriceps	<b>5-</b> /5	5/5
Tibialis Anterior	5-/5	5/5
Gluteus Medius	4+/5	5/5
Gluteus Maximus	5-/5 (prone)	5-/5 (prone)
Peroneus Longus/brevis	5-/5 "	<b>5-</b> /5

1/4-1/2 squat weight shift noted to lift, decreased use of gluts and quads on R side

#### Knee - Special Tests

Special Test

Deferred secondary to recent surgery

#### Knee - Joint Mobility

Joint	Force Direction	End-Feel
Patellofemoral	lateral/medial Glide	Boggy

Swelling present post patellar regionNo pain with glides or limitations noted. Hip AROM with functional limits: Obers positive on R>L, increased hip flexor tightness on R>L. SLR: 110 B, overall good hamstring flexibilityThomas position: Increased tightness noted through rectus femoris, illiopsoas, IT R>L

#### Palpation

Increaed tension noted throughout R iTB to lateral L knee retinaculum. Mild point tenderness. Increased adhession throughout ITB and hamstring interface.

Full Initial Evaluation (2/21/2011) -



Sports + Orthopedic Leaders Physical Therapy, Inc. 5297A College Ave Oakland, CA 94618 P 510,547,1630 F 510,923,1944

#### Assessment

#### Descriptions

Patient presents with post operative symptoms following arthroscopic surgery of the R knee, medial and lateral meniscectomy.

Patient educated about injury and was involved in the development of physical therapy goals.

#### Problem List

#### **Problems**

Decreased participation in recreational activities

Pain limits functional activities

Decreased ROM

Joint Swelling

Decreased strength

Gait Impairment

#### Plan

als		
Length	Status	Goal
Long Term	Not Met	<ol> <li>Independent with Home Exercise Program to continue improvement and prevent future injuries.</li> </ol>
Long Term	Not Met	2 Full Return to Activities in 6 weeks.
Short Term	Not Met	2a. Increase ROM to WNL in 4 weeks.
Short Term	Not Met	2b. Decrease Pain to allow painfree return to modified activities in 4 weeks
Short Term	Not Met	2c Increase Strength to WNL in 4 weeks.
Short Term	Not Met	2d. Decrease joint swelling to equal uninvolved side in 4 weeks.
Long Term	Not Met	3. Patient to demonstrate good balance on multiple surfaces in 6 weeks.
Short Term	Not Met	<ol> <li>Patient to demonstrate normal gait on multiple surfaces without gait deviations 4 weeks.</li> </ol>

#### Treatment Plan

Recommend Physical Therapy 2 time(s) a week for 6 week(s), with treatments to consist of: Flexibility (97110) - active and passive patient stretching. Gait Training - 97116; Improve overall gait function including stair climbing, Progressive Strengthening (97110) - Strength training, ROM (97110) - Passive or active activities to increase joint range of motion, Therabeutic Exercise 97110. Improve muscle strength, ROM, flexibility, and muscle function, Cryotherapy- 97010; Application of cold to decrease local swelling and decrease pain, IFC E-Stim- 97014 Application of E-Stim to modulate pain, Ultrasound- 97035, increase local circulation, improve tissue healing time, and modulate pain, Manual Stretching- 97140; passive or active stretching to improve muscle length and function, Soft Tissue Mobs- 97140: increase ROM tissue length, joint mechanics, and modulate pain, Plyometrics (97110) - Increase neuromuscular efficiency of muscle tissue.

#### Initial Treatment

- Patient Education Initial Evaluation Pt, understood injury and its management.
- Home Exercise Program See notes / handouts
- Modality Cryotherapy 10 Minutes
- Modality IFC E-Stim pain control, no skin irritation.
- Manual Soft Tissue Massage Refer to Treatment Flow Sheet
- Manual Stretching Refer to Treatment and Exercise Flow Sheet
- · Graston/\$TM R ITB, R lateral retinaculum

Full Initial Evaluation (2/21/2011)



Sports + Orthopedic Leaders Physical Therapy, Inc. 5297A College Ave Oakland, CA 94618
P 510.547.1630 F 510.923.1944

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X					
Ada Jauregui License # 36256					
(Document electronically signed by TheraOffice Docum	ientation)				
2/21/2011					
To Be Completed By Physician:					
have no revisions to this plan of care	Prognosis:	Excellent	Good	Fair	Poor
Revise plan of care as follows					_
Discharge Patient	Continue _	times per	for_	weeks /	months
Physician Signature: WKWn Vern com In signing this document, physician certifies that prescr	MAY)	)ate:			
In signing this document, physician certifies that prescr	はんちんだんのかな	a nedical nece	ssity.		
	By William B. Wor	kman MD at 9	01 am Fah	28 2011	
	by William D. Wo	minuti mp at 9	or certain co		



Sports + Orthopedic Leaders Physical Therapy, Inc. 5297A College Ave Oakland, CA 94618 P 510.547.1630 F 510.923.1944

# **Progress Note**

Patient Name:

Referring Physician: Diagnosis:

V67.00

William Workman, MD Following surgery,

unspecifie

836.2 Other

cartilage

kne

Date Seen: Patient ID: Date of Birth:

3/17/2011

9241

tear of

meniscus

### **Subjective**

#### Subjective Findings

Pt notes cont'd improvement since attending PT. Pt's AROM improved, no pain, swelling minimal.

#### Functional Statue

Functional Activity	Status	Level
Walk	Mild Limitation	Current
Stairs	Mild Limitation	Current
Running	Unable to Perform	Current
Recreational Sports	Unable to Perform	Current

Currently Working: No

### Objective

#### Todays Treatment

- Patient Education On going Pt. understood injury and its management.
- Home Exercise Program See notes / handouts
- Modality Cryotherapy 10 Minutes
- Modality IFC E-Stim pain control, no skin irritation.
- Manual Soft Tissue Massage Refer to Treatment Flow Sheet
- Manual Stretching Refer to Treatment and Exercise Flow Sheet

AROM: flexion 115 dgrs, extension -5AROM: post manual work: flexion 118, extension -5Increased adhessions: quad ITB interface

#### Observation

Gait minimal deviation noted during stance phase. No pain with full weight bearing when gait corrected. All transitional mymnts performed with good mechanics. SLB, and squat form noted fair -good form. Lacking full glut and quad recruitment.

#### Knee

Knee - Active Range Of Motion

	2/21/2011		3/17/2011	
Motion	Right	Left	Right	Left
Flexion	100 Degrees	120 Degrees	115 Degrees	120 Degrees

Progress Note / Dally Note (3/17/2011) -





Sports + Orthopedic Leaders Physical Therapy, Inc. 5297A College Ave Oakland, CA 94618 P 510,547.1630 F 510.923.1944

Extension -5 Degrees 0	Degrees -5 (	Degrees 0 (	Degrees
------------------------	--------------	-------------	---------

#### Knee - Gross Strength

Motion	
Flexion	
Extension	

#### Knee - Passive Range Of Motion

	2/21/2011	3/17/2011
Measurement	Right	Right
Flexion	110 Degrees	120 Degrees
Extension	0 Degrees	0 Degrees

#### Knee - Muscle Testing

	2/21/2011		3/17/2011	
Measurement	Right Strength	Left Strength	Right Strength	Left Strongth
Gastrocnemius	4+/5 ( SL calf	5/5 ( SL calf	5/5	5/5 ( SL calf
	raise)	raise)		rai <b>se</b> )
Hamstring	<b>5</b> -/5	5/5	5-/5	5/5
Quadriceps	5-/5	5/5	5-/5	5/5
Tibialis Anterior	5-/5	5/5	5-/5	<b>5</b> /5
Gluteus Medius	4+/5	5/5	4+/5	5/5
Gluteus Maximus	5-/5 (prone)	5-/5 (prone)	5-/5 (prone)	5-/5 (prone)
Peroneus Longus/brevis	5-/5 <sup>"</sup>	5-/5 "	5-/5	5 <b>-/</b> 5

#### Knee - Joint Mobility

_	3/17/2011	
Joint	Force Direction	End-Feel
Patellofemoral	lateral/medial Glide	Normal
e - Joint Mobility		
-	2/21/2011	
Joint	Force	End-Feel
	Direction	
Patellofemoral	lateral/medial Glide	Boggy

#### **Palpation**

Increaed tension noted throughout R ITB to lateral L knee retinaculum. Mild point tenderness. Increased adhession throughout ITB and hamstring interface.

#### **Assessment**

#### **Descriptions**

Pt making progress as expected. Pt however is noted to have functional strength deficits as noted with squat form, eccentric quad loading while descending a 7 inch step. Pt will benefit from cont'd PT for strengthening to return to full/modified duty.

#### Problem List

#### **Problems**

Decreased participation in recreational activities

Progress Note / Daily Note (3/17/2011) -



Sports + Orthopedic Leaders Physical Therapy, Inc. 5297A College Ave Oakland, CA 94618
P 510.547.1630 F 510.923.1944

Pain limits functional activities
Decreased ROM
Joint Swelling
Decreased strength
Gait Impairment

#### Plan

Length	Status	Goal
Long Term	Met	<ol> <li>Independent with Home Exercise Program to continue improvement and prevent future injuries.</li> </ol>
Long Term	In Progress	2. Full Return to Activities in 6 weeks
Short Term	In Progress	2a. Increase ROM to WNL in 4 weeks.
Short Term	Met	2b. Decrease Pain to allow painfree return to modified activities in 4 weeks.
Short Term	In Progress	2c. Increase Strength to WNL in 4 weeks.
Short Term	In Progress	2d Decrease joint swelling to equal uninvolved side in 4 weeks.
Long Term	In Progress	3. Patient to demonstrate good balance on multiple surfaces in 6 weeks.
Short Term	In Progress	4 Patient to demonstrate normal gait on multiple surfaces without gait deviations 4 weeks.

#### Treatment Plan

Recommend Physical Therapy 2 time(s) a week for 5 week(s), with treatments to consist of: Flexibility (97110) - active and passive patient stretching, Gait Training - 97116: Improve overall gait function including stair climbing, Progressive Strengthening (97110) - Strength training, ROM (97110) - Passive or active activities to increase joint range of motion, Therapeutic Exercise - 97110: Improve muscle strength, ROM, flexibility, and muscle function, Cryotherapy- 97010. Application of cold to decrease local swelling and decrease pain, IFC E-Stim- 97014: Application of E-Stim to modulate pain, Ultrasound- 97035: increase local circulation, improve tissue healing time, and modulate pain, Manual Stretching- 97140: passive or active stretching to improve muscle length and function, Soft Tissue Mobs- 97140: increase ROM tissue length, joint mechanics, and modulate pain, Plyometrics (97110) - Increase neuromuscular efficiency of muscle tissue.

Ada Jauregui Licer se #: 36256

(Document electrodically signed by TheraOffice Documentation) 3/21/2011

3/21/2011

Logic Completed By Physician:

I have no revisions to this plan of care Prognosis: \_\_\_\_ Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_\_ Revise plan of care as follows \_\_\_\_ Discharge Patient Continue \_\_\_\_ times per \_\_\_\_ for \_\_\_\_ weeks / months

WBWn leman MD APPROVED

By William B. Workman, MD at 12:02 pm. Mar 21, 2011

Progress Note / Daily Note (3/17/2011) -



#### Sports + Orthopedic Leaders Physical Therapy, Inc.

5297A College Ave Oakland, CA 94618 P 510.547,1630 F 510.923.1944

vears old)

9241

## **Progress Note/Discharge Summary**

Patient ID:

Date of Birth:

Patient Name:

Referring Physician: Diagnosis:

William Workman, MD V67.00

Following surgery,

unspecifie

836.2

Other tear of cartilage

> or meniscus kne

Subjective

#### Subjective Findings

Pt notes cont'd improvement since attending PT. Pt has intermittent knee pain with increased activity such as climbing stairs (repetitively >5 times), increased WB exercises such as repetitive squatting or lunging.

#### **Functional Status**

Functional Activity	Status	Level
Walk	Mild Limitation	Current
Stairs	Mild Limitation	Current
Running	Moderate Limitation	Current
Recreational Sports	Severe Limitation	Current
Currently Working, No		

### **Objective**

#### Observation

No deviation noted with gait. No swelling observed. 1/2 squat good form, past 1/2 squat position increases discomfort to B knees. Kneeling for greater than 10 minutes discomfort reported to B knees. Stepping up onto a surface greater than 23 inches, pt notes mild discomfort to B knees, motion is compensated by circumducting hip. Hopping greater than 10 times, discomfort to B knees.

#### Knee

#### Knee - Active Range Of Motion

	2/21/2011		4/14/2011	
Motion	Right	Left	Right	Left
Flexion	100 Degrees	120 Degrees	120 Degrees	120 Degrees
Extension	-5 Degrees	0 Degrees	0 Degrees	0 Degrees

#### Knee - Gross Strength

Motion	
Flexion	
Extension	

#### Knee - Passive Range Of Motion

Full Progress Note (4/14/2011) -

Page 1

From: FAX



#### Sports + Orthopedic Leaders Physical Therapy, Inc. 5297A College Ave Oakland, CA 94618 P 510.547.1630 F 510.923.1944

	2/21/2011	4/14/2011
Measurement	Right	Right
Flexion	110 Degrees	120 Degrees
Extension	0 Degrees	0 Degrees
Knee - Girth		
	2/21/2011	4/14/2011
Measurement	Right	Right
4 cm above joint line	43 cm	43 cm
4 cm below joint line	39 cm	39 cm

#### Knee - Muscle Testing

	2/21/2011		4/14/2011	
Measurement	Right Strength	Left Strength	Right Strength	Left Strength
Gastrocnemius	4+/5 ( SL calf	5/5 ( SL calf	5/5	5/5 ( SL calf
	raise)	raise)		raise)
Hamstring	5-/5	5/5	5-/5	5/5
Quadriceps	5-/5	5/5	5-/5	5/5
Tibialis Anterior	5-/5	5/5	5-/5	5/5
Gluteus Medius	4+/5	5/5	5-/5	5/ <b>5</b>
Gluteus Maximus	5-/5 (prone)	5-/5 (prone)	5-/5 (prone)	5-/5 (prone)
Peroneus Longus/brevis	5-/5	5- <b>/5</b>	5-/5	5-/5

#### **Knee - Joint Mobility**

-	4/14/2011	
Joint	Force Direction	End-Feel
Patellofemoral	lateral/medial Glide	Normal
- Joint Mobility		
_	2/21/2011	
loint	Force	End-Feel
	Direction	
Patellofemoral	lateral/medial Glide	Boggy

#### **Palpation**

Mild adhessions noted throughout quads, hamstrings, ITB

#### Assessment

#### **Descriptions**

Pt noted to have made substantial improvement with LE and core strength. Pt however, is still limited with functional tasks d/t B knee discomfort. Pt has great difficulty with repetitive step-ups onto elevated surface > 10", deep squats, and kneeling activities.

End of authorized visits

#### **Problem List**

#### **Problems**

Decreased participation in recreational activities
Pain limits functional activities
Decreased ROM
Joint Swelling

Full Progress Note (4/14/2011) -



From, FAX



Sports + Orthopedic Leaders Physical Therapy, Inc. 5297A College Ave Oakland, CA 94618 P 510.547.1630 F 510.923.1944

Decreased strength Gait Impairment

## Plan

oals		
Length	Status	Goal
Long Term	Met	<ol> <li>Independent with Home Exercise Program to continue improvement and prevent future injuries.</li> </ol>
Long Term	Met	2. Full Return to Activities in 6 weeks (road riding/stationary bike)
Short Term	Met	2a. Increase ROM to WNL in 4 weeks.
Short Term	Met	2b. Decrease Pain to allow painfree return to modified activities in 4 weeks.
Short Term	Met	2c. Increase Strength to WNL in 4 weeks.
Short Term	Met	2d. Decrease joint swelling to equal uninvolved side in 4 weeks.
Long Term	Met	3. Patient to demonstrate good balance on multiple surfaces in 6 weeks
Short Term	Met	<ol> <li>Patient to demonstrate normal gait on multiple surfaces without gait deviations 4 weeks.</li> </ol>

#### Treatment Plan

Recommend discharge with home exercise program 0 time(s) a week for 0 week(s), with treatments to consist of: Flexibility (97110) - active and passive patient stretching, Gait Training - 97116: Improve overall gait function including stair climbing, Progressive Strengthening (97110) - Strength training, ROM (97110) - Passive or active activities to increase joint range of motion, Therapeutic Exercise - 97110: Improve muscle strength, ROM, flexibility, and muscle function, Cryotherapy- 97010: Application of cold to decrease local swelling and decrease pain, IFC E-Stim- 97014: Application of E-Stim to modulate pain, Ultrasound- 97035 increase local circulation, improve tissue healing time, and modulate pain, Manual Stretching- 97140: passive or active stretching to improve muscle length and function, Soft Tissue Mobs- 97140: increase ROM tissue length, joint mechanics, and modulate pain, Plyometrics (97110) - Increase neuromuscular efficiency of muscle tissue.

X					
Ada Jauregui License #: 36256					
(Document electronically signed by TheraOffice Doce 4/18/2011	umentation)				
To Be Completed By Physician:					
I have no revisions to this plan of care	Prognosis:	Excellent	Good	Fair	Poor
Revise plan of care as follows					
Discharge Patient	Continue	times per	for	weeks /	months
Physician Signature:	I	Date:			
In signing this document, physician certifies that pro-	cribed rehabilitation is		eeitv		

Full Progress Note (4/14/2011)

Page 3

Check box if request is written confirmation of a prior oral request.

# State of California Division of Workers' Compensation Request for Authorization for Medical Treatment (DWC Form RFA)

To accompany the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or narrative report substantiating the requested treatment.

Check box if the patient faces an imminent and serious threat to his or her health.

Patient Info	ormation	Provider Information
Patient Name:		Provider Name: William B. Workman, MD
Date of Birth:		Practice Name: Walnut Creek Orthopedics
Date of Injury: 2/19/14 Employer: CITY OF V	/A E. IO	Address: 101 Ygnacio Valley Rd, Ste. 400 City, State, Zip Code: Walnut Creek, CA 94598
Employer: CITY OF V	ALLEJO	City, State, Zip Code: Walnut Creek, CA 94598 Telephone Number: 925-944-0110
		Fax Number: 925-944-0960
Claims Adı	ninistrator Information	Provider Specialty: Orthopedics
Claims Administrator: YO		Provider State License Number: 272343
Adjustor Name (If known):	SCHAUNNA	National Provider ID Number:
Address:		
City, State, Zip: Telephone Number:		
Fax Number: 866	548-2637	
		tional pages if more space is required.)
		specific page number(s) of the accompanying medical report on ence as necessary. More than one treatment request may be
included.	an be found. Include supporting evide	Acce as necessary. Were than one steament request may be
Diagnosis:	HIP PAIN, LABRAL TEAR	
ICD Code:	843.9, 719.45	
Procedure Requested:		MOROPLASTY, ACETABULOPLASTY AND LABRAL REPAIR
CPT/HCPCS Code:	29914, 29915, 29916, EO218(CTU) (HIP	BRACE-L1686 & L2622)
Other Information:		C, FOR PREOP CLEARANCE CPM for 10 day
(Frequency, Duration	PHYSICAL THERAPY 3X6, EKG, CBC	C, FOR PREOP CLEARANCE C/// /8/ /04/99
Quantity, Facility, etc.)	PREMIER SURGERY CENTER	
		1.26 00 1
5/27/14		Blower
Date of Request		Provider Signature
You may use this form for appr a request for authorization cann Labor Code section 4610 and C A decision on the requested m authorization, or 14 calendar	to the made using this form. Please rescalifornia Code of Regulations, title 8, nedical treatment must be made with days with a timely request for information.	or additional information, or a decision to modify, delay, or deny view all timeframes and requirements set forth in California sections 9792.9 and 9792.9.1.  In five (5) working days from receipt of this request for mation necessary to render a decision. For an expedited
		the maximum is 72 hours. Authorization may not be
denjed on the basis of lack of	<u>information Without documentation</u>	reflecting an attempt to obtain the necessary information.
The requested treatment(s) is approved		☐ The request has been previously denied by utilization review
Date request for authorization received		Claims Administrator/Authorized Agent Signature
Date of response to request	<del></del>	Adjuster/Authorized Agent Name (print)
DWC Form RFA (Version 12/20	12)	MAY ₹ 7 2014 1
		1117

## William B. Workman, M.D. 301 Lennon Lane, Suite 100, Walnut Creek, CA 94598

## **Surgery Authorization Request Form**

Date:

03/02/2010

To: Fax: UR/Stacy McAfee 925-609-9264

Phone:

Re:

Claim no:

Dr. Workman is requesting authorization for surgery or

Surgery:

Servetion Correction left knee arthroscopy and partial lateral menisectomy

ICD-9:

836.1, 715.16

CPT:

29881

Location:

Premier Surgery Center, Concord, CA 925-691-5000

Assistant:

none

Special Equip/DME: none

Post-op PT –

3x4

Please review included records as soon as possible.

Thank you,

Tere

Phone: (925) 944-0110 or 944-0475 (This number has voicemail)

Fax: (925) 944-0960

MAR 0 2 2010



March 3, 2010

Dr. William Workman, MD 301 Lennon Lane, Suite 100 Walnut Creek, Ca. 94598 (925) 944-0110 Fax (925) 944-0960

DOI: 10/3/09

Dear Dr. Workman,

This letter is sent on behalf of Stacey McAfee, Claims Examiner with York Insurance Services advising of authorization of the following in regards to

1. LEFT KNEE ARTHROSCOPY AND PARTIAL LATERAL MENISECTOMY
2. POST OPERATIVE PT 3X4

Authorization Period: March 3, 2010-June 3, 2010

Please fax additional requests for treatment to ATTN: Shelley Jones RN, BSN at (925) 609-9264. Please call with any questions or concerns regarding Mr. worker's comp. treatment (925) 349-3874.

Sincerely,

Still Warrow RW, REN Shelley Jones RN, BSN

TCM/UR Wellcomp

(925) 349-3874 (925) 609-9264

CC: Stacey McAfee, CE (925) 349-3886, Fax (925) 609-9264

York Insurance Services
1390 Willow Pass Road, Suite 400
Concord, Ca. 94520

This fax was recieved by Stryker's OrthoPad software. www.stryker.com

Received on March 1, 2010, Authorized on March 3, 2010

Provider:

Dr. William Workman, MD 301 Lennon Lane, Suite 100 Walnut Creek, CA. 94598 (925) 944-0110 (925) 944-0960

Diagnosis (body part): Lateral Meniscus Tear, Left Knee

What: is Requested? Post Operative PT 3x4

Status: Approved.

Guideline (s) Used:

MTUS:

http://www.dir.ca.gov/dwc/DWCPropRege/MedicalTreatment-UtilizationSchedule/MTUS Final CleanCopy.doc. § 9792.21. Medical Treatment Utilization Schedule, Dislocation of knee; Tear of medial/lateral cartilege/meniscus of knee; Dislocation of patella (ICD9 836; 836.0; 836.1; 836.2; 836.3; 836.5): Postsurgical treatment: (Meniscectomy): 12 visits over 12 weeks \*Postsurgical physical medicine treatment period: 6 months

UR Nurse referral Required? Yes

Medical Director referral Required? No

The IW is a 45y/e male working at The City of Vallejo as a fire engineer. DOI: 10/3/09 & DOH: 3/17/86. The current request is for Post operative PT 3x4. Based on the physicians report dated 2/25/10 and the above guidelines the request is approved.

Shelley Jones, RN, BSN Nurse Case Manager Wellcomp Managed Care Services Ph: 925-349-3874 Fax: 925-609-9264

York Insurance Services Group 1390 Willow Pass Road, Suite 400 Concord, Ca. 94520

Adjustor: Stacey MoAfee (925) 849-3886

Received on March 1, 2010, Authorized on March 3, 2010

Provider:

Dr. William Workman, MD 301 Lennon Lane, Suite 100 Walnut Creek, CA. 94598 (925) 944-0110 (925) 944-0960

Diagnosis (body part); Lateral Menisous Tear, Left Knee

What: is Requested? Left Knee Arthroscopy and partial lateral menisectomy

Status: Approved.

Guideline (s) Used:

ACOEM:

http://www.accempracquides.org/secure/Chapter\_13\_Knee.aspx#\_B\_Menisous\_TearsB. Meniscus Tears

Arthroscopic partial menisoectomy usually has a high success rate for cases in which there is clear evidence of a menisous teer—symptoms other than simply pain (looking, popping, giving way, recurrent effusion); clear signs of a bucket-handle tear on examination (tendemess over the suspected tear but not over the entire joint line, and parhaps lack of full passive flexion); and consistent findings on MRI. However, patients suspected of having meniscal tears, but without progressive or severe activity limitation, can be encouraged to live with symptoms to retain the protective effect of the meniscus. If symptoms are lessening, conservative methods can maximize heating, in patients younger than 35, arthroscopic meniscal repair can preserve meniscal function, although the recovery time is longer compared to partial meniscatomy. Arthroscopy and meniscus surgery may not be equally beneficial for those partients who are exhibiting signs of degenerative changes

UR Nurse referral Required? Yes

Medical Director referral Required? No

The IW is a 45y/o male working at The City of Vallejo as a fire engineer, DOI: 10/3/09 & DOH: 3/17/86. The current request is for Left knee arthroscopy and partial lateral meniscotomy. Based on the physicians report dated 2/25/10 and the above guidelines the request is approved.

Shelloy Jones, RN, BSN
Nurse Case Manager
Wellcomp Managed Care Services
Ph: 925-349-3874 Fax: 925-609-9264

York Insurance Services Group 1390 Willow Pass Road, Suite 400 Concord, Ca. 94520

Adjustor: Stacey MoAfee (925) 349-3886

Knee Injuries

From:

To: sports@md.aaos.org

BC:

Wednesday - October 20, 2010 2:55 PM Date:

Subject: Knee Injuries

Doctor Workman:

I am sending you this email regarding my right knee. As we have discussed in the past, my right knee also needs evaluating due to the normal wear and tear during my firefighting duties, as well as the over compensation that occurred while my left knee surgery and therapy was in progress. I spoke to our City's Risk Management Worker's Comp Coordinator, Vicky Scopesi, regarding the need for my right knee to also be evaluated and she stated that if you send a letter to my case worker at York Insurance that we can proceed with getting my right knee evaluated and repaired.

My case worker is Stacey McAfee, stacey.mcafee@yorkisg.com, (925) 349-3886, 1390 Willow Pass Road, Suite 400, Concord, CA, 94520. I would appreciate it if you could please contact Ms. McAfee and let her know the extent of my right knee and the fact that it needs to be addressed so that I can return to duty after its repaired.

Thank you.

## William B. Workman, M.D. 301 Lennon Lane, Suite 100, Walnut Creek, CA 94598

## **Surgery Authorization Request Form**

Date:
-------

01/10/11

To:

UR

Fax:

925-609-9264

Phone:

Re:



Claim no:

Dr. Workman is requesting authorization for surgery on



Surgery:

Right knee arthroscopy partial medial and lateral menisectomy.

ICD-9:

836.0 & 836.1

CPT:

29880

Location:

Premier Surgery Center, Concord, CA 94520

Assistant:

no

Special Equip/DME: no

Post-op PT -

12 post op visit

Please review included records as soon as possible.

Thank you,

Теге

Phone: (925) 944-0110 or 944-0475 (This number has voicemail)

Fax: (925) 944-0960

JAN **0 9** 2011



1901 E. Alton Ave. Suite 200 Santa Ana, CA 92705 Telephone: 800-559-5556, Fax: 866-409-1957

Hours: Monday - Friday 7 00 AM - 5 30 PM

William Workman, M.D. 301 Lennon Lane Suite 100 Walnut Creek CA 94598 Phone: 925-944-0110 Fax: 925-944-0960

Wednesday, January 12, 2011

Notice of Non-Certification

RE:

Paladin Managed Care Services #: 40142 Injury Date: 10/3/2009

Dear William Workman, M.D.,

Paladin Managed Care Services has received a request for treatment of the above named employee. After a thorough review of the available records, the reviewer is recommending that the request for authorization be non-certified. The following details provide specific information about the determination:

#### Specific Treatment Plan Requested

1 right knee arthroscopy with partial medial and lateral meniscectomy between 1/11/2011 and 3/12/2011; 12 post-op physical therapy sessions between 1/11/2011 and 4/11/2011.

#### **Determination Date**

Wednesday, January 12, 2011

#### UR Determination

- 1. Recommend prospective request for 1 right knee arthroscopy with partial medial and lateral meniscectomy between 1/11/2011 and 3/12/2011 be non certified.
- 2. Recommend prospective request for 12 post-op physical therapy sessions between 1/11/2011 and 4/11/2011 be non certified.

