ASSOCIATED REPRODUCTION SERVICES, INC.

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

Record Review

Name : [redacted]
Employer : Vallejo Fire Department
WCAB/ADJ # : [redacted]
ARS Invoice # : 450603-01
Copy Location : Walnut Creek Orthopedics & Sports Medicine – William B. Workman, M.D.
Date of Injury : [redacted]

Date	Review
10/05/2009 Page 0015	**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.

The order in which the records have been copied may have been changed to provide you with the sequence of medical treatment then followed by all other documents in the file. Please review all records carefully.

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 IMPRESSION: 1. Abnormal lateral meniscus. Findings may correspond to extensive lateral meniscus tear involving the posterior and anterior horns. 2. Mild sprain, medial collateral ligament. 3. 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.

Date	Review
02/25/2010 Page 0069	**Medical Report - William Workman, MD** 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 Page 0072	**Medical Report - William Workman, MD** 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 Page 0201	**Operative Report - William Workman, MD** 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 Page 0091	**PT Notes - Shivani Mehta, MPT** 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.

Date	Review
05/10/2010 Page 0028	**Progress Report - William Workman, MD** SUBJECTIVE COMPLAINT: Occasional knee discomfort. DIAGNOSES: 1. DJD knee. 2. Lateral meniscus tear. PLAN: PT. Follow-up 6 weeks.
07/29/2010 Page 0030	**Progress Report - William Workman, MD** SUBJECTIVE COMPLAINT: S/P left knee arthroscopy. DIAGNOSES: 1. DJD knee. 2. Lateral meniscus tear. PLAN: HEP. Encouraged biking. Knee injection.
11/29/2010 Page 0210	**Radiology - Vallejo Open MRI** MRI RIGHT KNEE WITHOUT CONTRAST 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 horn-body junction of the medial meniscus with associated small perimeniscal cyst. 5. Chronic stress changes in the extensor mechanism.

Date	Review
02/21/2011 Page 0095	**PT Notes - Ada Jaureguil, DPT** DIAGNOSES: 1. Following surgery, unspecified. 2. Other tear of cartilage or meniscus knee. CHIEF COMPLAINT: R/L knee pain. PLAN: Patient education. Home exercise program. Modalities. Manual. Graston.
02/28/2011 Page 0204	**Operative Report - William Workman, MD** 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 Page 0099	**PT Notes - Ada Jaureguil, DPT** DIAGNOSES: 1. Following surgery, unspecified. 2. 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.

Date	Review
04/14/2011 Page 0102	**PT Notes - Sports Orthopedic Leaders Physical Therapy, Inc.** DIAGNOSES: 1. Following surgery, unspecified. 2. 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.
08/22/2011 Page 0058	**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 Page 0017	**Doctor's First Report of Occupational Injury or Illness – Jennifer Sperandio, MD** HISTORY: While fighting fire, patient's left leg fell through a hole in a bedroom floor, straining left hip flexor. DIAGNOSIS: Left groin muscle strain. PLAN: Ice. Off work.

Date	Review
02/18/2014 Page 0019	**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.
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.

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. 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.

Date	Review
04/17/2014 Page 0212	**Radiology - NorCal Imaging** MR ARTHROGRAM LEFT HIP 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 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. 2. 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. 3. 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.
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

NOTICE OF OBLIGATIONS WITH REGARD TO PHI

Associated Reproduction Services, Inc., DBA ARS Legal, is providing this Notice as part of its compliance obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its regulations as implemented and/or amended from time to time.

Pursuant to HIPAA and its regulations, ARS Legal is obligated to take affirmative steps to ensure that any Protected Health Information ("PHI") that it provides to third parties is treated as confidential information and protected from inappropriate use or disclosure.

You are being provided copies of medical information which qualifies as PHI. By your receipt of these documents, you agree to the following:

1. You will use and/or disclose PHI only as necessary to perform your services or as otherwise required by law.

2. You agree to implement and use appropriate administrative, physical and technical safeguards to (i) prevent inappropriate use or disclosure of PHI and (ii) reasonably and appropriately protect the confidentiality and integrity of the PHI.

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.

If you have any questions about these obligations or incidents involving disclosure or potential security breach, please contact the Security & Privacy Officer at ARS Legal at (562) 696-1181.

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF INDUSTRIAL ACCIDENTS

ARS#: 4[redacted]

WORKERS' COMPENSATION APPEALS BOARD

Case No. [redacted]

[redacted]

Claimant/Applicant,

vs.

SUBPOENA DUCES TECUM

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

(NO APPEARANCE NECESSARY WHEN RECORDS ARE PRODUCED BY DEPOSITION DATE)

Vallejo Fire Department

Employer/Insurance Carrier/Defendant

The People of the State of California Send Greetings to:

Walnut Creek Orthopedics & Sports Medicine
William B. Workman, M.D.
WE COMMAND YOU to appear before: **Associated Reproduction Services at**

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

Legal Agent [redacted]
on Jul. 08, 2014, at 9 o'clock AM., to testify in the above entitled matter and to bring with you and produce the following described documents, papers, books and records:
See Attachment "A"-Subpoena for Medical Records. Include records from Dr. William Workman.

applicant : [redacted] **DOB:** [redacted] **SSN:** [redacted]
AKA:

For failure to attend and to produce said documents you may be deemed guilty of contempt and liable to pay to the parties aggrieved all damages sustained thereby and forfeit one hundred dollars in addition thereto.

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

Date Jun. 17, 2014

WORKERS' COMPENSATION APPEALS BOARD
OF THE STATE OF CALIFORNIA

By Cynthia Quiel
Secretary, Assistant Secretary, Workers' Compensation Judge

***FOR INJURIES OCCURING ON OR AFTER JANUARY 1, 1990 AND BEFORE JANUARY 1, 1994:**
If no application for Adjudication of Claim has been filed, a declaration under penalty of perjury that 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. [redacted]9

STATE OF CALIFORNIA, County of LOS ANGELES

I [redacted]
That he is the attorney(s) of record or 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.

That the subpoenaed Custodian of Record has in his/her possession or under his/her control the documents described on the reverse hereof. That said documents are material to the issues involved in the case for the following reason: To assist in determining one or more of the following: To determine present and/or past physical condition; nature, extent and duration of sickness; injury, disability arising out of employment & in the course of employment and/or necessity of further treatment; employment occupation and duties, earnings and earnings capacity self-procured and future medical treatment, vocational rehabilitation under Labor Code 129.5 and status as Q.I.W (Qualified Injured Worker).; Jurisdiction and statute of limitations.

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

Executed on **Jun. 17, 2014, at Whittier, California.**

cc: York Insurance Services

Associated Reproduction Services, Inc.
Legal Agent for: [redacted]

13925 Whittier Blvd., Whittier, CA 90605
Address

(562) 696-1181
Telephone

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of CONTRA COSTA

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
[redacted]	6.18.14	101 Ygnacio Valley Rd #400 Walnut Creek, CA 94596

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

Executed on JUNE 18, 2014, at WALNUT CREEK, California.

Kathy Rhoades
Signature

ARS#: 4[redacted]1

Attachment "A" - Subpoena for Medical Records

Record of: [redacted]
Location: 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

ARS# 450603-01-01 982(a)(15.5) D14

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, state bar number, and address): [redacted]

ATTORNEY FOR (Name) Applicant/Consumer, [redacted]

NAME OF COURT: WORKERS' COMPENSATION APPEALS BOARD
STREET ADDRESS:
MAILING ADDRESS:
CITY AND ZIP CODE:

PLAINTIFF/PETITIONER: [redacted]

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

NOTICE TO CONSUMER OR EMPLOYEE

TO(name): [redacted]

1. PLEASE TAKE NOTICE THAT REQUESTING PARTY(name): [redacted] SEEKS YOUR RECORDS FOR EXAMINATION by the parties to this action on (specifc 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.
3. YOU OR YOUR ATTORNEY MAY CONTACT THE UNDERSIGNED to determine whether an agreement can be reached in writing to cancel or limit the scope of the subpoena. If no such agreement is reached, and if you are not otherwise represented by an attorney in this action, YOU SHOULD CONSULT AN ATTORNEY TO ADVISE YOU OF YOUR RIGHTS OF PRIVACY.

Date: 06/17/2014

L[redacted]

> [redacted]
(SIGNATURE OF [ ] REQUESTING PARTY [XX] ATTORNEY)

OBJECTION BY NON-PARTY TO PRODUCTION OF RECORDS

1.[ ] I object to the production of all of my records specified in the subpoena.
2.[ ] I object only to the production of the following specified records:

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

Date:

.....
(TYPE OR PRINT NAME)

>
(SIGNATURE)

(See reverse for proof of service)

ARS# 450603-01-01 982(a)(15.5) D14

PLAINTIFF/PETITIONER: [redacted]

DE[redacted] ADJ[redacted]

PROOF OF SERVICE OF NOTICE TO CONSUMER OR EMPLOYEE AND OBJECTION

(Code Civ. Proc., §§ 1985.3, 1985.6)

[ ] Personal Service [X] Mail

1. At the time of service I was at least 18 years of age and **not a party to this legal action.**
2. I served a copy of the *Notice to Consumer or Employee and Objection* as follows *(check either a or b)* :
   a. [ ] **Personal service.** I personally delivered the *Notice to consumer or Employee and Objection* as follows:
      (1) Name of person served: (3) Date served:
      (2) Address: (4) Time served

   b. [X] **Mail.** I deposited the *Notice to Consumer or Employee and Objection* in the United States mail, in a sealed envelope with postage fully prepaid. The envelope was addressed as follows:
      (1) Name of person served: [redacted] (3) Date of mailing: 06/17/2014
      (2) Address: [redacted] (4) Place of mailing *(city and state)*: Whittier, CA

      [redacted] county where the *Notice to Consumer or Employee and Objection* was mailed.
   c. My residence or business address is *(specify)*: 13925 Whittier Blvd.
   d. My phone number is *(specify)*: (562)696-1181

   I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
   Date: 06/17/2014

Rachel Dorame
(TYPE OR PRINT NAME)

> /Rachel Dorame/
(SIGNATURE OF PERSON WHO SERVED)

PROOF OF SERVICE OF OBJECTION TO PRODUCTION OF RECORDS

(Code Civ. Proc., §§ 1985.3, 1985.6)

[ ] Personal Service [ ] Mail

1. At the time of service I was 18 years of age and **not a party to this legal action.**
2. I served a copy of the *Objectin to Production of Records* as follows *(complete either a or b)*:
   a. ON THE REQUESTING PARTY
      (1)[ ] **Personal service.** I personally delivered the *Objection to Production of Records* as follows:
         (i) Name of person served: (iii) Date served:
         (ii) Address where served: (iv) Time served:

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

         (v) I am a resident of or employed in the county where the *Objection to Production of Records* was mailed.
   b. ON THE WITNESS
      (1)[ ] **Personal service.** I personally delivered the *Objection to Production of Records* as follows:
         (i) Name of person served: (iii) Dete served:
         (ii) Address where served: (iv) Time served:

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

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

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

(TYPE OR PRINT NAME)

>
(SIGNATURE OF PERSON WHO SERVED)

DECLARATION OF CUSTODIAN OF RECORD

Record Of: [redacted] ARS#: 4[redacted]1

SSN [redacted] DOB: [redacted]64 DOI: [redacted]-02/15/14

I am duly authorized as Custodian of Record (or other qualified witness) with authority to certify records for:

Walnut Creek Orthopedics & Sports Medicine
William B. Workman, M.D.

CERTIFICATION OF RECORD COPIES

Including this declaration, all documents, records and other things called for in the Subpoena Duces Tecum or Authorization which are in my custody have been photocopied either by a photocopy company or my office staff at my office, in my presence, under my direction and control; and the copy submitted with declaration is a true copy thereof.

To the best of my knowledge all records in existence referred to above were prepared or compiled and provided by the personnel of the above named business, in the ordinary course of business, at or near the time of the acts, conditions, or events recorded. No documents, records or other things have been withheld to prevent being photocopied.

Certain records were omitted because: _____

CERTIFICATION OF NO RECORDS

A thorough search of the business revealed no records described in the attached subpoena or authorization for the following reason(s):

Medical/Billing/X-Ray Records

[ ] Patient never treated at this facility
[ ] 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:(_____) _____
[ ] Billing is: ___ lost / misplaced ___ Not kept because of prepaid Health Plan at another facility:
Name: _____
Contact: _____ Phone: _____
[ ] No records for date(s) specified
[ ] Other - comments: _____

Personnel/Wage/Non-Medical Records

[ ] Never Worked for this Company
[ ] Records destroyed after ___5 ___7 ___9 years
[ ] Previous owner kept original files
[ ] Records kept at: _____
Contact: _____ Phone: _____
[ ] Records were lost / misplaced

[ ] Other: _____

This certification is limited to the information provided in the attached document. Records may exist under another name, spelling or other identifying data.