#### Clinical Rationale

Non-certify request for 1 right knee arthroscopy with partial medial and lateral memscectomy between 1/11/2011 and 3/12/2011. A review of medical records does not indicate that the request is medically reasonable. The only subjective complaint stated was ongoing pain. There was no mention of locking, clicking or giving way. The only objective finding was the MRI report. If the subjective and objective exam can be better stated and include joint line tenderness and positive McMurray's, ROM, effusion etc. the request can be re-considered. Below are the ACOEM and the 2011 ODG evidence-based recommendations:

Non-certify request for 12 post-op physical therapy sessions between 1/11/2011 and 4/11/2011. A review of medical records does not indicate that the request is medically reasonable. The surgical procedure has not yet been approved. Below are the 2011 ODG evidence-based recommendations:

#### Criteria/Guidelines Applied

#### Meniscectomy

Recommended as indicated below for symptomatic meniscal tears. Not recommended for osteoarthritis (OA) in the absence of meniscal findings. (Kirkley, 2008) Meniscectomy is a surgical procedure associated with a high risk of knee osteoarthritis (OA). One study concludes that the long-term outcome of meniscal injury and surgery appears to be determined largely by the type of meniscal tear, and that a partial meniscectomy may have better long-term results than a subtotal meniscectomy for a degenerative tear. (Englund, 2001) Another study concludes that partial meniscectomy may allow a slightly enhanced recovery rate as well as a potentially improved overall functional outcome including better knee stability in the long term compared with total meniscectomy. (Howell-Cochrane, 2002) The following characteristics were associated with a surgeon's judgment that a patient would likely benefit from knee surgery: a history of sports-related trauma, low functional status, limited knee flexion or extension, medial or lateral knee joint line tenderness, a click or pain noted with the McMurray test, and a positive Lachmann or anterior drawer test. (Solomon, 2004) Our conclusion is that operative treatment with complete repair of all torn structures produces the best overall knee function with better knee stability and patient satisfaction. In patients younger than 35, arthroscopic meniscal repair can preserve meniscal function, although the recovery time is longer compared to partial meniscectomy. Arthroscopy and meniscus surgery will not be as beneficial for older patients who are exhibiting signs of degenerative changes, possibly indicating osteoarthritis, and meniscectomy will not improve the OA. Meniscal repair is much more complicated than meniscal excision (meniscectomy). Some surgeons state in an operative report that they performed a meniscal repair when they may really mean a meniscectomy. A meniscus repair is a surgical procedure done to repair the damaged meniscus. This procedure can restore the normal anatomy of the knee, and has a better long-term prognosis when successful. However, the meniscus repair is a more significant surgery, the recovery is longer, and, because of limited blood supply to the meniscus, it is not always possible. A meniscectomy is a procedure to remove the torn portion of the meniscus. This procedure is far more commonly performed than a meniscus repair. Most meniscus tears cannot be treated by a repair. See also Meniscal allograft transplantation. (Harner, 2004) (Graf, 2004) (Wong, 2004) (Solomon-JAMA, 2001) (Chatain, 2003) (Chatain-Robinson, 2001) (Englund, 2004) (Englund, 2003) (Menetrey, 2002) (Pearse, 2003) (Roos, 2000) (Roos, 2001) Arthroscopic debridement of meniscus tears and knees with low-grade osteoarthritis may have some utility, but it should not be used as a routine treatment for all patients with knee osteoarthritis. (Siparsky, 2007) Arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical and medical therapy, according to the results of a single-center, RCT reported in the New England Journal of Medicine. The study, combined with other evidence, indicates that osteoarthritis of the knee (in the absence of a history and physical examination suggesting meniscal or other findings) is not an indication for arthroscopic surgery and indeed has been associated with inferior outcomes after arthroscopic knee surgery. However, osteoarthritis is not a contraindication to arthroscopic surgery, and arthroscopic surgery remains appropriate in patients with arthritis in specific situations in which osteoarthritis is not believed to be the primary cause of pain. (Kirkley, 2008) Asymptomatic meniscal tears are common in older adults, based on studying MRI scans of the right knee of 991 randomly selected, ambulatory subjects. Incidental meniscal findings on MRI of the knee are common in the general population and increase with increasing age. Identifying a tear in a person with knee pain does not mean that the tear is the cause of the pain. (Englund, 2008) Arthroscopic memscal repair results in good clinical and anatomic outcomes. (Pujol, 2008) Whether or not meniscal surgery is performed, meniscal tears in the knee increase the risk of developing osteoarthritis in middle age and elderly patients, and individuals with meniscal tear were 5.7 times more likely to develop knee osteoarthritis. (Englund, 2009)

ODG Indications for Surgeryä -- Meniscectomy:

Criteria for meniscectomy or meniscus repair (Suggest 2 symptoms and 2 signs to avoid scopes with lower yield, e.g. pain without other symptoms, posterior joint line tenderness that could just signify arthritis, MRI with degenerative tear that is often false positive):

- 1. Conservative Care: (Not required for locked/blocked knee.) Physical therapy. OR Medication. OR Activity modification. PLUS
- 2. Subjective Clinical Findings (at least two): Joint pain. OR Swelling. OR Feeling of give way. OR Locking, clicking, or popping. PLUS
- 3. Objective Clinical Findings (at least two): Positive McMurray's sign. OR Joint line tenderness. OR Effusion.

OR Limited range of motion. OR Locking, clicking, or popping. OR Crepitus. PLUS

4. Imaging Clinical Findings: (Not required for locked/blocked knee.) Meniscal tear on MRI.

(Washington, 2003)

#### ACOEM:

Arthroscopic partial meniscectomy usually has a high success rate for cases in which there is clear evidence of a meniscus tear-symptoms other than simply pain (locking, popping, giving way, recurrent effusion); clear signs of a bucket-handle tear on examination (tenderness over the suspected tear but not over the entire joint line, and perhaps lack of full passive flexion); and consistent findings on MRI. However, patients suspected of having meniscal tears, but without progressive or severe activity limitation, can be encouraged to live with symptoms to retain the protective effect of the meniscus. If symptoms are lessening, conservative methods can maximize healing. In patients younger than 35, arthroscopic meniscal repair can preserve meniscal function, although the recovery time is longer compared to partial meniscectomy. Arthroscopy and meniscus surgery may not be equally beneficial for those patients who are exhibiting signs of degenerative changes.

"No guidelines are provided as the non-certification is based on non-certification of the associated surgical procedure."

Our determination does not mean that the patient should not receive further medical treatment or personal care and does not refer to compensability. However, if the above specific medical services are provided, these services may not be covered by workers compensation. For questions regarding compensability, please contact the employer or claim administrator.

#### Optional Internal UR Appeals Process

In the event that a requesting physician has additional medical information that may impact an initial denial of treatment authorization, he/she may submit a written request within twenty (20) days of the receipt of this letter to have the additional information reviewed by a clinical peer who did not make the original determination to modify the request for authorization. Appeals and information may be faxed to Paladin Managed Care Services at 866-409-1957 or may be submitted via mail to 1901 E. Alton Ave. Suite 200. Santa Ana, CA 92705.

Additionally, the injured worker has the right to use the UR Appeal Process as per Title 8 of the CCR 9792.10 as described below:

#### UR Appeals Process as per CCR 9792.10

If you disagree with the utilization review decision and wish to dispute it, you must send written notice of your objection to the claims administrator within 20 days of receipt of the utilization review decision in accordance with Labor Code section 4062. This 20-day time limit may be extended for good cause or by mutual agreement of the parties. You must meet this deadline even if you are participating in the claims administrator's internal utilization review appeals process.

The injured worker may file an Application for Adjudication of Claim and Request for Expedited Hearing, DWG Form 4, showing a bona fide dispute as to entitlement to medical treatment in accordance with sections 10136(b)(1), 10400, and 10408.

#### Required Language as per CCR 9792.9

If you want further information, you may contact the local state Information and Assistance office closest to you. Please see attached listing or you may receive recorded information by calling 1-800-736-7401.

Information & Assistance Unit - District Offices

Anahelm, CA 92801	<b>Bakersfield, CA 93301</b>	Eureka, CA 95501-0421
1661 No. Raymond Avenue, #200	1800 30th Street, Suite 100	100 "H" Street, Room 201
[714] 738-4038	(661) 395-2514	(707) 441-5723
Fresno, CA 93721-2280	Goleta, CA 93117	Grover Beach, CA 93433-2261
2550 Mariposa Street, Room 2035	6755 Hollister Avenue, Room 100	1562 W. Grand Avenue
(559) 445-5355	(805) 968-4158	(805) 481-3296
Long Beach, CA 90802-4460	Los Angeles, CA 90013	Marina del Rey, CA 90292
300 Oceangate Street, 3rd floor	320 W, 4th Street, 9th floor	4720 Lincoln Blvd
(562) 590-5240	(213) 576-7389	(310) 482-3820

Oakland, CA 94612	Oxnard, CA 93030	Pomona, CA 91768
1515 Clay Street, 6th floor	2220 E. Gonzales Road, Suite 100	732 Corporate Center Drive
(510) 622-2861	(805) 485-3528	(909) 623-8568
Redding, CA 96001-2796	Riverside, CA 92501	Sacramento, CA 95825
2115 Akard, Room 21	3737 Main Street, Room 300	2424 Arden Way, Suite 230
(530) 225-2047	(951) 782-4347	(916) 263-2741
Salinas, CA 93906-2204	San Bernardino, CA 92401	San Dlego, CA 92102-4402
1880 North Main Street, Suite 100	464 W. Fourth Street, Suite 239	7575 Metropolitan Drive, #202
(831) 443-3058	(909) 383-4522	(619) 767-2082
San Francisco, CA 94102	San Jose, CA 95113	Santa Ana, CA 92701-4701
455 Golden Gate Avenue, 2nd floor	100 Paseo de San Antonio, Room 240	28 Givic Center Plaza, Room 451
(415) 703-5020	(408) 277-1292	(714) 558-4597
Santa Rosa, CA 95404	Stockton, CA 95202	Van Nuys, CA 91401-3373
50 "D" Street, Room 430	31 East Channel Street, Room 450	6150 Van Nuys Blvd., Room 105
(707) 576-2452	(209) 948-7980	(818) 901-5367

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

The hours of availability of the reviewer, expert reviewer or the medical director for the treating physician to discuss the decision include 9:00 AM until 3:00 PM PST, Monday through Friday, during normal business hours. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Additionally, please feel free to contact us should you have any additional questions regarding this claim or if medical necessity substantiates further treatment.

Respectfully,

Carmen Arriola, M.D. CA License# G63500

Board-certified in Occupational Medicine

Alman A Linera Mans

cc:

Stacey Mcafee, Claims Administrator Nancy Immer, L.V.N., Claims Administrator

#### STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS: COMPENSATION
MEDICAL UNIT
MAILING ADDRESS
P. O. Box 71010
Oakland, CA. 94612
(510) 286-3700 or (800) 794-6900

## HOW TO REQUEST A QUALIFIED MEDICAL EVALUATOR IF YOU DO NOT HAVE AN ATTORNEY (Attachment to Form 105)

Use QME Form 105 when there is a dispute over a medical decision or medical opinion of the primary treating physician or utilization review. Read these instructions to know what you must do and the time limits for making decisions. You must have given your employer or the claims administrator a claim form before you may get a QME or any benefits.

Answer all of the questions on QME form 105, sign the form and mail it to the DWC Medical Unit.

The DWC Medical Unit will use the information on the form to issue a "QME panel". A "QME panel" is a list of three physicians who are certified as Qualified Medical Evaluators ("QME"). One physician from the list must be selected. The QME selected will do a medical examination and write a report. This QME report provides an independent, second medical opinion on all of the disputed and unresolved issues in the case that need a medical opinion.

#### How to Get a OME Panel - Send OME Form 105 to the DWC Medical Unit

You, the injured worker, will have the first opportunity to choose the specialty of physician to perform the exam.

You must do so within ten (10) days of the date the claims administrator sent you the QME Form 105. Within the 10-day time limit, fill out the form, write in the three letter code for the specialty you have picked, sign the form and mail it to the DWC Medical Unit. If you do not return the form, the claims administrator may gain the legal right to select the specialty of the QME instead.

All three physicians on the "QME panel" will have the same specialty. The names are selected randomly within the general geographic area of your home. Sometimes it is necessary to travel far to see a QME in the specialty you select. Your employer must pay all reasonable transportation expenses to attend the exam, including lodging if needed. If you and the claims administrator agree in writing for your convenience to have the panel issued in the area of your workplace, attach that written agreement including the street address and zip code of your workplace to the panel request form.

If the DWC Medical Unit does not send you and the claims administrator a "QME panel" within fifteen (15) business days of receiving the request, you may select any QME to do the evaluation. If this happens, call your Information and Assistance Officer at 1-800-736-7401 or the Medical Unit at 1-800-794-6900. The QME database, listing all QMEs by specialty and location, can be found on the internet at http://www.dir.ca.gov/databases/dwc/qmestartnew.asp.

#### How to Complete the Form

"Request Date": Write the date you sign this form.

"Requesting Party": Check the box for the person who selects the QME specialty and signs the form at the bottom

Answer the questions, about whether any part of the claim has been accepted, whether the claim has been denied, and about the wording of the notice from the claims administrator to you about the need to get a QME report, by checking the box that answers each question.

#### Selecting a Reason for Requesting the OME Panel

Select "§ 4060 (compensability exam)" whenever 1) during the 90 days since you gave the employer your claim form, the claims administrator says the employer requests a QME report to determine whether to accept your claim and asks you to complete the form and select the specialty for the QME; or 2) when the claim is denied altogether and the claims administrator has refused to provide or has stopped all benefits including medical treatment; or 3) if the treating physician writes that your injury was not caused by work and you disagree with that opinion. If the claims administrator has accepted any body part in the claim, select a different reason. If the notice from the claims examiner during the only says the employer has not accepted liability and you may request a panel, you are not required by law to send the panel request form to the Medical Unit. Call the Information and Assistance officer 1-800-736-7401 to discuss your options.

Select "§ 4061 (permanent impairment or disability dispute)" if there is a dispute about temporary disability or whether you have any permanent impairment permanent disability, or you disagree over the amount or percentage of permanent impairment or permanent disability.

Select "§ 4062 (injured employee only - medical treatment or UR dispute or other 4062 reason)" if treatment, that your treating physician has recommended, has been denied, delayed or modified based on a decision by utilization review or the claims administrator; or, whenever there is a dispute over the amount or frequency or type of treatment that you need now or will need in the future. Select this reason also if the dispute is about 'permanent and stationary' status

Select "§ 4062 (claims administrator only – other non-treatment, non-UR reason under § 4062)" if you are the claims administrator who has objected to some other medical determination or issue under Labor Code § 4062. However, the requesting claims administrator must state the reason on the line provided. Examples may include medical determinations on new and further disability, medical eligibility for vocational rehabilitation, the permanent and stationary date, MPN continuity of care or transfer of care, that a new body part needing treatment is causally connected to the claimed injury.

If you are covered for medical treatment in an MPN and you disagree over the MPN physician's diagnosis or treatment you do not need a QME. Call the Information and Assistance officer I-800-736-7401 to discuss how to get another MPN physician or an MPN second opinion. You may request a QME panel and select § 4062 for disputes over a treating physician's opinion about whether you qualify for continuity of care (care by the same treating physician after your MPN physician left or is terminated by the MPN) or transfer of care (whether your condition or treatment qualifies for your claims administrator to transfer your care to an MPN physician).

Select "§§ 4061 and 4062 issues" if currently there are disagreements about both permanent disability and medical determinations. The claims administrator may not select this reason if the only disputes under § 4062 are because of a denial, delay or modification of your medical treatment by a utilization review physician.

#### Prior OME Panel List or Examination

Answer the questions about any QME panel lists you have received in the past. This information is needed to avoid delays in issuing the QME panel list you are requesting now.

#### Select the Medical Specialty. Sign and Mail the Form

Use the list on the back of QME Form 105 to select a medical specialty. If necessary, request help from your treating physician to choose the specialty. Write the 3 letter code for the medical specialty you select on the front of Form 105. Also, sign the form and print your name below the signature.

#### What if I pick the wrong medical specialty and wish to change the medical specialty?

You may request a change of medical specialty if you have not had the QME evaluation yet and you and the claims administrator agree in writing to the change of medical specialty. Please include the QME panel number on your request.

#### What if there is a need for another OME report in a different specialty?

Sometimes, there may be a need for an additional examination and report by a QME in a different specialty. Generally this will occur only if the first QME states in the report that an exam by a physician in another specialty is necessary, or if a Workers' Compensation Judge orders the additional report, or if the parties meet with Information and Assistance Officer who determines that the conditions for obtaining an additional report are met.

#### Your rights to an attorney

You are entitled to be represented by an attorney at any stage of your workers' compensation claim. However, after you have had an evaluation by a QME, you are not entitled to a new QME evaluation. Should you decide to be represented by an attorney, you may or may not receive a larger award, but unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

#### Other questions?

For other questions about the QME process, please call the DWC Medical Unit at 1-800-794-6900. For general questions about your workers' compensation claim and benefits, please call the Information and Assistance Officer at the Division of Workers' Compensation 1-800-736-7401 or look on our website at http://www.dir.ca.gov/dwc/InjuredWorker.htm.

### State of California DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT REQUEST FOR QME PANEL UNDER LABOR CODE § 4062.1 UNREPRESENTED

(Please print or type)

Request date (Required):	Date of Injury (Req	uired):	Claim Number (require	ed)
			uesting Party (Check one hox only): prepresented Injured Employee	
(use 3 letter code only)			□ Claims Administrator,	if none, Employer
Reason QME Panel is being re  § 4060 (compensability exam  § 4061 (permanent impairmed  § 4062 Injured employee only  § 4062 Claims administrator  § 4061 and 4062 dispute (m	n) nt or disability dispute) y (medical treatment deter only (non treatment medic	rmine, UR dis cal determina	tion or non-UR reason unde	r 4062)
If the Claims administrator is re	questing a 4062 panel exp	olain the reaso	on for the request:	
Answer each question below: Has this claim been denied?	□ Yes □ No		part in this claim been accepted	
If yes, indicate the date of the denia	ປ			
Did notice to injured employee stat	e employer requests an eval	uation to deten	mine compensability?(Attach cop	y of notice) 🗆 Yes 🗀 No
Does dispute involved an MPN:   Con	ntinuity or transfer of Care 🛘 F	ermanent Disab	ility, Future Medical, UR decision	☐ Diagnosis/Treatment <sup>o</sup>
	Emplo	yee Informat	tion	
First Name,	Middle II	ntial	_ Last Name	
Street Address.				
City	State	Zıp Code	Daytime Phone No	
If you now live out of state, list the	California city and zip code	of your reside	nce when injured:	
If you never resided in California, I	ist the California zip code ir	ı which you wo	ould like to be evaluated	
	Employer and Claim	ı <b>s Admini</b> str	ator Information	
Employer.				
Claims Administrator Name:				
Adjustor name:				
Street Address or P.O Box'				
City'	State	Zip Code <sup>.</sup>	Daytime Phone No.	
QME Form 105 (rev. February 2009)		Page 1 of 3	ı	(Continue form on next page)

				Claim Number	:
	Prior QME Panel I	nformation (Ans	wer all th	at apply)	
Has the employee ever receive	ed a QME panel before?	☐ Yes	□No	□ Unknown	
If yes, did the employee ever	see any QME from that panel?	☐ Yes	□No	☐ Unknown	
If yes, has that claim been sett	tled or resolved?	□ Yes	□ No	□ Unknown	
If yes, name of QME seen				Specialty:	
Date of Injury.	Body parts:				Date of exam
Panel Number (if known)		Is that QME avai	ilable nov	w 🛘 Yes 🗆 No	□ Unknown
	Division of Worker P.O Box 71	ed form must he m s' Compensation - 010, Oakland, Ca 3700 or (800) 794	– <b>Med</b> ica 194612		
Date					
Print Name of Requestor				Signature of Inju	rred Employee

Note: Each employer or claims administrator submitting this form to request a QME panel must attach a copy of the correspondence and required notices sent to the injured employee with the panel request form.

#### STATE OF CALIFORNIA

DEPARTMENT OF INDUSTRIAL RELATIONS DIVISION OF WORKERS' COMPENSATION MEDICAL UNIT MAILING ADDRESS: P.O. Box 71010 Oakland, CA. 94612 (510) 286-3700 or (800) 794-6900

## HOW TO REQUEST A QUALIFIED MEDICAL EVALUATOR IN A REPRESENTED CASE (Attachment to Form 106)

Use QME Form 106 only in cases in which the injured employee is represented by an attorney. To request a panel of three QMEs in a represented case, the parties first must have attempted to agree on an Agreed Medical Evaluator to resolve a disputed issue as provided by Labor Code Section 4062.2. Once ten (10) days have passed from the date of the first written proposal to use an AME that names one or more physicians, either party may request a panel on QME Form 106. Complete form 106, specify the specialty requested, attach a copy of the first written AME proposal, and send your request by first class U.S. mail to the DWC – Medical Unit address on the bottom of the form. You must serve a copy of your panel request on the other party. If the panel request form is not fully completed, it will be returned.

#### Completing the form:

- "Request Date": Write the date you sign this form.
- "Requesting Party": Check the box that describes the person or party with the legal right to request a panel who is signing the form at the bottom.

Answer the questions, about whether any part of the claim has been accepted, whether the claim has been denied, and about attaching a copy of the earliest written AME offer that identifies a disputed issue and names one or more physicians to be the AME.

#### Selecting the reason for requesting a OME panel:

Select "§ 4060 (compensability exam)" if the claims administrator advises within ninety (90) days of receipt of the claim form that a QME report is needed to determine whether to accept the claim; or if there is a dispute over the treating physician's opinion that the claimed injury was not caused by work. If the claims administrator has accepted any part of the claim, such as accepting one body part or injury, select a different reason (Lab. Code § 4060(a).) If the ninety (90) day period has passed since the claim form was received, a request from a claims administrator or employer for a QME panel for this reason will not be filled until the conditions in section 30(d)(4) of Title 8 of the California Code of Regulations have been satisfied.

Select "§ 4061 (permanent impairment or disability dispute)" if there is a dispute about temporary or permanent impairment or disability, or you disagree over the amount or percentage of permanent impairment or permanent disability.

Select "§ 4062 (injured employee only - medical treatment or UR dispute or other 4062 reason)" if treatment has been denied, delayed or modified by a utilization review physician or the claims administrator; or if there is a dispute over the amount or frequency or type of treatment that the injured employee needs now or will need in the future. Select this reason also if the dispute is about 'permanent and stationary' status. The claims administrator may not select this after treatment has been denied, delayed or modified in utilization review.

Select \*§ 4062 (claims administrator only – other non-treatment, non-UR reason under § 4062)" whenever the claims administrator, or if none the employer, objects to some other medical determination or issue under Labor Code § 4062. The requesting claims administrator must state the reason on the line provided. Examples may include medical determinations on new and further disability, medical eligibility for vocational rehabilitation, the permanent and stationary date, MPN continuity of care or transfer of care, that a new body part needing treatment is causally connected to the claimed injury.

If the injured employee is covered for medical treatment by an MPN and the parties disagree over the MPN physician's diagnosis or treatment, you do not need a QME. The parties must follow the MPN second opinion process set out in Labor Code section 4614.3 and section 9767.7 of Title 8 of the California Code of Regulations.

Select "§§ 4061 and 4062" if currently there are disputes about both permanent disability and medical determinations.

#### Selecting the medical specialty:

Enter the 3 letter code from the reverse side of QME Form 106 for the medical specialty requested. If known, also state the medical specialty of the treating physician and the specialty preferred by the opposing party. If you are requesting a specialty that is different than the medical specialty of the primary treating physician, it is strongly recommended that you submit additional, relevant medical documentation in support of the requested specialty and an explanation of the reasons you believe the specialty being selected is more appropriate for review by the Medical Director of DWC. Such additional medical documentation may include, but is not limited to, copies of the most recent primary treating physician's progress report (DWC Form PR-2), the Doctor's First Report of Occupational Injury or Illness (Form DLSR 5021), a consulting physician's report, etc. It is not necessary to send copies of all medical records in the case. (See sections 31.1 and 31.5 of Title 8 of the California Code of Regulations.)

The DWC-MU uses a random selection program to assign three QMEs to the panel If there are too few QMEs of the specialty requested in the geographic area of the injured worker's residence, the system will pick QMEs from other geographic areas and the employer is responsible for paying for necessary travel costs incurred. The non-requesting party will receive a copy of the panel letter when it is issued. If the Medical Unit does not issue a panel within thirty (30) calendar days of receiving the request in a represented case, either party may seek an order from a Workers' Compensation Administrative Law Judge to obtain a QME panel.

#### The AME or OME selection process in represented cases:

Upon receipt of the QME panel list, the parties in a represented case are required to confer and attempt to agree on an Agreed Panel QME from the panel list provided. (See, Labor Code section 4062.2(c).) If the parties have not agreed on an Agreed Panel QME by the 10th day after the panel is issued, each party may then strike one name from the panel. The remaining QME shall serve as the medical evaluator. If a represented party fails to exercise the right to strike a name from the panel within three business days of gaining the right to do so, the other party may select any QME who remains on the panel to serve as the medical evaluator. (Labor Code §4062.2(c))

#### Requests returned for additional information and replacement evaluators:

If a QME panel was previously issued for this injured worker and there is insufficient information on the form 106 to process the request, the request will be returned by the Medical Unit with a request for necessary information. The time periods for selecting an Agreed Panel QME and for striking QME names are tolled during this period (See, 8 Cal Code Regs §§ 30(c), 31 5)

#### Scheduling the evaluation appointment:

The represented employee is responsible for arranging the appointment for the examination. Upon his or her failure to inform the employer/insurer of the appointment within 10 business days after the medical evaluator has been selected, the employer/insurer may arrange the appointment and notify the employee of the arrangements.

#### How long will it take to have the examination and to get the OME's report?

If the QME selected is unable to schedule the exam within 60 calendar days of the initial call, the party with the legal right to schedule may either waive the 60 day limit, as long as an appointment within 90 days of the initial scheduling call is

available, or request a replacement QME. If no appointment is available within 90 days of the initial request, either party may request a replacement QME or QME panel. You are entitled to an evaluation report within 30 calendar days of the commencement of the exam by an Agreed Panel QME or QME. At times, an AME or QME may request the Medical Director to extend the deadline for completing the report (for example if the evaluator has not received test results or a consulting physician's report or for legal 'good cause'). The evaluator must notify the DWC-Medical Unit and you of the request for approval of an extension of time to complete the report. You will be notified of the decision. If the evaluator selected cannot complete the report within 30 days or the extension of time approved by the Medical Director, the parties may agree in writing (on QME Form 113 or 116) to wait until the physician can complete the report, or either party may request a replacement panel of QMEs. If this occurs, you must go through the selection process again.

#### Obtaining a OME in a different specialty:

As provided in section 31.7(b) of Title 8 of the California Code of Regulations, parties in a represented case may obtain an additional QME panel in a different specialty under certain circumstances. All such requests for an additional QME panel must be written and submitted with supporting information or documentation showing how the conditions in § 31.7 are being met

#### Other questions?

For questions about the QME process, please call the DWC-MU at 1-800-794-6900. For questions about the workers' compensation claim dispute resolution process, call an Information and Assistance officer at the Division of Workers' Compensation office listed in your phone book, or look on our website at http://www.dir.ca.gov/dwc.

#### State of California DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT REQUEST FOR QME PANEL UNDER LABOR CODE § 4062.2 REPRESENTED

(Please print or type)

Request date (Required)	Date of Injury (I	Required)	Specialty Requested	(3 letter code required):	Claim Number (required)
Specialty of treating physi-	cian	Opposing	party's specialty prefer	☐ Applicar	testing Party (Check one box only): nt's Attorney (or injured employee) Attorney / Claims Administrator
Reason QME Panel is  \$ 4060 (compensability  \$ 4061 (permanent imples \$ 4062 Injured employe)  \$ 4062 Claims administ  \$ \$ 4061 and 4062 dispense.	exam) airment or disabilities only (medical trater only (non tre	ty dispute) eatment de eatment me	termine, UR dispute or dical determination or i	other 4062 reason) non-UR reason under 406.	
If the Claims administrator	r is requesting a 40	062 panel e	xplain the reason for th	e request below	
You must attach a copy an AME	of your written	proposal :	identifying a dispute	d issue and naming one	e or more physicians to be
Answer each question L Has this claim been denied		□No	Has any body p	art in this claim been acce	epted"
If yes, indicate the date of	the demal				
Did notice to injured empl	oyee state employ	er requests	an evaluation to determ	nine compensability?(Attac	h copy of notice)   Yes   No
Does dispute involved an MP	PN 🛘 Continuity of	transfer of (	Care 🗆 Permanent Disabi	lity, Fittine Medical, UR dec	ision 🗆 Diagnosis/Treatment?
			Employee Information	on	
First Name;			Middle Initial	Last Name	
Street Address					
City.		State	zZıp Code: _	Daytime Plic	one No
If you now live out of state	e, list the Californ	ia city and:	zip code of your resider	nce when injured:	
If you never resided in Cal	lifornia, list the Ca	ılifornıa zıp	code in which you wo	uld like to be evaluated _	<u>-</u>
			Employee's Attorne	У	
First Name			Last Name		Firm Number
Law Firm Name					
Address/PO Box (Please le	eave blank spaces	between nu	umbers, names or words	s)	
City		State	Zip Code	Phone No	
QME Form 106 (rev. February 2)	009)		Page 1 of 3		(Continue form on next page)

			Claim	Number:	
	Employer and Cla	ims Administrato	r Inforn	nation	
Employer					
Claims Administrator Name:			<del></del> -		
Adjustor name:					
Street Address or P O Box					
City	State	Zıp Code		Phone No	
	Em	ployee's Attorney			
First Name	Last N	Name			Firm Number
Law Firm Name					
Address/PO Box (Please leave blank spac	es between number	s, names or words)	<u> </u>		
City	State	Zıp Code	Phone 1	No	
Pı	ior QME Panel	Information <i>(Ans</i>	wer a <b>l</b> l (l	nut apply)	
Has the employee ever received a QME p	anel before?	□ Yes	□No	□ Unknown	
If yes, did the employee ever see any QM	T. C 41. 410.	<b>-</b>			
	E from that paner	□Yes	□ No	□ Unknown	
If yes, has that claim been settled or resolu	-			☐ Unknown	
If yes, has that claim been settled or resol-	-				
	ved'	□ Yes	□ No	☐ Unknown  Specialty:	Date of exam
If yes, has that claim been settled or resolution of QME seen  Date of Injury Body page 15.	ved"	□ Yes	□ No	☐ Unknown  Specialty:	Date of exam
If yes, has that claim been settled or resolution of QME seen	This completed Division of Worker P.O. Box 7	□ Yes  Is that QME ava	□ No  Ilable no  anled to: - Medica	□ Unknown  Specialty:  w □ Yes □ No	
If yes, has that claim been settled or resolution of QME seen  Date of Injury Body page 15.	This completed Division of Worker P.O. Box 7	Is that QME availed form must be mers' Compensation-1010, Oakland, Ca	□ No  Ilable no  anled to: - Medica	□ Unknown  Specialty:  w □ Yes □ No	

Note: The party submitting this form must attach a copy of the written proposal identifying a disputed issue and naming one or more physicians to be a AME.