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

Executed on 6/27/14 (Date) at Walnut Creek (City), CA (State)

Declarant [signature] Print Name Tere Harding

Witness _____ Print Name _____

CERTIFICATION OF PROFESSIONAL PHOTOCOPIER

I, the undersigned hereby declare that I am an employee of Associated Reproduction Services Inc., 13925 Whittier Blvd, Whittier, CA 90605, Registration Number 3640, Los Angeles County. The attached copy of records produced to me by the above Custodian of Records shall be transmitted or distributed to the authorized persons or entities and will be true copies thereof. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on 6-27-14 (Date) at WALNUT CREEK (City), CA (State)

Print Name KATHY RHOADES Signature Kathy Rhoades

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

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: [redacted]
[redacted] CA 94591
Phone: 70[redacted]8
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: [redacted]
[redacted] 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.: [redacted] **Date of Injury:** [redacted]

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: [redacted] Date of Birth: [redacted]4

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

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:
Phone:
Fax:

Notes:

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

PATIENT REGISTRATION FORM

(Please Print)

Date 2/25/2010

Referring Physician: PCP:

PATIENT INFORMATION

Patient's last name: [redacted] First: [redacted] Middle: P ☒ Mr. ☐ Mrs. ☐ Dr. ☐ Miss ☐ Ms.

Marital status (circle one): Single / (Mar) Div / Sep / Wid

Is this your legal name? ☑ Yes ☐ No If not, what is your legal name? (Former name):

Birth date: [redacted] Age: [redacted] Sex: ☒ M ☐ F

Street address: [redacted] City: [redacted] State / Zip Code: [redacted]

Phone number: [redacted] Other contact number: Cell X Work ___ Social Security #: [redacted]

Occupation: [redacted] Employer: [redacted] Address: 555 Santa Clara St Employer phone no.: [redacted]

IF PATIENT IS A MINOR PLEASE COMPLETE: Father: / Work# / Cell# /

Mother / Work# / Cell# /

Other family members seen here: ___

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: / / Address (if different): Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: Employer: Employer address: Employer phone no.: ( )

Is this patient covered by insurance? ☑ Yes ☐ No

Name of primary insurance: CITY OF VALLEJO / WORKERS COMP. ADMINISTERS YORK INSURANCE SERVICE 1390 Willow Pass Rd Suite 400 Concord CA. 94520

Subscriber's name: CLAIM # [redacted] Subscriber's S.S. no.: Birth date: / / Policy no.: Group no.: Co-payment: $ -0-

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): KAISER

Subscriber's name: [redacted] Subscriber's S.S. no.: [redacted] Birth date: [redacted] Policy no.: [redacted] Group no.: [redacted] Co-payment: $ 15 -

[redacted]: ☒ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

[redacted] local friend or relative: [redacted] [redacted]

REASON FOR VISIT

Chief Complaint: SWELLING / PAIN LEFT KNEE Body Part: KNEE Right: ___ Left: X

Related to: Employment X Date of Injury: 10/3/2009 Other ___ Date of Incident: / /

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

PATIENT REGISTRATION FORM

(Please Print)

Date 6/11/2012

Referring Physician: [redacted] PCP:

[redacted]

TION

☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss ☐ Ms.

Marital status (circle one)

Single (Mar) Div / Sep / Wid

Is this your legal name? If not, wh[redacted] Birth date: Age: Sex:

[redacted]

Occupation: Firefighter Employer: C[redacted] Address: 9[redacted] Limitz Ave Employer phone no.: (707) 6[redacted]

[redacted]

COMPLETE: [redacted]

Other family members seen here: [redacted]

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Policy no.:	Group no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Policy no.:	Group no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative: [redacted]	Relationship to patient: [redacted]	Home phone no.:	Work phone no.:

REASON FOR VISIT

Chief Complaint: Body Part: KNEES Right: X Left: X

Related to: Employment ✓ Date of Injury: 10/3/09 Other ___ Date of Incident: / /

12/16/2010

UPDATED

WALNUT CREEK ORTHOPEDICS SPORTS MEDICINE

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

PATIENT REGISTRATION FORM

(Please Print) Date 5/22/14

Referring Physician: PCP:

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss ☐ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☑ Yes ☐ No | If not, what is your legal name? | (Former name): | Birth date: [redacted] | Age: | Sex: ☐ F

[redacted]

Phone number: | Other contact number: Cell / Work | Social Security #:

[redacted]

IF PATIENT IS A MINOR PLEASE COMPLETE: Father: Work# Cell#

Mother Work# Cell#

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: | Employer: | Employer address: Work Comp | Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Policy no.:	Group no.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Policy no.:	Group no.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative: | Relationship to patient: | Home phone no.: | Work phone no.:

[redacted]

Chief Complaint: PAIN | Body Part: Hip | Right: ____ | Left: X

Related to: Employment X | Date of Injury: 2/15/2014 | Other ____ | Date of Incident: / / ____

KAISER PERMANENTE Did employee notify employer of this injury? Y Inquiry refer to: MR 01977909

KAISER PERMANENTE Claim#:2009095282 DOI:10-03-2009 Visit:10-06-2009 13:32 ReportDate: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, send two copies of this report to the employer's Workers' Compensation insurance carrier or the self-insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of this report to Division of Labor Statistics and Research, P.O.Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1.	INSURER NAME AND ADDRESS Carrier Claim # 2009095282 YORK INS SVCS 1390 WILLOW PASS RD, STE# 400 CONCORD,CA 94520	Please do not use this column
2.	EMPLOYER NAME [redacted]	Case No.
3.	Address No. and Street [redacted] City Zip	Industry
4.	Nature of Business (e.g. food manufacturing, building construction, retailer of women's clothes) (707) 648-4355	County
5.	PATIENT NAME (First Name, Middle Initial, Last Name) [redacted]	6. Sex M / 7. Date of Birth [redacted] / Age
8.	Address No. and Street [redacted] City Zip	9. Telephone Number [redacted] / Hazard
10.	Occupation (Specific Job Title) FIREFIGHTER	11. Social Security No: [redacted] / Disease
12.	Injured at: No. and Street 140 JORDAN	County SOLANO / Hospitalization
13.	Date and hour of injury or onset of illness: Yr. Mo. Day 10-03-2009 Hour 02:18 AM	14. Date last worked: Yr. Mo. Day 10-03-2009 / Occupation
15.	Date and hour of first examination or treatment: Yr. Mo. Day 10-06-2009 Hour 01:32 PM	16. Have you (or your office) previously treated patient? / Return

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code

17. Describe how the accident or exposure happened. (Give specific object, machinery or chemical. Use reverse side if more space is required)
PATIENT STATES: "TRIPPED AND FELL OVER UNEVEN PAVEMENT AND STRAINED MY LEFT KNEE."

18. Subjective Complaints (Use reverse if more space is required.):
JEFFREY LEEG GAO MD Tue Oct 6, 2009 4:27 PM Signed DOCTOR'S FIRST REPORT OF INJURY/ILLNESS Reason for Visit : Patient presents with: KNEE PROBLEM

19. Objective Findings (Use reverse if more space is required.): A. Physical examination: Physical Examination: 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
B: X-ray and laboratory results (State if none pending): KNEE, W/OBUTUNU/PTU/STN/MERCH - Done

20. DIAGNOSIS (If occupational illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? N
SPRAIN/STRAIN, KNEE/Left - Primary — Primary ICD9 Code 844.9
CONTUSION OF KNEE — Secondary ICD9 Code 924.11

21. Are your findings and diagnosis consistent with the patient's account of injury or onset of illness? Y
If 'No' please explain:

22. Is there any other current condition that will impede or delay patient's recovery? N
If 'Yes' please explain:

23. TREATMENT RENDERED (Use reverse side if more space is required.)
Assessment: This injury/illness is more likely than not work related because work caused or contributed to the injury/illness or aggravated a pre-existing condition. SPRAIN/STRAIN, KNEE. (primary encounter

24. If further treatment required, specify treatment plan, estimated duration.
Occ.Health Clinic

25. If hospitalized as inpatient, give hospital name and location. Date Admitted: Yr.Mo.Day Estimated stay

26. Work Status - Is patient able to perform usual work? N If 'No', date when patient can return to : Regular work: Modified work: 10-06-2009
Restrictions: as above

Doctor's Signature: Susan Lambert, M.D. Chief of Occ. Medicine CA License Number: G80920G
Doctor's Name and Degree GAO, JEFFREY LEE, MD TREATING MD IRS Number: [redacted]
Address: 975 Sereno Drive Vallejo, CA 94589 Telephone Number: (707) 651-2966 LBD

FORM 5021 (REV.4.5) 1992-06 Any person who makes or causes to be made any knowingly false or fraudulent material statement or material
90362 (Rev.2-93) representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony. v2.4

[redacted]

KAISER PERMANENTE Claim#:2009095282 DOI:10-03-2009 Visit:10-06-2009 13:32 ReportDate:10-07-2009 Final:Y
[redacted] PMR:01977909 WCAB#: FAC:VAL Contact:(707) 651-2968 LBD Carrier DOI (if available):

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

Continuation

17. History continued,

18. Complaints continued:
- L KNEE [redacted] is a 45 Y male right handed [redacted] is a 45 Y male born 6/3/1964 . PRIMARY LANGUAGE: English: OCCUPATION: fire fighter/engineer DATE OF HIRE: 23 years ago DATE/TIME OF INJURY: 10/3/09 DATE LAST WORKED: 10/3/09 CHIEF COMPLAINT: left knee pain History: Data Reviewed: none History of Present Illness : 45 years old male with no previous injury, surgery or fracture in his left knee, now with CC of on that day at work, he tripped over a walkway and fell on his left knee when fighting a fire, then a few minutes later, he fell on his left knee again, he iced the area and took Motrin OTC without relief, no urgent care or ER seen for this so far, been off work since injury, now with pain 8/10, sharp and intermittent, decreased in sleep and driving secondary to pain, no N/T or burning or spasm, positive intermittent popping, no clicking, locking or giveaway sensations in his left knee. RELEVANT PAST MEDICAL HISTORY: None. RELEVANT HOBBIES/OUTSIDE ACTIVITIES:?No Allergies :none MEDS: Medications marked Taking as of 10/6/09 encounter (Work Comp) with GAO, JEFFREY LEEG (M.D.): IBUPROFEN 800 MG ORAL TAB, Take 1 tablet orally 2 to 3 times a day with meals as directed by doctor, Disp: 60, Rfl: 3 SPORT NEOPRENE KNEE SUPPORT MISC MISC, PRN use, Disp: 1, Rfl: 0 Tobacco History: no Diabetes ?: no. Review of Systems: Constitutional: Negative Musculoskeletal: positive for myalgias and joint pain Neurological: Negative.

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 cyanosis Vital Signs: BP 133/87 | Pulse 69 | Ht 5' 9" | Wt 215 lb (97.523 kg) alert, well appearing, and in no distress.

B.

23. Treatment continued:
diagnosis) Note: Will check xray to r/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 ORAL TAB SPORT NEOPRENE KNEE SUPPORT MISC MISC CANE CONTUSION OF KNEE Note: same as above Plan: RADIOLOGIC EXAM, KNEE, COMPLETE, 4+ VIEW. IBUPROFEN 800 MG ORAL TAB 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/climb stairs/ladders/scaffolds. No kneeling, stand and walk as tolerated, sit down work preferred. F/u appt. 10/20 0310P.

KAISER PERMANENTE Did employee notify employer of this injury? Y Inquiry refer to: MR 01977909

KAISER PERMANENTE Claim#: DOI:02-15-2014 Visit:02-15-2014 21:43 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 illness, send two copies of this report to the employer's Workers' Compensation insurance carrier or the self-insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of this report to Division of Labor Statistics and Research, P.O.Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1.	INSURER NAME AND ADDRESS YORK INS SVCS PO BOX 619079 ROSEVILLE CA 95661				RECEIVED MAR 06 2014 A OSC West		Please do not use this column Case No.
2.	EMPLOYER NAME CITY OF VALLEJO						
3.	Address No. and Street 555 SANTA CLARA ST	City VALLEJO	CA	Zip 945900000			Industry
4.	Nature of Business (e.g. food manufacturing, building construction, retailer of women's clothes)			(707) 648-4355			County
5.	PATIENT NAME (First Name, Middle Initial, Last Name) [redacted]			6. Sex M	7. Date of Birth Yr. Mo. Day [redacted]		Age
	[redacted]						Hazard
10.	Occupation (Specific Job Title) FIREFIGHTER ENGINEER				11. Social Security No: [redacted]		Disease
12.	Injured at: No. and Street STRUCTURE FIRE			County SOLANO			Hospitalization
13.	Date and hour of injury or onset of illness	Yr. Mo. Day 02-15-2014	Hour 09:15 PM	14. Date last worked	Yr. Mo. Day 02-15-2014		Occupation
15.	Date and hour of first examination or treatment	Yr. Mo. Day 02-15-2014	Hour 09:43 PM	16. Have you (or your office) previously treated patient?			Return

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code

17. Describe how the accident or exposure happened. (Give specific object, machinary or chemical. Use reverse side if more space is required)
PT STATES: WHILE FIGHTING FIRE MY LEFT LEG FELL THROUGH A HOLE IN A BEDROOM FLOOR; STRAINING MY LEFT HIP FLEXOR.