QME Form 106 (rev. February 2009)

Page 2 of 3

#### For Use with the QME Panel Request Form 106

#### MD/DO SPECIALTY CODES\_\_\_\_\_

#### NON-MD/DO SPECIALTY CODES \_

MAI	Allergy and Immunology
MDE	Dermatology
MEM	Emergency Medicine
MFP	Family Practice
MPM	General Preventive Medicine
MHH	Hand

MMM Internal Medicine
MMV Internal Medicine - Cardiovascular Disease

MME Internal Medicine - Endocrinology Diabetes and

**M**etabolism

MMG Internal Medicine – Gastroenterology MMH Internal Medicine – Hematology MMI Internal Medicine – Infectious Disease MMN Internal Medicine – Nephrology

MMP Internal Medicine – Pulmonary Disease MMR Internal Medicine – Rheumatology

MNB Spine MPN Neurology

MNS Neurological Surgery (other than Spine)

MOG Obstetrics and Gynecology MPO Occupational Medicine

MMO Oncology - Orthopaedic Surgery Internal

Medicine or Radiology MOP Ophthalmology

MOS Orthopaedic Surgery (other than Spine or Hand)

MTO Otolaryngology MPA Pain Medicine MHA Pathology

MPR Physical Medicine and Rehabilitation
MPS Plastic Surgery (other than Hand)
MPD Psychiatry (other than Pain Medicine)
MSY Surgery (other than Spine or Hand)

MSG Surgery - General Vascular

MTS Thoracic Surgery

MTT Toxicology
MUU Urology

ACA Acupuncture
DCH Chiropractic
DEN Dentistry
OPT Optometry
POD Podiatry
PSY Psychology

PSN Psychology - Clinical Neuropsychology



1/25/2011

William Workman, MD 301 Lennon Lane, Ste 100 Walnut Creek, CA 94598 COPY

Re

D/Injury: 10/03/2009

Authorization No: 2009095282-

#### Dear Dr. Workman:

This istur will confirm that the treatment recommendation(s) outlined by you/your office on 01/24/2011 is authorized. Below please find the specific outline of that authorization to include description/duration and frequency.

Description and Duration

Authorization is provided for Outpatient Right knee arthroscopic partial medial/lateral meniscoctomy and Post-operative physical therapy x | 12, as per your request.

Should the procedures or treatment detailed above not accurately reflect what has been recommended, please contact me immediately. This certification expires on 03/15/2011. Should you anticipate that you will not be able to initiate the treatment by said date, please contact our Client Service Center at (800) 932-5535. If the treatment is initiated after said date, your billing for services may be subject to retrospective utilization review.

Sincerely,

Maurice Houllou Medical Coordinator

WellComp's Utilization Review Department

Enclosure(s)

ltrUU4/tt

cc: City of Valicjo
James Brunson

P.O. Box 619058 Roseville, CA 95661 • Phone (916) 783-0100 • Fax (800) 618-1439

This fax was recieved by Stryker's OrthoPad software, www.stryker.com

SpecialtyHealth MCO, Inc.

UTILIZATION REVIEW AND CASE MANAGEMENT 330 East Liberty Street, Suite 200 Reno, Nevada 89501 71304-53

March 24, 2011



Date of Injury: 10/3/2009

Requesting Physician: William B. Workman, M.D.

Diagnoses: Degenerative disc disease; lateral meniscus tear

## Request(s): Postoperative physical therapy, two times per week for five weeks for the right knee

Date of Birth: 6/3/1964, 46 year old male

Height (inches) / Weight (pounds): Unknown / Unknown, BMI: Unknown

Current Medications: Unknown

#### **Decisions and Comments:**

Request(s): Post-operative physical therapy, two times per week for five weeks for the right knee is APPROVED with MODIFICATION. Four (4) additional post-operative physical therapy sessions are APPROVED, Further physical therapy does not appear to be medically indicated at this time for this patient. If situations change and further medical justification is provided, I would be glad to address further physical therapy. Otherwise, any requests, either retrospectively or prospectively, would be denied at this point. See discussion below.

Comments: The utilization review determination above is performed on behalf of WellComp Managed Care Services, and falls in line with the utilization review plan filed by WellComp's as the Utilization Review Organization (URO). We are in receipt of the medical reporting received to support the review of this treatment request.

Due to the need to perform utilization review functions on claims that may not yet be accepted, either due to 90-day investigation period, dispute of body part, or denied liability of claim pending trial and determination by the WCAB; this notice is not deemed authorization of treatment, rather a determination (certification or non certification) based upon the application of nationally recognized guidelines as applied to industrial treatment.

Employer: Claim No:

Date Of Injury: 10/3/2009

Requesting Physician: William B. Workman, M.D.

March 24, 2011

The request for ten (10) post-operative physical therapy sessions is not supported by research; four (4) sessions are supported.

The most current medical report, dated 3/21/2011 from Doctor Workman, has been reviewed along with the rest of the submitted records.

The patient is noted to have suffered a right knee injury, and is status post right knee arthroscopy with meniscus repair on date 2/18/2011. The patient has undergone 12 post-operative physical therapy sessions since the surgery, with improvements in the knee noted. The patient is noted to be having some continued knee pain, weakness, and decreased range of motion, and the provider is requesting an additional ten sessions of post-operative physical therapy.

Regarding post-operative physical therapy following a knee arthroscopy with meniscus repair, the evidence based guidelines recommend a total of 12 session of physical therapy following the surgery. The patient is noted to have undergone the recommended amount of physical therapy since the surgery (12 sessions completed). For physical therapy to be continued beyond the guideline recommendations, a quantifiable measurable functional improvement must be documented from the prior sessions, and residual symptoms should exist. Also, the goal of physical therapy is the instruction and transition of the patient in a home exercise program, which allows the patient to become self-sufficient and continue rehabilitation on their own. As the patient is noted to have received measurable improvement in strength and range of motion in the right knee, continues to have residual symptoms, and has not been documented to be fully transitioned to a home program, a short course of additional sessions would be supported.

Therefore, based on review of the medical record, evidence based medicine and the preceding discussion, the request for <u>post-operative physical therapy</u>, two times per week for five weeks for the right knee is APPROVED with MODIFICATION. Four (4) additional post-operative physical therapy sessions are APPROVED.

CA Labor codes 9792.6-9792.9; 9792.20-9792.26 states:

Controversy exists about the effectiveness of therapy after arthroscopic partial meniscectomy. (Goodwin, 2003) Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term therapy interventions with exercises based on functional activities may be

Employer: Claim No:

Date Of Injury: 10/3/2009

Requesting Physician: William B. Workman, M.D.

March 24, 2011

more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. (Minns Lowe, 2007) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008)

Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella (ICD9 836; 836.0; 836.1; 836.2; 836.3; 836.5):

Postsurgical treatment: (Meniscectomy): 12 visits over 12 weeks \*Postsurgical physical medicine treatment period: 6 months.

Old bucket handle tear; Derangement of meniscus; Loose body in knee; Chondromalacia of patella; Tibialis tendonitis (ICD9 717.0; 717.5; 717.6; 717.7; 726.72):

Postsurgical treatment: 12 visits over 12 weeks \*Postsurgical physical medicine treatment period: 4 months

CA Labor codes 9792.6-9792.9; 9792.20-9792.26 defines functional improvement in 9792.20 (F):

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

A request for copies of the referenced evidence-based medical literature noted and/or the clinical rationale for this decision may be obtained by written request to SpecialtyHealth MCO.

Discussion regarding this review can be made to a physician reviewer Monday through Friday between the hours of 8:00 a.m. and 5:30 p.m. PST at 888-442-2230.

Employer: Claim No:

Date Of Injury: 10/3/2009

Requesting Physician: William B. Workman, M.D.

March 24, 2011

I have reviewed the provided documents, including medical reports, x-rays, and diagnostic studies, if available. The recommendation is based on the ACOEM Guidelines and the Guidelines for Utilization Review under Labor Code 4610, the July 2009 Medical Treatment Utilization Review Schedule (MTUS) and any other applicable evidence-based medical literature.

Please note: Current workers' compensation law mandates that utilization review decisions be made on the basis of evidence-based treatment guidelines. The ACOEM Guidelines are considered presumptively correct.

IF YOU DISAGREE WITH THIS MEDICAL DECISION, PLEASE SUBMIT A FORMAL WRITTEN REQUEST FOR MEDICAL APPEAL WITHIN 10 WORKING DAYS FROM RECEIPT OF THIS NOTIFICATION. YOU MUST MAIL AND FAX YOUR REQUEST TO:

WellComp Managed Care Services

Attention: Utilization Review Department

P.O. Box 59914 Riverside, CA 92517 Phone: 951-231-6800 Fax: 951-683-3539

A peer review decision will be mailed within 25 working days from the receipt of your medical appeal request.

Declaration: These evaluations were performed at SpecialtyHealth MCO, Inc. The review of medical records and/or reading of x-ray studies and/or medical evaluation were performed entirely by myself or another panel physician at my direction. The composing of these reports was performed by my staff and myself. All reports that have been prepared with the assistance of my staff are reviewed and signed entirely by me.

The above determination is based upon the reasonable medical necessity of treatment requested. Such determination may not be construed to waive or relinquish any legal basis for denial of liability of other issues that may or may not arise on the underlying claim.

Employer: Claim No:

Date Of Injury: 10/3/2009

Requesting Physician: William B. Workman, M.D.

March 24, 2011

I declare under penalty of perjury that the information and opinions contained in this report and its attachments are true and correct to the best of my knowledge and belief, except as to information I have indicated that I have received from others. As to the information, I declare under penalty of perjury that the information accurately describes the information provided to me, except as noted herein, I believe to be true. This report is in compliance with the guidelines established by the Administrative Director pursuant to Labor Code Section 4610.

I have not violated Labor Code Section 139.3 and the content of the report is true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Signed in: Reno, Nevada

Scott Hall, M.D.
Physician Reviewer
Board Certified – Family Medicine
CAQ – Sports Medicine
SpecialtyHealth MCO, Inc.
CA License: A102587

## <u>E James Greenwald</u>



E. James Greenwald, M.D.
Medical Director
Board Certified – Orthopedic Surgery
SpecialtyHealth MCO, Inc.
CA License: G19747

Cc: WellComp Managed Care Services Utilization Review Department

File

Date: 3/28/2011 9:13:38 AM

925 9440960



March 28, 2011

William Workman, MD 301 Lennon Lane #100 Walnut Creek, CA 94598



DOI: 10-03-09

Dear Dr. Workman:

This letter is sent on behalf of Christine Course, Senior Claims Adjustor with York insurance Services, Inc in regards to the City of Vallejo does have modified duty available. Modified duty consists of desk work and answering phones.

Please answer the following questions and fax back to Nancy immer, LVN at 888-620-6919.

Is Mr. able to work modified duty at this time?

If yes, what are his specific restrictions?

If no, why not and when is he anticipated to return to modified work?

Thank you for your prempt response.

Sincerety,

Nancy ImmeOLYN OPUR CPDM

WellComp NCM Phone: 916-872-2540 Fax: 888-620-6919

cc: Christine Course, CE (925) 349-3865 Fax (925) 609-9264

York Insurance Services 1390 Willow Pass Road, Suite 400 Concord, CA. 94520

This fax was recieved by Stryker's OrthoPad software, www.stryker.com



3/28/2011

William Workman, MD 101 Ygnacio Valley Rd., #400 Walnut Creek, CA 94596

D/Injury: 10/03/2009

Authorization No: 2009095282-001

Dear Dr. Workman:

We have carefully reviewed your detailed treatment recommendation dated 03/22/2011 regarding the above-captioned employee. After careful consideration in compliance with Labor Code Section 4610, we are recommending, as an alternative, the treatment plan detailed in the attached report from Dr. Greenwald.

This proposed modified treatment plan, as follows:

Post-operative physical therapy, two times per week for five weeks for the right knee is APPROVED with MODIFICATION. Four (4) additional post-operative physical therapy sessions are APPROVED. This certification expires on 05/30/2011.

Should you disagree with the proposed modifications to your treatment plan, please contact me immediately so that I may coordinate a teleconference between you and Dr. Greenwald in order to reach an agreement on an appropriate treatment plan for the above-captioned employee.

If I do not hear from you, I will assume that you are in agreement with the proposed modified treatment plan and will initiate the treatment accordingly.

You are also provided the option to discuss this determination with the Medical Director, Dr. Greenwald and or specialty reviewer who can be reached between the hours of M-F 8:00am to 5:30pm PST at (888) 442-2230 or an agreed upon scheduled time to discuss the decision with the requesting physician.

If you are the requesting or treating physician and disagree with the utilization review decision and wish to appeal it, we offer a voluntary appeal process wherein you are afforded the right to an appeal and to provide further documentation or explanation to support your opinion. To start this process, you must send written notice of your request for medical appeal within 10 working days from receipt of this notification. Your request must include further documentation supporting your appeal and should be supported by nationally recognized evidence based medical information. You must mail or fax your request to: WellComp at (800) 618-1439. A peer review decision will be mailed within 25 working days from the receipt of your medical appeal request.

By copy of this letter to the above referenced employee we are advising the employee of his/her right to dispute this medical decision as defined in L.C. Section 4062, A "Injured Worker Notice of Right to Dispute MD Delay, Denial, or Modification" as well as instructions are included as an attachment.

## Page 2 2009095282

If you have any questions or concerns, please do not hesitate to contact our Client Service Center at (800) 932-5535.

Sincerely,

Laura Keeney

Medical Coordinator

WellComp's Utilization Review Department

Attachment(s) U16 Injured Worker Notice of Right to Dispute MD Delay, Denial or Modification

ltrU07/ks

cc: City of Vallejo



NOTICE OF AUTHORIZATION	Date: 5/2/20	OII TOTA	AL PAGES (inc cover): 2
FAXED TO: 925-944-0960 ATTN: William FAXED TO: ATTN:	n Workman, MD		
William Workman, MD 101 Ygnacio Valley Rd., #400 Walnut Creek, CA 94596			
RE:  Requesting Physician: William Workm Requesting Provider (if applicable): Received Date: 04/28/2011 Authorization Date: 04/29/2011  Type of Review:   Expedited/Rush	nan, MD	Retrospective	[X] Prospective
Dear Provider:			
This letter will confirm that the treatment rec specific outline of that authorization to inclu	commendation out de description to i	lined by you is authori nclude frequency, dura	zed. Below please find the ation and quantity if applicable:
Authorization is provided for TRX band for	home exercise, as	per your request.	
Please be advised this certification expires or initiate said treatment by said expiration date reflect what has been recommended, please the treatment is initiated after said date, your	or should the pro- contact our Client	cedure or treatment de Service Center immed	tailed above not accurately liately at (800) 932-5535. If
Sincerely,  Allo Chery  Laura Keeney, Medical Coordinator			
ltrU03/ks			
cc: City of Valleio			

SpecialtyHealth MCO, Inc.

UTILIZATION REVIEW AND CASE MANAGEMENT 330 East Liberty Street, Suite 200 Reno, Nevada 89501 74005-53

May 3, 2011

Case Name:

Employer:
Claim Number:
Date of Injury:

10/3/2009

Requesting Physician: William Workman, M.D.

Diagnoses: Status post right knee arthroscopy, partial lateral menisectomy 02/18/2011

#### Request(s): Postoperative physical therapy, three times per week for four weeks

Date of Birth: 6/3/1964, 46 year old male

Height (inches) / Weight (pounds): Unknown / Unknown, BMI: Unknown

Current Medications: Unknown

#### **Decisions and Comments:**

Request(s): Postoperative physical therapy, three times per week for four weeks is DENIED. Further physical therapy does not appear to be medically indicated at this time for this patient. If situations change and further medical justification is provided, I would be glad to address further physical therapy. Otherwise, any requests, either retrospectively or prospectively, would be denied at this point.

Comments: The utilization review determination above is performed on behalf of WellComp Managed Care Services, and falls in line with the utilization review plan filed by WellComp's as the Utilization Review Organization (URO). We are in receipt of the medical reporting received to support the review of this treatment request.

Due to the need to perform utilization review functions on claims that may not yet be accepted, either due to 90-day investigation period, dispute of body part, or denied liability of claim pending trial and determination by the WCAB; this notice is not deemed authorization of treatment, rather a determination (certification or non certification) based upon the application of nationally recognized guidelines as applied to industrial treatment.

The medical reporting does not support this request.

The most recent medical record dated 04/28/2011 from William B. Workman, M.D. has been reviewed along with other submitted documents.

Case Name:

Employer: Claim No:

Date Of Injury: 10/3/2009

Requesting Physician: William Workman, M.D.

May 3, 2011

Affiliated review records reveal that a short course of additional physical therapy was approved on 3/24/2011 to address any remaining functional deficits and to ensure proper transition to a home exercise program. The patient has completed those visits, for a total of sixteen, and the provider is requesting additional care at this time.

Evidence based guidelines support a general course of up to twelve physical therapy visits over twelve weeks for rehabilitation after surgery similar to the one performed on the patient. The goal of physical therapy is not only the acute management of a condition but also the transition to a home exercise program so that patients can continue rehabilitation on his/her own.

The current reporting indicates that the patient's knee range of motion is 0 to 120 degrees. The physical therapy progress note, dated 4/18/2011, indicates that the patient is noted to be pain free with most exercise and is compliant with a home exercise program. The plan was to discharge the patient to a home exercise program to continue rehabilitation on his own. The patient's only functional limitation is slightly decreased knee motion and the patient is noted to be compliant with a home exercise program. As there are no extenuating factors that would support additional care beyond guideline recommendations, additional physical therapy is not supported for this patient.

Based on the reporting provided, the evidence-based guidelines, and the preceding discussion, the request for <u>postoperative physical therapy</u>, three times per week for <u>four weeks is DENIED</u>.

CA Labor codes 9792.6-9792.9; 9792.20-9792.26 states:

9792.24. 3. Postsurgical Treatment Guidelines

- (1) General course of therapy means the number of visits and/or time interval which shall be indicated for postsurgical treatment for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section.
- (2) Initial course of therapy means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section.
- (3) If postsurgical physical medicine is medically necessary, an initial course of therapy may be prescribed. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional

Case Name: Employer:

Claim No:

10/3/2009

Date Of Injury:

Requesting Physician: William Workman, M.D.

May 3, 2011

improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period.

CA Labor codes 9792.6-9792.9; 9792.20-9792.26 states:

Controversy exists about the effectiveness of therapy after arthroscopic partial meniscectomy. (Goodwin, 2003) Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term therapy interventions with exercises based on functional activities may be more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. (Minns Lowe, 2007) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008)

Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella (ICD9 836; 836.0; 836.1; 836.2; 836.3; 836.5):

Postsurgical treatment: (Meniscectomy): 12 visits over 12 weeks \*Postsurgical physical medicine treatment period: 6 months.

Old bucket handle tear; Derangement of meniscus; Loose body in knee; Chondromalacia of patella; Tibialis tendonitis (ICD9 717.0; 717.5; 717.6; 717.7; 726.72):

Postsurgical treatment: 12 visits over 12 weeks \*Postsurgical physical medicine treatment period: 4 months

CA Labor codes 9792.6-9792.9; 9792.20-9792.26 defines functional improvement in 9792.20 (F):

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

A request for copies of the referenced evidence-based medical literature noted and/or the clinical rationale for this decision may be obtained by written request to

Case Name:

Employer: Claim No:

10/3/2009

Date Of Injury:

Requesting Physician: William Workman, M.D.

May 3, 2011

#### SpecialtyHealth MCO.

Discussion regarding this review can be made to a physician reviewer Monday through Friday between the hours of 8:00 a.m. and 5:30 p.m. PST at 888-442-2230.

I have reviewed the provided documents, including medical reports, x-rays, and diagnostic studies, if available. The recommendation is based on the ACOEM Guidelines and the Guidelines for Utilization Review under Labor Code 4610, the July 2009 Medical Treatment Utilization Review Schedule (MTUS) and any other applicable evidence-based medical literature.

Please note: Current workers' compensation law mandates that utilization review decisions be made on the basis of evidence-based treatment guidelines. The ACOEM Guidelines are considered presumptively correct.

IF YOU DISAGREE WITH THIS MEDICAL DECISION, PLEASE SUBMIT A FORMAL WRITTEN REQUEST FOR MEDICAL APPEAL WITHIN 10 WORKING DAYS FROM RECEIPT OF THIS NOTIFICATION. YOU MUST MAIL AND FAX YOUR REQUEST. TO:

WellComp Managed Care Services

Attention: **Utilization Review Department** 

> P.O. Box 59914 Riverside, CA 92517 Phone: 951-231-6800 Fax: 951-683-3539

A peer review decision will be mailed within 25 working days from the receipt of your medical appeal request.

Declaration: These evaluations were performed at SpecialtyHealth MCO, Inc. The review of medical records and/or reading of x-ray studies and/or medical evaluation were performed entirely by myself or another panel physician at my direction. The composing of these reports was performed by my staff and myself. All reports that have been prepared with the assistance of my staff are reviewed and signed entirely by me.

The above determination is based upon the reasonable medical necessity of treatment requested. Such determination may not be construed to waive or relinquish any legal basis for denial of liability of other issues that may or may not arise on the underlying claim.

Case Name:

Employer: Claim No:

Date Of Injury: 10/3/2009

Requesting Physician: William Workman, M.D.

May 3, 2011

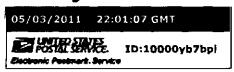
I declare under penalty of perjury that the information and opinions contained in this report and its attachments are true and correct to the best of my knowledge and belief, except as to information I have indicated that I have received from others. As to the information, I declare under penalty of perjury that the information accurately describes the information provided to me, except as noted herein, I believe to be true. This report is in compliance with the guidelines established by the Administrative Director pursuant to Labor Code Section 4610.

I have not violated Labor Code Section 139.3 and the content of the report is true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Signed in: Reno, Nevada

Scott Hall, M.D.
Physician Reviewer
Board Certified – Family Medicine
CAQ – Sports Medicine
SpecialtyHealth MCO, Inc.
CA License: A102587

#### E James Greenwald



E. James Greenwald, M.D.

Medical Director

Board Certified – Orthopedic Surgery

SpecialtyHealth MCO, Inc.

CA License: G19747

Cc: WellComp Managed Care Services

**Utilization Review Department** 

File



5/4/2011

William Workman, MD 101 Ygnacio Valley Rd., #400 Walnut Creek, CA 94596

Re: D/Injury: 10/03/2009

Dear Dr. Workman:

This letter is to inform you that the treatment recommendation of postoperative physical therapy, three times per week for four weeks made by you regarding the above captioned employee is being denied. The attached report from Dr. Greenwald details the specific treatment that is being denied, as well as the specific reasons, the guidelines and criteria used and, if appropriate, the clinical reason for the denial.

If you proceed with said treatment recommendations, or if they have already been rendered, your request for reimbursement will be denied.

You are also provided the option to discuss this determination with the Medical Director, Dr. Greenwald and/or specialty reviewer who can be reached between the hours of M-F 8:00am to 5:30pm PST at (888) 442-2230 or an agreed upon scheduled time to discuss the decision with the requesting physician.

If you are the requesting/treating physician, and disagree with the utilization review decision and wish to appeal it, we offer a voluntary appeal process wherein you are afforded the right to an appeal and the opportunity to provide further documentation or explanation to support your opinion. To start this process, you must send written notice of your request for medical appeal within 10 working days from receipt of this notification. Your request must include further documentation supporting your appeal and should be supported by nationally recognized evidence based medical information. You must mail and fax your request to: WellComp (800) 618-1439. A peer review decision will be mailed within 25 working days from the receipt of your medical appeal request

By copy of this letter to the above referenced employee we are advising the employee of his/her right to dispute this medical decision as defined in L.C. Section 4062, the "Injured Worker Notice of Right to Dispute MD Delay, Denial, or Modification" as well as instructions are included as an attachment.

If you have any questions or concerns, please do not hesitate to contact our Client Service Center at (800) 932-5535.



Sincerely,

Laura Keeney

Laura Keeney Medical Coordinator

WellComp's Utilization Review Department

Attachment(s) U16 Injured Worker Notice of Right to Dispute MD Delay, Denial or Modification

ltrU09/ks

cc: City of Valleio

William Workman, MD 1 Shrader Street, #650 San Francisco, CA 94117

Dear Dr. Workman,

We trust and understand when you refer a patient for physical therapy services you expect your patients to be given the best treatment possible and the highest level of care. Our Mission Statement at Sports + Orthopedic Leaders Physical Therapy, Inc. promises to treat each and every patient with the utmost care and we take pride in achieving objective results. We have enclosed an example of these results written by your patients. We have been diligently working with Aa Jauregui, DPT and Chris Contois, MPT ART. We are very grateful for this referral.

Thank you again, and please know that we are personally available to assist you with any of your patients' questions and/or requests.

Respectfully,

Moon

Tammara Moore, DPT, OCS, Owner

(510) 823-7154, ceil

Menson, MPT, OCS, Owner

Stothani Sau

(510) 435-6839, cell

Stephanie Sousa, Patient Care Coordinator

(510) 735-7990, cell

Enclosure

#### Hands-on Physical Therapy + Performance Care

5297-A College Avenue **Oakland,** California 94618 **P** 510 547 1630 **F** 510.923.1944
1510 Seabright Avenue **Santa Cruz,** California 95062 **P** 831 425.3588 **F** 831.425.3538
800 South Broadway, Suite 309 **Walnut Creek,** California 94596 **P** 925.977.9300 **F** 925.952.9568

#### NOTICE OF AUTHORIZATION

Date:	May	3,	2012
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TOTAL PAGES (inc cover) 1

FAXED TO: 925-944-0960 ATTN: Dr. Workman FAXED TO:

William B. Workman, MD 101 Ygnacio Valley Road #400 Walnut Creek, CA. 94596

RE:



Requesting physician: Dr. Workman Requesting provider (if applicable):

Received date: 04/30/2012 Authorization Date: 05/01/2012 Authorization No: CVCD-524954-003

Type of Review:

Expedited/Rush

Concurrent

Retrospective

x Prospective

Dear Dr. Workman:

This letter will confirm that the treatment recommendation outlined by you is authorized. Below please find the specific outline of that authorization to include description to include frequency, duration and quantity if applicable:

Authorization is provided for aquatic therapy ten sessions, as per your request.

Please be advised this certification explies on 06/30/2012. Should it be anticipated that you will be unable to initiate said treatment by said expiration date or should the procedure or treatment detailed above not accurately reflect what has been recommended, please contact our client services center immediately at 1-800-932-5535. If the treatment is initiated after said date, your billing for services may be subject to retrospective utilization review.

Sincerely.

Gina Mendoza Medical Coordinator



City of Vallejo 555 Santa Clara Street, Vallejo, CA 94590



#### NOTICE OF AUTHORIZATION

Date: July 13, 2012

FAXED TO: 925-944-0960 ATTN: Dr. Workman

William B. Workman, MD 101 Ygnacio Valley Road #400 Walnut Creek, CA. 94596 **TOTAL PAGES: 1** 

FAXED TO: 901-653-2695 ATTN: StoneRiver Pharmacy

RE:

D/Injury: 10/3/2009

Requesting physician: Dr. Workman Requesting provider (if applicable): Received date: 07/12/12 Authorization Date: 07/12/12

Authorization No: -004

Type of Review:

Expedited/Rush

Concurrent

Retrospective

Prospective

Dear Dr. Workman:

This letter will confirm that the treatment recommendation outlined by you is authorized. Below please find the specific outline of that authorization to include description to include frequency, duration and quantity if applicable:

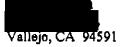
Authorization is provided for Diclofenac 75mg #30 with no refills, as per your request.

Please be advised this certification expires on 08/13/12. Should it be anticipated that you will be unable to initiate said treatment by said expiration date or should the procedure or treatment detailed above not accurately reflect what has been recommended, please contact our client services center immediately at 1-800-932-5535. If the treatment is initiated after said date, your billing for services may be subject to retrospective utilization review.