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 fell

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 | Ht 1.753 m (5' 9.02") | Wt 95.255 kg (210 lb) | BMI 31 kg/m2 | 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
843.9
Secondary ICD9 Code

21. Are your findings and diagnosis consistent with the patient's account of injury or onset of illness?
If 'No' please explain:

22. Is there any other current condition that will impede or delay 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 cc to occ med to f/up LEFT GROIN MUSCLE

24. If further treatment required, specify treatment plan, estimated duration.
Z TANG MD. OCC HEALTH. 02/18/14

25. If hospitalized as inpatient, give hospital name and location. Date Admitted: Yr.Mo.Day Estimated stay

26. Work Status - Is patient able to perform usual work? Y If 'No', date when patient can return to: Regular work: 02-18-2014
Restrictions: SEE #23. Modified work:

REVIEWED BY:

Doctor's Signature:
Doctor's Name and Degree: SPERANDIO, JENNIFER, MD TREATING MD
Address: 975 Sereno Drive, Vallejo, CA 94589
CA License Number: C504480
IRS Number: [redacted]
Telephone Number: (707) 651-1370

FORM 5021 (REV.4-5) 1992-05 Any person who makes or causes to be made any knowingly false or fraudulent material statement or material
90362 (Rev.2-93) representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony. v2.5

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

Continuation

17. History continued:

18. Complaints 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 Gastrointestinal: no N/V

19. Findings continued:
A. tachypnea Skin - warm, dry, no rashes Normal gait Perrla, eomi, 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

B.

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

KAISER PERMANENTE Did employee notify employer of this injury? Y Inquiry refer to: MR 01977909

KAISER PERMANENTE Claim#: DOI:02-15-2014 Visit:02-18-2014 15:56 ReportDate:02-19-2014 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, send two copies of this report to the employer's Workers' Compensation insurance carrier or the self-insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of this report to Division of Labor Statistics and Research, P.O.Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1.	INSURER NAME AND ADDRESS YORK INS SVCS PO BOX 619079 ROSEVILLE,CA 95661						Please do not use this column
2.	EMPLOYER NAME CITY OF VALLEJO						Case No.
3.	Address No. and Street 555 SANTA CLARA ST	City VALLEJO		CA	Zip 945900000		Industry
4.	Nature of Business (e.g. food manufacturing, building construction, retailer of women's clothes) (707) 648-4366						County
5.	PATIENT NAME (First Name, Middle Initial, Last Name) [redacted]				6. Sex M	7. Date of Birth Yr. Mo. Day [redacted]	Age
8.	Address No. and Street [redacted]	City [redacted]			Zip [redacted]	9. Telephone Number [redacted]	Hazard
10.	Occupation (Specific Job Title) firefighter					11. Social Security No: [redacted]	Disease
12.	Injured at: No. and Street STRUCTURE FIRE				County SOLANO		Hospitalization
13.	Date and hour of injury or onset of illness	Yr. Mo. Day 02-15-2014	Hour 09:15	PM	14. Date last worked	Yr. Mo. Day 02-15-2014	Occupation
15.	Date and hour of first examination or treatment	Yr. Mo. Day 02-18-2014	Hour 03:56	PM	16. Have you (or your office) previously treated patient?		Return

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code

17. Describe how the accident or exposure happened. (Give specific object, machinery or chemical. Use reverse side if more space is required)
PT STATES: WHILE FIGHTING FIRE MY LEFT LEG FELL THROUGH A HOLE IN A BEDROOM FLOOR; STRAINING MY LEFT HIP FLEXOR.

18. Subjective Complaints (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 pain

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% Gait: 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 illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? N
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' please explain:

22. Is there any other current condition that will impede or delay patient's recovery? n
If 'Yes' please explain:

23. TREATMENT RENDERED (Use reverse side if more space is required.)
SPRAIN OR STRAIN OF HIP OR THIGH Note: left, acute Continue icing 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 required, specify treatment plan, estimated duration.
Z TANG MD, OCC HEALTH, 03/04/14

25. If hospitalized as inpatient, give hospital name and location. Date Admitted: Yr.Mo.Day Estimated stay

26. Work Status - Is patient able to perform usual work? N If 'No', date when patient can return to: Regular work: Modified work: 02-18-2014
Restrictions: SEE #23.

Doctor's Signature:
Doctor's Name and Degree: TANG, ZILUE, MD TREATING MD
Address: 975 Sereno Drive, Vallejo, CA 94589
CA License Number: 100782A
IRS Number: [redacted]0
Telephone Number: (707) 651-1370

FORM 5021 (REV.4.5) 1992-06 Any person who makes or causes to be made any knowingly false or fraudulent material statement or material 90362 (Rev.2-93) representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony. v2.5

KAISER PERMANENTE Claim#: DOI:02-15-2014 Visit:02-18-2014 16:56 ReportDate:02-19-2014 FinalY
Patient:BRUNSON, JAMES P MR:01077909 WCAB#: FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available):

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

Continuation

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

B.

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 event/exposure.

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

PRE-OP HISTORY and PHYSICAL

DATE OF SURGERY: 03/31/10 DATE: 03/29/2010

CHIEF COMPLAINT: LEFT KNEE PAIN AGE: 45

INDICATIONS FOR SURGERY: 45yo with L knee pain x 6months.

PAST HISTORY:

OPERATIONS	NEG	☑	or
ALLERGIES	NEG	☑	or
MEDICAL ILLNESS	NEG	☑	or
HIV/AIDS	NEG	☑	or
CURRENT DRUGS	NEG	☐	or motrin prn
ANESTHETIC PROBLEMS	NEG	☑	or
SIG. FAM. HISTORY	NEG	☑	or
ROS - HEENT	NEG	☑	or
GI-GU	NEG	☑	or
CHEST CVS	NEG	☑	or
OTHER			

GRAVIDA _____ PARA _____

FEMALES LMP _____ PAP: DATE _____ RESULT _____

PHYSICAL EXAMINATION: BP 110/80

EYES	WNL	☑	or
THROAT	WNL	☑	or
NECK	NEG	☑	or
CHEST	NEG	☑	or
BREASTS	NEG	☐	or DEF
HEART	NEG	☑	or
ABD	NEG	☑	or
PELVIC	NEG	☐	or DEF
RECTAL	NEG	☐	or DEF
EXTRM	NEG	☐	or L knee: no effusion, stable NVI
NEURO	NEG	☑	or
OTHER			

IMPRESSIONS: L knee pain

SURGERY PROPOSED: LEFT KNEE ARTHROSCOPY PARTIAL LATERAL MENISECTOMY.

SIGNED William B. Workman, M.D.

PATIENT'S NAME [redacted] DOCTOR'S NAME William B. Workman, M.D.

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

Faxed to Premier
2/17/11@2:30 pm-
th

PRE-OP HISTORY and PHYSICAL

DATE OF SURGERY: 02/18/11 DATE: 02/17/2011

CHIEF COMPLAINT: RIGHT KNEE PAIN AGE: 46

INDICATIONS FOR SURGERY: RT. KNEE PAIN/MED & LAT MENISCUS TEARS

PAST HISTORY:

OPERATIONS	NEG	☐	or LT. KNEE LAT. MENISCECTOMY-3/10
ALLERGIES	NEG	☑	or
MEDICAL ILLNESS	NEG	☑	or
HIV/AIDS	NEG	☑	or
CURRENT DRUGS	NEG	☑	or
ANESTHETIC PROBLEMS	NEG	☑	or
SIG. FAM. HISTORY	NEG	☑	or
ROS - HEENT	NEG	☑	or
GI-GU	NEG	☑	or
CHEST CVS	NEG	☑	or
OTHER			

GRAVIDA _____ PARA _____

FEMALES LMP _____ PAP: DATE _____ RESULT _____

PHYSICAL EXAMINATION: BP _____

EYES	WNL	☑	or
THROAT	WNL	☑	or
NECK	NEG	☑	or
CHEST	NEG	☑	or
BREASTS	NEG	☐	or DEF
HEART	NEG	☑	or
ABD	NEG	☑	or
PELVIC	NEG	☐	or DEF
RECTAL	NEG	☐	or DEF
EXTRM	NEG	☐	or
NEURO	NEG	☑	or
OTHER			

IMPRESSIONS: KNEE PAIN/MENISCAL TEARS

SURGERY PROPOSED: RIGHT KNEE ARTHROSCOPY PARTIAL MEDIAL & LATERAL MENISECTOMIES.

SIGNED _____, M.D.

PATIENT'S NAME [redacted] DOCTOR'S NAME William B. Workman, M.D

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

PRE-OP HISTORY and PHYSICAL

DATE OF SURGERY: 07/09/14 DATE: 07/01/14

CHIEF COMPLAINT: LEFT HIP PAIN AGE: 49

INDICATIONS FOR SURGERY: LEFT HIP PAIN

PAST HISTORY:

OPERATIONS	NEG ☐	or KNEES
ALLERGIES	NEG ☐	or NO KNOWN
MEDICAL ILLNESS	NEG ☐	or
HIV/AIDS	NEG ☐	or
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	NEG ☐	or
OTHER		

GRAVIDA _____ PARA _____

FEMALES LMP _____ PAP: DATE _____ RESULT _____

PHYSICAL EXAMINATION: BP _____

EYES	WNL ☐	or
THROAT	WNL ☐	or
NECK	NEG ☐	or
CHEST	NEG ☐	or
BREASTS	NEG ☐	or DEF
HEART	NEG ☐	or
ABD	NEG ☐	or
PELVIC	NEG ☐	or DEF
RECTAL	NEG ☐	or DEF
EXTRM	NEG ☐	or LEFT HIP PAIN
NEURO	NEG ☐	or
OTHER		

☐ Start IV in Pre-Op

IMPRESSIONS: LEFT HIP PAIN

SURGERY PROPOSED: LEFT HIP ARTHROCOPY WITH FEMOROPLASTY, ACETABULOPLASTY AND LABRAL REPAIR.

SIGNED WBWorkman, M.D.

PATIENT'S NAME [redacted] DOCTOR'S NAME William B. Workman, M.D

KAISER PERMANENTE Claim#:2009095282 DOI:10-03-2009 Visit:11-25-2009 11:20 ReportDate:11-30-2009 Final:N
Patient: [redacted] PMR:01977909 WCAB#: PAC:VAL Contact(707) 651-2969 GYR 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

[redacted]

11. ☐ Patient will be permanently precluded from engaging in his/her usual and customary occupation
12 ☐ Patient's condition is permanent and stationary with residual disability on:
13. ☐ Patient will require future medical care

If any of these boxes are checked you must use Form PR-3 or narrative report

14. Claims Administrator YORK INS SVCS 1390 WILLOW PASS RD, STE# 400 CONCORD CA 94520	Patient: [redacted] 16. SSN [redacted] 17. Name [redacted] 18. Addres [redacted] 19. City VALLEJO State [redacted] 20. DOI 10-03-2009 21. DOB [redacted] 22. Sex M 23. Phone [redacted] 24. Fax 25. Occupation
26. Phone (925) 349-3880 27. Fax (925) 609-9264	28. Claim [redacted] 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:**

[redacted] is a 45 Y male Reason for Visit : Patient presents with: KNEE PROBLEM. He Report Symptom(s) : have not changed Pain Level Current : 5/10. PT record reviewed. Constitutional: Negative Musculoskeletal: joint pain Neurological: Negative.

33. **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 Musculoskeletal -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**

1st
SPRAIN/STRAIN, KNEE/Left - Primary — ICD-9 844.9

2nd
CONTUSION OF KNEE — 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. 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
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:

KAISER PERMANENTE Claim#:2009095282 DOI:10-03-2009 Visit:11-25-2009 11:20 ReportDate 11-30-2009 Final:N
Patient [redacted] MR:01977909 WCAB#: PAC:VAL Contact:(707) 651-2969 GYR Carrier DOI (if available):

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

40. Drugs:

41. Physical Medical Service: 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 full duty on with no limitations or restrictions.
48. ☒ Return to modified work on 11-25-2009 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 are deemed permanent.

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

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 GAO, JEFFREY LEE MD 55 California Lic# 0809200
56. Address 975 Sereno Drive Vallejo, CA 94589 57. Phone (707) 651-2969

v 2.6.1

KAISER PERMANENTE Claim#:2009095282 DOI:10-[illegible]2009 Visit:01-07-2010 11:04 Report Date:01-08-2010 Final:N
Patient: [redacted] MR:01077909 WCAB#: [illegible] 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

01.	X	Periodic Report (required 45 days after last report)	02.	Change in Treatment Plan	03.	Released from care
04.		Change in work status	05.	Need for referral to [illegible]	06.	Response to request for information
07.		Change in patient's condition	08.	Need for authorization	09.	Request for Authorization
10.		Other:				

11.	Patient will be permanently precluded from engaging in his/her usual and customary occupation	If any of these boxes are checked you must use Form PR-3 or narrative report
12.	Patient's condition is permanent and stationary with residual disability	
13.	Patient will require future medical care	

14. Claims Administrator YORK INS SVCS 1390 WILLOW PASS RD. STE# 400 CONCORD CA 94520	Patient: 15 [redacted] 16. SSN [redacted] 17. Name 18. Address 19. City 20. DOI 21. Phone 22. Occupation
26. Phone (925) 349-3880 27. Fax (925) 609-9264	28. Claim [illegible]

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:**

[redacted] is a 45 Y male Reason for Visit: Patient presents with: RECHECK - L KNEE. He Report Symptom(s): have not changed Pain Level Current: 5/10. Constitutional: Negative Musculoskeletal: positive for myalgias and joint pain Neurological: Negative.

33. **Objective Findings:** (Include significant physical examination findings, laboratory, imaging, or other diagnostic findings.)
Vital Signs: BP 131/79 | Pulse 70 General appearance: vital signs reviewed and stable, 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 Musculoskeletal - abnormal exam of left knee with TTP in left knee joint, no swelling or spasm or bruising, decreased in ROM by 20%, slow gait, crepitus with movements 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**

1st
SPRAIN/STRAIN, KNEE/Left - Primary — ICD-9 844.9

2nd
CONTUSION OF KNEE — 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. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, chiropractic, acupuncture). Use of CPT codes is encouraged.
MWP: 01/07/10-01/21/10 SQUAT/CLIMB STAIRS OCCAS, CLIMB LADDERS/SCAFFOLDS NOT AT ALL, No kneeling, stand and walk as tolerated. still waiting for auth for MRI of left knee by carrier, meds PO PRN, HEP continues, ice/heat PRN use, support use PRN, MW continues, follow up in 2 weeks for reassessment.

37. Have there been any changes in treatment plan? 38. If so, why?

39. Other Physician/Non-Physician Providers:

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

40. Drugs:

41. Physical Medical Service: 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 full duty on** with no limitations or restrictions.
48. ☒ **Return to modified work on** 01-07-2010 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 are deemed permanent.**

Primary Treating Physician: (original signature, do not stamp) 52. Date of exam 01-07-2010
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 94-2728880

Signature ______________________ Specialty ______________________

Executed at ______________________ Signature Date ______________________

54. Name GAO, JEFFREY LEE 55. California Lic# 080920G
56. Address 975 Sereno Drive Vallejo, CA 94589 57. Phone (707) 651-2969

v 2.6.1

State of California Additional pages attached ☐
Division of Workers' Compensation

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

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.

☑ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released to regular work
☐ Change in work status ☐ Need for referral or other action ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Request for authorization
☐ Other

Patient:
Last [redacted] First [redacted] M.I. ____ Sex M
Address 26[redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date of Birth [redacted]
Occupation ____ SS# [redacted] Phone: [redacted]

Claims Administrator:
Name YORK INSURANCE SERVICES Claim Number [redacted]
Address ____ City ____ State ____ Zip ____
Phone ____ Fax 925-609-9264

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:
45yo M f/u L knee arthroscopic partial lateral meniscectomy x 5-6wks. Responding well to water PT. Some cont occasional knee discomfort with increased activity, kneeling.

Objective findings:
L knee: Incisions well healed. FROM. No effusion. Strength intact. Tender around incisions.

Diagnosis: (Please indicate right or left)
1. 715.16 - DJD knee ICD-9 ____
2. 836.1 - Lat. Meniscus tear ICD-9 ____
3. ____ 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?
1. cont with PT for conditioning, pt responding well to aqua PT, cont to advance
2. f/u 6wks

Work Status: [redacted]

Next Appointment: 6wks

Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 05/10/2010
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: JQuintellaPA-C **Date:** 05/10/2010
Executed at: Contra Costa County, CA California License No.: A72343
Name: William B. Workman, MD Specialty: Orthopedic Surgeon
Address: 301 Lennon Lane, Ste. 100, Walnut Creek, CA 94598 Phone: (925) 944-0110 Fax: (925) 944-0[redacted]

State of California Additional pages attached ☐
Division of Workers' Compensation

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

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.

- ☒ Periodic Report (required 45 days after last report)
- ☐ Change in treatment plan
- ☐ Released from care
- ☐ Change in work status
- ☐ Need for referral or consultation
- ☐ Response to request for information
- ☐ Change in patient's condition
- ☐ Need for surgery or hospitalization
- ☐ Request for authorization
- ☐ Other:

Patient:

Last [redacted] First [redacted] M.I. ____ Sex ____
Address [redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date [redacted]
Occupation ____ SS# [redacted] Phone: [redacted]

Claims Administrator:

Name YORK INSURANCE SERVICES Claim Number [redacted]
Address ____ City ____ State ____ Zip ____
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: Has had two. straight mos of H_2O therapy. Has been riding bike [illegible]

Objective findings: 0-130 [illegible]
(-) Lachman

Diagnosis: (Please indicate right or left)

1. 715.16 - DJD knee ICD-9 ____
2. 836.1 - Lat. Meniscus tear ICD-9 ____
3. ____ 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?

cont manage [illegible]

Work Status: [illegible] 6/22/10 [illegible]

Next Appointment: 07/29/10

Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 06/21/2010

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: [signature] **Date:** 06/21/2010

Executed at: Contra Costa County, CA
Name: William B. Workman, MD
Address: 301 Lennon Lane, Ste. 100, Walnut Creek, CA 94598

California License No.: A72343
Specialty: Orthopedic Surgeon
Phone: (925) 944-0110 Fax: (925) 944-[illegible]

000029

State of California Additional pages attached ☐
Division of Workers' Compensation

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

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.

☑ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Request for authorization
☐ Other:

Patient:
Last [redacted] First [redacted] M.I. ______ Sex M
Address [redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date [redacted]
Occupation ______ SS# [redacted] Phone [redacted]

Claims Administrator:
Name YORK INSURANCE Claim Number [redacted]
Address ______ City ______ State ______ Zip ______
Phone ______ Fax 866-548-2637

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:
46yo M s/p L knee arthroscopy x 4mos with cont pain posterior knee with kneeling and increased activity/ climbing stairs or jumping. HEP includes biking with improvement.

Objective findings:
L LE: Incisions well healed. no atrophy. no effusion. peripatellar tenderness lat>medial. Stable. strength 5/5 quad/hams. FROM

Diagnosis: (Please indicate right or left)
1. 715.16 - DJD knee ICD-9 ______
2. 836.1 - Lat. Meniscus tear ICD-9 ______
3. ______ 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?
1. cont recommendation for advancement of HEP, encouraged biking
2. consider knee injection coming moths if no further improvement.

Work Status: This patient has been instructed to:
[illegible]
☐ Return to full duty on [illegible]

Next Appointment: 6wks

Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 07/29/2010
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: JQUINTELLAPA-C **Date:** 07/29/2010
Executed at: Contra Costa County, CA California License No.: A72343
Name: William B. Workman, MD Specialty: Orthopedic Surgeon
Address: 301 Lennon Lane, Ste. 100, Walnut Creek, CA 94598 Phone: (925) 944-0110 Fax: (925) 944-0960

000030

State of California — Additional pages attached ☐

Division of Workers' Compensation

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

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 Form PR-3 or PR-4.

☑ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Request for authorization
☐ Other:

Patient:

Last [redacted] First [redacted] M.I. ____ Sex M

Address [redacted] City VALLEJO State CA Zip 94591

Date of Injury 10/03/2009 Date of [redacted]

Occupation ____ SS# 5[redacted] Phone: [redacted]

Claims Administrator:

Name YORK INSURNACE Claim Number [redacted]

Address ____ City ____ State ____ Zip ____

Phone ____ Fax 925-609-9264

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 been doing pretty well. Rode three hours on bike on Sunday

Objective findings:

Ø change

Diagnosis: (Please indicate right or left)

1. 715.16 - DJD knee ICD-9 ____
2. 836.1 - Lat. Meniscus tear ICD-9 ____
3. ____ 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?

cont management

Work Status: This patient has been instructed to:
☐ Remain off-work until [illegible]
☐ Return to modified work on [illegible]
[illegible]
☐ Return to full duty on [illegible]

Next Appointment: ____

Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 09/09/2010

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: [signature] **Date:** 09/09/2010

Executed at: Contra Costa County, CA — California License No.: A72343

Name: William B. Workman, MD — Specialty: Orthopedic Surgeon

Address: 301 Lennon Lane, Ste. 100, Walnut Creek, CA 94598 — Phone: (925) 944-0110 Fax: (925) 944

State of California Additional pages attached ☐
Division of Workers' Compensation

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

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.

☑ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☑ Request for authorization
☐ Other:

Patient:
Last [redacted] First [redacted] M.I. ____ Sex M
Addr[redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date o[redacted]
Occupation ____ SS# X[redacted] Phone: [redacted]

Claims Administrator:
Name YORK INSURANCE Claim Number [redacted]
Address ____ City ____ State ____ Zip ____
Phone ____ Fax 866-548-2637

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 light duty. Right knee is still painful

Objective findings:
↓ROM (R) knee 1+ effusion [illegible]

Diagnosis: (Please indicate right or left)
1. 715.16 - DJD knee ICD-9 ____
2. 836.1 - Lat. Meniscus tear ICD-9 ____
3. ____ 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?
needs an MRI of right knee

Work Status: This patient has been instructed to: [illegible]

Next Appointment: ____
Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 10/21/2010
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: [signature] **Date:** 10/21/2010
Executed at: Contra Costa County, CA California License No.: A72343
Name: William B. Workman, MD Specialty: Orthopedic Surgeon
Address: 301 Lennon Lane, Ste. 100, Walnut Creek, CA 94598 Phone: (925) 944-0110 Fax: (925) 944-[illegible]

State of California Additional pages attached ☐

Division of Workers' Compensation

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

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.

☑ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☑ Request for authorization
☐ Other:

Patient:

Last [redacted] First [redacted] M.I. ____ Sex M

Address [redacted] City VALLEJO State CA Zip 94591

Date of Injury 10/03/2009 Date [redacted]

Occupation ______ SS# 5[redacted] Phone: [redacted]

Claims Administrator:

Name YORK INSURANCE SERVICES Claim Number [redacted]

Address ______ City ______ State ____ Zip ______

Phone ______ Fax 925-609-9264

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:

Right knee

Objective findings:

pain medially

Diagnosis: (Please indicate right or left)

1. 715.16 - DJD knee ICD-9 ______
2. 836.1 - Lat. Meniscus tear ICD-9 ______
3. ______ 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?

waiting for MRI

Work Status: This patient has been instructed to: [illegible]

Next Appointment: ______

Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 11/24/2010

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: [signature] **Date:** 11/24/2010

Executed at: Contra Costa County, CA California License No.: A72343

Name: William B. Workman, MD Specialty: Orthopedic Surgeon

Address: 301 Lennon Lane, Ste. 100, Walnut Creek, CA 94598 Phone: (925) 944-0110 Fax: (925) 944-

State of California Additional pages attached ☐
Division of Workers' Compensation

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

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 Form PR-3 or PR-4.

☑ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Request for authorization
☐ Other:

Patient:
Last [redacted] First [redacted] M.I. Sex M
Address [redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date of [redacted]
Occupation SS# 54[redacted] Phone: 707-333-9258

Claims Administrator:
Name YORK INSURANCE SERVICES Claim Number [redacted]
Address City State Zip
Phone Fax 925-609-9264

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:

ongoing pain

Objective findings:

MRI R knee lat/med meniscus tear

Patient has intermittent locking, 1+ effusion, med and lat joint line tenderness and decreased ROM -5 to 120 degrees with pain.