Sincerely,

Gina Mendoza Medical Coordinator

CC:



City of Vallejo 555 Santa Clara Street, Vallejo, CA 94590

StoneRiver Pharmacy Solutions via facsimile

#### \*\* INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY

TIME RECEIVED March 25, 2014 4:45:34 PM EDT

REMOTE CSID

DURATION 138 **PAGES**  STATUS Received

2014-03-25 13:18

occ med

7076512955 >>

P 1/4

MR:01977909 WCAB#: FAC:VAL Contact:(707) 651-1370 Currier DOI (if available); State of California, Division of Workers' Compensation REQUEST FOR AUTHORIZATION

DWC Form RFA

Attach the Doctor's First Report of Occupational injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

X New Request	Resut	bmission - Change in Material I	acts Retros	pective Review
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	Serono Drive		City: Vullejo	State: CA
Zip Code: 945			Fax Number: (707) 651-	
Specialty:		)	NPI Number: 120503148	<u> </u>
E-mail Address:				
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Company Name	_		Contact Name: SCHAL	
Address: POBC			City; ROSEVILLE	State: CA
Zip Code: 95661		e; (800) 422-7244	Fax Number: (050) * 10	- Pag. (51.8.14.12h) -
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occ med

MRN:01977909 Shows P Bruncos Patient Name: Requesting Provider: Zilium Tung, M.D. Provider Id: 000067878 Mm: 03977909 Gender: Male Fac/Adm Dept: VAL/OCC Apa: 49y 9m Language: 8NGLISH Contact Phone: (787)556-0432 Tie Line/Ent: 8-460-2853 Fish Tie Lines PCP: Brian D Winter, M.D. - (VAL)MED इंजिल्डा व्युक्ता Actors Time; & days Status: (02) RESPONSE NEEDED Data Inklatof: 63/18/2014 Response Date: FAC/SPE: Valide/Occupational Modicine Assigned to For Triage: Last Modified By: KVAZT1 03/18/2014 9109 AM Triage Provider: Britared By: 20144 Tang, M.D. 03/18/2014 9:09 AM Problem Resons Authorization -Work Related Injury E B M COGINE! Nane THE THE WOYKUDE 1. Sadilty where referral is generated: Aè Vallejo 2. Date of Injury (mm/dd/yy): Ai 02/13/14 3. Type of Consult: A: 4. Passible Procedure Needed: AI NRI, 5. Possible Treatment Needed: At 6. Postible Surpery Needed: A 7. This patient is part of a Medical Provider Network (MPN) Az 5. Name of provider to whom this patient is being referred: 9. Reason patient is being referred outside: 10. Transfer of Care? 11. For MRI requests the following is required: Ai 12. Patient History/Comments: Ar left hip injury, itmited progress with PT, evidence of labral test, request left hip arthrogram study for farther evaluation ning Internation:

Provideri

3/19/2014

Validio

Prieritys

HRN:01977909

Booking Instructions:

Dept:

OCM

Rowning & Romor,



April 22, 2014

William Workman, M.D. Walnut Creek Orthopedics & Sports Medicine 101 Ygnacio Valley Rd., Suite 400 Walnut Creek, 94596

RE: WCAB/ADJ#:

Dear Dr. Workman,

You have been designated as the Primary Treating Physician for growing. In this regard you come under the provisions of 8 CCR \$9785, "Reporting Duties of the Primary Treating Physician". This regulation is attached and we ask you to review the time frames and reporting requirements therein when submitting your reports concerning the employee's medical condition.

The employee's claim for injury has been accepted for the Left Hip. You are authorized to provide reasonable and necessary medical treatment for the accepted medical conditions to cure and relieve from the effects of the employee's injury in accordance with the Medical Treatment Utilization Schedule (\$5307.27), utilization review guidelines pursuant to \$4610 and other nationally recognized scientific evidence-based guidelines.

## Please have your office staff contact Mr. at (707) 333-9258.

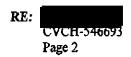
I look forward to receiving your report with a treatment plan. If you have any questions or need additional information please contact me at (209) 320-0809.

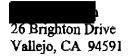
Sincerely,

Schaunna McEachron

Schaunna McEachron Claims Examiner

cc: City of Vallejo Attn: Maria Olvera 555 Santa Clara Street Vallejo, CA 94590





Enclosure: Reporting Duties of the Primary Treating Physician - 8 CCR 9785

#### Reporting Duties of the Primary Treating Physician – 8 CCR §9785

- (a) For the purposes of this section, the following definitions apply:
- (1) The "primary treating physician" is the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. The primary treating physician is the physician selected by the employer, the employee pursuant to Article 2 (commencing with Section §4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code, or under the contract or procedures applicable to a Health Care Organization, certified under Section §4600.5 of the Labor Code, or in accordance with the physician selection procedures contained in the medical provider network pursuant to Labor Code Section §4616.
- (2) A "secondary physician" is any physician other than the primary treating physician who examines or provides treatment to the employee, but is not primarily responsible for continuing management of the care of the employee.
- (3) "Claims Administrator" is a self-administered insurer providing security for the payment of compensation required by Division 4 and 5 of the Labor Code, a self-insured employer, or a third-party administrator for a self-insured employer, insurerer, legally uninsured employer or joint powers authority.
- (4) "Medical determination" means, for the purpose of this section, a decision made by the primary treating physician regarding any and all medical issues necessary to determine the employee's eligibility for compensation. Such issues include but are not limited to the scope and extent of an employee's continuing medical treatment, the decision whether to release the employee from care, the point in time the employee has reached permanent and stationary status, and the necessity for future medical treatment.
- (5) "Released from care" means a determination by the primary treating physician that the employee's condition has reached a permanent and stationary status with no need for continuing or future medical treatment.
- (6) "Continuing medical treatment" is occurring or presently planned treatment that is reasonably required to cure or relieve the employee from the effects of the injury.
- (7) "Future medical treatment" is treatment which is anticipated at some time in the future and is reasonably required to cure or relieve the employee from the effects of the injury.

- (8) "Permanent and stationary status" is the point when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized and unlikely to change substantially in the next year with or without medical treatment.
- (b)(1) An employee shall have no more than one primary treating physician at a time.
- (2) An employee may designate a new primary treating physician of his or her choice pursuant to Labor Code §4600 or §4600.3 provided the primary treating physician has determined that there is a need for:
  - (A) continuing medical treatment; or
- (B) future medical treatment. The employee may designate a new primary treating physician to render future medical treatment either prior to or at the time such treatment becomes necessary.
- (3) If the employee disputes a medical determination made by the primary treating physician, including a determination that the employee should be released from care, or if the employee objects to a decision made pursuant to Labor Code Section §4610 to modify, delay, or deny a treatment recommendation, the dispute shall be resolved under the applicable procedures set forth in Labor Code Sections §4601 and §4602. No other primary treating physician shall be designated by the employee unless and until the dispute is resolved.
- (4) If the claims administrator disputes a medical determination made by the primary treating physician, the dispute shall be resolved under the applicable procedures set forth at Labor Code Sections §4610, §4601 and §4062.
- (c) The primary treating physician, or a physician designated by the primary treating physician, shall make reports to the claims administrator as required in this section. A primary treating physician has fulfilled his or her reporting duties under this section by sending one copy of a required report to the claims administrator. A claims administrator may designate any person or entity to be the recipient of the required report.
- (d) The primary treating physician shall render opinions on all medical issues necessary to determine the employee's eligibility for compensation in the manner prescribed in subdivisions  $\epsilon$ , (f) and (g) of this section. The primary treating physician may transmit reports to the claims administrator by mail or FAX or by any other means satisfactory to the claims administrator, including electronic transmission.
- (e) (1) Within 5 working days following initial examination, a primary treating physician shall submit a written report to the claims administrator on the form entitled "Doctor's First Report of Occupational Injury or Illness" Form DLSR 5021. Emergency and urgent care physicians shall also submit a form DLSR 5021 to the claims

administrator following the initial visit to the treatment facility. On line 24 of the Doctor's first Report, or on the reverse side of the form, the physician shall (A) list methods, frequency, and duration of treatment(s), (B) specify planned consultations or referrals, surgery or hospitalization and (C) specify the type, frequency and duration of planned physical medicine services 9e.g. physical therapy, manipulation, acupuncture).

- (2) Each new primary treating physician shall submit a Form DLSR 5021 following the initial examination in accordance with subdivision (e)(1).
- (3) Secondary physicians, physical therapists and other health care providers to whom the employee is referred shall report to the primary treating physician in the manner required by the primary treating physician.
- (4) The primary treating physician shall be responsible for obtaining all of the reports of secondary physicians and shall, unless good cause is shown, within 20 days of receipt of each report, incorporate, or comment upon, the findings and opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator.
- (f) A primary treating physician shall, unless good cause is shown, within 20 days report to the claims administrator when any one or more of the following occurs:
- (1) The employee's condition undergoes a previously unexpected significant change;
- (2) There is any significant change in the treatment plan report including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a new need for referral for consultation by another physician, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic device;
- (3) The employee's condition permits return to modified or regular work;
- (4) The employee's condition requires him or her to leave work or requires changes in work restrictions or modifications;
- (5) The employee is released from care;
- (6) The primary treating physician concludes that the employee's permanent disability precludes, or is likely to preclude, the employee from engaging in the employee's usual occupation or the occupation in which the employee was engaged at the time of the injury, as required pursuant to Labor Code §4636 (b)[REPEALED]

- (7) The claims administrator reasonably requests appropriate additional information that is necessary to administer the claim. "Necessary" information is that which directly affects the provision of compensation benefits as defined in Labor Code Section §3207];
- When continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred. If an examination has occurred, the report shall be signed and transmitted within 20 days of the examination. Except for a response to a request for information made pursuant to subdivision (f) (7), the reports required under this subdivision shall be submitted on the "Primary Treating Physician's Progress Report' form (PR-2) contained in section §9785.2, or in the form of a narrative report. If a narrative report is used, it must be entitled "Primary Treating Physician's Progress Report" in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2. A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-2: "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:.

By mutual agreement between the physician and the claims administrator, the physician may make reports in any manner and form.

- (g) When the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall, unless good cause is shown, report within 20 days from the date of the examination any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing and/or future medical care resulting from the injury. The information may be submitted on the "Primary Treating Physician's Permanent and Stationary Report" form (DWC Form PR-3) or DWC Form PR-4) contained in section §9785.3 or section §9785.4 or in such other manner which provides all the information required by Title 8, California Code of Regulations, section §10606. For permanent disability evaluation performed pursuant to the permanent disability evaluation schedule adopted on or after January 1, 2005, the primary treating physician's reports concerning the existence and extent of permanent impairment shall describe the impairment in accordance with the AMA Guides to the Evaluation of Permanent Impairment, 5th edition (DWC Form PR-4). Qualified Medical Evaluators may not use DWC Form PR-3 or DWC Form PR-4 to report medical-legal evaluations.
- (h) Any controversies concerning this section shall be resolved pursuant to Labor Code Section §4603 or §4604, whichever is appropriate.

(i) Claims administrators shall reimburse primary treating physicians for their reports submitted pursuant to this section as required by the Official Medical Fee Schedule

Review 5/22/14 Offer west.





526 Washington St, Ste 1 · Ashland OR 97520 · phone 800,497,1368 · fax 541,488,5408

To:	Dr. William Workman		From:	Sharon Riv	ers
Fax:	9259440960		Pages:	2	
Phone:	9259440110		Date:	5/20/14	
Re:	Vallejo F	Tre, CVCH-546693	CC:		
x Urgent	☐ For Review	☐ Please Comment	X Pleas	se Reply	☐ Please Recycle

Comments:

Dear Dr. Workman:

As you may recall, my name is Sharon Rivers and I am an early-return-to-work consultant working with City of Valiejo Human Resources Dept. The City is a participant in the OUR System®, a structured program designed to accommodate injured workers with physically appropriate work during their recovery process. The OUR System® consists of temporary assignments called Bridge Assignments. We also send for Increased Capacities requests under this program when the worker is already working in a modified capacity. There is no Bridge Assignment attached with this action. We request your professional opinion regarding the worker.

According to our records, the worker has an accepted claim for injuries suffered on 2/15/14 and is presently working in a modified capacity. The employer would like to add some more tasks with your approval. Could the worker now lift, carry, push, pull up to 25 -- 30 lbs.? Could the worker occasionally bend knee for squat or kneel tasks? Please consider this request. I have attached a release form for your convenience to reply as soon as possible.

Mr. Is a valued employee and the employer is willing to accommodate any medically necessary restrictions to aid in the healing process. It has also been proven that workers heal faster when able to participate in the workforce in a valid capacity. Please note that the worker can usually participate in Physical Therapy while on a modified work assignment. We would greatly appreciate your professional opinion on the attached release at your earliest convenience.

Thank you for your time and consideration of this request. **Please fax back your response to Sharon Rivers at 541-488-5408.** And should you have any questions you'd like to discuss with me please feel free to contact me directly at 541-955-1657.

Sincerely,

Sharon Rivers
Return-to-Work Coordinator
Norman Peterson & Associates

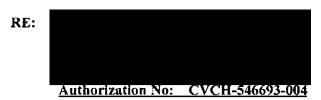
Attached: = Request for release to increased capacities

NOTICE: This fax message and all attachments transmitted with it may contain legally privileged and confidential information intended solely for the use of the addressee. If the reader of this message is not the intended recipient, you are hereby notified that any reading, dissemination, distribution, copying, or other use of this message or its attachments is strictly prohibited. If you have received this message in error, please notify the sender immediately and destroy this correspondence. Thank you.



June 4, 2014

William B. Workman, M.D 101 Ygnacio Valley Rd., Ste. 400 Walnut Creek, CA 94598



Dear Dr. William B. Workman, M.D.

This letter will confirm that the treatment recommendation(s) outlined by you/your office on 05/27/2014 is authorized. Below please find the specific outline of that authorization to include description/duration and frequency.

#### Description and Duration

Purchase of Hip Brace and Post-operative physical therapy (PT) for twenty four (24) visits. Outpatient Left hip arthroscopy with Femoroplasty, Acetbuloplasty and Labral Repair, with preoperative EKG and CBC and Preoperative Clearance by physician.

Please be advised this certification expires on 08/31/2014. Should it be anticipated that you will be unable to initiate said treatment by said expiration date or should the procedure or treatment detailed above not accurately reflect what has been recommended, please contact our Client Service Center at (800) 932-5535. If the treatment is initiated after said date, your billing for services may be subject to retrospective utilization review.

Sincerely,

Penny Moody/af
Medical Coordinator
WellComp's Utilization Review Department

Enclosure(s)

vallejo, CA 94591

City of Vallejo

A ITN: VICKY SCOPESI



June 4, 2014,

William B. Workman, M.D. 101 Ygnacjo Valley Rd., Ste. 400 Walnut Creek & CA 94598

RE.



Authorization No: CVCH-546693-004

Dear William B. Workman, M.D.

We have carefully reviewed your detailed treatment recommendation dated 05/27/2014 regarding the above-captioned employee. After careful consideration in compliance with Labor Code Section 4610, we are recommending, as an alternative, the treatment plan detailed in the attached report from Dr. Gary Taff, MD.

This proposed modified treatment plans as follows:

Post operative DME rental of GPM machine for seven (7) day rental Cold Therapy Unit for seven (7). Expiration Date: 08/31/2014.

'Yourare also, provided the option to discuss this idetermination with Dr. Gary Faffs MD and or specially reviewer who can be reached between the hours of M-F-8:00am to 5:00pm CST at (800) 580-2273 to schedule an agreed upon time to discuss the decision with the requesting physician:

If you are the requesting or treating physician and disagree with the utilization review decision and wish-to appeal it, we offer a voluntary appeal process, wherein you are afforded the right to an appeal and to provide further documentation or explanation to support your opinion. To start this process, you must send written notice of your request for medical appeal within 10 working days from receipt of this notification. Your request must include further documentation supporting your appeal and should be supported by nationally recognized evidence based medical information. You must mail or fax your request to: WellComp at (800) 618-1439. A peer review decision will be mailed within 25 working days from the receipt of your medical appeal request.

By-copy of this letter to the above referenced employee we are advising the employee of his/her right to dispute this medical decision as defined in L.C. Section 4610.5 and 4610.6 and the DWC form IMR-1, the "Injured Worker Notice of Right to Dispute MD delay, Denial, or Modification" as well as instructions are included as an attachment.

If you have any questions or concerns, please do not hesitate to contact our Client Service Center at (800) 932-5535.

Sincerely,

Penny Moody/at
Medical Coordinator
WellComp's Utilization Review Department

cc: Linda Joanne Brown Attorney At Law 999 Fifth Ave., Suite 430, San Rafael, CA 94901 Main Office: Vacuville

(707)447-8462 Phone: Fax: (707)447-8463

# "The Next Step" Physical Repair

Phone: (707)644-7013 Fax: (707)644-7014

BRIDGING THE GAP BETWEEN PHYSICAL THERAPY AND FUNCTIONAL INDEPENDENCE

#### PRESCRIPTION FORM

Patient Name		Date
Injury Rehab Programs	Exercises	Total Gym
Ankle/Foot	Strengthening	
Ќлее	Stretching	Other Work Hannening to R
Hip	Aerobic	Phase I: RTW Requirement
Back	Conditioning	Phase II:
Neck	Aqua Therapy	Phase III:
Shoulder	Lumbar Stabiliz	ation
Elbow		Independent Gym (IEP)
Wrist/Hand	'Authorizațion	· · · · · · · · · · · · · · · · · · ·
	<u></u>	
Diagnosis	Fre	queпсу
	Du	ration
Remarks		· · · · · · · · · · · · · · · · · · ·

Referring Doctor's Signature

By James Quintella PA-C at 1:54 pm, Jul 13, 201

Date: <u>02/26/2010</u>	Patient: BI			
Facility: <b>☑</b> Pr	remier	<b>□</b> ЈММС- <i>WC</i>	Other Facility	DOB: (
<b>Z</b> o	UT Patient □AM Admit □23	Hour Observatio	n	
URGENT	Patient request	s:		Patient will Call
Procedure: Left kr	nee arthroscopy and partial late	ral menisectomy	1	
			PL #	:
ANESTHETIC:	<b>☑</b> General	□Fem	noral Block	
OPEN	<b>ARTHROSCOPIC</b>	Length	of Procedure: 3/4	hr.
Assistant: none	PCP Pre-0	Op:	Date/Time	e:
Diagnosis:				
ICD9: <u>715.16 - DJD</u>	knee 836.1 - Lat. Meniscus te	ear		
CPT:	29881			
Misc Equipment:				
Post-Op Equipment:	Pain Pump:    □ 2 Day	Disp by:		
	☐4 Day☐ COLD THERAPY	Disp by:		
	Cradle Arm Sling	Disp by:		
	ROM Knee Brace	Disp by:		
	□срм	Disp by:		
Surgery Date/Time: 0	<b>3/31/10</b> Pre-Op Date/Ti	me: <b>03/29/10</b>	CONF. I	No.:
Computer DEVG	: ☐Sent nationt nanenwork ■ Pos	of OD DT Eavade	13/16/10 Eavad 9	Surgen, 03/16/10



# Post-Operative Physical Therapy Prescription

# WILLIAM B. WORKMAN, M.D.

V6360387	A-72343
0_	Fax #: 707-747-9477
ay	
	_
31/10	
ARTHROSCO	DPY PARTIAL LATERAL MENISECTOMY.
office day. Attache	Surgery is scheduled for the above date. We ask that ed is the patient demographic and insurance sary, the patient's insurance to make the necessary our patients.
	ICD-9: 836.1
<b>1</b> _week(s)	(MD f/u appt. 2 weeks/post-op)
ROL [	Shoulder Knee
RC S	DALITIES FOR PAIN & SWELLING TRENGTHENING PULAR STABILITY
	31/10  ARTHROSCO  escription below. Soffice day. Attaches ient and, if necess excellent care of a second se

WSWn leman, MD
William B. Workman, MD

301 Lennon Lane, Suite 100 - Walnut Creek, CA 94598 Phone: 925.944.0110 - Fax: 925.944.0960

# William B. Workman, MD Orthopedic Sports Medicine Surgeon

DATE:	03/2	29/20	10		_							
TO WH	TI MOI	MAY (	CONCE	RN:								
RE:_												
The ab	ove pa	atient i	s;									
	Relea	sed to	return t	to regula	ar work	as of _						
	Relea	sed to	return t	to light	duty as	of			wit	h these	restrict	ions:
	•	•	•	•	•	•	•	•	•	•	•	•
Ø								nths				
		<u>: 3/29</u>						5/31/1				
	Due t	<sub>o</sub> Kne	e sur	gery								
	•	•	•	•	•	•	•	•	•	•	•	•
	May t	take ph	ysical e	ducatio	n as of_							
	May I	NOT tal	ke phys	ical edu	ication f	or			due	to:		
Signed	√Willia 301 L	.ennon	Vorkman	n, MD Suite 10	1an,	lm						

Phone (925) 944-0110 Fax (925) 944-0960

William B. Workman, MD

301 Lennon Lane, Suite 100 Walnut Creek, California 94598 Phone: (925) 944-0110 Fax: (925) 944-0960

## Physical Therapy Order Form

Date: 06/02/2010
Patient Nam
Diagnosis(es):s/p knee arthroscopy, partial lateral mnsctmy
☐ RIGHT ☐ BILATERAL
EVALUATION & TREATMENT  AROM
Frequency: 2 Times / Week Duration: 6 Weeks
Physician's Signature

•

# William B. Workman, M.D. 301 Lennon Lane, Suite 100 Walnut Creek, CA 94598 Phone: (925) 944-0110 Fax: (925) 944-0960

# **MRI REQUEST**

Date	e: <u>10/21/2010</u>				
Pati	ent Nam				
	With Contrast Without Contra	st			Right Left
匃	Kn <b>e</b> e		Elbow	□ C	-Spine
	Shoulder	□	Wrist	□ L-	Spine
	Hip		Ankle		
	Other				
Dia His	gnosis: medeal tory: R/v med	pa le	m O nemocn	) <del> </del>	?a—
2				, o	
	□ URGENT				
	☐ ROUTINE		UBWo kw	nan	im
			William	B. W	orkman, M.D.

Date: <u>01/07/2011</u>	Patien			Age <u>: 46</u>
Facility: 🗹	Premier JMMC- <i>Concord</i> [	☐ JMMC- <i>WC</i>	Other Facility	DOE
<b>Z</b>	OUT Patient	Hour Observation	on	
URGENT	Patient requests	s:		Patient will Call
Procedure: RIGH	IT KNEE ARTHROSCOPY PARTIA	L MEDIAL & LA	TERAL MENISECT	ЭМҮ
			PL #	:
ANESTHETIC:	<b>☑</b> General	□Fer	noral Block	
OPEN	<b>ARTHROSCOPIC</b>	Lengti	of Procedure: 1	hr.
Assistant: NONE	PCP Pre-C	)p:	Date/Time	ə:
Diagnosis:				
[CD9; 836.1 - Lat. Meni	scus tear 836.0 - Med. Meniscus Te	ar		
		_		
	☐ Mini C-ARM ☐ C-ARM			
Post-Op Equipment	<u> </u>			
	☐4 Day			
	COLD THERAPY	Disp by:		
	☐ Cradle Arm Sling	Disp by:		
	ROM Knee Brace	Disp by:		
	□СРМ	Disp by:		
Surgery Date/Time:	<b>02/18/11</b> Pre-Op Date/Tin	ne: <b>02/17/11</b>	CONF.	No.:
☑Computer □Ek	G  ☐Sent patient paperwork ■ Posi	t OP PT Faxed:	<b>01/28/11</b> Faxed S	Surgery <b>01/28/11</b>



# Post-Operative Physical Therapy Prescription

# WALNUT CREEK ORTHOPEDICS SPORTS MEDICINE WILLIAM B. WORKMAN, M.D. BW6360387 A-72343

Date: 01/28/2011	Fax #: 510-923-1944
TO: SOL	_
FROM: TERE	
Patient Names	
Date of Surgery: 02/18	/11
Procedure: RIGHT KNEE ARTHI	ROSCOPY PARTIAL MEDIAL & LATERAL MENISECTOMY
therapy commence the following office of	ion below. Surgery is scheduled for the above date. We ask that day. Attached is the patient demographic and insurance and, if necessary, the patient's insurance to make the necessary ent care of our patients.
Dx: MED/LAT MENISCU	JS TEARS ICD-9: 836.0 & 836.1
day(s)/week X	week(s) (MD f/u apptweeks/post-op)
Evaluate and Treat R	L Shoulder Knee
PROM AAROM AROM PRE HEP	MODALITIES FOR PAIN & SWELLING RC STRENGTHENING SCAPULAR STABILITY QUAD/HAMSTRING STRENGTH/FLEXABILITY
12 VISITS CERTIFIED - S	SEE ATTACHED.
SIGNED: William B. Wo	rkman, MD

101 Ygnacio Valley Road, Suite 400 - Walnut Creek, CA 94596 Phone: 925.944.0110 - Fax: 925.944.0960

## William B. Workman, MD Orthopedic Sports Medicine Surgeon

DATE	<u>:</u> 02/	24/20	011		_							
TO W	/HOM I	T MAY	CONCE	RN:								
RE;							*FA	XED	TO 7	′07-6	48-52	<u>89</u>
The a	bove p	atient i	ls:									
	Relea	ased to	return	to regui	ar work	as of _						
	Relea	ased to	return	to light	duty as	of			wi	th thes	e restric	tions:
	•	•	•	•	•	•	•	•	•	•	•	•
				work fo	-						PT. D	ATE)
	Due	to										
	•	•	•	•	•	•	•	•	•	•	•	•
	May	take ph	ıysical e	ducatio	n as of_							
	May	NOT ta	ke phys	ical edu	ication 1	for			due	e to:		
Signe ⁄	Willia 101 Y	gnaclo	Vorkmai Valley R	oad, Sui		lm						

William B. Workman, MD

101 Ygnacio Valley Road, Suite 400 - Walnut Creek, CA 94596 Phone: (925) 944-0110 Fax: (925) 944-0960

## Physical Therapy Order Form

Date: 04/28/2011	
Patient Name:	
Diagnosis(es):836.1 - Lat. Me	niscus tear
☐ RIGHT ☐ LEFT	Γ • BILATERAL
□ AAROM □ C □ PROM □ H □ PRE □ F	VORK HARDENING QUAD STRENGTH HAMSTRING FLEXIBILITY RTC STRENGTH GCAP STAB STRENGTH ND INFLAMMATION
Special Instructions:  Merls  heme prey	TRX fr
Frequency: 5 Times / Week	
Physician's Signature :  William B. Wo	rkman, MD

William B. Workman, MD

101 Ygnacio Valley Road, Suite 400 - Walnut Creek, CA 94596 Phone: (925) 944-0110 Fax: (925) 944-0960

#### Physical Therapy Order Form

Date: 04/30/2012
Patient Name:
Diagnosis(es):836.1 - Lat. Meniscus tear
☐ RIGHT ☐ LEFT ☐ BILATERAL
■ EVALUATION & TREATMENT  ■ AROM ■ QUAD STRENGTH ■ PROM ■ HAMSTRING FLEXIBILITY ■ PRE ■ RTC STRENGTH ■ WORK CONDITIONING ■ SCAP STAB STRENGTH ■ MODALITIES TO REDUCE PAIN AND INFLAMMATION ■ SOFT TISSUE MOBILIZATION
HOME EXERCISE PROGRAM
Special Instructions: WATER THERAPY 10 VISITS
Frequency: 1-2 Times / Week Duration: 8 Weeks
Physician's Signature: WBWn leman, MD William B. Workman, MD

William B. Workman, MD

101 Ygnacio Valley Road, Suite 400 - Walnut Creek, CA 94596 Phone: (925) 944-0110 Fax: (925) 944-0960

## Physical Therapy Order Form

Date: 04/30/2012
Patient Name:
Diagnosis(es):836.1 - Lat. Meniscus tear
☐ RIGHT ☐ LEFT ● BILATERAL
EVALUATION & TREATMENT  AROM  AAROM  PROM  PROM  PRE  WORK HARDENING  QUAD STRENGTH  HAMSTRING FLEXIBILITY  RTC STRENGTH  WORK CONDITIONING  SCAP STAB STRENGTH
MODALITIES TO REDUCE PAIN AND INFLAMMATION SOFT TISSUE MOBILIZATION HOME EXERCISE PROGRAM
Special Instructions:  Water Therapy
Frequency: Times / Week Duration: Weeks
Physician's Signature & Warner
William B. Workman, MD



### Post-Operative Physical Therapy Prescription

# ORTHOPEDICS WILLIAM B. WORKMAN, M.D. BW6360387 A-72343

VIEDICINE J	D W 030030 /		A-72343	
Date: <u>05/22/20</u>	14		Fax #: 707	7-552-9638
TO: GROVE,	ANDERS	SEN,	GHIRIN	<u>IGELLI PT</u>
FROM: TERE				
Patient Name:				
Date of Surgery: 07	7/09/14			
Procedure: LEFT HIP ART	HROSCOPY WITH FEM	MOROPLAST	Y, ACETABULOPLAS	STY AND LABRAL REPAIR
Please schedule therapy per the therapy commence the followir information. Please contact the arrangements. Thank you for you	ng office day. Attache patient and, if necess	ed is the pat sary, the pat	tient demographic a tient's insurance to	and insurance
Dx:		I	CD-9:	
Dx:day(s)/week X	$\frac{1}{2}$ week(s)	(MD	f/u appt. <u>/</u>	/ weeks/post-op)
Evaluate and Treat	□R <b>●</b> L □	Shoul	derKnee	• huff
PROM				& SWELLING
AAROM	RC S'	TRENG	THENING	
AROM	SCAF	PULAR	<b>STABILITY</b>	
PRE	QUA	D/HAM	ISTRING	
_HEP	ST	<b>TRENG</b>	TH/FLEXAB	ILITY
SIGNED: WB	Wolema	m,m	Ŋ	

101 Ygnacio Valley Road, Suite 400 - Walnut Creek, CA 94596

William B. Workman, MD

Phone: 925.944.0110 - Fax: 925.944.0960

### Surgery Information APPROVED

By William B. Workman, MD at 9:55 am, May 27, 2014

William B. Workman, MD

Date: 05/27/2014	Patient:			Age: <u>49</u>
Facility:	Premier	rd 🔲 JMMC-WC	Other Facility	DOB:
₫	OUT Patient  AM Admit	23 Hour Observati	on	
URGENT	Patient red	quests:		Patient will Call
Procedure: <u>LEF</u>	T HIP ARTHROSCOPY WITH	FEMOROPLASTY, A	ACETABULOPLASTY	AND LABRAL REPAIR
			PL #	f:
ANESTHETIC:	<b>☑</b> General	□Fe	moral Block	
OPEN	<b>ARTHROSC</b>	OPIC Lengt	th of Procedure: 3	hr.
Assistant:	PCP	Pre-Op:	Date/Time	e:
Diagnosis: labral t	ear, hip pain		***************************************	
ICD9: <u>843.9</u>	719.45			
CPT: <b>29914</b>	29915	2991	16	*****
Special Equipmen	t:	. All Gr	. war.	
Misc Equipment:	☐ Mini C-ARM ☐ 0			
Post-Op Equipme	nt: Pain Pump: 2 Day	Disp by:		
	<b>□</b> 4 Day	No.	DENTAL ONLY	
	☑ COLD THERAPY	Disp by: NO-	RENTAL ONLY	
	Cradle Arm Sling	Disp by:		
	MROM BRACE	Disp by: PRE	MIER	
	<b>⊈</b> СРМ	Disp by: Inte	grated Health	
Surgery Date/Time	e: <b>07/09/14</b> Pre-Op D	ate/Time: 07/01/14	CONF.	. No.:
☑Computer ☑F	KG Sent patient paperwork	■ Post OP PT Faxed	; <b>06/11/14</b> Faxed	Surgery <b>06/11/14</b>

### Walnut Creek Orthopedics & Sports Medicine

William B. Workman, MD

101 Ygnacio Valley Road, Suite 400 - Walnut Creek, CA 94596 Phone: (925) 944-0110 Fax: (925) 944-0960

Date: 07/01/2014
Patient Name:
Pre-operative Order
♠ EKG
BASIC METABOLIC PANEL
☐ Other.
Diagnosis: 843.9
Physician's Signature: William B. Workman, MD

Please fax results/copy of EKG and/or lab work to: (925) 944-0960

541-488-5408

NORMAN & PETER5ON 01:01:16 p.