Diagnosis: (Please indicate right or left)
1. 715.16 - DJD knee ICD-9
2. 836.1 - Lat. Meniscus tear ICD-9
3. 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?

rec arthroscopy med and lat menisectomy

Work Status: This patient has been instructed to: [illegible]

Next Appointment:
Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 01/06/2011
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 139.3.
Signature: [signature] **Date:** 01/06/2011
Executed at: Contra Costa County, CA California License No.: A72343
Name: William B. Workman, MD Specialty: Orthopedic Surgeon
Address: 301 Lennon Lane, Ste. 100, Walnut Creek, CA 94598 Phone: (925) 944-0110 Fax: (925) 944-0960

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Division of Workers' Compensation

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

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.

☑ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Request for authorization
☐ Other:

Patient:
Last [redacted] First [redacted] M.I. ____ Sex M
Address [redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date [redacted]
Occupation ____ SS# [redacted] Phone: 707-333-9258

Claims Administrator:
Name YORK INSURANCE SERVICES Claim Number [redacted]
Address ____ City ____ State ____ Zip ____
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.

Pain

Objective findings:

2+ effusion 0 – 90

Diagnosis: (Please indicate right or left)
1. 836.1 - Lat. Meniscus tear ICD-9 ____
2. 836.0 - Med. Meniscus Tear ICD-9 ____
3. ____ 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?

Indocin F/U 3 weeks

Work Status: This patient has been instructed to:
☑ Remain off-work until 4/11/11
☐ Return to modified duty on ____ with the following limitations or restrictions (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):
☐ Return to full duty on ____ with no limitations or restrictions.

Next Appointment: ____

Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 02/28/2011

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 139.3.

Signature: ____ **Date:** 02/28/2011

Executed at: Contra Costa County, CA California License No.: A72343
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) 944-0060

State of California Additional pages attached ☐
Division of Workers' Compensation

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

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.

☑ Initial report, treated since last report ☐ Change in treatment plan ☐ Request authorization
☐ Supplemental report ☑ Need for referral/consultation ☐ Prescription refill/medication
☐ Change in patient work status ☐ Need for surgery or surgical authorization ☐ Request for work status
☐ Other

Patient:
Last [redacted] First [redacted] M.I. Sex M
Address [redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date o[redacted]
Occupation Phone: 707-333-9258

Claims Administrator:
Name YORK INSURANCE SERVICES Claim Number [redacted]
Address City State Zip
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. ROM is better
had a bout of pain on medial side

Objective findings:

0 – 120°

Diagnosis: (Please indicate right or left)
1. 836.1 - Lat. Meniscus tear ICD-9
2. 836.0 - Med. Meniscus Tear ICD-9
3. 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?

doing well, on managed - CONTINUE PHYSICAL THERAPY 2X5 WEEKS to right knee

[redacted]

Next Appointment:
Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 03/21/2011
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 139.3.
Signature: **Date:** 03/21/2011
Executed at: Contra Costa County, CA California License No.: A72343
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) 944-0036

State of California Additional pages attached ☐
Division of Workers' Compensation

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

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.

[redacted]

Patient:
Last [redacted] First [redacted] M.I. ____ Sex M
Address [redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date o[redacted]
Occupation ____ SS# [redacted] Phone: [redacted]

Claims Administrator:
Name ____ Claim Number [redacted]
Address ____ City ____ State ____ Zip ____
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 c right

Objective findings:

0–120° MT knee

Diagnosis: (Please indicate right or left)
1. 836.1 - Lat. Meniscus tear ICD-9 ____
2. 836.0 - Med. Meniscus Tear ICD-9 ____
3. ____ 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?

Lat Meniscus

[redacted]

Next Appointment: ____
Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 05/23/2011
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 139.3.
Signature: [signature] **Date:** 05/23/2011
Executed at: Contra Costa County, CA California License No.: A72343
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) 944-0960

State of California — Additional pages attached ☐
Division of Workers' Compensation

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

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.

☑ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Request for authorization
☐ Other:

Patient:
Last [redacted] First [redacted] M.I. ____ Sex M
Address [redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date o[redacted]
Occupation ____ SS# 5[redacted] Phone: [redacted]

Claims Administrator:
Name YORK INSURANCE Claim Numbe[redacted]
Address ____ City ____ State ____ Zip ____
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: Pain in knees is better but still swelling

Objective findings: 1+ effusion
0-120

Diagnosis: (Please indicate right or left)
1. 836.1 - Lat. Meniscus tear ICD-9 ____
2. 836.0 - Med. Meniscus Tear ICD-9 ____
3. ____ 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?

doing well

[illegible]

Next Appointment: ____
Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 07/14/2011
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 139.3.
Signature: [signature] **Date:** 07/14/2011
Executed at: Contra Costa County, CA California License No.: A72343
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) 94[illegible]

State of California — Additional pages attached ☐

Division of Workers' Compensation

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

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 Form PR-3 or PR-4.

☐ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Request for authorization
☐ Other:

Patient:

Last [redacted] First [redacted] M.I. ____ Sex M

Address [redacted] City VALLEJO State CA Zip 94591

Date of Injury 10/03/2009 Date of [redacted]

Occupation ____ SS# 54[redacted] Phone: [redacted]

Claims Administrator:

Name YORK INSURANCE SERVICES Claim Number [redacted]

Address ____ City ____ State ____ Zip ____

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: c/o [illegible] of pain in knee

Objective findings:

0–120

+ effusion

Diagnosis: (Please indicate right or left)

1. 836.1 - Lat. Meniscus tear ICD-9 ____
2. 836.0 - Med. Meniscus Tear ICD-9 ____
3. ____ 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?

OA (L) knee S/P meniscectomy

please send job description and [illegible] PR+

Work Status: This patient has been instructed to:

☐ Remain off work until ____

☐ Return to modified duty on ____ with the following limitations or restrictions

(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

8/22/11

☐ Return to full duty on ____ with no limitations or restrictions.

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 139.3

Signature: [signature] **Date:** 08/22/2011

Executed at: Contra Costa County, CA California License No.: A72343

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) 94[illegible]

State of California Additional pages attached ☐
Division of Workers' Compensation

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

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.

[redacted]

Patient:
Last [redacted] First [redacted] M.I. Sex
Address [redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date [redacted]
Occupation SS# [redacted] Phone: [redacted]

Claims Administrator:
Name Claim Number [redacted]
Address City State Zip
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: Patient has improved but also only granted partial PT

Objective findings:

0—120° MR distal grossly

Diagnosis: (Please indicate right or left)
1. 836.1 - Lat. Meniscus tear ICD-9
2. 836.0 - Med. Meniscus Tear ICD-9
3. 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?

improved — would be better
new if he had full course of PT

[redacted]

Next Appointment:
Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 04/28/2011
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 139.3.
Signature: **Date:** 04/28/2011
Executed at: Contra Costa County, CA California License No.: A72343
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) 944-0040

State of California Additional pages attached ☐
Division of Workers' Compensation

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

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.

Patient:
Last [redacted] First [redacted] M.I. ____ Sex M
Address [redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date [redacted]
Occupation ____ SS# [redacted] Phone: [redacted]

Claims Administrator:
Name YORK INSURANCE Claim Number [redacted]
Address ____ City ____ State ____ Zip ____
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.

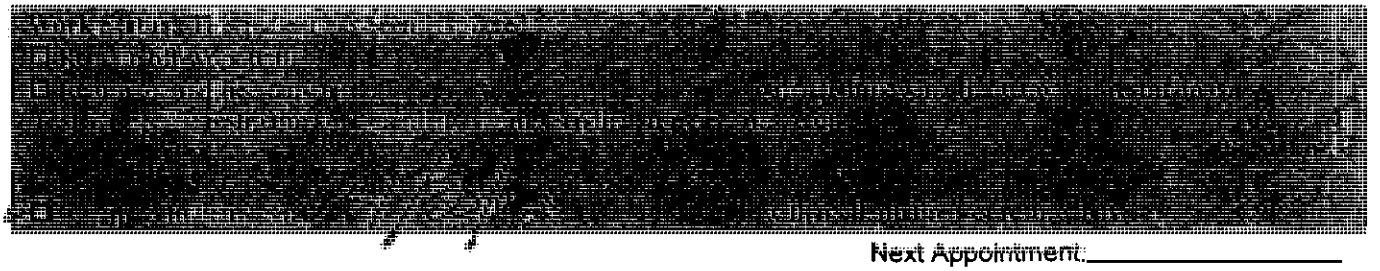
Subjective complaints: Patient has ongoing pain in both knees

Objective findings: ↓ROM, ↓ strength

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?

Patient has decreased strength/ROM in (B) knees
he would benefit from water therapy 3x week x 6 weeks



Next Appointment: ____
Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 04/30/2012
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: [signature] **Date:** 04/30/2012
Executed at: Contra Costa County, CA California License No.: A72343
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) 944-0060

State of California Additional pages attached ☐
Division of Workers' Compensation

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

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.

[redacted]

Patient:
Last [redacted] First [redacted] M.I. ____ Sex M
Address [redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date [redacted]
Occupation ____ SS# [redacted] Phone: [redacted]

Claims Administrator:
Name YORK INSURANCE Claim Number [redacted]
Address ____ City ____ State ____ Zip ____
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: Has had some improvement
Had deep achy right knee pain

Objective findings:
WNL

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?
Rec PT for ROM and strength
Water therapy

[redacted]

Next Appointment: ____
Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 06/11/2012
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: [signature] **Date:** 06/11/2012
Executed at: Contra Costa County, CA California License No.: A72343
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) 944-0060

State of California Additional pages attached ☐
Division of Workers' Compensation

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

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.

Patient:
Last [redacted] First [redacted] M.I. ____ Sex M
Address [redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date o[redacted]
Occupation ____ SS# 5[redacted] Phone: [redacted]

Claims Administrator:
Name ____ Claim Number [redacted]
Address ____ City ____ State ____ Zip ____
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:

c/o pain in knee

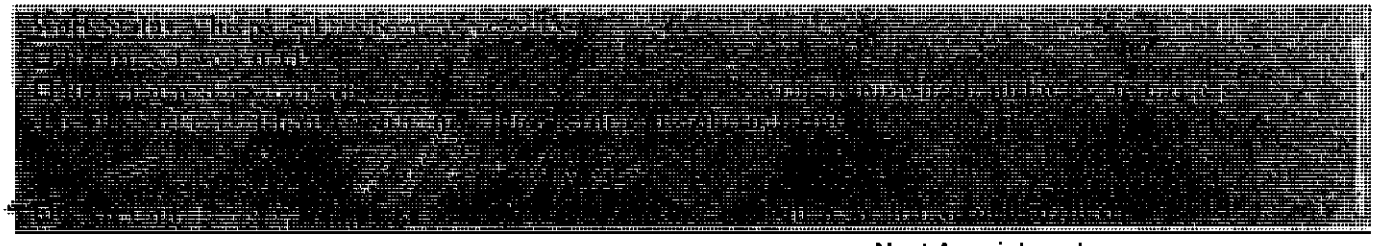
Objective findings:

0–120° ldm
slight effusion

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?

see mangle



Next Appointment: ____
Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 07/26/2012
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:** 07/26/2012
Executed at: Contra Costa County, CA California License No.: A72343
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) 944-0960

State of California Additional pages attached ☐
Division of Workers' Compensation

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

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.

Patient:
Last [redacted] First [redacted] M.I. Sex M
Address [redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date [redacted]
Occupation _____ SS# [redacted] Phone: [redacted]

Claims Administrator:
Name YORK INSURNACE Claim Number [redacted]
Address _____ City _____ State _____ Zip _____
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.

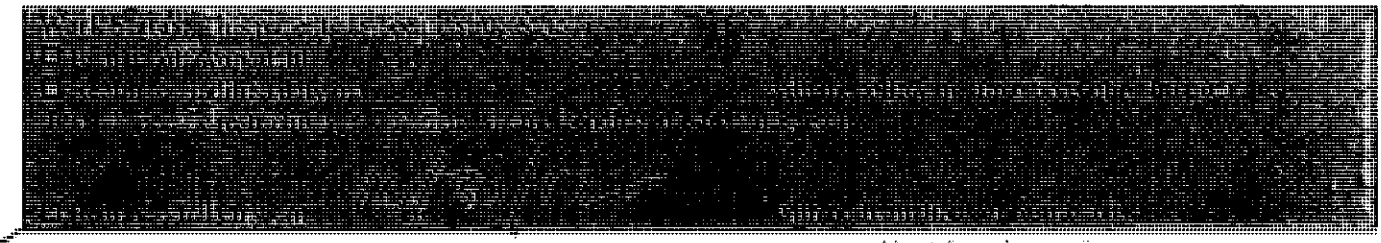
Subjective complaints: c/o pain in knees

Objective findings: ØA

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?

Ken man
Voltaren



Next Appointment: _____
Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 10/30/2012

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: WB Workman, MD **Date:** 10/30/2012

Executed at: Contra Costa County, CA California License No.: A72343
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) 944-0660

State of California Additional pages attached ☐
Division of Workers' Compensation

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

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.

[redacted]

Patient:
[redacted] First [redacted] M.I. Sex M
Address [redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date o[redacted]
Occupation SS# 5[redacted] Phone: [redacted]

Claims Administrator:
Name YORK Claim Numbe[redacted]
Address City State Zip
Phone 209-475-3102 Fax 866-548-2637

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:

c/o pain

Objective findings:

ROM 0-120°

NVI dated

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?

Pain management

[redacted]

Next Appointment:
Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 03/05/2013
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:** 03/05/2013
Executed at: Contra Costa County, CA California License No.: A72343
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) 944-0960

State of California Additional pages attached ☐
Division of Workers' Compensation

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

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.

[redacted]

Patient:
Last [redacted] First [redacted] M.I. Sex
Address [redacted] City VALLEJO State CA Zip 94591
Date of Injury 10/03/2009 Date [redacted]
Occupation SS# [redacted] Phone: [redacted]

Claims Administrator:
Name york Claim Numbe[redacted]
Address City State Zip
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: E c/o pain in right knee

Objective findings: -5 → 120 ROM Stable

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?

switch NSAIDS / rest

[redacted]

Next Appointment:
Primary Treating Physician: (original signature, do not stamp) **Date of exam:** 11/04/2013
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:** 11/04/2013
Executed at: Contra Costa County, CA California License No.: A72343
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) 944-0046

KAISER PERMANENTE Claim#:CVCH-546593 DOI:02-15-2014 Visit:03-04-2014 08:37 ReportDate:03-05-2014 Final:N
Patient: [redacted] 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 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

[redacted]

11. ☐ Patient will be permanently precluded from engaging in his/her usual and customary occupation
12. ☐ Patient's condition is permanent and stationary with residual disability on:
13. ☐ Patient will require future medical care

If any of these boxes are checked you must use Form PR-3 or narrative report.

14. Claims Administrator YORK INS SVCS PO BOX 619079 ROSEVILLE CA 95661	Patient: 15. MR 01977909 16. S[redacted] 17. Name [redacted] 18. Addres[redacted] 19. City VALLEJO [redacted] Zip 945918322 20. DOI [redacted] 21. DOB [redacted] 22. Sex M 23. Phon[redacted] 24. Fax 25. Occu[redacted]
26. Phone (800) 422-7244 27. Fax (866) 548-2637	28. Clain[redacted] 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:**

[redacted] 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/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 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 knees s/p surgery
Relevant Family History: No relevant family history
Hobbies/Leisure Activities: Patient denies any relevant recreational/leisure activities

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MAR 25 2014 A
OSC West

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 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:

State of California Division of Workers' Compensation

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

35. Diagnoses

1st — ICD-9 843.9
SPRAIN OR STRAIN OF HIP OR THIGH (L)

2nd — 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 ?

39. Other Physician/Non-Physician Providers:

40. Drugs:

41. Physical Medical Service: 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 full duty on with no limitations or restrictions.
48. ☒ Return to modified work on 03-04-2014 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 are deemed permanent.

State of California Division of Workers' Compensation

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

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 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 KOJ Occupational Health

Executed at _____ Signature Date MAR 05 2014

54. Name TANG, ZILUE MD 55. California Lic# 100782A

56. Address 975 Sereno Drive, Vallejo, CA, 94589 57. Phone (707) 651-1370 Vallejo Facility

v2.9

KAISER PERMANENTE Claim#:CVCH-546693 DOI:02-15-2014 Visit:03-18-2014 08:53 ReportDate:03-19-2014 Final:N
[redacted] MR:01977909 WCAB#: PAC: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

[redacted]

11. ☐	Patient will be permanently precluded from engaging in his/her usual and customary occupation	If any of these boxes are checked you must use Form PR-3 or narrative report.
12. ☐	Patient's condition is permanent and stationary with residual disability on:	
13. ☐	Patient will require future medical care	

14. Claims Administrator YORK INS SVCS PO BOX 619079 ROSEVILLE CA 95661	Patient: [redacted] 15. MR 01977909 16. [redacted] 17. Name [redacted] 18. Address [redacted] 19. City VALLEJO State CA Zip 945918322 20. DOI 02-15-2014 21. DO[redacted] 22. Sex M 23. Phon[redacted] 24. Fax 25. Occu[redacted]
26. Phone (800) 422-7244 27. Fax (866) 548-2637	28. Clai[redacted] 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:**

[redacted] 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.

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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 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 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:

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

35. **Diagnoses**

1st — ICD-9 843.9
SPRAIN OR STRAIN OF HIP OR THIGH (L)

2nd — 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, r/o labrum tear
Plan: MRA

I have reviewed the Physical Therapy progress notes. The patient has shown functional gains from therapy, specifically improved range of motion, improvement in activities of daily living and reduction in work restrictions. I am requesting authorization for an additional 4 visits of physical therapy over 3 weeks.
Work Status: Modified duty advanced 3/18/2014 through 4/1/2014 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: 4/1/2014 1:50 PM

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 45. Hospitalization/ Surgery
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** 03-18-2014 **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 are deemed permanent.**

State of California Division of Workers' Compensation

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

Primary Treating Physician: (original signature, do not stamp) 52. Date of exam 03-18-2014

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 KOJ Occupational Health

Executed at _____ Signature Date _____

54. Name TANG, ZILUE MD 55. California Lic# 100782A

56. Address 975 Sereno Drive, Vallejo, CA, 94589 57. Phone (707) [illegible] Vallejo Facility

v2.9

KAISER PERMANENTE Claim#:CVCH:546693 DOI:02-15-2014 Visit:04-01-2014 13:59 ReportDate:04-02-2014 Final:N
Patient: [redacted] P MR:01977909 WCAB#: PAC: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.

[redacted]

11. ☐	Patient will be permanently precluded from engaging in his/her usual and customary occupation	If any of these boxes are checked you must use Form PR-3 or narrative report
12. ☐	Patient's condition is permanent and stationary with residual disability on:	
13. ☐	Patient will require future medical care	

14. Claims Administrator YORK INS SVCS PO BOX 619079 ROSEVILLE CA 95661	Patient: [redacted] 16. SSN [redacted] 17. Name [redacted] 18. Address [redacted] 19. City VALLEJO State CA Zip 945918322 20. DOI 02-15-2014 21. [redacted] 22. Sex M 23. Phone [redacted] 24. Fax 25. Occ [redacted]
26. Phone (800) 422-7244 27. Fax (866) 548-2637	28. Clai [redacted] 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:

[redacted] 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
Current complaints: as above.

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OSC West

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 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 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 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:

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

35. **Diagnoses**
1st SPRAIN OR STRAIN OF HIP OR THIGH (L) ICD-9 843.9
2nd 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, r/o labrum tear

MRA requested. Waiting for appt.
I certify the medical necessity of the care and have reviewed and approve
the Plan of Care. Continue PT
Work Status: Modified duty if available 4/1/2014 through 4/15/2014 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: 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. Drugs:

41. Physical Medical Service: 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 full duty on with no limitations or restrictions.
48. ☒ Return to modified work on 04-01-2014 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 are deemed permanent.

Primary Treating Physician: (original signature, do not stamp) 52. Date of exam 04-01-2014

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 [redacted]

Signature _____ Specialty KOJ Occupational Health

Executed at _____ Signature Date APR 02 2014

54. Name TANG, ZILUE MD 55. California Lic# 100782A
56. Address 975 Sereno Drive, Vallejo, CA, 94589 57. Phone (707) 651-[redacted] Vallejo Facility

v2.9

KAISER PERMANENTE Claim#:CVCH-546693 DOI:02-15-2014 Visit:04-15-2014 14:32 ReportDate:04-16-2014 Final:Y
Patient: [redacted] 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

01.	X	Periodic Report (required 45 days after last report) 02. ☐ Change in treatment plan	03. ☐ Released from care
04.	☐	Change in work status 05. ☐ Need for referral or consultation	06. ☐ Response to request for information
07.	☐	Change in patient's condition 08. ☐ Need for surgery or hospitalization	09. ☐ Request for Authorization
10.	☐	Other:	
11.	☐	Patient will be permanently precluded from engaging in his/her usual and customary occupation	If any of these boxes are checked you must use Form PR-3 or narrative report
12.	☐	Patient's condition is permanent and stationary with residual disability on:	
13.	☐	Patient will require future medical care	

14. Claims Administrator		Patient:	15. MR 01977909 16. SSN [redacted]
YORK INS SVCS		17. Name	[redacted]
		18. Address	[redacted]
PO BOX 619079		19. City	[redacted] Zip 945918322
ROSEVILLE		20. DOI	[redacted] 22. Sex M
CA	95661	23. Phone	[redacted] 24. Fax
		25. Occupat	[redacted]
26. Phone (800) 422-7244	27. Fax (866) 548-2637	28. Claim C	[redacted]

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:

[redacted] 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

1st ICD-9 843.9
SPRAIN OR STRAIN OF HIP OR THIGH (L)

2nd ICD-9

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

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.. (primary encounter diagnosis)
Note: left, acute, r/o labrum tear
Plan: 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.

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 45. Hospitalization/ Surgery
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** 04-15-2014 **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 are deemed permanent.**

State of California Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2) Page 3

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 [redacted]

Signature _____ Specialty _____

Executed at _____ Signature Date _____

54. Name TANG, ZILUE MD 55. California Lic# 100782A

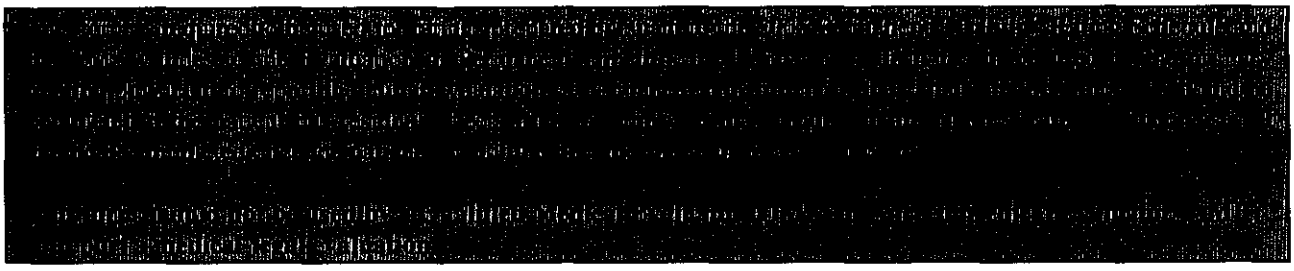
56. Address 975 Sereno Drive, Vallejo, CA, 94589 57. Phone (707) 651-1370

v2.9

STATE OF CALIFORNIA

Division of Workers' Compensation

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



Patient:

Last Name [redacted] Middle Initial ____ First Name [redacted] Sex M Date of Birth [redacted]

Address [redacted] City VALLEJO State CA Zip 94591

Occupation _____ Social Security Number [redacted] Phone No. [redacted]

Claims Administrator/Insurer:

Name YORK INSURANCE SERVICES CLM#: 2009095282 Phone Number F:925-609-9264

Address _____ City _____ State ____ Zip _____

Employer:

Name CITY OF VALLEJO Phone Number _____

Address _____ City _____ State ____ Zip _____

Treating Physician:

Name Willam B. Workman, MD Phone Number 925 944-0110

Address 101 Ygnacio Valley Road, Ste 400 City Walnut Creek State CA Zip 94596

You must address each of the issues below. You may substitute a detailed narrative report if you feel that you have adequately reported these issues.

Date of Injury 10/03/2009 (Date) Last date worked _____ (Date) Permanent & Stationary 8/22/11 (Date) Date of current examination 8/22/11 (Date)

Description of how injury/illness occurred (e.g. Hand caught in punch press; fell from height onto back; exposed 25 years ago to asbestos):

injured at work

Patient's Complaints:

bilateral 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, 5th 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
1. **mmt**	**836.0**
2. **lmt**	**836.1**
3.	
4.	

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

Impairment	**left med and lat**	WPI%	**4**	Table #(s). **17-33 p546**	Page #(s)
Explanation					
Impairment	**right lat**	WPI%	**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
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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, 5th 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.

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(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 regions of the body not listed in subparagraphs (A) to (F), inclusive.

(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 directly caused, by an injury or illness arising out of and in the course of employment?	☑	☐
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 percentage of the permanent disability that is due to factors other than the injury or illness arising out of and in the course of employment; and (2) a complete narrative description of the basis for your apportionment finding. If you are unable to include an apportionment determination in your report, state the specific reasons why you could not make this determination. You may attach your findings and explanation on a separate sheet.

n/a

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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:

[ ] 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

no restrictions

SIT a total of:

[ ] 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

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

[ ] UNLIMITED

[ ] LIMITED (Describe degree of limitation)

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ACTIVITIES ALLOWED.