01:01:16 p.m. 05-20-2014

#### 2/2

Date:	5/20/14	Claim #:						
Physician:	Dr. William Workma	n Phone:	9259440110	Fax:	9259440960			
Patient Name:		Employer:	Vallejo Fire Dep	t.				
and the second of the second o	~		arteria e personala de la companya		etakan menerakan kenerakan kenerakan kenerakan kenerakan kenerakan kenerakan kenerakan kenerakan kenerakan ken			
	Worker is released to	o lift, carry, push,	pull to 25 – 30 lb	s. (plea	se circle):			
	Worker is released to		e bend tasks (25% Return-to-Work Re		-			
	Approved with modif	ications specified	below:	e mere ter he perperan mere	(uniquesta) bergue latine (attachment) der konstelle (unique) and de de der konstromen (			
V	desh	. Wn	لا					
Return-to-Work Release Date:								
Disapproved for the following medical reasons:								
annamasis es este es en en en en en en en en en en en en en		WZWO	leman,"	AV)	mand ann ar an an an an an an an an an an an an an			
	PROVED	Attending Phys	ar retum to full	duty:	ate of Signature			
By William B. Workman, MD at 11.40 am May 22 2014.  We have read and understand the requirements, indications, we agree to respect the restrictions.  Bridge Assignment and all related physician's modifications. We agree to respect the restrictions.								
and the state of t	addlar. Milant	Employer Repre	esentative		Date			
Norman Peters	YSTEM <sup>®</sup> on and Associates 488.0162	Employee			Date			

PLEASE FAX TO: 541.488.5408 - Sharon Rivers

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#### WALNUT CREEK ORTHOPEDICS AND SPORTS MEDICINE (1) William B. Workman, M.D. Lic. # A72343 DEA # BW6360387 ☐ James T. Quintella, P.A.-C. Lic. # PA14994 DEA # MQ0542426 301 Lennon Lane, Suite 100 Walnut Creek, CA 94598 (925) 944-0110 Fax (925) 944-0960 000 NOUS □ 1-24 4 25-49 □ 50-74 □ 75-100 □ 101 150 □ f50 · Do Not Substitute Refill 0 + 1 - 2 + 3 - 4 - PRN [] 1-24 [] 25-49 [] 50-74 [] 75-100 [] 101-150 [] 150 . Do Not Substitute Hotili 0 - 1 - 2 - 3 - 4 - PRN Units [] 1-24 [] 25-49 [] 50-74 [] 75 100 [] 101 150 [ ] 190 --Do Not Substitute Refill 0 - 1 2 - 3 4 PRN Units er of drugs prescribed is not noted. Prescription is void if the Void after

Signature

Spanish

090316208717

SP01

#000449

WALNUT CHEEK ORTHOPEDICS AND SPORTS MEDICINE 🗇 William B. Workman, M.D. Lic. # A72343 DEA # BW6360387 7 Jamas T. Quintells, P.A.-C. Lic # PA14994 DEA # MQ0542426 301 Lennon Lane, Suite 100 Walnut Creek, CA 94598 (925) 944-0110 Fax (925) 944-0960 NDER CERATURE NUMBERING, PRIMITED ON SAFETY PARKE 1-24 25-49 50-74 75-100 101-150 150 + Do Not Substitute Refili 0 - 1 - 2 - 3 - 4 - PRN Units [] 1-24\[ 25-49 [] 50-74 [] 75-100 [] 101-150 [] 150 + Oo Not Substitute Units 1.24 25 49 50-74 75-100 101-150 150 F Do Not'Substitute Refill 0 - 1 - 2 - 3 - 4 - PRN Units rescription is void if the ther of drugs prescribed is not noted. Vojd after... Spanish 90316208717 **SP01** 

Signature

#000742



## William B. Workman, M.D. BW6360387 A-72343

NAME: _	DATE: <u>02/28/201</u> 1
R	Andorin 25 mg
	H DD
	TpoTIDX Days
SIGNED:	Maller
May Refill	Times

101 Ygnacio Valley Road, Suite 400, Walnut Creek, CA 94596 Phone: 925.944.0110 - Fax: 925.944.0960



## William B. Workman, M.D. BW6360387 A-72343

NAME:	date: <u>05/16/201</u> 1
$\mathbb{R}$	
TRX BAND	
DX: 836.0	

SIGNED: \* MBWnJeman, MD

May Refill\_\_\_\_Times

101 Ygnacio Valley Road, Suite 400, Walnut Creek, CA 94596 Phone: 925.944.0110 – Fax: 925.944.0960



CALLED IN TO CVS-707-747-3450 -TH

### WILLIAM B. WORKMAN, M.D.

BW6360387

A-72343

NAME:

DATE: 07/10/2012

 $P_X$ 

Voltaren 75mg

Disp: #30 [thirty]

sig: i po qD prn

SIGNED: WKWn leman, MY)

May Refill \_\_\_\_ Times

101 Ygnacio Valley Road, Suite 400 - Walnut Creek, CA 94596

Phone: 925.944.0110 - Fax: 925.944.0960



### WILLIAM B. WORKMAN, M.D.

BW6360387

A-72343

NAME:

DATE: 10/30/2012

R

Voltaren 75mg

Disp: #30 [thirty]

sig: i po qD prn

**SIGNED:** 

May Refill Times

101 Ygnacio Valley Road, Suite 400 - Walnut Creek, CA 94596

Phone: 925.944.0110 - Fax: 925.944.0960



William B. Workman, MD BW6360387 A-72343

David T. Bowden, MD, MPH FB1915276 A-108081

Patient Name:		Date: _	12/19/2012

R

ONE YEAR GYM MEMBERSHIP FOR WATER THERAPY 3-4 TIMES A WEEK.

PER PATIENT ADJ. STATES SHE WILL AUTH THIS.

Signed: X	WBWn leman, mo	
May Refill	Times	

101 Ygnacio Valley Road, Suite 400 Walnut Creek, CA 94596 Phone: 925-944-0110 Fax: 925-944-0960





#### PRIOR AUTHORIZATION REQUEST FORM

AUTO-FAX ELECTRONICALLY TRANSMITTED: 01-10-2013 21:16

PRIOR AUTHORIZATION REQUIRED - ACTION REQUIRED							
As the prescriber, this patient's insurance company requires that a prior authorization is completed for this prescription. Your patient and our pharmacy appreciate your assistance in obtaining the prior authorization by using the contact method below:							
PA Phone # 8662008393							
Action Taken:							
PA Authorization # PA Authorize	ed as of		Denied				
PRESCRIBER INFORMATION:		PHARMACY	/ INFORMATION:				
Name: WILLIAM WORKMAN		From: Store Numb	CVS/pharmacy per: 9761				
Address: 101 YGNACIO VALLEY ROAD SUITE 4001 WALNUT CREEK, CA 94596	10	Address:	2100 COLUMBUS PKWY BENICIA, CA 94510				
Phone: 925-944-0110		Phone:	707-747-3453				
Fax: 925-944-0960		Fax:	707-747-6022				
PATIENT INFORMATION: Name:  DOB: Address:		THIRD PAR Name: Cardholder I Group Numb Person Code Relationship	per: e:				
Phone:		TP Help Desk Phone: 866-200-8393					
NEW PRESCRIPTION:	ORIGIN	AL PRESCRIF	PTTON:				
Medication:	Rx #: Drug:		234073 DICLOFENAC SOD EC 75 MG TAB				
Quantity: Refills: 5IG:	Qty. Pres Prescribe Date Wn SIG:	ed Refills:	30.0 EA 3 OK AM 10-30-2012 TAKE 1 TABLET BY MOUTH EVERY DAY				
Prescriber Comments:							
OR 2H							
Prescriber's Name (Printed):			Prescriber's DEA #				
Transmitted By:	(KS/T)	(ONLY)	DPS # / Orai Code				
Prescriber's Signature:		ſ	Date:				
Massachusetts Only: Interchange is mandated unless Practiti			Substitution"				
The information contained in this electronic message as well a the intended recipient and may contain confidential or privileg copies of this message as well as its attachments and advise t	s any attach	ments to this motion. If you are r	lessage are intended for the exclusive use of				
FOR CVS USE ONLY: PRX1			2900000000545116590				

### CVS/pharmacy



#### **REQUEST FOR A REFILL OR NEW PRESCRIPTION**

AUTO-FAX ELECTRONICALLY TRANSMITTED: 12-22-2013 03:05

	PR	ES	CR	ΙB	ER	t:
--	----	----	----	----	----	----

Name: WILLIAM WORKMAN From: CVS/pharmacy

Store # 9761

Address: 101 YGNACIO VALLEY ROAD SUITE 4Address: 2100 COLUMBUS PKWY

WALNUT CREEK, CA 94596 BENICIA, CA 94510

Phone: 925-944-0110 Phone: 707-747-3453

Fax: 925-944-0960 Fax: 707-747-6022

Orig. Prescriber:

Patient expects to pick-up prescription at: 12-26-2013 at 13:00

#### **FOR PATIENT:**

Name:
DOB:
Address:

Phone:

#### FOR ORIGINAL PRESCRIPTION:

CVS Rx# 268029 Date Last Filled: 11-26-2013

Medication: DICLOFENAC SOD DR 75 MG TAB

Qty. Prescribed: 30.0 EA Thirty

Prescribed Refills: 3

Date Written: 08-20-2013

SIG: TAKE 1 TABLET BY MOUTH EVERY DAY AS NEEDED

**Pharmacy Comments:** 

ľ	'KES	CKTE	SER .	ACTI	ON	KEQU	TKED:

Authorized this time plus \_\_\_\_\_ additional refills

■ Not Authorized

#### Prescriber Comments:

The information contained in this electronic message as well as any attachments to this message are intended for the exclusive use of the intended recipient and may contain confidential or privileged information. If you are not the intended recipient, please destroy all copies of this message as well as its attachments and advise the sender immediately.

FOR CVS USE ONLY: SRX1 2900000000859700925

#### Lv5/pnarmacy

#### 

#### **REQUEST FOR A REFILL OR NEW PRESCRIPTION**

AUTO-FAX ELECTRONICALLY TRANSMITTED: 04-01-2014 03:06

PRESCRIBER:

Name; WILLIAM WORKMAN From: C

CVS/pharmacy

Store # 9761

Address: 101 YGNACIO VALLEY ROAD SUITE 4Address:

2100 COLUMBUS PKWY

WALNUT CREEK, CA 94596

BENICIA, CA 94510

Phone:

925-944-0110

Phone: 707-747-3453

Fax: 925-944-0960

Fax: 707-747-6022

Orig. Prescriber:

Patient expects to pick-up prescription at: 04-03-2014 at 13:00

FOR PATIENT;

Name: DOB: Address:

Phone:

FOR ORIGINAL PRESCRIPTION:

CV5 Rx# 281690 Date Last Filled: 02-25-2014

Medication: DICLOFENAC SOD DR 75 MG TAB

Qty. Prescribed: 30.0 EA Thirty

Prescribed Refliis: 2

Date Written: 12-27-2013

SIG: TAKE 1 TABLET BY MOUTH EVERY DAY AS NEEDED

**Pharmacy Comments:** 

PRESCRIBER ACTION REQ	UIRED:		
Authorized this time plus	addition	nai refiils	
☐ Not Authorized			FAXEL
			APR 6 1 2014
Prescriber Comments:			BY:
Prescriber's Name (Printed): WW IC  Transmitted by:  Prescriber's Signature:	, (KS/TX onl	Prescriber's DEA #	
Massachusetts Only: Interchange is ma	andated unless Practiti	•	ution"
The information contained in this electrexclusive use of the intended recipient recipient, please destroy all copies of the contained in the contained in the contained in the contained in the contained in the contained in the contained in the contained in the contained in the contained in the contained in the contained in the contained in the contained in the contained in this electric exclusive and the contained in this electric exclusive and the contained in this electric exclusive and the contained in this electric exclusive use of the contained in this electric exclusive use of the contained in this electric exclusive use of the contained in this electric exclusive use of the contained in this electric exclusive use of the contained in the	and may contain conf	idential or privileged information.	If you are not the intended
FOR CVS USE ONLY:	SRX1	29000000000	958411740



Consent for Surgical Procedure Procedure: LEFT HIP ARTHROSCOPY WITH FEMOROPLASTY, ACETABULOPLASTY AND LABRAL REPAIR. I have been informed of the risks and benefits of the above procedure. I understand that surgical procedures have risks, including a chance of infection, nerve and blood vessel damage, blood clots, and problems with anesthesia. I understand the risks associated with the use of implantable devices such as hardware and donor tendons, including rejection and problems with infection. Patient Name: Signed X: \_\_\_\_\_

## WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE PATIENT CONSENT FORM

Page 2 of 2

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	28 1.			1 7 2	

C.	PERMISSION TO TREAT A MINOR: ( i	f applicable)
	I give permission to have my son/daughter represcribed by the medical providers of Walni	
	PARENT/GUARDIAN NAME/SIGNATURE	DATE
	RELATIONSHIP TO MINOR	
D.	ACKNOWLEDGEMENT OF RECEIPT	OF PRIVACY NOTICE:
	I acknowledge that I have been provided an o	opportunity to review the NOTICE OF
	PRIVACY PRACTICES for Walnut Creek C	
	PATIENT SIGNATURE	DATE
	PARENT/GUARDIAN NAME/SIGNATURE	DATE
E.	PERMISSION TO LEAVE VERBAL DIA	GNOSTIC STUDY RESULTS:
	I give permission to have Walnut Creek Orth diagnostic results on my voicemail at the phocannot be reached.	one numbers I have listed in the event that I
×		2/25/2010 DATE
	PATIENT SIGNATURE	DATE
	PARENT/GUARDIAN NAME/SIGNATURE	DATE

8/26/2008

## WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE FINANCIAL POLICIES

(updated February 2009)

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Please bring your insurance card to the office every visit: You must bring your insurance card on your first visit, as well as any time your coverage changes in any way. If you do not have a current insurance card we appreciate and expect payment at the time of service. Always be sure to tell us right away when you obtain new insurance coverage, updated information or a new insurance card. It is your responsibility to determine that we are contracted providers before you are seen. We are not responsible for any changes in your insurance coverage.

**Please update your address, telephone numbers, and employer information:** Please call the billing department at **(925)944-0334** if your contact information changes prior to your next appointment.

**Co-payments are due at the time of service:** If your insurance policy requires you to pay a co-payment for office visits, you will be asked to pay that co-payment at the time of your appointment. Being a participating provider with most insurance companies, the insurance companies require that we collect these fees, as they are terms of your health care contract. *If* you do not pay for your co-payment at the time of service, we must add an additional fee of \$10 to cover our billing and administrative costs. The co-payment and any billing fee are due upon receipt of statement from us.

If we are unable to verify your insurance coverage, you will be asked to pay for our charges at the time of service: If we cannot confirm that you are covered by an insurance plan that we accept, you will be expected to pay our charges in full at the time of your visit. Upon receipt of confirmed insurance coverage, we will bill your insurance company. When we receive an insurance payment, we will promptly refund any money due to you.

**Auto Accidents and other injuries:** We do not bill third parties. We do not accept liens. If you do not have commercial insurance, you must inform the front office staff. You will be expected to pay our charges in full at the time of service. *Sorry- no exceptions*.

When your insurance company delays payment: If you have commercial insurance, we will bill your insurance carrier as a courtesy to you. If your insurance carrier does not make payment within 90 days, the balance of our full charges will be due and payable immediately from you. We will send you a statement. If there is a problem or dispute over payment with your insurance carrier, we will ask you to pursue the matter with them directly. If your insurance carrier subsequently makes a payment, we will promptly refund any money due to you.

When your insurance company denies a claim: If your insurance company denies a claim, you will be billed for all services provided, in accordance with our contract with your insurance company. This may include, but is not limited to, denials due to eligibility, out of network services, when the insurance carrier has requested information from the patient and that information is not provided in a timely manner and instances where maximum benefits have been reached. We are not able to determine your specific coverage and benefits, plan limitations or plan provisions. For this information, you should contact your insurance carrier directly. We must emphasize that as a health care provider our relationship is with <u>you</u> and <u>not</u> the insurance company.

**Workers' Compensation cases:** If you have a workers' compensation case, you need to bring all of your insurance information with you to your appointment. You cannot be seen without prior authorization and we will ask you to reschedule your appointment if your treatment is not authorized.

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**Delinquent Accounts:** It is your responsibility to keep your account and contact information current. All charges are due in full at the time of service, or upon your receipt of a statement from us. We assume receipt by you of all statements we send to you at the most recent address you provide to us. We assume you accept all charges as accurate unless you contact us promptly upon receipt of a statement to dispute them. Statements returned to us due to the expiration of a postal forwarding order, or as undeliverable for any reason will be assumed accurate. Charges on account outstanding over 90 days may be submitted to an outside collection agency and any applicable fees from the agency will be added to your balance due.

**Returned or "Bounced" Checks:** We pass along our banks' service charge to you for any checks that are returned for non-payment for any reason. A service fee of \$25.00 will be added to your balance for all returned checks.

I have read and understand the Financial Policies of Walnut Creek Orthopedics & Sports Medicine. I also understand that no guarantee has been made to me about my insurance coverage. I do not hold William B. Workman, MD any of the providers or staff responsible for my insurance coverage, or for decisions made by my insurance company.

Parent/Guardian Name, if applicable (Please print)

Relationship to Patient

Parient or Guardian Signature

2/25/2010 Date

## WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE PATIENT CONSENT FORM

Page 1 of 2

Patient's Name

I, _ & \$	hereby authorize Walnut Creek Orthopedics kman, M.D. to disclose the following
protected health/billing information to:	
1	(name/relationship) contact #
A TOTAL SICHATUS	2/25/2016
ATTENT SIGNATURE	DATE
PARENT/GUARDIAN NAME/SIGNATURE	DATE
PARTY RESPONSIBLE FOR PAYME	<u>ENT</u> *:
Assignment and Release: I hereby assign Walnut Creek Orthopedics & Sports Medifinancially responsible for non-covered sessuch as splints, supports and other supplies	icine and/or William B. Workman, M.D. I am ervices, which may include non-durable goods is not covered under my personal insurance. I lease any information required to process my  2/25/2010 DATE
Assignment and Release: I hereby assign Walnut Creek Orthopedics & Sports Medifinancially responsible for non-covered sets such as splints, supports and other supplies also authorize the medical providers to relectains for payment.  PATILINT SIGNATURE	my insurance benefits to be paid directly to icine and/or William B. Workman, M.D. I am ervices, which may include non-durable goods is not covered under my personal insurance. I lease any information required to process my  2/25/2010  DATE
Assignment and Release: I hereby assign Walnut Creek Orthopedics & Sports Medifinancially responsible for non-covered sets such as splints, supports and other supplier also authorize the medical providers to relectains for payment.  PATILENT SIGNATURE  PARENT/GUARDIAN NAME/SIGNATURE	my insurance benefits to be paid directly to icine and/or William B. Workman, M.D. I am ervices, which may include non-durable goods as not covered under my personal insurance. I lease any information required to process my

8/26/2008



### **Consent for Surgical Procedure**

Procedure:
LEFT KNEE ARTHROSCOPY WITH PARTIAL LATERAL MENISECTOMY.
I have been informed of the risks and benefits of the above procedure. I understand that surgical procedures have risk, including a chance of infection, nerve and blood vessel damage blood clots, and problems with anesthesia.
□ I understand the risks associated with the use of implantable devices such as hardware and donor tendons, including rejection and problems with infection.
Patient Name
Signed X
olnal.
Date



### ONE CALL MEDICAL, INC. **Patient Scheduling Notification**

20 Waterview Blvd. P.O. Box 614

Parsippany, New Jersey 07054-0614

TEL (973) 257-1000 FAX (973) 257-0044

Fax Date: Friday November 19, 2010

To Referring Physician: WILLIAM WORKMAN

Fax #: (925)944-0960

#### One Call Medical, Inc. has scheduled the following patient:

Patient: Claim Number Date of Injury:

#### Please fax the Medical Order to:

Provider: VALLEJO OPEN MRI CENTER 155 GLEN COVE MARINA RD

VALLEJO, CA 94591

Phone: (707)644-1292 Fax: (707)644-1362

Procedure

Scheduled Date and Time

MRI ANY JOINT LOWER EXTREMITY; WITHOUT CONTRAST - RIGHT 11/29/2010 09:45 AM KNEE

#### Notes Sent to the Provider:

If you have any questions, please contact us at referrals@onecalimedical.com or call us at 800-872-2875, 8AM - 8PM EST. One Call Medical, Inc. - The Connection to Quality http://www.onecallmedical.com

Sincerely,

ROSINAH **MFARINYA** 

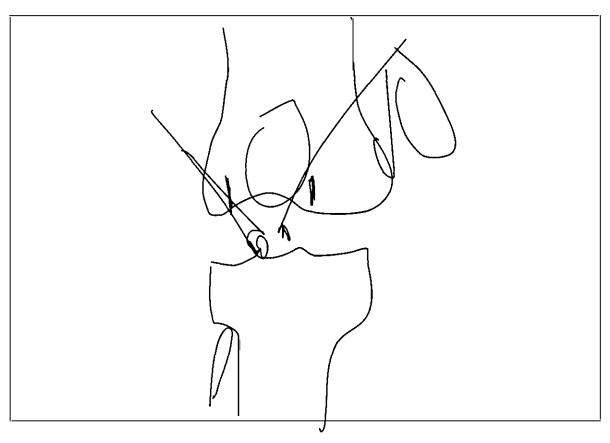
**OCM Service Consultant** 

#### NOTICE OF PRIVILEGE AND CONFIDENTIALITY

The information contained in this facsimile transmission is privileged and confidential and is intended solely for the addressee. Any unsutherized disclosure, reproduction, distribution or the taking of any action in reliance on the contents of this information is prohibited. If you received this facsimile in error, please notify us immediately.



### **Consent for Surgical Procedure**



Procedure:		
RIGHT KNEE ARTHROSCOPY PARTIAL MEDIAL AND LATERAL MENISECTOMY.		
I have been informed of the risks and benefits of the above procedure. I understand that surgical procedures have risk, including a chance of infection, nerve and blood vessel damag blood clots, and problems with anesthesia.		
understand the risks associated with the use of implantable devices such as hardware and donor tendons, including rejection and problems with infection.		

Patient Name

Signed X\_

Date\_

## WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE PATIENT CONSENT FORM

Page 1 of 2



١.	PERMISSION TO GIVE MY HEALTH SPOUSE/SIBLING/CHILD/FRIEND/ET	
	I,	hereby authorize Walnut Creek Orthopedics
		_ (name/relationship) contact #
		(name/relationship) contact #
	PATIENT SIGNATURE	<u>C/1//2</u> DATE /
	PARENT/GUARDIAN NAME/SIGNATURE	DATE
3.	PARTY RESPONSIBLE FOR PAYMEN	<u>\T</u> *:
	financially responsible for non-covered ser- such as splints, supports and other supplies	ny insurance benefits to be paid directly to ine and/or William B. Workman, M.D. I am vices, which may include non-durable goods not covered under my personal insurance. I ase any information required to process my
	PATIENT SIGNATURE	DATE
	PARENT/GUARDIAN NAME/SIGNATURE	DATE
	*Statements will be sent to patient or Par here:	rent/Guardian unless otherwise specified

## WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE PATIENT CONSENT FORM

Page 2 of 2



C.	PERMISSION TO TREAT A MINOR: (if a	pplicable)
	I give permission to have my son/daughter rece prescribed by the medical providers of Walhut	
	PARENT/GUARDIAN NAME/SIGNATURE	DATE
	RELATIONSHIP TO MINOR	
D.	ACKNOWLEDGEMENT OF RECEIPT OF	PRIVACY NOTICE:
	I acknowledge that I have been provided an op PRIVACY PRACTICES for Walnut Creek Ort	
	1-12/12	
	PATIENT SIGNATURE	DATE ///2
,	YATIENT SIGNATURE	DAIR /
	PARENT/GUARDIAN NAME/SIGNATURE	DATE
E.	PERMISSION TO LEAVE VERBAL DIAG	NOSTIC STUDY RESULTS:
	I give permission to have Walnut Creek Orthon diagnostic results on my voicemail at the phone cannot be reached.	
	11020	6/11/12
	PATIENT SIGNATURE	DATE
		DATE
	PARENT/GUARDIAN NAME/SIGNATURE	DATE

## WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE FINANCIAL POLICIES

(updated February 2009)

We have adopted the following financial policies to simplify the billing process and help secure reimbursement for medical services provided to you.

Please bring your insurance card to the office every visit: You must bring your insurance card on your first visit, as well as any time your coverage changes in any way. If you do not have a current insurance card we appreciate and expect payment at the time of service. Always be sure to tell us right away when you obtain new insurance coverage, updated information or a new insurance card. It is your responsibility to determine that we are contracted providers before you are seen. We are not responsible for any changes in your insurance coverage.

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**Auto Accidents and other injuries:** We do not bill third parties. We do not accept liens. If you do not have commercial insurance, you must inform the front office staff. You will be expected to pay our charges in full at the time of service. *Sorry- no exceptions.* 

When your insurance company delays payment: If you have commercial insurance, we will bill your insurance carrier as a courtesy to you. If your insurance carrier does not make payment within 90 days, the balance of our full charges will be due and payable immediately from you. We will send you a statement. If there is a problem or dispute over payment with your insurance carrier, we will ask you to pursue the matter with them directly. If your insurance carrier subsequently makes a payment, we will promptly refund any money due to you.

When your insurance company denies a claim: If your insurance company denies a claim, you will be billed for all services provided, in accordance with our contract with your insurance company. This may include, but is not limited to, denials due to eligibility, out of network services, when the insurance carrier has requested information from the patient and that information is not provided in a timely manner and instances where maximum benefits have been reached. We are not able to determine your specific coverage and benefits, plan limitations or plan provisions. For this information, you should contact your insurance carrier directly. We must emphasize that as a health care provider our relationship is with <u>you</u> and <u>not</u> the insurance company.

**Workers' Compensation cases:** If you have a workers' compensation case, you need to bring all of your insurance information with you to your appointment. You cannot be seen without prior authorization and we will ask you to reschedule your appointment if your treatment is not authorized.

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**Delinquent Accounts:** It is your responsibility to keep your account and contact information current. All charges are due in full at the time of service, or upon your receipt of a statement from us. We assume receipt by you of all statements we send to you at the most recent address you provide to us. We assume you accept all charges as accurate unless you contact us promptly upon receipt of a statement to dispute them. Statements returned to us due to the expiration of a postal forwarding order, or as undeliverable for any reason will be assumed accurate. Charges on account outstanding over 90 days may be submitted to an outside collection agency and any applicable fees from the agency will be added to your balance due.

**Returned or "Bounced" Checks:** We pass along our banks' service charge to you for any checks that are returned for non-payment for any reason. A service fee of \$25.00 will be added to your balance for all returned checks.

I have read and understand the Financial Policies of Wainut Creek Orthopedics & Sports Medicine. I also understand that no guarantee has been made to me about my insurance coverage. I do not hold William B. Workman, MD any of the providers or staff responsible for my insurance coverage, or for decisions made by my insurance company.

Parent/Guardian Name, if applicable (Please print)

Relationship to Patient

6/11/12

Patient or Guardian Signature

## WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE PATIENT CONSENT FORM

PATIENT CONSENT FORM

the phone numbers I have listed in the event that I cannot be reached.

A.	PERMISSION TO GIVE MY HEALTH RELATED INFORMATION TO SPOUSE/SIBLING/CHILD/FRIEND/ETC:			
	hereby authorize Walnut Creek Orthopedics & Sports Medicine providers and it medican start to discrete the formula protected health/billing information to:			
	(name/relationship) contact #			
	(name/relationship) contact #			
	PATIENT/GUARDIAN SIGNATURE DATE			
В.	PARTY RESPONSIBLE FOR PAYMENT*:			
	Assignment and Release: I hereby assign my insurance benefits to be paid directly to Walnut Creek Orthopedics & Sports Medicine. I am financially responsible for non-covered services, which may include non-durable goods such as splints, supports and other supplies not covered under my personal insurance. I also authorize the medical providers to release any information required to process my claims for payment.			
	*Statements will be sent to patient or Parent/Guardian unless otherwise specified here:			
	PATIENT/GUARDIAN SIGNATURE DATE			
C.	PERRMISSION TO TREAT A MINOR: ( If applicable)			
	I give permission to have my son/daughter receive the necessary medical treatment as prescribed by the medical providers o Walnut Creek Orthopedics & Sports Medicine.			
	PATIENT/GUARDIAN SIGNATURE DATE			
D.	ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:			
	I acknowledge that I have been provided an opportunity to review the NOTICE OF PRIVACY PRACTICES for Walnut Creek Orthopedics & Sports Medicine.  PATIENT/GUARDIAN SIGNATURE  DATE			
E.	PERMISSION TO LEAVE VERBAL DIAGNOSTIC STUDY RESULTS:			
	Laive permission to have Welnut Creek Orthopedics & Sports Medicine leave MRI or diagnostic results on my voicemail at			

5/22/14 DATE

> page 3 of 5 000198

### WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE FINANCIAL POLICIES

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## WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE FINANCIAL POLICIES

(updated October 2012)

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	D. I. I. J. L. Bolinsk
Parent/Guardian Name, If applicable Please print)	Relationship to Patient
Patient or Guardian Signature	5/22/14 Date



Naı

MR#

Date of Procedure: 3/31/10 Physician: William Workman, M.D.