	Frequently	Occasionally	Never
Climbing	[ ]	[ ]	[ ]
Balancing	[ ]	[ ]	[ ]
Stooping	[ ]	[ ]	[ ]
Kneeling	[ ]	[ ]	[ ]
Crouching	[ ]	[ ]	[ ]
Crawling	[ ]	[ ]	[ ]
Twisting	[ ]	[ ]	[ ]
Reaching	[ ]	[ ]	[ ]
Handling	[ ]	[ ]	[ ]
Fingering	[ ]	[ ]	[ ]
Feeling	[ ]	[ ]	[ ]
Seeing	[ ]	[ ]	[ ]
Hearing	[ ]	[ ]	[ ]
Speaking	[ ]	[ ]	[ ]

no restrictions

Describe in what ways the impaired activities are limited:

none

Environmental restrictions (e.g. heights, machinery, temperature extremes, dust, fumes, humidity, vibration etc.)

	Yes	No
Can this patient now return to his/her usual occupation?	☑	☐

List information you reviewed in preparing this report, or relied upon for the formulation of your medical opinions:

Medical Records:

patients chart

Written Job Description:

received 8/25/11

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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: WB Workman, MD

Cal. Lic. # : **A72343**

Executed at: **Contra Costa, CA**

Date: **08/26/2011**

(County and State)

Name (Printed): **William B. Workman, MD**

Specialty: **Orthopedic Surgeon**

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

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

[redacted]

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

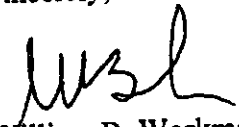
3. any that include avoidance of symptomatic movements and (B) Treatment with NSAIDs or acetaminophen.
4. The etiology of the hip pain was confirmed by relief after injection of local anesthetic into the joint or the signs and symptoms of FAIS were so obvious that the injection was not performed due 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.

DISCUSSION

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,



William B. Workman, M.D.

WBW/msh

MD NOTE

Walnut Creek Orthopedics & Sports Medicine

Patient Name: [redacted] Date: 05/22/2014

Birthdate: [redacted]

S —

Ⓛ Hip labral tear

PT

William B. Workman, MD

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

Name [redacted]

Date 2/25/2010

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

SWELLING & SEVERE PAIN OF LEFT KNEE MAINLY BEHIND THE KNEE

DATE OF ONSET/INJURY: 10/3/2009

CAUSE: (If injury, please explain.)

WHILE WORKING ON AN ACTIVE FIRE, TRIP AND FELL SEVERAL TIMES WHILE RESCUING VICTIM TRAPPED IN FIRE

☒ 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: [redacted]
Claim#:
Date of Injury: 10/03/09

Dear Claims Examiner:

I saw [redacted] 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

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 [redacted] DATE: 02/25/2010

MECHANISM OF INJURY/COMPLAINT: ______________________ DOI: ______________

PREVIOUS TREATMENT: ______________________

	RIGHT	(LEFT)
Alignment		
Effusion		
PFC		
Atrophy		
Extension		
Flexion		
Lachman		
Pivot Shift		
Posterior Drawer		
Valgus at 30 degrees		
Varus at 30 degrees		
Tenderness		
medial joint line		
lateral joint line		
inferior pole		

10/3/09
Fighting fire
fell onto
concrete.
Then fell in hallway
twice rescue

cycling doesn't
bother it
lateral movement is
a problem

X-RAYS: Lt comp OA in office ∅ other injuries

MRI: films ∅

IMPRESSION:

PLAN:

James T. Quintella, PA-C

William B. Workman, MD

PATIENT: [redacted]

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.
3. Preoperative history and physical paperwork was completed.

James Quintella, PA-C

William B. Workman, M.D.

JQ/av

KNEE

NAME [redacted] DATE: 04/05/2010

MECHANISM OF INJURY/COMPLAINT: _____ DOI: _____

PREVIOUS TREATMENT. _____

	RIGHT	LEFT
Alignment		
Effusion		trace
PFC		
Atrophy		
Extension		0
Flexion		120
Lachman		
Pivot Shift		
Posterior Drawer		
Valgus at 30 degrees		
Varus at 30 degrees		
Tenderness		
medial joint line		
lateral joint line		
inferior pole		

5:
Bright
better than
before exam

X-RAYS:

MRI:

IMPRESSION: 1-day med

PLAN: 1. PT starting tomorrow @ Benecia Bay
2- f/u one month

James T. Quintella, PA-C

William B. Workman, MD

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 QUAD, Glute STRENTH WAS VERY WEAK. I felt myself getting STRONGER AFTER EVERY VIST. my CARDIO ALSO improved. I feel 5-8 more vists would improve my overALL leg STRENGTH & FITNESS

Name: [redacted] JB Ok to publish with initials only.

Date: 4/18/11

Therapist/Trainer: Ada Jauregui, DPT

MD: Dr. William Workman, MD

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[redacted]

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

MEDICAL HISTORY FORM

Patient Name: [redacted] Date: 6/11/12

I. RELATIONS:

Relation	Age (if living)	If deceased, cause of death	Age at death
Father		HEART	76
Mother		BRAIN CLOT	38
Brothers		GUN SHOT	42
Sisters			
Spouse			
Children			

II. ILLNESSES:

Have you or your relations had any of the following? (Specify if you or your relation)

ILLNESS	YES	NO	WHO	ILLNESS	YES	NO	WHO
Rheumatic Fever		✓		Hepatitis		✓	
Glaucoma		✓		Asthma	✓		SON/DAUGHTER
Epilepsy		✓		Kidney Stone	✓		DAUGHTER
Cancer		✓		Gout	✓		FATHER
Heart Disease		✓		Sickle Cell Anemia		✓	
Tuberculosis		✓		Diabetes		✓	
High Blood Pressure		✓		Allergies		✓	

List any serious illnesses and your age at the time you had them:

III. OPERATIONS:

Have you had any surgical treatments or operations? YES ✓ NO ___

If yes, describe and give your age at which they occurred: AGE 46, 47 MENISCUS

IV. INJURIES:

Have you had any serious accidents or injuries? YES ✓ NO ___

If yes, describe and give your age at which they occurred: 45 KNEE INJURY

V. FEMALES ONLY:

Are you or could you be pregnant? YES ___ NO ___

VI. Do you smoke? YES ___ NO ✓ If yes, how many packs per day? ___

Do you drink alcoholic beverages? NO ___ Occasionally ___ Weekly ✓ Daily ___

VII. MEDICATION REACTIONS:

Have you had any reactions, allergies, or bad effects from any of the following?

	YES	NO		YES	NO
Cortisone Injection		✓	Novocaine		✓
Penicillin		✓	Aspirin		✓
Other antibiotics		✓	Morphine		✓
Codeine		✓	Other Drugs		✓

Please list other drug allergies N/A

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

MEDICAL HISTORY FORM

Patient Name: [redacted] Date: 6/11/12

VIII. Do you take any of the following medicines or drugs regularly?

	YES		YES
Digitalis (for heart)		Insulin	
Anticoagulants (blood thinner)		Cortisone	
Diuretics (to remove fluid)		Sleeping Pills	
Drugs to lower high blood pressure		Tranquilizers	
Thyroid		Aspirin	

Current Medications (Please list dosage and frequency): N/A

IX. Have you ever had or do you currently have any of the following? (Check only those which pertain to you.)

	Frequent Headaches		Vomiting of blood
	Frequent or severe dizziness		Vomiting of material resembling coffee grounds
	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		Hemorrhoids (piles or rectal disease)
	Frequent hoarseness		Hernia
	Lived with anyone with tuberculosis		Blood in urine
	Frequent sweating at night		Frequent or painful urination
	Chronic cough		Trouble starting or stopping urine
	Coughed up blood		Urinate more than once at night
	Severe or recurrent chest pain		Prostate trouble
	Pneumonia		Disabling back pain
	High blood pressure		Worn a back brace
	Heart murmur		Foot trouble
	Shortness of breath on climbing stairs		Trick or locked knee
	Pressure or tightness in chest		Painful or trick shoulder or elbow
	Pain or cramps in legs with walking		Blood disorder
	Irregular heart beat		Tendency to bleed
	Varicose veins		Skin cancer
	Phlebitis		Claustrophobia
	Recent change in appetite		Allergies to shellfish and/or iodine

X. DIET

Are you on any special diet? YES ____ NO X If yes, what kind? ____

What is your present weight? 212 and Height? 5'9"

UPDATED

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

MEDICAL HISTORY FORM

Patient Name: [redacted] Date: 5/22/14

I. RELATIONS:

Relation	Age (if living)	If deceased, cause of death	Age at death
Father		Heart	67
Mother			
Brothers			
Sisters			
Spouse			
Children			

II. ILLNESSES:

Have you or your relations had any of the following? (Specify if you or your relation)

ILLNESS	YES	NO	WHO	ILLNESS	YES	NO	WHO
Rheumatic Fever		X		Hepatitis		X	
Glaucoma		X		Asthma	X		SON/Daughter
Epilepsy		X		Kidney Stone	X		Daughter
Cancer		X		Gout		X	
Heart Disease	X		Father	Sickle Cell Anemia		X	
Tuberculosis		X		Diabetes		X	
High Blood Pressure				Allergies		X	

List any serious illnesses and your age at the time you had them:

III. OPERATIONS:

Have you had any surgical treatments or operations? YES X NO ___

If yes, describe and give your age at which they occurred: Age 45 – L & R KNEES

IV. INJURIES:

Have you had any serious accidents or injuries? YES X NO ___

If yes, describe and give your age at which they occurred: ___

V. FEMALES ONLY:

Are you or could you be pregnant? YES ___ NO ___

VI. SOCIAL HISTORY: Do you smoke? YES ___ NO X If yes, how many packs per day? ___

Do you drink alcoholic beverages? NO ___ Occasionally ___ Weekly X Daily ___

VII. MEDICATION REACTIONS:

Have you had any reactions, allergies, or bad effects from any of the following?

	YES	NO		YES	NO
Cortisone Injection		X	Novocaine		X
Penicillin		X	Aspirin		X
Other antibiotics		X	Morphine		X
Codeine		X	Other Drugs		X

Please list other drug allergies NONE

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

MEDICAL HISTORY FORM

Patient Name: [redacted] Date: 5/22/14

VIII. Do you take any of the following medicines or drugs regularly?

	YES		YES
Digitalis (for heart)		Insulin	
Anticoagulants (blood thinner)		Cortisone	
Diuretics (to remove fluid)		Sleeping Pills	
Drugs to lower high blood pressure		Tranquillizers	
Thyroid		Aspirin	

Current Medications (Please list dosage and frequency): _____

IX. Have you ever had or do you currently have any of the following? (Check only those which pertain to you.)

	Frequent Headaches		Vomiting of blood
	Frequent or severe dizziness		Vomiting of material resembling coffee grounds
	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		Hemorrhoids (piles or rectal disease)
	Frequent hoarseness		Hernia
	Lived with anyone with tuberculosis		Blood in urine
	Frequent sweating at night		Frequent or painful urination
	Chronic cough		Trouble starting or stopping urine
	Coughed up blood		Urinate more than once at night
	Severe or recurrent chest pain		Prostate trouble
	Pneumonia		Disabling back pain
	High blood pressure		Worn a back brace
	Heart murmur		Foot trouble
	Shortness of breath on climbing stairs	X	Trick or locked knee PAIN
	Pressure or tightness in chest	X	Painful or trick shoulder or elbow
	Pain or cramps in legs with walking		Blood disorder
	Irregular heart beat		Tendency to bleed
	Varicose veins		Skin cancer
	Phlebitis		Claustrophobia
	Recent change in appetite	X	Allergies to shellfish and/or iodine

X. DIET

Are you on any special diet? YES ___ NO X If yes, what kind? _____

What is your present weight? 209 and Height? 5'9"

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

Name [redacted]

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 left hip flexor

☒ X-rays or MRI's brought to today's appointment. SENT by YORK 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

PHYSICIAN COMPLETE

EMPLOYEE STATUS REPORT

CONFIDENTIAL INFORMATION

EMPLOYEE NAME: [redacted]	DATE OF INJURY: 10-3-09
MEDICAL RECORD #: [redacted]	DATE OF BIRTH: [redacted]

APPT. DATE:	TIME IN:	TIME OUT:
10-21-10	1315	1345
NEXT APPT. DATE:	INJURY TYPE: ☐ Recordable ☐ First Aid	

Dr. Initial: _____ **"Yes, I have reviewed the Employee's Usual & Customary job description prior to addressing work status."**