#### **Operative Report**

Preoperative Diagnosis:

Left knee lateral meniscus tear, ICD9 Code 836.1.

Postoperative Diagnosis:

Left knee lateral meniscus tear, ICD9 Code 836.1.

Name of Operation:

Left knee arthroscopy with partial lateral meniscectomy, CPT Code 29881.

Surgeon:

William Workman, M.D.

Assistant:

None.

Anesthesia:

Laryngeal mask airway anesthesia.

Complications:

None.

Drains:

None.

#### Findings:

There was extensive articular cartilage wear on the lateral femoral condyle as well as the lateral tibial plateau. There is a large parrot beak tear in the anterior horn of the lateral meniscus as well as posterior horn tearing. The medial compartment was intact as were the cruciate ligaments.

#### Description of Procedure:

The patient was brought to the Operating Room and placed on the Operating Room table. General anesthesia was induced and laryngeal mask airway anesthesia was established. The patient was then placed supine on the Operating Room table with a tourniquet high on the affected side and the affected side was prepped and draped as a sterile field.

The leg was then flexed over the side of the table and 0.25 percent Marcaine with epinephrine was injected into the location just anterolateral to the patella, as well as anteromedial to the patella, and

Name:

MR#:

Date of Procedure: 3/31/10 Physician: William Workman, M.D.

#### **Operative Report**

once the injection was performed, a #11 blade scalpel was used to make an incision on the anterolateral aspect of the patella, as well as the medial aspect of the patella, through and through into the knee joint.

The arthroscopic cannula was then introduced into the knee in the flexed position. As the knee was extended, the cannula was placed up into the suprapatellar pouch and then the arthroscope was introduced into the cannula. A thorough arthroscopic inspection of the knee was done, with the above findings. The patellofemoral joint, as well as the medial gutter, the medial compartment, the notch, the lateral compartment and the lateral gutter were all examined, with the above findings.

At this point, through the anterolateral portal a basket cutter was introduced into the knee and the lateral meniscus tear portion was morcellized in part and the basket was removed. The rotary shaver was then introduced into the lateral compartment and the morcellized fragments were evacuated from the knee. This procedure was carried out in alternating steps until a final full resection of the unstable lateral meniscus tissue was performed back to a stable rim.

At this point, the knee was copiously irrigated and then drained. 4-0 Vicryl was used to close the anteromedial incision. A pursestring suture was placed in the anterolateral incision and the scope cannula was then reintroduced into the knee. 30 cc of 0.25 percent Marcaine with epinephrine was injected in the knee. The pursestring stitch was closed over the local anesthetic. The knee was then dried. Mastisol was then applied, followed by Steri-Strips, 4 x 4s, ABD and an ACE wrap.

The patient was then extubated and delivered to the Recovery Room in stable condition.

William Workman, M.D.

Job # 4613 D: 3/31/10 T: 4/1/2010 WW:jj

2222 East St. Suite 200 Concord, CA 94520

## smith&nephew

Patient:

Surgeon: William Workman, MD

Procedure: left knee scope w partial lateral menisectomy

Procedure Date: 3/31/2010 Procedure ID: 03302010155014



IMG\_001



IMG\_003



IMG\_005



IMG\_002



IMG\_004



IMG\_006

Name: MR#:

Date of Procedure: 2/18/11 Physician: William Workman, M.D.

### **Operative Report**

Pain in the knee.

Preoperative Diagnosis: Right knee medial and lateral meniscus tear.
Postoperative Diagnosis: Right knee lateral meniscus tear.
Name of Operation: Right knee arthroscopic partial lateral meniscectomy, CPT Code 29881.
Surgeon: William Workman, M.D.
Assistant: None.
Anesthesia: Laryngeal mask airway anesthesia.
Anesthesiologist: Carolyn Garduno, M.D.
Complications: None.
Implants: None.
Drains: None.
Durable Medical Equipment: None.
Findings: Right knee lateral meniscus tear with Grade IV cartilage loss on the trochlea.
Indications for Procedure:

Name:

MR#:

Date of Procedure: 2/18/11 Physician: William Workman, M.D.

#### **Operative Report**

Operative Summary:

The patient was brought to the Operating Room and placed on the Operating Room table. General anesthesia was induced and laryngeal mask airway anesthesia was established. The patient was then placed supine on the Operating Room table with a tourniquet high on the affected side and the affected side was prepped and draped as a sterile field.

The leg was then flexed over the side of the table and 0.25 percent Marcaine with epinephrine was injected into the location just anterolateral to the patella, as well as anteromedial to the patella, and once the injection was performed, a #11 blade scalpel was used to make an incision on the anterolateral aspect of the patella, as well as the medial aspect of the patella, through and through into the knee joint.

The arthroscopic cannula was then introduced into the knee in the flexed position. As the knee was extended, the cannula was placed up into the suprapatellar pouch and then the arthroscope was introduced into the cannula. A thorough arthroscopic inspection of the knee was done, with the above findings. The patellofemoral joint, as well as the medial gutter, the medial compartment, the notch, the lateral compartment and the lateral gutter were all examined, with the above findings.

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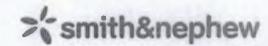
The patient was then extubated and delivered to the Recovery Room in stable condition.

William Workman, M.D.

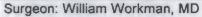
Job # 1339787 D: 2/18/11 T: 2/24/2011

WW:jj

2222 East St. Suite 200 Concord, CA 94520







Procedure: rt knee scope w medial and lateral menîsectomy

Procedure Date: 2/18/2011 Procedure ID: 02182011065607



IMG\_001



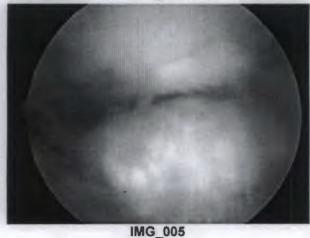
IMG\_002



IMG\_003



IMG\_004



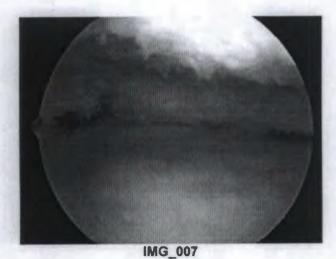
IMG\_006

2222 East St. Suite 200 Concord, CA 94520





Sex: M



Surgeon: William Workman, MD

Procedure: rt knee scope w medial and lateral menisectomy

Procedure Date: 2/18/2011 Procedure ID: 02182011065607

155 OLEN COVE MARINA ROAD, SUITE 101 VALLEJO, CA 94591 Telephone (707) 644-1292 / Fax (707) 644-1362



JEFFREY GAO, MD 970 SERENO DR VALLEJO, CA 94589

Date of Service: 1/15/2010 1:31:00PM

Exam: (BOA) LT/WORKCOMP MRI KNEE WITHOUT

CONTRAST

Fax # (707) 651-2955

: !

**EXAMINATION: MRI LEFT KNEE WITHOUT CONTRAST** 

HISTORY: 45-year-old with knee pain. History of work-related in Try. Evaluate for internal derangement.

TECHNIQUE: Study is performed on a Hitachi AIRIS II Open MRI unit utilizing the following sequences: Sagittal PD, T2 FSE; Axial PD MTC: Coronal IR. PD.

#### FINDINGS:

MENISCI: The posterior and anterior horns of the medial meniscus are intact.

The posterior horn and lateral meniscus is blunted. In the absence of prior surgical intervention, the findings are consistent with a posterior horn lateral meniscal tear. The anterior horn is also blunted and the findings may reflect a focal tear in this region versus postoperative change.

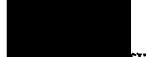
LIGAMENTS: The visualized portions of the quadriceps and patellar tendens are intact. The cruciate ligaments are intact. There is mild thickening of the medial collateral ligament consistent with mild sprain. The lateral collateral ligament is intact. The medial and lateral retinacula are intact.

BONY, CARTILAGINOUS STRUCTURES AND SOFT TISSUES: There is a small suprapatellar effusion. No large fluid collections surrounding the knee are demonstrated. There is mild-to-moderate narrowing involving the medial and lateral knee compartment as well as the patellofemoral articulation. Grade 3-4 changes of chondromalacia are present along the antereinferior aspect of the lateral femoral condyle and the superior aspect of the lateral tibial plateau.

#### IMPRESSION:

- 1. Abnormal lateral menisous, Findings may correspond to extensive lateral meniscal tear involving the posterior and atterior horns. Clinically correlate to exclude previous partial meniscectomy.
- 2. Mild sprain, medial collateral ligament.

155 GLEN COVE MARINA ROAD, SUITE 101 VALLEJO, CA 94391 Telephone (707) 644-1292 / Pax (707) 644-1362



JEFFREY GAO, MD 975 SERENO DR VALLEJO, CA 94589

Date of Service: 1/15/2010 1:31:00PM

(BOA) LT/WORKCOMP MRI KNEE WITHOUT

Fax # (707) 651-2955

3. Tricompartmental degenerative ostcoarthritis with grade 3-4 changes of chondromalacia primarily involving the anteroinferior aspect of the lateral femoral condyle and superior aspect of the lateral tibial plateau.

In compliance with recent Worker's Compensation legislation (Labor Code Section 4628 (j) and 5703 (a) and Insurance Code Section 556): I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the information contained in this report and its attachments, if any, is true and correct to the best of my mowledge 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 described the information provided to me and, except as noted herein, that I believe it to be true. Furthermore, this evaluation is in compliance with the guidelines established by the Industrial Medical Council or Administrative Director parsuant to paragraph (5) of subdivision (7) of Labor Code Section 139.2 or 5307.6.

Signed by me in the County of Alameda, this 15th day of January 2010.

ind of diagnostic report for accession:

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Dictated: 01/18/2010 4:42PM

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Fosici, lo,, MD

GG 911 /2010 2:54AM

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DU TANK, MD 01/19/2010 10:09AM

manced By: CC. PDM NETWORK

155 GLEN COVE MARINA ROAD, SUITE 101 VALLEJO, CA 94591 Telephone (707) 644-1292 / Fax (707) 644-1362



Sex: M

Date of Service: 11/29/2010

(BOA) RT/WORKCOMP MRI KNEE WITHOUT Exam:

CONTRAST

WILLIAM WORKMAN, M.D. 301 LENNON LANE STE 301 WALNUT CREEK, CA 94598

Fax# (925) 944-0960

EXAMINATION: MRI RIGHT KNEE WITHOUT CONTRAST

HISTORY: Work-related right knee injury. Pain medially for six months.

COMPARISON: No prior imaging of the right knee for comparison.

TECHNIQUE: Study is performed on a Hitachi Airis II Open MRI unit utilizing the following sequences: Sagittal PD, T2 FSE; Axial PD MTC; Coronal IR, PD.

#### FINDINGS:

MEDIAL COMPARTMENT: There is peripheral localized tearing in the posterior hom-body junction of the medial meniscus as seen on sagittal 18 where the outer meniscus is conjoined with capsular fibers. Tearing is associated with small intrameniscal /perimeniscal cyst which decompresses into the coronary recess. Medial compartment joint space is maintained noting mild marginal spur. The medial collateral ligament is slightly thickened. Splits in the anterior root attachment of the medial meniscus give rise to a small ganglion seen in the medial portion of the anterior interval.

LATERAL COMPARTMENT: There is a well-defined flap tear of the lateral meniscus which occurs at the junction of the anterior horn and body segments from coalescing oblique and radial tear vectors. There is associated perimeniscal cyst in the lateral coronary recess. Cartilage is worn to bone through the outer third of the lateral tibial plateau deep to the area of meniscal tearing and there is associated subcortical cystic change with edema. Joint space shows some narrowing. The lateral collateral ligament complex is intact.

INTERCONDYLAR NOTCH: There is scarring of the cruciate ligaments. Infrapatellar plica noted at the entrance to the intercondylar notch.

PATELLOFEMORAL COMPARTMENT: There is chronic high-grade cartilage wear in the central and medial femoral trochlea, sagittal 9 and axial 10. Patellar cartilage is relatively well preserved. Chronic stress changes in the extensor mechanism are seen as enthesal spurring and thickening of tendon.

MISCELLANEOUS FINDINGS: Overall, there is only physiologic amount of fluid present in the joint.

155 GLEN COVE MARINA ROAD, SUITE 101 VALLEJO, CA 94591 Telephone (707) 644-1292 / Fax (707) 644-1362



Sex: M

Date of Service: 11/29/2010

Exam: (BOA) RT/WORKCOMP MRI KNEE WITHOUT

CONTRAST

WILLIAM WORKMAN, M.D. 301 LENNON LANE STE 301 WALNUT CREEK, CA 94598

Fax# (925) 944-0960

#### IMPRESSION:

1. Flap tear of the lateral meniscus.

- 2. Localized full-thickness cartilage wear outer third of the lateral tibial plateau with bone edema.
- 3. High-grade chronic cartilage wear in the femoral trochlea.
- 4. Far peripheral small tear in the posterior hom-body junction of the medial meniscus with associated small perimeniscal cyst.
- 5. Chronic stress changes in the extensor mechanism.

If needed, the referring physician can contact the interpreting radiologist Dr. Meghan Blake at 415-922-6767.

In compliance with recent Worker's Compensation legislation (Labor Code Section 4628 (J) and 5703 (a) and Insurance Code Section 556): I declare under penalty of perjury that I have not violated Labor Code Section 139.3 and that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately described the information provided to me and, except as noted herein, that I believe it to be true. Furthermore, this evaluation is in compliance with the guidelines established by the Industrial Medical Council or Administrative Director pursuant to paragraph (5) of subdivision (j) of Labor Code Section 139.2 or 5307.6.

Signed by me in the County of San Francisco, this 29th day of November 2010. **End of diagnostic report for accession:** 19400197

Dictated: 11/29/2010 10:58AM

Dictated By: Blake. Meghan, MD Transcribed By: GG 11/30/2010 9:59AM

**Signed By:** Meghan Blake, MD 11/30/2010 3:19PM

#### INBOUND NOTIFICATION: FAX RECEIVED SUCCESSFULLY

TIME RECEIVED April 18, 2014 4:43:08 PM EDT

REMOTE CSID

DURATION

**STATUS** Received

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Fax Server 4/18/2014 4:41:43 PM PAGE

88 3/004

Fax Server

**PAGES** 

6/17/2016 2:08 PM FROM: Fax TO: +1 (614) 717-6500 PAGE: 001 OF 002



NorCal Imaging Walnut Creek 114 La Casa Via

Walnut Creek, CA 94598 Phone: (925) 937-6100 Fax: (925) 938-9940



Date of Service: 04-17-2014 Exam: MR Arthrogram Hlp [MR701] - Hlp - L Copy to: ADIN Healthcare inc. 761 Old Hickory Blvd Suite 300 Brentwood TN 37027

FAX: (614) 717-6500

EXAM: MR ARTHROGRAM LEFT HIP

HISTORY: History of fall. Left hip injury. Evaluate labral tear.

TECHNIQUE: Combination of PD and fat-suppressed PD images as part of right hip arthrogram study. Sagittal images with fat-suppressed PD contrast. T1 weighted coronal images. T1 weighted axial images.

COMPARISON: None available.

There is delamination of articular cartilage of the acetabular roof lateral 9.6 mm with subchondral cystic changes in the acetabular roof indicating fissuring of the overlying articular cartilage. There is partial tearing of the junctional zone at the chondrolabral interface which has a more chronic appearance.

There is degeneration of the labrum on sagittal images anteriorly. The articular cartilage in the anterior 2.8 cm shows areas of delamination of the articular cartilage surface.

There is an aspherical femoral head and neck junction. There is mild fibrocystic changes characteristic on the MR findings seen in patients with femoroacetabular impingement. These fibrocystic changes are in the lateral femoral head and neck junction. There is mild selerosis of the subchondral plate of the acetabular rim laterally both anteriorly and posteriorly in the acetabular rim, also consistent with findings seen femoroacetabular impingement. There is mild spurring of the acetabular rim.

The gluteus minimus and medius tendons are intact.

Axial images confirm mild aspherical contour of the femoral head and neck junction.

Large field of view shows the common hamstring tendons with symmetric attachments with minimal tendinosis. The contralateral right hip shows mild aspherical contour and mild fibrocystic change as well.

#### Confidential

Patient;

DOB: 06-03-1964

Page 1 of 2

#### INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY \*\*

TIME RECEIVED
April 18, 2014 4:43:08 PM EDT

43:08 PM EDT REMOTE CSID Fax Server DURATION PAGES

STATUS Received

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4/18/2014 4:41:43 PM PAGE

4/17/2014 2:08 PM FROM: Fax TO: +1 (614) 717-6500

4/004 F2

Fax Server



NorCal Imaging Walnut Creek 114 La Casa Via Walnut Creek, CA 94598

Phone: (925) 937-6100 Fax: (925) 938-9940

#### IMPRESSION:

- 1. There is aspherical contour of the left femoral head and neck junction. There are areas of delamination of articular cartilage with subchondral cystic changes in the acetabular roof of the left hip in an area of greater than 9.6 mm from medial to lateral. This partial junctional hyperintensity of intermediate signal consistent with degeneration of the labrum laterally.
- The articular cartilage on corresponding sagittal images shows degeneration of the acctabular roof in a greater than 2 cm extent from anterior to posterior as described.
- The iliopsoas tendon is normal on corresponding sagittal images. The gluteus minimus and medius tendons are intact.
- 4. Large field of view images show the contralateral right hip with aspherical contour.

End of diagnostic report for accession:

263732

Dictated:

4/17/2014 11:55:36 AM

Dietated By:

Stoller, David MD

Transcribed By:

KA 4/17/2014 12:29:21 PM

Signed By:

Stoller, David MD 4/17/2014 2:04:28 PM

Exam requested by: Zilue Tang

Confidential

Patient:

DOB: 06-03-1964

Page 2 of 2

From. 7076440906 Page 2/6 Date: 7/9/2010 2 27 25 PM

10.9 JATOT

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#### Walnut Creek Orthopedics & Sports Medicine

William B. Workman, MD

301 Lennon Lane, Suite 100 Walnut Creek, California 94598 Phone: (925) 944-0110 Fax: (925) 944-0960

#### Physical Therapy Order Form

Date: 06/02/2010	· ·		
Patient Name:			
Diagnosis(es):s/p kne	e arthroscopy,	partial lateral r	nnsctmy
☐ RIGHT	● LEFT	□ BILATERA	.L
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Frequency: 2 Tin	nes / Week	Duration: 6	Weeks
Physician's Signature	Shripur_	nan, MD - James T.	

From. 7076440906 Page 2/6 Date: 7/9/2010 2 27 25 PM

10.9 JATOT

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#### Walnut Creek Orthopedics & Sports Medicine

William B. Workman, MD

301 Lennon Lane, Suite 100 Walnut Creek, California 94598 Phone: (925) 944-0110 Fax: (925) 944-0960

#### Physical Therapy Order Form

Date: 06/02/2010			
Patient Name:			
<u>Diagnosis(es):s/p knee art</u>	throscopy,	partial lateral n	nnsctmy
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From. 7076440906 Page 2/6 Date: 7/9/2010 2 27 25 PM

10.9 JATOT

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#### Walnut Creek Orthopedics & Sports Medicine

William B. Workman, MD

301 Lennon Lane, Suite 100 Walnut Creek, California 94598 Phone: (925) 944-0110 Fax: (925) 944-0960

#### Physical Therapy Order Form

Date: 06/02/2010	<u>.</u>		
Patient Name:			
<u>Diagnosis(es):s/p knee arth</u>	roscopy,	partial lateral n	nnsctmy
☐ RIGHT	LEFT	☐ BILATERA	
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90362 (Pav.2-93)

Did amployee notify employer of this injury? Y

Inquiry refer to: MPI 01977909

KALSER PERMANENTE Claims: DOI:02-15-2014 Vicit:02-15-2014 21:43 ReportDate:02-19-2014 Final:N

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

- STATE OF CALIFORNIA

Wahin 5 days of your initial examination, is a every occupational injury or litness, send two copies of this report to the employer's Workers' Compensation Insurance carrier or the selfinsured employer. Failure to file a timely doctor's report may result in assessment of a civil panelty. In the case of diagnosed or suspected positively poleoning, send a copy of this report

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2.	EMPLOYER NAME					_		. <del></del>		Case No.
	CITY OF VALLEJO						1541	B 0.4	anel -	
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5.	PATIENT NAME (First Name	Middle Initial, Last Nam	A)		16.	Sex	7.	Date of	Yr. Mo. Day	Age
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10.	Occupation (Specific Job Title)						11.			Disease
•	FIREFIGHTER ENGINEER									
12.		=			Cou	nty			-	Hospitalization
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13.	Date and hour of injury or	Yr. Mo. Day	Hour			Date les	<u> </u>	Yr, Mo,	Dev	Occupation
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	PT STATES: WHILE FIGHTING									

- 18. Subjective Complaints (Use reverse if more space is required.): HIP PAIN Injury: Where; left upper front thigh When; ptg. How; during fire fightling job - on second floor - went into room with respirator and
- 19. Objective Findings (Use reverse if more space is required.); A. Physical examination; BP 151/105 | Pulse 84 | Temp(Src) 97.6 F (36.4 C) | Resp. 18 I Ht 1.753 m (5' 9.02') I Wt 95.255 kg (210 lb) I BMI 31 kg/m2 | SpO2 92-95% General - WDWN, NAD, A&O x 3, clothes smell of emoke Respiratory effort - no distress, no
- B: X-ray and laboratory results (State if none pending): 20. DIAGNOSIS (If occupational filness, specify eficilogic agent and duration of exposure.) Chemical or toxic compounds involved? LEFT GROIN MUSCLE STRAIN

Primary ICD9 Code 843,9

			•	Seconda	uy ICD9 Code
Ž1.	Are your findings and diagnosts consistent with the patient's account of injury of	or onset of Whe	35?	<u> </u>	
_	il 'No' please exptain:				
22.	is there any other current condition that will impede or delay patient's recovery	a			
	If "Yes' please explain:				
23.	TREATMENT RENDERED (Use reverse slide if more space is required.)	)		·	
	ED course - stable, concern about low p ox - asymptomatic - perhaps due		smoke inhalation vs ch	ronic inhalation	PLACE OF INJURY,
	INDUSTRIAL PLACE Note: will as to accomed to thus LEFT GROIN MUSC				
24.	If further treatment required, specify treatment plan, estimated duration.	<del></del>		_	
	Z TANG MD. OCC HEALTH	02/	18/14		
25.	If hospitalized as inpetient, give hospital name and location. Da	ite Yr.I	Wo.Dav	Estimate	d stav
		initied:			
26.	Work Status - is patient able to perform usual work? Y if	No', date when	n patient can return to :	Regular work:	02-18-2014
	Work Status - is palient able to perform usual work?  Restrictions: SEE #23, HEVIEWED BY-	~		Modified work;	
	Doctor's Signature:	$\overline{\sim}$	CA License Number:	C504480	
	Doctor's Name and Degree SPERANDIO, JENNIFER, MD TREATING MD	//	IRS Number: 94-272	8480	
	Address: 975 Sereno Drive, Vallejo, CA 94589	v	Telephone Number: (7	07) 651-1370	
_	FORM 5021 (REV.4.5) 1992-06 Any person who makes or causes to be made	any impyringh		•	wierfal

representation for the purpose of chestring or danying workers' compensation benefits of payments is guilty of a followy.

**v2.**5

KAISER PERMANENTE Claim#: DOL02-15-2014 Visit02-15-2014 21:43 ReportDate:02-19-2014 Final:N
Patient:BRUNSON, JAMES P MR:01977909 WCAB#: FAC:VAL Contact;(707) 651-1370 Carrier DOI (# available):
DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS
Continuation

- STATE OF CALIFORNIA Page 2

17. History continued:

18. Complaints continued;

through a hole in the floor with his telt thigh and fell forward and now with pain when he flexes his thigh up at the crease in his groin. No h/o RAD. Fight fires for almost 30 years. Bikes 60 miles a week and does other exercise, denies SOB Execerbated by: movement Relieved by: rest Meds tried; none ROS: Constitutional: No fever Gastrointestinal; no N/V

19. Findings continued:

A. tachypnea Skin - warm, dry, no rashes Normal gait Perria, somi, neck from Ht - RRR Lungs - CTA bilateral Left thigh - from but pain with flexion and abduction, no bruise or swelling Can bear weight on left hip independent review of xray, my read: No fx

8.

23. Treatment continued:

STRAIN Note: motrin, ice, reassured, work note for a couple days OFF WORK: 2/15/2014 through 2/17/2014. RTW-FD 02/18/14. Condition at discharge - stable Return for worsening or no improvement

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MAR 06 2014 A
OSC West

KAISER PERMANENTE

occmed

Oid employee notify employer of this Injury? Y

Inquiry refer to: MR 01977909

KAISER PERMANENTE Chims: DOI:02-15-2014 Visit;02-18-2014 15:56 ReportDate:02-19-2014 Food:Y

#### DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

- STATE OF CALIFORNIA

Within 5 days of your initial examination, for every occupational injury or limbss, send two copies of life teport to the employer's Workers' Componentian insurance carrier or the sollinsured employer. Feture to file a firely decion's report may result in assessment of a divit ponalty. In the case of diagnosed or suspected posterior, send a copy of this report to Division of Labor Stribstics and Rosearch, P.O.Box 42060s, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

١.	INSURER NAME AND ADDRE	156								Plazaso do nos
	YORK INS SVC\$ PO BOX 619	079 ROSEVILLE,CA 958	561							use this solumn
2	EMPLOYER NAME									Case No.
	CITY OF VALLEJO									
3.	Address No. and Street	•	City		Zip					Industry
	555 SANTA CLARA ST		VALLEJO	CA	945	900000				
4.	Nature of Businoss (e.g. food m	nanulacturing, building co	nstruction, relaiter d	women's cla	othos)					County
					(707	) 648-43 <u>5</u> 1	5			
5,	PATIENT NAME (First No	ame, Middlo Initial, Last N	Name)		6.	Sex	7.	Dale of	Yr. Mo. Dav	Age
					. ! N	!		Birth	ļ	
8.	Address No. and Sirea	··	City	•	Zip		9,	Telephon	a Number	Нахагд
	· · · · · · · ·		VALLEJO		945	18322				
10.	Occupation (Specific Job Title)	/ <b>-</b>	•				11,		o:	Diséaso
	firefighler		į.							
12.	Injured at: No. and Street				Cou	nty				Hospitalizatlor
	STRUCTURE FIRE				<b>\$</b> Q1	ANO				
13.	Date and hour of injury or	Yr. Mo. Day	Hour		14.	Dale last		Yr. Mo. D	ay	Occupation
	onset of illness	02-15-2014	09:15	PM		worked		02-15-201	4	
16.		Yr. Mo. Day	Hour		16.			your offico)	previously	Relum
	ox <u>ami</u> nation or (realment	02-18-2014	03:56	PM		tracted pa	atien	1?		
	Patient please complete this					diately. In:	abčity	y or failure o	of a palient to	complete this
	portion shall not affect his/hor ri									
17.		exposure happened.	(Give specific object	ct, machinery	or chemica	i. Usa reve	irac i	sido li moro	opace is requ	ulred)
	PT STATES: WHILE FIGHT	îng fire My Left Li	eg fell throu	SH A HOLÉ	IN A BED	room fi	LOO	A; Straii	NING MY LE	FT HIP
	SI EYOD							•		

- FLEXOR.
- 18. Subjective Comptaints (Use reverse if more space is required.): Mechanism of Injury: He went into room with respirator and fell through a hole in the floor with his left thigh and fell forward and now with
- 19. Objective Findings (Use reverse if more space is required.); A. Physical examination; Physical Exam: no apparent distress BP 137/82 | Pulse 97 | SpO2 100% Gail: no antalgic Left thigh - mild TTP at lateral groin area. No hernia, pain and mild reduced ROM with flexion and abduction, no bruise or swelling Can B: X-ray and laboratory results (State if none pending);
- 20. DIAGNOSIS (If occupational litress, specify otiologic agent and duration of exposure.) Chemical or toxic compounds involved? SPRAIN OR STRAIN OF HIP OR THIGH (L)

Primary ICD9 Code

843.9

Secondary ICD9 Code

- 21. Are your findings and diagnosis consistent with the patient's account of injury or onset of illness? y If 'No' ploase explain:
- 22. Is there any other current condition that will impode or delay patient's recovery? In Il "Yes" please explain:
- 23. TREATMENT RENDERED (Uso reverse side if more space is required.)

SPRAIN OR STRAIN OF HIP OR THIGH Note: lait, acute Continue icing and NSAID Physical Therapy Trealment Authorization Request Physical Therapy targeted at left hip and thight up to 6 visits over 4 weeks for

24. If further freatment required, specify freatment plan, estimated duration.

Z TANG MD. OCC HEALTH, 03/04/14 25. If hospitalized as inpatient, give hospital name and location. Yr.Mo.Day Estimated stay Date Admitted: 26. Work Status - is patient able to parletth usual work? If 'No', date when patient can return to: Hegular work: Restriations: SEE #23. Modified work 02-18-2014 Doctor's Signature: CA License Numbor: 1007B2A Doctor's Name and Dogree TANG, ZILUE, MD TREATING MD IRS Number: 94-2728480 Address: 975 Sereno Drive, Valleio, CA 94589 Tolephone Number: (707) 651-1370

FORM 5021 (REV.4.5) 1992-06 Any powers who makes or causes to be made any knowledgy labor or traudulent material statement or meterial 90362 (Rev.2-93) representation for the purpose of obtaining or denying workers' compansation benefits or payments is guilly of a follow.

v2.5

KAISER PERMANENTE Claimt: DOI:02-15-2014 Visit:02-18-2014 16:56 ReportDate:02-19-2014 Finalty P MR:01077809 WCABs: FAC:VAL Contact:(707) 651-1370 Carrier DOI (if avoilable): DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

occmed

 STATE OF CALIFORNIA Page 2

17. History continued:

18. Complaints continued: a 49 Y male presents with when he flexes his thigh up at the crease in his groin. Chief Complaint: LEG PROBLEM. left inner groin area pain. . ER visited, left hip xr negative. Ibu given, Some improving, but could not climb. Prior treatment for this Injury/illness: as above Current complaints: as above. Review of Systems: Constitutional: negative for fevers or chills Muscufoskeletal: negative for generalized myalgias/arthralgias Skin; negative for rash or prunitus Neurological; negative for weakness, bowel/bladder Incontinence, or clumsiness. Relevant Medications: none Allergies. Review of patient's altergies indicates no known altergies, Social History, reports that he has never smoked. He does not have any smokeless tobacco history on file. Occupational History: date last worked: 02/15/14 Relevant Past Medical/Surgical History: Patient denies prior relevant injuries/surgeries and Prior industrial injury/surgery - bij knee s/p surgery Relevant Family History; No relevant family history Hobbies/Leisure Activities; Patient denies any relevant recreational/leisure activities

Continuation

19. Findings continued:

bear Weight on left hip. Additional Information Reviewed: Data Reviewed radiology results: left hip no fx Reviewed other records: HC notes reviewed

В,

23. Troatment continued:

Individual Instruction, home exercise program, therapeutic techniques to decrease pain and inflammation and to restore pre-injury functional status. This is consistent with ACOEM guidelines, Work Status; Modified duty 2/18/2014 through 3/4/2014 Squat/kneel, knee bending: Not at all. Climb ladders; Not at all. Use of scaffolds/work at height: Not at all. Llit/carry/push/pull no more than 10 pounds. Return to Clinic: 3/4/2014 8:30 AM Causation: The stated mechanism is consistent with my clinical exam findings and no information has been presented that would indicate a cause other than the alleged employment event/exposure.

KAISER PERMANENTE Claim#;CVCH-546693 DOI:12-15-2014 Visit(03-04-2014 08:37 ReportDate:03-05-2014 Final:N P MR:01977909 WEAB#: FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available):

State of California Division of Workers' Compensation

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

Page 1 Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has

reached maximum medical improvement	I), do not use uns form. You may use DVC, Form PR-3	
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Patient will be permanently precluded from engaging in his/her usual and customary occupation If any of these boxes are checked Parient's condition is permanent and stationary with residual disability on: you must use Form FR-3

13-1   Patient with reducte 10 tole institute care	or ratifacte repoi <u>t.</u>
14. Claims Administrator	Patient: 16. SSN.
ÝORK INS SVCS	17. Name
	18. Address
PO BOX 619079	19. City V CA Zip 945918322
ROSEVILLE	20. DOI 0 64 22. Sex M
CA 95661	23. Phone ( 24. Fax —
,	25. Occupat
26. Phone (800) 422-7244 27. Fax (866) 548-2637	,   28. Claim C

30. Employer Name: CITY OF VALLEJO

31. Employer Phone (707) 648-4355

The information below must be provided. You may use this form or you may substitute or append a narrative report.

32. Subjective Complaints:

49 Y male presents with left inner groin area pain.

Some improving, but still could not climb. PT once so far.

Prior treatment for this injury/illness: as above

Current complaints; as above.

Review of Systems:

Constitutional; negative for fevers or chills

Musculoskolotal: negative for generalized myalgias/arthralgias

Skin: negative for rash or pruritus

Neurological: negative for weakness, boweVbladder incontinence, or

clumainess

Relevant Medications: none

Allergies: Review of patient's allergies indicates no known allergies: Social History: reports that he has never smoked. He does not have any

smokeless tobacco history on file.

Occupational History: date last worked: 02/15/14

Relevant Past Medical/Surgical History: Patient denies prior relevant injuries/surgeries and Prior industrial injury/surgery - bil knee-s/p

Relevant Family History: No relevant family history Hobbies/Leisure Activities: Patient denies any relevant

recreational/leisure activities

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

Physical Exam: no apparent distress

Gait: no entalgic

Left thigh - mild TTP at lateral groin area. No hernis, mild reduced ROM

with flexion and abduction, no braise or swelling.

Can bear weight on left hip.

Additional Information Reviewed

Data Review: Reviewed radiology results: left hip no fx

Reviewed other records: HC notes reviewed

34. Diagnostic Studies Ordered:

KAISED BERMANDNTE: Claims: CVCH-546693 DOI:02-13-2014 VIsit:03-04-2014 08:37 ReportDate:03-05-2014 Final:N MR:01977909 WCAB#: FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available): State of California Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2) Page 2 35. Diagnoses RCD-9 843.9 lst SPRAIN OR STRAIN OF HIP OR THIGH (L) ICD-9 2nd 36. Treatment Plan; (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. SPRAIN OR STRAIN OF HIP OR THIGH Note: left, acute, improving. Plan: Continue icing and NSAID I certify the medical necessity of the care and have reviewed and approve the Plan of Care, Continue PT Work Status: Modified duty advanced 3/4/2014 through 3/18/2014 Squat/kneel, knee bending: Not at all. Climb ladders: Not at all. Use of scaffolds/work at height: Not at all, Lift/carry/push/pull no more than 20 pounds. Return to Clinic; 3/18/2014 8:50 AM Causation: The stated mechanism is consistent with my clinical exam findings and no information has been presented that would indicate a cause other than the alleged employment event/exposure.

37. Have there been any changes in treatment plan? 38. If so, why?

- 39. Other Physician/Non-Physician Providers:
- 40. Drugs:
- 41, Physical Medical Service:

42. Times per Week

43. Duration:

44. Hospitalization/Surgery Date

46. Consult/Other Services:

45. Hospitalization/ Surgery

Work Status: This patient has been instructed to:

47. Petera to full duty on

with no limitations or restrictions,

48. X Return to madified work on 03-04-2014 with the following limitation or restrictions.

49. Limitations:

SEE #36.

Patient discharged as cured (no permanent disability or need for future medical cure).

Patient is permanently precladed from engaging in his/her usual and customary occupation and the above limitations/restrictions are detuned permanent.

#### 

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

Page 3

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#### Primary Treating Physician: (original signature, do not stamp) 52. Date of exam 03-04-2014 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 which probibits referral to a physician or entity with whom the physician has an unlawful financial interest. The Permanente Medical Group, Inc. 53. IRS Number 94-2728480 KÖJ Öccupational Health Signature Specialty MAR 05 2014 Executed at Signature Date 54. Name TANG, ZILUE MD 55. California Lic# 100782A. (707) 651 1370 Facility 56. Address 975 Screno Drive, Vallejo, CA, 94589 57. Phone

KAISER PERMANENTB Claim#;CVCH-546693 DOI:02-15-2014 Visic0J-18-2014 08:53 ReportDate:03-19-2014 Final:N MR:01977909 WCAB#; FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available):

#### State of California Division of Workers' Compensation

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

Page 1 Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3

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ient will be permanently precluded from engaging in his/l Patient's condition is permanent and stationary with residual disability on: you must use Form PR-3

13. Patient will require future medical care 14. Claims Administrator YORK INS SVCS 17. Name 18. Address Zip 945918322 PO BOX 619079 City ROSEVILLE 20. DOI I-19**6**4 22. Sex M CA 95661 23, Phone ( 24. Pax 25. Occupat WCAB 26. Phone (800) 422-7244 27. Fax (866) 548-2637 28. Claim C

30. Employer Name: CITY OF VALLEJO

31. Employer Phone (707) 648-4355

The information below must be provided. You may use this form or you may substitute or append a narrative report.

#### 32. Subjective Complaints:

is a 49 Y male presents with left inner groin area pain.

Some improving, but still could not climb. PT 6x. Still sore with lifting left leg. Could not stretch the thigh out.

Prior treatment for this injury/illness: as above

Current complaints: as above.

Review of Systems:

Constitutional: negative for fevers or chills

Musculoskeletal: negative for generalized myalgias/arthralgias

Skin: negative for rash or pruritus

Neurological: negative for weakness, bowel/bladder incontinence, or

clumsiness

Relevant Medications: none

Allergies: Review of patient's allergies indicates no known allergies. Social History: reports that he has never smoked. He does not have any

amokeless tobacco history on file.

Relevant Past Medical/Surgical History: Patient denies prior relevant injuries/surgeries and Prior industrial injury/surgery - bil knee s/p

surgery

Relevant Family History: No relevant family history Hobbies/Leisure Activities: Patient denies any relevant

recreational/leisure activities

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

Physical Exam: no apparent distress

RP 149/80 i Pulse 70 i SpO2 97%...

Gait: no antalgic

Left thigh - mild TTP at lateral groin area. No hernia, mild reduced ROM

with flexion and abduction, no bruise or swelling,

Can bear weight on left hip.

Additional Information Reviewed

Data Review: Reviewed radiology results: left hip no fx

Reviewed other records: HC notes reviewed

34. Diagnostic Studies Ordered:

KAISER PERMANENTE Claim#:CVCH-546693 DOI:02-15-2014 Visit:03-18-2014 08:53 ReportDate:03-19-2014 Final:N PatientEBRUNSON, JAMES P MR:01977909 WCAB#; FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available):

### State of California Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Page 2

35. <u>Diagnoses</u> 1st SPRAIN OR STRAIN OF HIP OR THIGH (L)		ICD-9 843.9	
2nd		ICD-9	
36. Treatment Flan: (Include treatment rendered to day consultation/referral, surgery, and hospitalization. Identify duration of physical medicine services (e.g., physical therap SPRAIN OR STRAIN OF HIP OR THIGH Note: left, acute, r/o labrum tear Plan: MRA	each physician and non-physician provider. S	pecify type, frequency and	
I have reviewed the Physical Therapy progress notes, functional gains from therapy, specifically improved r improvement in activities of daily living and reduction restrictions. I am requesting authorization for an addit physical therapy over 3 weeks.  Work-States: Modified duty advanced 3/19/2014 throat Climb ladders: Not at all.  Use of scaffolds/work at height: Not at all.  Lift/carry/push/pull no more than 20 pounds.  Return to Clinic: 4/1/2014 1:50 PM	range of motion, n in work tional 4 visits of	Not meall	
Causation: The stated mechanism is consistent with m findings and no information has been presented that w other than the alleged employment event/exposure.	•		. g sa <del>ranter e le deg</del> en
37. Have there been may changes in treatment plan?	38. If #0, why ?		
39. Other Physician/Non-Physician Providers;			
40. Drugs:			
41. Physical Medical Service; 44. Hospitalization/Surgery Date 46. Consult/Other Services;	42. Times per Week 45. Hospitalization/ Surgery	43. Duration:	
Work Status: This patient has been instructed to 47. Return to full duty on with no limitate 48. Return to modified work on 93-18-2014 with the tol 49. Limitations: see #36.	om or restrictions.		_
50. Patient discharged as cured (no permanent disability of 51. Patient is permanently precluded from engaging (a his/ are decided permanent).	r need for future medical care). Her usual and customary occupation and the ab	ové limítations/restrictions	

Page 3

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Primary T	reating Physician: (original sig	nature,	, do not stamp)	52. Date of exam	03-18-2014
	r penalty of perjury that this report is true a ral to a physician or entity with whom the p				s not violated labor code 139.3 which
The Permane	nte Medical Group, Inc.		<del></del>	53. IRS Number 9	94-2728480 KOJ <b>Occupational H</b> ealth
Signature		<del>_/</del> -		Specialty	
Executed at		$-\!$		Signature Date	Paul de Le Y
54. Name 56. Address	TANG, ZILUE 975 Sereno Drive, Vallejo, CA, 94589	V	MD	55. California Lic# 57. Phone	100782A (707 <u>4654)</u> 637 <u>9</u> cility

TIME RECEIVED March 25, 2014 4:45:34 PM EDT

REMOTE CSID occ med

**PAGES** DURATION 138

STATUS Received

2014-03-25 13:18 PMR:01977909 WCAB#: PAC:VAL Contact:(707) 651-1370 Carrier DOI (if available): Patient

occ med

7076512955 >>

P 1/4

State of California, Division of Workers' Compensation REQUEST FOR AUTHORIZATION

#### **DWC Form RFA**

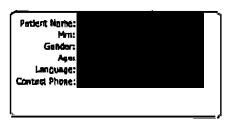
Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent marrative report substantiating the requested treatment.

X New Request				
Musem Dedoest	∐ Resul	bmission - Change in Material I	Facts Retros	pective Review
Expedited Rev	/lew: Check bo	ox if employee faces an immine	nt and serious threat to	his or her health
<b>=</b> '		tten confirmation of a prior oral		ed Requesi
Employee invo	mation 0.34			THE STATE OF THE S
Name (Last, Firs	i, Middle):			
Date of Injury (M	IM/DD/YYYY):	02-15-2014	Date of Birth (MM/DD/	MYY):
Claim Number:			Employer: CITY OF	/ALLEJO
Propesting Pin	is it an infolding	auoni in a salah sa		
Name:	TANG, ZILUI	E		
Practice Name:	Kniser Perman	ionto KOJ (	Contact Name: MAK	1950 A. BYRILL
<del></del>	Serono Drive		City: Vallejo	State: CA
Zip Code: 945			Fax Number: (707) 651	
Specialty:	W/ W	U	NPI Number: 120503149	<u>,</u>
E-mail Address:				Sandra is a service of the latest street and the service of the se
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Сотралу Name	: YORK INS ST	VCS	Contact Name: SCHAL	JNNA MCBACHRON
Address: POBO	X 619079		City: Roseville	State: CA
Zip Code: 9566]	Phon	e: (BOO) 422-7244	ax Number: 4960,548	100 BOU COLE 1439
E-mail address:				
Requested re	itment seein		Chardelonal pages	
List each specific	requested med	lical services, goods, or Items in 11	ne below space or Indica	ite the specific page number(s)
	_ 41 . 4			
or the anacheo m	edical report on	which the requested treatment c	an be found. Up to five (	5) procedures may be entered;
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Diagnosis (Required)	heare ou a seba	which the requested treatment curate sheet if the space below is in Service/Good Requested (Required)	an be found. Up to five ( sufficient.  CPT/HCPCS Code  (II known)	
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list additional requi	ICD-Code (Required)	rate sheet if the space below is in Service/Good Requested (Required)	Sufficient.  CPT/HCPCS Code	Other Information:
Diagnosis (Required)	ICD-Code (Required)	rate sheet if the space below is in Service/Good Requested (Required)	Sufficient.  CPT/HCPCS Code	Other Information: (Frequency, Duration, Quantity, etc)
Diagnosis (Required)	ICD-Code (Required)	rate sheet if the space below is in Service/Good Requested (Required)	Sufficient.  CPT/HCPCS Code	Other Information: (Frequency, Duration, Quantity, etc)
Diagnosis (Required)	ICD-Code (Required)	rate sheet if the space below is in Service/Good Requested (Required)	Sufficient.  CPT/HCPCS Code (II known)	Other Information: (Frequency, Duration, Quantity, etc)  I Request MRI L hip
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)  MRI  Note: Abov	ce data may be truncat	Other Information: (Frequency, Duration, Quantity, etc)
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)  MRI  Note: Abov	Sufficient.  CPT/HCPCS Code (II known)	Other Information: (Frequency, Duration, Quantity, etc)  I Request MRI L hip
Diagnosis (Required)  SPRAIN OR STRA	ICD-Code (Raquired)  843.9  98t(s) on this f	Service/Good Requested (Required)  MRI  Form. Note: Abov. See (	ce data may be truncat	Other Information: (Frequency, Duration, Quantity, etc)  I Request MRI L hip  ed due to Insufficient space-
Diagnosis (Required)  SPRAIN OR STRA	ICD-Code (Raquired)  843.9  98t(s) on this f	Service/Good Requested (Required)  MRI  Note: Abov	ce data may be truncat	Other Information: (Frequency, Duration, Quantity, etc)  I Request MRI L hip
Diagnosis (Required)  SPRAIN OR STRA  There are   required	ICD-Code (Raquired)  843.9  98t(s) on this fi	Service/Good Requested (Required)  MRI  Note: Above See of TANG, ZILUE	ce data may be truncat	Other Information: (Frequency, Duration, Quantity, etc)  I Request MRI L hip  ed due to Insufficient space-
Diagnosis (Required)  SPRAIN OR STRA  There are I required  Requesting Phy	ICD-Code (Required)  843.9  Best(s) on this finatures are signatures.	Service/Good Requested (Required)  MRI  Note: Above See of TANO, ZILUE	continuation pages.	Other Information: (Frequency, Duration, Quantity, etc)  1 Request MRt L hip  ed due to Insufficient space-  Date: 03-25-2014
Diagnosis (Required)  SPRAIN OR STRA  There are I required  Requesting Phy  Claims Adminit	ICD-Code (Required)  843.9  Best(s) on this finature sician Signature Denied or Mod	Service/Good Requested (Required)  MRI  Note: Above See of TANO, ZILUE  dified (See separate decision letters)	continuation pages.	Other Information: (Frequency, Duration, Quantity, etc)  1 Request MRt L hip  ed due to Insufficient space.  Date: 03-25-2014  separate notification of delay)
Diagnosis (Required)  SPRAIN OR STRA  There are   required  Requesting Phy  Approved    Requested tre	ICD-Code (Required)  843.9  sician Signatur  sician Signatur  best(s) on this to	Service/Good Requested (Required)  MRI  Note: Above: Fe: Electronically Signed TANG, ZILUE  dified (See separate decision leten previously denied Liabien.	continuation pages.	Other Information: (Frequency, Duration, Quantity, etc)  1 Request MRt L hip  ed due to Insufficient space.  Date: 03-25-2014  separate notification of delay)
Diagnosis (Required)  SPRAIN OR STRA  There are I required  Requesting Phy  Claims Adminit  Approved  Requested tre Authorization No	ICD-Code (Required)  843.9  sician Signatur strator, Hillips Denied or Moratment has be	Service/Good Requested (Required)  MRI  Note: Above: Fe: Electronically Signed TANG, ZILUE  dified (See separate decision leten previously denied Liabien.	c data may be truncated the continuation pages.  Delay (See little) Delay (See Date:	Other Information: (Frequency, Duration, Quantity, etc)  1 Request MRt L hip  ed due to Insufficient space.  Date: 03-25-2014  separate notification of delay)
Diagnosis (Required)  SPRAIN OR STRA  There are   required  Requesting Phy Claims Adminit Approved   Requested tre Authorization Nu Authorized Ager	ICD-Code (Raquired)  843.9  843.9  Section Signatures  Section Signatures  Company Sig	Service/Good Requested (Required)  MRI  Note: Above:  continuation pages.  CPT/HCPCS Code (II known)  The data may be truncated to the continuation pages.  Continuation pages.  Continuation pages.  Continuation pages.  Continuation pages.  Signature:	Other Information: (Frequency, Duration, Quantity, etc)  1 Request MR1 L hip  ed due to Insufficient space-  Date: 03-25-2014  separate notification of delay) puted (See separate letter)	
Diagnosis (Required)  SPRAIN OR STRA  There are I required  Requesting Phy  Claims Adminit  Approved  Requested tre Authorization No	ICD-Code (Raquired)  843.9  843.9  Section Signatures  Section Signatures  Company Sig	Service/Good Requested (Required)  MRI  Note: Above: Fe: Electronically Signed TANG, ZILUE  dified (See separate decision leten previously denied Liabien.	c data may be truncated the continuation pages.  Delay (See little) Delay (See Date:	Other Information: (Frequency, Duration, Quantity, etc)  1 Request MR1 L hip  ed due to Insufficient space-  Date: 03-25-2014  separate notification of delay) puted (See separate letter)

MRN:01977909

James P Bruncon

occ med



Requesting Provider: Zilus Tong, M.D. Provider Id: 000067078 Fac/Adm Dapt: VAL/OCC The Unie/Ext: 8-460-2853

Fak Yla Line:

PCP: Brian D Winter, M.D. - (VAL)MED

Referral Detail

Status: (02) RESPONSE NEEDED

Access Time: 1 days Date Initiated: 03/19/2014

Response Date:

FAC/SPE: Vellejo/Occupational Madicing

Assigned to For Triage: Triage Provider:

Lesi Modified By: KVAZT1 03/18/2014 9:09 AM

Entered by: 4/196 TBRQ, M.D. 03/18/2014 9:09 AM

Problem Agaton:

Authorization -Work Related Intury

E B M Coding:

Non4

#### Referral Workspr

- L. Facility where referral is generated:
- A: Valleio
- 2. Date of Injury (mm/dd/yy):
  - A: 02/15/14
- 3. Type of Consult:

A:

- 4. Possible Procedure Needed:
- AI MRI,
- 5. Possible Treatment Meeded:

6. Passible Surgery Needed:

7, This patient is part of a Medical Provider Natwork (MPN)

A:

8. Name of provider to whom this patient is being referred:

9. Rosson potient is being referred outside:

A:

10. Transfer of Care?

11. For HRI requests the following is required;

٩ï

12. Fatient History/Comments:

A: left hip injury, limited progress with PT. evidence of labral tear, request left hip arthrogram study for further evaluation

<u>Respon≐e Nutesi</u>

Fooling Information:

Priority

Facility: Valleto

Dept: OCM

Type:

Provider

Backing Instructions:

MRN:01977909

P Brunnen کوسیا

KAISER PE. 1ANENTE Claim#CVCH:546693 DOI:02-15-2014 Visit:04-01-2014 13:59 ReportDate:04-02-2014 Final:N P.MR:01977909 WCAB#: FAC:VAL Contact(707) 651-1370 Carrier DOI (if available):

State of California Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2) Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has

reached maximum medical improvement); do not use this form: You may use DWC Form PR-3.

Patient will be permanently precluded from engiging in his/her usual and customary occupation If any of these boxes are checked 12. Patient's condition is permanent and stationary with residual disability on:

von must me Form PR-3

14. Clainu Administrator		Patient:	15.	
YORK INS SVCS		17. Name		
		18. Address		
PO BOX 619079		19. City V		A Zip 945918322
ROSEVILLE		20. DOI 02		4 22. Sex M
ÇA 95661	•	23. Phone (7		24. Pax
	-	25. Occupati		
26. Phone (800) 422-7244	27. Pax (866) 548-2637	28. Claim C		A.B.

30. Employer Name: CITY OF VALLEJO

31. Employer Phone (707) 648-4355

The information below must be provided. You may use this form or you may substitute or append a marrative report.

32. Subjective Complaints:

a 49 Y male presents with left inner groin area pain.

PT 8x. Still sore with lifting left leg, Could not stretch the thigh out.

Overall symptoms no sig improving.

Prior treatment for this injury/illness: as above

Corrent complaints: as above.

Review of Systems:

Constitutional: negative for fevers or chills

Musculoskeletal: negative for generalized myalgias/arthralgias

Skin: negative for rash or prurious

Neurological: negative for weakness, bowel/bladder incontinence, or

clumsiness

Relevant Medications: none

Allergies: Review of patient's allergies indicates no known allergies. Social History: reports that he has never smoked. He does not have any

smokeless tobacco history on file.

Relevant Past Medical/Surgical History: Patient denies prior relevant injuries/surgeries and Prior industrial injury/surgery - bil knee s/p

Relevant Family History: No relevant family history Hobbies/Leisure Activities: Patient denies any relevant

recreational/leisure activities

APR 15 2014 A

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

Physical Exam: no apparent distress BP 129/68 | Pulse 89 | SpO2 98%

Gait: no antalgic

Left thigh - mild TTP at lateral groin area. No hernia, mild reduced ROM

with flexion and abduction, no braise or swelling.

Can bear weight on left hip.

Additional Information Reviewed

Data Review: Revlewed radiology results: left hip no fx

Reviewed other records: HC notes reviewed

34. Diagnostic Studies Ordered:

### KANSER PS. MANENTE Claims: CVCH-546693. DOI:02-15-2014 Visit:04-01-2014 13:59 ReportDate:04-02-2014 Final:N P MR:01977909. WCABs: FAC:VAL Contact:(707) 651-1370. Carrier DOI (if svailable):

### State of California Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Page 2

	•	
35. Diagnoses	RECEIVED	ICD-9 843.9
1st SPRAIN OR STRAIN OF HIP OR THIGH (L)	APR 1 5 2014 A	(CD-7 843.5
2nd		ICD-9
	OSC West	
36. Treatment Plan: (Declude treatment rendered consultation/referral, surgery, and hospitalization. Iduration of physical medicine services (e.g., physical SPRAIN OR STRAIN OF HIP OR THIGH Note: left, acute, r/o labrum tear	lentify each physician and non-physician provi	ider. Specify type, frequency and
MRA requested. Waiting for appt. I certify the medical necessity of the care and hat the Plan of Care. Continue PT Work Status: Modified duty if available 4/1/201 Climb ladders: Not at all. Use of scaffolds/work at height: Not at all. Lift/carry/push/pull no more than 20 pounds. Return to Clinic: 4/15/2014 2:30 PM		ending: Not at all.
<ul><li>37. Have there been any changes in treatment pla</li><li>39. Other Physician/Non-Physician Providers:</li></ul>	on? 38. If so, why ?	
40. Drugs:		
4). Physical Medical Service: 44. Hospitalization/Surgery Date 46. Consul/Other Services.	42. Times per Week 45. Hospitalization/ Surgery	43. Duration:
Work Status: This patient has been instru  47. Return to full daty on with no  48. X Return to modified work on 04-01-2014 with 49. Unitations: SEE #36.  50. Patient discharged as curve (no permanent dan Patient is permanently precluded from engaging are deemed permanent.  mary Treating Physician: (original sign	Regimitations or restrictions.  In the following limitations or restrictions.  Builty or need for intere medical care).  In higher usual and exstemacy occupation and	
clare under penalty of perjury that this report is true as ibits referral to a physician or entity with whom the presented the medical Group, Inc.	nd correct to the best of my knowledge and the hysician has an unlawful financial interest.	
ature	Specialty	KOJ Occupational Health
outed at	Signature Date	APR 0.2 2014
Name TANG, ZILUE	MD '55, Californi	in Lic# 100782A
Address 975 Sereno Drive, Vallejo, CA, 94589	57. Phòne	(707) 651 <b>valle</b> jo Facility

KAISER PERMANENTE Claim#:CVCH-546693 D&i:02-15-2014 Visit:04-15-2014 14:32 ReportDate:04-16-2014 Final; Y S P MR:01977909 WCAB#: FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available); Patient State of California Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2) Page 1 Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 01. X Periodic Report (required 45 days after last report) 02. Change in treatment plan 03. Released from care Change in work status 05. Need for referral or consultation 06. Response to request for information Change in patient's conditions. Need for surgery or hospitalization 09. Request for Authorization Other: - -Patient will be permanently precluded from engaging in his/her usual and customary occupation 
If any of these boxes are checked 12. Patient's condition is permanent and sta 13. Patient will require future medical care Patient's condition is permanent and stationary with residual disability on: you must use Form PR-3 or narrative report. 14. Claims Administrator Patient: 16. YORK INS SVCS 17. Name 18. Address PO BOX 619079 19. City Zip 945918322 ROSEVILLE 20. DOI 22, Sex M CA 95661 23. Phone 24. Fax 25. Occupa 26. Phone (800) 422-7244 27. Fax (866) 548-2637 28. Claim 30. Employer Name: CITY OF VALLEJO 31. Employer Phone The information below must be provided. You may use this form or you may substitute or append a narrative report. 32. Subjective Complaints: n is a 49 Y male presents with left inner groin area pain. PT 10x. Still sore with lifting left leg. Could not stretch the thigh out. Pain level is much less. MRA scheduled on 04/17/14 outside of kaiser Prior treatment for this injury/illness: as above Current complaints: as above. Allergies: Review of patient's allergies indicates no known allergies. Social History: reports that he has never smoked. He does not have any smokeless tobacco history on file. Relevant Past Medical/Surgical History: Patient denies prior relevant injuries/surgeries and Prior industrial injury/surgery - bil knee s/p surgery Relevant Family History: No relevant family history Hobbies/Leisure Activities: Patient denies any relevant recreational/leisure activities 33. Objective Findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.) Physical Exam: no apparent distress BP 145/80 | Pulse 74 | SpO2 98% Gait: no antalgic Left thigh - mild TTP at lateral groin area. No hernia, mild reduced ROM with flexion and abduction, no bruise or swelling. Can bear weight on left hip. Additional Information Reviewed Data Review: Reviewed radiology results: left hip no fx Reviewed other records: HC notes reviewed 34. Diagnostic Studies Ordered: 35. Diagnoses ICD-9 843.9 SPRAIN OR STRAIN OF HIP OR THIGH (L)

2nd

ICD-9

### KAISER PERMANENTE Claim#:CVCH-546693 DQE:02-15-2014 Visit:04-15-2014 14:32 ReportDate:04-16-2014 Final:Y S.P MR:01977909 WCAB#: FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available):

### State of California Division of Workers' Compensation PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Page 2

36. Treatment Plan: (Include treatment rendered to desconsultation/referral, surgery, and hospitalization. Identify duration of physical medicine services (e.g., physical theraps SPRAIN OR STRAIN OF HIP OR THIGH (primary Note: left, acute, r/o labrum tear Plan: PHYSICIANS REPORT, PR-2 TREATING PF MRA 04/17/14  Work Status: Modified duty if available.  Return to Clinic: 1 week to review MRI results.	each physician and non-physician provider. Spy, manipulation, acupuncture). Use of CPT of encounter diagnosis)	specify type, frequency and
The total visit time face to face with the patient was 1 greater than 50% of this time counseling and in discuspatient. We reviewed injury, exam findings, pathogen and medications.	ssion with the	
MWP: 4/15-4/23/14: Squat/kneel, knee bending: Not	at all.	·
Climb ladders: Not at all.		
Use of scaffolds/work at height: Not at all.		
Lift/carry/push/pull no more than 20 pounds.		
F/U APPT ON 4/23/14 @ 4:30PM.	•	
<ul><li>37. Have there been any changes in treatment plan?</li><li>39. Other Physician/Non-Physician Providers:</li></ul>	38. If so, why ?	
40. Drugs:		
41. Physical Medicol Service: 44. Hospitalization/Surgery Date 46. Consult/Other Services:	42. Times per Weok 45. Hospitalization/ Surgery	43. Duration:
Work Status: This patient has been instructed to 47. Return to full duty on with no limitate 48. X Return to modified work on 04-15-2014 with the following the following see 476.	ions or restrictions.	_

50. Patient discharged as cured (no permanent disability or need for future medical cure).

are deemed permanent.

51. Patient is permanently precluded from engaging in his/her usual and customary occupation and the above limitations/restrictions

### KAISER PERMANENTE Claim#:CVCH-546693 DG:02-15-2014 Visit:04-15-2014 14:32 ReportDate:04-16-2014 Final:Y MR:01977909 WCAB#: FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available): State of California Division of Workers' Compensation

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

Page 3

RECEIVED

APR 24 2014 A

OSC West

#### Primary Treating Physician: (original signature, do not stamp) 52. Date of exam 04-15-2014

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 which prohibits referral to a physician or entity with whom the physician has an unlawful financial interest.

The Permanente Medical Group, Inc.

53. IRS Number 94-2728480

Signature _			Specialty	
Executed at			Signature Date	
54. Name	TANG, ZILUE	MD	55. California Lic#	100782A ·
56. Address	975 Sereno Drive, Vallejo, CA, 94589		57. Phone	(707) 651-1370

#### \*\* INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY \*\*

TIME RECEIVED April 18, 2014 4:43:08 PM EDT REMOTE CSID Fax Server DURATION PAGES

Fax Server

STATUS Received

Fax Server

4/18/2014 4:41:43 PM PAGE



NorCal Imaging Walnut Creek

3/004

PAGE: 001 OF 002

114 La Casa Via Walnut Creek, CA 94598 Phone: (925) 937-6100 Fax: (925) 938-9940



Date of Service: 04-17-2014

Exam. MR Arthrogram Hip [MR701] - Hip - L

Copy to; ADIN Healthcare Inc. 761 Old Hickory Blvd Suite 300 Brentwood TN 37027

FAX: (614) 717-6500

EXAM: MR ARTHROGRAM LEFT HIP

HISTORY: History of fall. Left hip injury. Evaluate labral tear.

TECHNIQUE: Combination of PD and fat-suppressed PD images as part of right hip arthrogram study. Sagittal images with fat-suppressed PD contrast. T1 weighted coronal images. T1 weighted axial images.

COMPARISON: None available.

#### FINDINGS:

There is delamination of articular cartilage of the acetabular roof lateral 9.6 mm with subchondral cystic changes in the acetabular roof indicating fissuring of the overlying articular cartilage. There is partial tearing of the junctional zone at the chondrolabral interface which has a more chronic appearance.

There is degeneration of the labrum on sagittal images anteriorly. The articular cartilage in the anterior 2.8 cm shows areas of delamination of the articular cartilage surface.

There is an aspherical femoral head and neck junction. There is mild fibrocystic changes characteristic on the MR findings seen in patients with femorosectabular impingement. These fibrocystic changes are in the lateral femoral head and neck junction. There is mild selectosis of the subchondral plate of the acetabular rim laterally both anteriorly and posteriorly in the acetabular rim, also consistent with findings seen femoroacetabular impingement. There is mild spurring of the acetabular rim.

The glutous minimus and medius tendons are intact.

Axial images confirm mild aspherical contour of the femoral head and neck junction.

Large field of view shows the common hamstring tendons with symmetric attachments with minimal tendinosis. The contralateral right hip shows mild aspherical contour and mild fibrocystic change as well.

**Confidential** 

#### \*\* INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY \*\*

TIME RECEIVED April 18, 2D14 4:43:08 PM EDT REMOTE CSID Fax Server DURATION PAGES

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4/18/2014 4:41:43 PM PAGE

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4/17/2014 2:09 PH FROM: Fax TO: +1 (614) 717-6500 PAGE: 002 OF 002



NorCal Imaging Walnut Creek

114 La Casa Via Walnut Creek, CA 94598 Phone: (925) 937-6100

Fax: (925) 938-9940

#### IMPRESSION:

- 1. There is aspherical contour of the left femoral head and neck junction. There are areas of delamination of articular cartilage with subchondral cystic changes in the acetabular roof of the left hip in an area of greater than 9.6 mm from medial to lateral. This partial junctional hyperintensity of intermediate signal consistent with degeneration of the labrum laterally.
- 2. The articular cartilage on corresponding sagittal images shows degeneration of the acetabular roof in a greater than 2 cm extent from anterior to posterior as described.
- The iliopsoas tendon is normal on corresponding sagittal images. The gluteus minimus and medius tendons are intact.
- 4. Large field of view images show the contralateral right hip with aspherical contour.

End of diagnostic report for accession: 263732

Dictated: Dictated By: 4/17/2014 11:55:36 AM

Transcribed By:

Stoller, David MD KA 4/17/2014 12:29.21 PM

Signed By:

Stoller, David MD 4/17/2014 2 04:28 PM

Exam requested by Zilue Tang.

Carrier Name         ID#         Group#           Date Called         Spoke with         Effective Date           Deductible Amount In\$Out\$Limitations	
Date Called         Spoke with         Effective Date           Deductible Amount In\$         Out\$         Limitations           Deductible Met In\$         Out\$         Exclusions           Insurance Pays In         % Out         % Pre-Existing Provision         yes         no           Patient Pays In         % Out         % MD _in network         out of network	
Deductible Amount In\$         Out\$         Limitations           Deductible Met         In\$         Out\$         Exclusions           Insurance Pays In         % Out         % Pre-Existing Provision	
Deductible Met         In\$Out\$Exclusions	
Insurance Pays In% Out% Pre-Existing Provisionyesno Patient Pays In% Out% MDin networkout of network	
Patient Pays In% Out% MDin networkout of network	
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Out of Pocket Max In \$ Out \$ Facilityin networkout of network	
Out of Pocket Met In \$ Out \$	
Effective Date Deductible \$ Deductible Met \$	
Ins Pays%	
Out Of Pocket Max \$ Pt Pays % Pre-cer	
CPM E0935 Covered Not-covered days Y N	
Cold Therapy E0218 Covered Not-covered Y N	<u> </u>
ROM Knee Brace L1832 Covered Not-covered Y N	<u>1</u>
Slingshot L3670 Covered Not-covered Y N	1
Pain Pump A4306 Covered Not-covered Y N	1
Custom Brace L1846 Covered Not-covered Y N	1
OTS Brace L1845 Covered Not-covered Y N	1
Other: Covered Not-covered Y N	<u> </u>
Phone# Fax# Spoke With	
Precert/Auth# Expiration Date Date Completed /_ / by	
Total Estimated Surgical Fee \$ Deposit: Ded \$ + Co-ins = Total \$	
Total Estimated DME Fee \$ Deposit: Ded \$ + Co-ins = Total \$	
Total Deposit \$	-
•	—

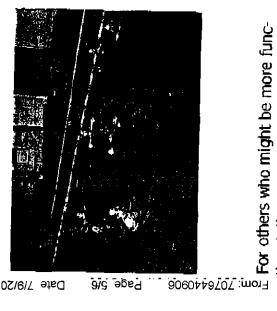
Patient Notified of deposit on \_\_\_\_\_/\_\_\_\_by\_\_\_\_\_

		Gel					
Carrier Name				Phone#			
Insured's Name			ID#	Group#			
Date Called		Spok	ce with	Effective Date			
Deductible Amount In\$Out\$_	Limit	ations	S		_		
Deductible Met In\$ Out\$_	Exclu	usions			_		
Insurance Pays In% Out	% P	re-Exi	sting Provisionyes _	no			
Patient Pays In% Out	% <b>M</b> I	Di	n networkout of ne	etwork			
Out of Pocket Max In \$ Out	\$ F	acility	in networkout of ne	etwork			
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			Pays%				
Out Of Pocket Max \$	•	Pt Pa	ı ı			Pre-	
СРМ	E0935		Covered	Not-covered	days	Υ	N
Cold Therapy	E0218		Covered	Not-covered		Y	N
ROM Knee Brace	L1832		Covered	Not-covered		Y	N
Slingshot	L3670		Covered	Not-covered		Υ	N
Pain Pump	A4306		Covered	Not-covered		Υ	N
Custom Brace	L1846		Covered	Not-covered		Υ	N
OTS Brace	L1845		Covered	Not-covered		Υ	N
Other:			Covered	Not-covered		Υ	N
Phone#			Fax#	Spoke With			
Precert/Auth#			Expiration Date	Date Completed /	/by_		
			Denosii				
Total Estimated Surgical Fee \$	Depos	ıt: De	d\$ + Co-ins	= Total \$			
Total Estimated DME Fee \$	Depos	it: De	d\$ + Co-ins	= Total \$			
Total Deposit \$							
Patient Notified of a	denosit on		/ / by				

# The Next Step program Progressive Phases of

ion completed by our Physical Therandudes dient history and client goals ind then determines the level at which Each client receives an initial evaluaalong with prescription adherence pist upon request. The evaluation

bearing environment, we initiate the For those who require a non-weight the client will initiate the program. client into our water therapy.



tional, the program initiates with our functional restoration program to inemphasis on proprioception and inand ROM to the affected area with



ude; core strengthening, stabilization, creased proper body mechanics.

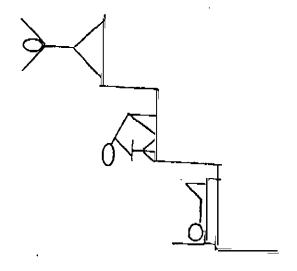


not progressed as expected, they will be program or progressed out of "The Next and 12 week intervals. If the client has care provider for further assessment. If referred back to the prescribing health assessment, they will be progressed to Step" program into either a home exer-Reassessments are completed at 4,8, the next phase in their rehabilitation dise program or an independent prothe client is on target with the initial gram in a health club.



# THE NEXT STEP" Physical Repair

Bridging the Gap Between Functional Independence Physical Therapy and





mons Valley Rd. 3250 Renotes Solano Plesy facaiville, CA 95688

# WHAT IS THE NEXT STEP?

gist, Physical Therapy Assistant who, out of a passion for wellbeing, have made physical recal Therapist, Exercise Physioloary staff that consists of a Physinabilitation and functional train-The Next Step is a multi-disciplinand Certified Athletic Trainers, all ing their areas of expertise.



# WHAT IS OUR ROLE?

cost-containing program that specializes in functional restoration of the client in a group setting. Our multi-disciplinary approach guides Our primary goal in this group setting is to progress the client status in order to improve quality of progressive, comprehensive and the patient toward maximal results life at home and/or to maximize functional ability within their current "The Next Step" is an efficacious, expeditiously to return to pre-injury while minimizing time and costs. iob requirements.

## WATER THERAPY (Phase 1)

ects, extending across essentially all homeostatic systems. These effects are both variety of rehabilitative problems. Aquatic therapies are beneficial in the management addition, the margin of therapeutic safety is wider than that of almost any other treatment Aquatic immersion has profound biologic efmmediate and delayed, and they allow water of patients with musculoskeletal problems, neurologic problems, cardiopulmonary to be used with therapeutic efficacy for a great diseases and many other conditions.



Our group water sessions are designed with CORE trunk stabilization, strengtherring, gait training, and ROM as its foundation. Because of the decreased amount of weight bearing on the body, water is an environment where periencing high pain levels preventing them early entry is possible with those clients exaddition, water is appropriate for those with muscle imbalances, arthritic issues, gait imfrom tolerating land based exercises. balances, and general deconditioning,

ter, we are able to help these clients build a Many of our dients are those that have not had success in a land therapy setting. In wabetter foundation insuring a more effective progression in their overall rehabilitation needs

# FUNCTIONAL RESTORATION (Phase 2)

hase 2 is designed to transition the client from a accomplish this progression we are incorporating flexibility, and strength helps the client to achieve progression of care. Appropriate land exercises addition to increasing overall proprioception. To ineraball exercises, dynaband, Pilates mat and bearing environment is an essential part of the increasing the overload principal to the body in bearing environment. The transition to a weight non weight bearing environment into a weight medicine balls. This functional approach to aid in the progression of overall function by overall conditioning through balance, ROM, a more safe and effective recovery.

proper lifting techniques and postural awareness. sitting, lowering and rising to and from the floor, We also work on proper body mechanics in

Our group dynamic continues to aid in compliance and increased learning potential through

cises that can be done at home rehabilitation time and pushing independent or home exercise ultimate committment is to emsponsibility for continuing their at the outcome of therapy, our able tools and effective exer-With managed care reducing own care by providing affordpower our clients to take reor in a gym.

#### WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

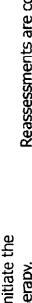
	Name _	<del></del>
	Date	_
CHIEF COM	IPLAINT: (Please present complain	ts in patient's own words.)
DATE OF O	NSET/INJURY:	
CAUSE:	(If injury, please explain.)	
□ X-rays or	MRI's brought to today's appointme	nt.
□ X-rays or	MRI's exist but not brought to today	's appointment.
□ No previou	ous imaging done.	

## The Next Step program Progressive Phases of

tion completed by our Physical Theraincludes client history and client goals and then determines the level at which bearing environment, we initiate the For those who require a non-weight Each client receives an initial evaluaalong with prescription adherence pist upon request. The evaluation the client will initiate the program. client into our water therapy.



clude; core strengthening, stabilization, tional, the program initiates with our functional restoration program to in-For others who might be more funcemphasis on proprioception and inand ROM to the affected area with creased proper body mechanics.

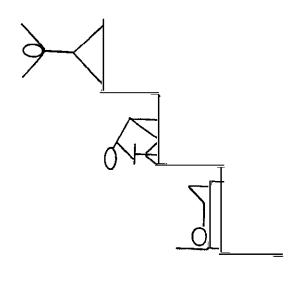


not progressed as expected, they will be program or progressed out of "The Next and 12 week intervals. If the client has care provider for further assessment. If assessment, they will be progressed to referred back to the prescribing health Step" program into either a home exer-Reassessments are completed at 4,8, the next phase in their rehabilitation cise program or an independent prothe client is on target with the initial gram in a health club,



# THE NEXT STEP" Physical Repair

Bridging the Gap Between Functional Independence Physical Therapy and





Whitennum Vacavile Milennum Rancho Solano 3446 Browns Valley Rd 3250 Rancho Solano Prwy Yacavile, CA 95688 Farrield, CA 94533 Vacaville, CA 95688

Valleyo, CA 94591

# WHAT IS THE NEXT STEP?

passion for ary staff that consists of a Physical Therapist, Exercise Physiologist, Physical Therapy Assistant wellbeing, have made physical re-The Next Step is a multi-disciplinand Certified Athletic Trainers, all habilitation and functional training their areas of expertise. who, out of a



# **WHAT IS OUR ROLE?**

cost-containing program that multi-disciplinary approach guides status in order to improve quality of of the client in a group setting. Our the patient toward maximal results Our primary goal in this group setting is to progress the client ife at home and/or to maximize progressive, comprehensive and specializes in functional restoration expeditiously to return to pre-injury functional ability within their current "The Next Step" is an efficacious, while minimizing time and costs.

## **WATER THERAPY** (Phase 1)

variety of rehabilitative problems. Aquatic Aquatic immersion has profound biologic efhomeostatic systems. These effects are both immediate and delayed, and they allow water to be used with therapeutic efficacy for a great therapies are beneficial in the management neurologic problems, cardiopulmonary diseases and many other conditions. In addition, the margin of therapeutic safety is wider than that of almost any other treatment of patients with musculoskeletal problems, fects, extending across essentially all



Our group water sessions are designed with training, and ROM as its foundation. Because on the body, water is an environment where periencing high pain levels preventing them CORE trunk stabilization, strengthening, gait of the decreased amount of weight bearing early entry is possible with those clients exaddition, water is appropriate for those with muscle imbalances, arthritic issues, gait imfrom tolerating land based exercises. balances, and general deconditioning,

ter, we are able to help these clients build a had success in a land therapy setting. In wa-Many of our dients are those that have not better foundation insuring a more effective progression in their overall rehabilitation needs.

# FUNCTIONAL RESTORATION



Phase 2 is designed to transition the client from a accomplish this progression we are incorporating flexibility, and strength helps the client to achieve progression of care. Appropriate land exercises addition to increasing overall proprioception. To bearing environment. The transition to a weight increasing the overload principal to the body in theraball exercises, dynaband, Pilates mat and bearing environment is an essential part of the non weight bearing environment into a weight medicine balls. This functional approach to aid in the progression of overall function by overall conditioning through balance, ROM, a more safe and effective recovery.

sitting, lowering and rising to and from the floor, proper lifting techniques and postural awareness We also work on proper body mechanics in

Our group dynamic continues to aid in compliance and increased learning potential through others.

rehabilitation time and pushing ultimate committment is to emcises that can be done at home sponsibility for continuing their independent or home exercise at the outcome of therapy, our With managed care reducing able tools and effective exerown care by providing affordpower our clients to take re-

or in a gym.

job requirements.



To:	m Workman	nMO	Prom: WYU- KLINEY Date:
Fax:  Alternate Fax:	-944-091	Total I	Senders Phone Number: Number of Pages Including Cover:
Regarding:			You're Reference Number:
□ Urgent	□ For Review	□ Please Comment	□ Please Reply
Notes/Comme	nts:		

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Deductible Amount In\$ Out\$ Limitations Deductible Met In\$ Out\$ Exclusions Insurance Pays In % Out % Pre-Existing Provision yes no Patient Pays In % Out % MD in network out of network Out of Pocket Max In \$ Out\$  Deductible \$ Deductible Met In\$ Out \$ Facility in network out of network Out of Pocket Met In \$ Out\$  Deductible \$ Deductible Met \$ In\$ Out of Pocket Max \$ Covered Not-covered days Y N Cold Therapy E0218 Covered Not-covered Y N Slingshot L3670 Covered Not-covered Y N Pain Pump A4306 Covered Not-covered Y N Cotsom Brace L1846 Covered Not-covered Y N OTS Brace L1845 Covered Not-covered Y N Other: Covered Not-covered Y N Covered Not-covered Y N Others Covered N Others Covered N Other Covered N Other Covered N Other Covered N Other Covered N Other Covered N Other Covered N Other Covered N Ot
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Total Deposit \$
Patient Notified of deposit on / / by

### For Use with the QME Panel Request Form 105

### MD/DO SPECIALTY CODES

#### MAI Allergy and Immunology MDE Dermatology

MEM Emergency Medicine

Family Practice MFP

MPM General Preventive Medicine

MHH Hand

MMM Internal Medicine

MMV Internal Medicine - Cardiovascular Disease

MME Internal Medicine - Endocrinology Diabetes and

Metabolism

MMG Internal Medicine - Gastroenterology

MMH Internal Medicine - Hematology

MMI Internal Medicine - Infectious Disease

MMN Internal Medicine - Nephrology

MMP Internal Medicine - Pulmonary Disease

MMR Internal Medicine - Rheumatology

MNB Spine

MPN Neurology

MNS Neurological Surgery (other than Spine)

MOG Obstetrics and Gynecology

Occupational Medicine MPO

MMO Oncology - Orthopaedic Surgery Internal

Medicine or Radiology

MOP Ophthalmology

Orthopaedic Surgery (other than Spine or Hand) MOS

MTO Otolaryngology

MPA Pain Medicine

MHA Pathology

MPR Physical Medicine and Rehabilitation

MPS Plastic Surgery (other than Hand)

MPD Psychiatry (other than Pain Medicine)

MSY Surgery (other than Spine or Hand)

Surgery - General Vascular MSG

Thoracic Surgery MTS

MTT Toxicology

MUU Urology

### NON-MD/DO SPECIALTY CODES

ACA Acupuncture

DCH Chiropractic

Dentistry DEN

OPT Optometry

POD **Podiatry** 

PSY Psychology

PSN Psychology - Clinical Neuropsychology



### Fire Fighter/Engineer

Class Code: 04115

CITY OF VALLEJO Revision Date: Jun 5, 2007

### **DEFINITION:**

DEFINITION

Under supervision, to be responsible for the operation and driving of fire apparatus; to respond to fire alarms and other emergency calls; to engage in fire fighting and fire prevention activities in protecting life and property; to participate in station maintenance and training activities; and to do other related work as required.

SUPERVISION RECEIVED AND EXERCISED

Receives supervision from supervisory or management staff.

### **EXAMPLES OF DUTIES:**

EXAMPLES OF IMPORTANT RESPONSIBILITIES AND DUTIES - Important responsibilities and duties may include, but are not limited to the following:

Responds to alarms and assists in the suppression of fires, including rescue, entry, ventilation and salvage work.

Performs clean-up and overhaul work and checking, testing and maintenance activities on apparatus and equipment to return it to readiness for further alarms; operates resuscitators and inhalators and administers first aid.

Drives equipment to fire scenes and assumes responsibility for readiness of fire fighting apparatus.

Assists in making residential, commercial and industrial inspections to discover potential fire hazards.

Educates the public in fire prevention and is prepared for fire suppression tactics.

Participates in a continuing training and instruction program by individual study of technical material and attendance at scheduled drills and classes.

To be quartered overnight at a fire station.

In addition, lays out hose lines to hydrant and pumping equipment and assures that necessary water pressure is maintained.

Inspects fire apparatus and equipment to assure proper maintenance and care.

Calculates engine pressures and nozzle pressures for operation of hose streams; positions

engines and aerial apparatus in most effective positions at scenes of fire; notifies the company officer or officer in charge of significant changes in water supply system during a fire; calculates hydraulics problems that may be confronted.

### **KNOWLEDGE AND ABILITIES:**

**QUALIFICATIONS** 

### Knowledge of:

Modern fire suppression equipment and department procedures of operation and maintenance of pumps and pumping equipment; target hazards and street locations and hydrant and water main locations and sizes.

### Ability to:

To meet the essential functions and physical requirements contained in the Physical Analysis of Job Assignment attached to this specification and incorporated herein by this reference.

### MINIMUM QUALIFICATIONS:

Experience and Training Guldelines

A typical way to obtain the knowledge and abilities would be:

### Experience:

Three years of experience in the City of Vallejo Fire Department.

#### License or Certificate:

Applicants must obtain a Class B California driver's license prior to appointment as an Engineer.

*ยเวรเวก*000247



### FACSIMILE TRANSMITTAL SHEET

man	Shelley Jones RN, BSN		
	ξ) «TRα	23) 349-3674	
	MA	RCH 3, 2010	
	TOTAL NO. OF PAGES INCLUDING COVER:		
<del>14-</del> 0960	9		
Ri	sender's reference number		
	YOUR REPERENCE NUMBER		
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	14-0960 R	DATE:  MA  TOTAL  14-0960  R: SENDE:	Shelley Jones RN (925) 349-3874  DATE  MARCH 3, 2010  1'OTAL NO. OF PAGES INCLUDING 14-0960 9 SENDER'S REFERENCE NUMBER YOUR REFERENCE NUMBER

### Please Fax all Additional Requests for Treatment to:

### ATTN:

Shelley Jones RN, BSN
Nurse Case Manager
Wellcomp Managed Care Services/York Insurance Services
Shelley.Jones@wellcomp.com
Ph: 925-349-3874

Fax: 925-609-9264

York Insurance Services Group 1390 Willow Pass Road, Suite 400 Concord, Ca. 94520

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Benicia Bay Phyliscal Therapy 560 First Street Ste C 103 Benicia, CA 945103266

Phone: (707) 747-9977

Fax: (707) 747-9477

William Workman, M.D. 301 Lennon Lane Walnut Creek, CA 94598



Phone: (925) 944-0110 Fax: (925) 944-0960



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## "The Next Step"

Main Office:

Vacaville

(707)447-8462

Phone: Fax:

1.1

(707)447-8463

Physical Repair JYJ L L SECLUE

Vallejo Phone: (707)644-7013 (707)644-7014

**Fairfield** Phone: (707) 438-2582 Fax: (707)438-2581

## FAX COVER SHEET TIME: 12:25 m FAX#: 925-944-0

Main Office Street Address: 3446 Browns Valley Road

Vacaville, CA 95688

Main Office: (707) 447-8462 Cell. (707) 592.8774 Phone:

Fax: Main Office: (707), 447-8463

From:

To:

# of pages (including cover):

**COMMENTS:** 

# "The Next Step"

Main Office:

Vacaville

Phone:

Fax:

(707)447-8462

(707)447-8463

Physical Repair MILLEGCLUB

PORTH MINIS

Vallejo

Phone: (707)644-7013

(707)644-7014

Fairfield

Phone: (707)438-2582

Fax: (707)438-2581

ME: 2'00m FAX#: 925-940

Main Office Street Address: 3446 Browns Valley Road

Vacaville, CA 95688

Phone:

Main Office: (707) 447-8462

Fax:

Main Office: (707) 447-8463

From:

To:

# of pages (including cover):

**COMMENTS:** 

is script for cano thingy only Harnening for RTW outres (full outres

wover you be okay wit Apring water Thursp script partial ablic as the case mer HAD of it for progression to came in June betore leaving on Leave - Pleur fax & Glalio script and corrent script

1901 E, Alton Ave. Suite 200 Santa Ana CA92705 800-559-5556 phone 866-409-1957 fax

# Paladin Managed Care Services



011811 10a Dear Adjuster, Added more information about patient's symptoms in last PR-2. Thanks!

WBWorkman

William Workman, M.D. To:

925-944-0960

Phone: 925-944-0110

Wednesday, January 12, 2011 Date:

Re:

Fax:

Please find attached the most recent correspondences associated with the claim referenced above. If you have any questions, please contact the Paladin Managed Care Services via phone at 800-559-5556, via fax at 866-409-1957, or at the address listed on this coversheet.

Total HealthCare Management (THM) is now Paladin Managed Care Services

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### **FAX COVER SHEET**

# SPORTS + ORTHOPEDIC LEADERS PHYSICAL THERAP 5297 COLLEGE AVE. OAKLAND, CA 94618

FAX #: 510.923.1944

### **TELEPHONE #: 510.547.1630**

### PLEASE DELIVER THE FOLLOWING PAGES TO THE ATTENTION OF

NAME: Dr. William Workman MD
DATE: February.22.11
FAX: 925.944.0960
TELEPHONE:
· ·
FROM: Ada Jauregui DPT
TOTAL NUMBER OF PAGES, INCLUDING COVER SHEET: 5
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IF YOU DO NOT RECEIVE ALL THE PAGES, PLEASE CALL THE SENDER AS SOON AS POSSIBLE.
Dear Dr. William Workman MD,
Attached is my initial evaluation report for your patient to be a pack to our office.
Thank you!
CONFINENTIALITY OF ATRIALITY

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FAX #: 510.923.1944

### TELEPHONE #: 510.547.1630

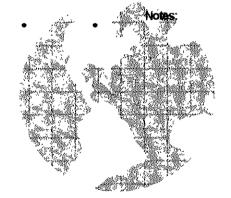
### PLEASE DELIVER THE FOLLOWING PAGES TO THE ATTENTION OF:

NAME: Dr. William Workman, M.D
DATE: March 21, 2011
FAX: 925. 944.0960
TELEPHONE:
FROM: Ada Jauregui, DPT
TOTAL NUMBER OF PAGES, INCLUDING COVER SHEET: 6
IF YOU DO NOT RECEIVE ALL THE PAGES, PLEASE CALL THE SENDER AS SOON AS POSSIBLE.
Dear Dr. William Workman, M.D
Attached is my progress report for your patient from Ada Jauregui, DPT. If you agree with the plan of care, please sign and date and fax back to our office.  Thank you!
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## facsimille transmittal

То:	Wılliam Workman M	D Fax:	19259440960	
From:	Ada Jauregui	Date.	Apr 18, 2011	· · · · · · · · · · · · · · · · · · ·
Re:		Pages:	5	
Urgent	For Review	Please Comment	Please Reply	Please Recycle





Sports + Orthopedic Leaders Physical Therapy, Inc. 5297A College Ave Oakland, CA 94618 P 510.547.1630 F 510.923.1944



To: William Workman MD

Fax: (925) 944-0960

Phone: (925) 944-0110 Re:

Comments:

From: Ada Jauregui

Pages: 2

**Phone:** (510) 547-1630 **Date:** 4/18/2011

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### YORK RISK SERVICES GROUP, INC.

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TO:	FROM:			
Dr. Workman	Erika Perry			
Walnut Creek Orthopedics	AUGUST 25, 2011			
FAX NUMBER: (925) 944-0960	TOTAL NO. OF PAGES INCLUDING COVER:			
PHONE NUMBER: (925) 944-0110	5ENDER'S REFERENCE NUMBER:			
RE-	your reference number:			
URGENT FOR REVIEW PLEA	SE COMMENT			
NOTES/COMMENTS: Dear Dr. Workman, I have attached a job desription on Mr. please call our office if you require additions				
Thank you,				
Erika Perry				
Claims Assistant				

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P.O. BOX 619079, ROSEVILLE, CA 95661-9079 PHONE: (925) 349-3880 PAX: (866) 548-2637