INJURY/TREATMENT

TYPE OF INJURY:

PHYSICAL THERAPY:

____ sessions per week for ____ weeks

SURGERY SCHEDULED?:

☐NO ☐YES, DATE: _____

WORK STATUS

☐ A. RELEASED TO USUAL & CUSTOMARY ON *(Date)*:

☒ B. RELEASED TO RESTRICTED DUTY ON *(Date)*: 10/21/10

☐ C. TOTAL TEMPORARY DISABILITY EFFECTIVE *(Date)*:

☐ D. PERMANENTLY DISABILED FROM USUAL & CUSTOMARY EFFECTIVE *(Date)*:

WORK ABILITIES

Maximum hours Employee can perform each activity per day

	No restriction	6 hours	4 hours	2 hours	1 hour	0 hours	COMMENTS
Sitting	☒	☐	☐	☐	☐	☐	
Standing/Walking	☐	☐	☒	☐	☐	☐	
Kneeling/Crawling/ Squatting	☐	☐	☐	☐	☐	☒	
Climbing	☐	☐	☐	☐	☐	☒	
Laying Back/Stomach	☒	☐	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	☐	
Pushing/Pulling	☐	☐	☐	☐	☐	☐	Weight limitations:
HAND/ARM USE:							
Reaching Overhead	☒	☐	☐	☐	☐	☐	
Reaching Above Shoulder	☐	☐	☐	☐	☐	☐	
Fine Manipulation	☐	☐	☐	☐	☐	☐	
Keyboard/Mouse Use	☐	☐	☐	☐	☐	☐	
Simple Grasping	☐	☐	☐	☐	☐	☐	
Power Grasping	☐	☐	☐	☐	☐	☐	
LIFTING/ CARRYING:							Specify height limitations for each restriction:
0-10 lbs.	☐	☐	☐	☐	☐	☐	
11-25 lbs.	☐	☐	☐	☒	☐	☐	
26-50 lbs.	☐	☐	☐	☐	☐	☐	
51-75 lbs.	☐	☐	☐	☐	☐	☐	
76+ lbs.	☐	☐	☐	☐	☐	☐	

Can Employee work entire shift?	☒ Yes	☐ No	If no, how many hours?
Does Employee need periodic rest breaks?	☒ Yes	☐ No	If yes, how often? every 2 hrs.
Can Employee operate/work around moving equipment?	☐ Yes	☒ No	
Can Employee work at heights?	☐ Yes	☒ No	
Is Employee on any medication that affects work ability?	☐ Yes	☒ No	If yes, explain:

PHYSICIAN INFORMATION

I declare under penalty of perjury that to the best of my information and belief I have not violated California Labor Code Section 139.3 and have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration for any referral for examination or evaluation by a physician.

☒ Medical ☐ Physical Therapy ☐ Other:

NAME: William Workman, MD	SIGNATURE: [signature]	DATE: 10/21/10
TELEPHONE: 925-944-0110	FAX: 925-944-0960	E-MAIL:

PHYSICIAN: Fax to City of Vallejo, Risk Management Division at (707) 649-5443
AND give completed original to Employee to return to Department Workers' Compensation Contact.

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.

Initial Distribution: Treating Physician Envelope

Fax 707-648-5289

From: 707 6485289 Page: 1/1 Date: 11/30/2010 9:05:00 AM

CITY OF VALLEJO WORKERS' COMPENSATION MANAGEMENT PROGRAM
INITIAL INJURY PACKET

PHYSICIAN COMPLETE

EMPLOYEE STATUS REPORT

CONFIDENTIAL INFORMATION

EMPLOYEE NAME: [redacted]	DATE OF INJURY: 10-3-09	APPT. DATE: 11-24-10	TIME IN: 1530	TIME OUT: 1600
MEDICAL RECORD #	DATE OF BIRTH: [redacted]	NEXT APPT. DATE: 1/6/11	INJURY TYPE: ☒ Recordable ☐ First Aid	

Dr. Initial: "Yes, I have reviewed the Employee's Usual & Customary job description prior to addressing work status."

INJURY/TREATMENT

TYPE OF INJURY: Torn L meniscus

PHYSICAL THERAPY: ____ sessions per week for ____ weeks — Jan x 8 PT

SURGERY SCHEDULED?: ☐ NO ☒ YES, DATE: 3/31/10

WORK STATUS

- ☐ A. RELEASED TO USUAL & CUSTOMARY ON *(Date)*:
- ☒ B. RELEASED TO RESTRICTED DUTY ON *(Date)*: 11-24-10
- ☐ C. TOTAL TEMPORARY DISABILITY EFFECTIVE *(Date)*:
- ☐ D. PERMANENTLY DISABLED FROM USUAL & CUSTOMARY EFFECTIVE *(Date)*:

WORK ABILITIES

Maximum hours Employee can perform each activity per day

	No restrictions	6 hours	4 hours	2 hours	1 hour	0 hours	COMMENTS
Sitting	☒	☐	☐	☐	☐	☐	
Standing/Walking	☐	☒	☐	☐	☐	☐	
Kneeling/Crawling/ Squatting	☐	☐	☐	☐	☐	☒	
Climbing	☐	☐	☐	☐	☐	☒	
Laying Back/Stomach	☒	☒	☐	☐	☐	☐	
Bending	☒	☐	☐	☐	☐	☐	
Twisting	☒	☐	☐	☐	☐	☐	
Pushing/Pulling	☐	☒	☐	☐	☐	☐	Weight limitations
HAND/ARM USE:							
Reaching Overhead	☐	☐	☐	☐	☐	☐	
Reaching Above Shoulder	☐	☐	☐	☐	☐	☐	
Fine Manipulation	☐	☐	☐	☐	☐	☐	
Keyboard/Mouse Use	☐	☐	☐	☐	☐	☐	
Simple Grasping	☐	☐	☐	☐	☐	☐	
Power Grasping	☐	☐	☐	☐	☐	☐	
LIFTING/ CARRYING:							Specify height limitations for each restriction:
0-10 lbs.	☒	☐	☐	☐	☐	☐	
11-25 lbs.	☒	☐	☐	☐	☐	☐	
26-50 lbs.	☒	☐	☐	☐	☐	☐	
51-75 lbs.	☐	☐	☐	☐	☒	☒	
76+ lbs.	☐	☐	☐	☐	☐	☐	

Can Employee work entire shift?	☒ Yes	☐ No	If no, how many hours?
Does Employee need periodic rest breaks?	☒ Yes	☐ No	If yes, how often? every 2 hrs.
Can Employee operate/work around moving equipment?	☐ Yes	☒ No	
Can Employee work at heights?	☐ Yes	☒ No	
Is Employee on any medication that affects work ability?	☐ Yes	☒ No	*If yes, explain:*

PHYSICIAN INFORMATION

I declare under penalty of perjury that to the best of my information and belief I have not violated California Labor Code Section 139.3 and have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration for any referral for examination or evaluation by a physician.

☒ Medical ☐ Physical Therapy ☐ Other:

NAME: William B. Workman — SIGNATURE: [signature] — DATE: 11/30/10

TELEPHONE: 925 944-0110 — FAX: 925 944-0960 — E-MAIL:

PHYSICIAN: Fax to City of Vallejo, Risk Management Division at (707) 649-5448
AND give completed original to Employee to return to Department Workers' Compensation Contact.

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.

Initial Distribution: Treating Physician Envelope

12/2/10

Fax 707-648-5289

From: 707 6485289 Page: 1/1 Date: 11/30/2010 9:05:00 AM

CITY OF VALLEJO WORKERS' COMPENSATION MANAGEMENT PROGRAM
INITIAL INJURY PACKET

PHYSICIAN COMPLETE

EMPLOYEE STATUS REPORT
CONFIDENTIAL INFORMATION

EMPLOYEE NAME: [redacted]	DATE OF INJURY: 10-3-09	APPT. DATE: 11-24-10	TIME IN: 1530 / TIME OUT: 1600
MEDICAL RECORD #:	DATE OF BIRTH: [redacted]	NEXT APPT. DATE: 1/6/11	INJURY TYPE: ☒ Recordable ☐ First Aid

Do Initial: "Yes, I have reviewed this Employee's Usual & Customary job description prior to addressing work status."

INJURY/TREATMENT

TYPE OF INJURY: Torn Rt. meniscus

PHYSICAL THERAPY: ____ sessions per week for done at PT

SURGERY SCHEDULED? ☐ NO ☒ YES, DATE: 3/31/10

WORK STATUS

☐ A. RELEASED TO USUAL & CUSTOMARY ON (Date):

☒ B. RELEASED TO RESTRICTED DUTY ON (Date): 11-24-10

☐ C. TOTAL TEMPORARY DISABILITY EFFECTIVE (Date):

☐ D. PERMANENTLY DISABLED FROM USUAL & CUSTOMARY EFFECTIVE (Date):

WORK ABILITIES

Maximum hours Employee can perform each activity per day

	No restriction	6 hours	4 hours	3 hours	1 hour	0 hours	COMMENTS
Sitting	☒	☐	☐	☐	☐	☐	
Standing/Walking	☐	☒	☐	☐	☐	☐	
Kneeling/Crawling/Squatting	☐	☐	☐	☐	☐	☒	
Climbing	☐	☐	☐	☐	☐	☒	
Laying Back/Stomach	☒	☐	☐	☐	☐	☐	
Bending	☒	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	☐	
Pushing/Pulling	☐	☒	☐	☐	☐	☐	Weight limitations
HAND/ARM USE:							
Reaching Overhead	☐	☐	☐	☐	☐	☐	
Reaching Above Shoulder	☐	☐	☐	☐	☐	☐	
Fine Manipulation	☐	☐	☐	☐	☐	☐	
Keyboard/Mouse Use	☐	☐	☐	☐	☐	☐	
Simple Grasping	☐	☐	☐	☐	☐	☐	
Power Grasping	☐	☐	☐	☐	☐	☐	
LIFTING/CARRYING:							Specify height limitations for each restriction:
0-10 lbs.	☒	☐	☐	☐	☐	☐	
11-25 lbs.	☒	☐	☐	☐	☐	☐	
26-50 lbs.	☒	☐	☐	☐	☐	☐	
51-75 lbs.	☐	☐	☐	☐	☒	☐	
76+ lbs.	☐	☐	☐	☐	☐	☒	

Can Employee work entire shift?	☒ Yes	☐ No	If no, how many hours?
Does Employee need periodic rest breaks?	☒ Yes	☐ No	If yes, how often? every 2 hrs.
Can Employee operate/work around moving equipment?	☐ Yes	☒ No	
Can Employee work at heights?	☐ Yes	☒ No	
Is Employee on any medication that affects work ability?	☐ Yes	☒ No	If yes, explain:

PHYSICIAN INFORMATION

I declare under penalty of perjury that to the best of my information and belief I have not violated California Labor Code Section 139.3 and have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration (in any amount) for referring or soliciting for a physician.

☐ Verbal ☐ Email ☐ Other:

NAME: William B. Workman SIGNATURE: [signature] DATE: 11/6/11

TELEPHONE: 925 944-0110 FAX: 925 944-0960 E-MAIL:

PHYSICIAN: Fax to City of Vallejo Risk Management Division at (707) 648-4448
AND give completed original to Employee to return to Department Workers' Compensation Contact.

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.

Initial Distribution: Treating Physician Envelope

FAXED 12/2/10

CITY OF VALLEJO WORKERS' COMPENSATION MANAGEMENT PROGRAM
INITIAL INJURY PACKET

PHYSICIAN COMPLETE

EMPLOYEE STATUS REPORT
CONFIDENTIAL INFORMATION

EMP [redacted] DATE OF INJURY: 10-3-09
MEDICAL RECORD #: KAISER [redacted] DATE OF BIRTH: [redacted]

APPT. DATE: 2-28-11 TIME IN: 1215 TIME OUT:
NEXT APPT. DATE: 3/21/11 INJURY TYPE: ☑ Recordable ☐ First Aid

Dr. Initial: "Yes, I have reviewed the Employee's Usual & Customary job description prior to addressing work status."

INJURY/TREATMENT

TYPE OF INJURY: RT KNEE
PHYSICAL THERAPY: 2 sessions per week for 6 weeks
SURGERY SCHEDULED?: ☐ NO ☐ YES, DATE. ______

WORK STATUS

☐ A. RELEASED TO USUAL & CUSTOMARY ON (Date):
☒ B. RELEASED TO RESTRICTED DUTY ON (Date): [illegible]
☐ C. TOTAL TEMPORARY DISABILITY EFFECTIVE (Date):
☐ D. PERMANENTLY DISABILED FROM USUAL & CUSTOMARY EFFECTIVE (Date):

WORK ABILITIES

Maximum hours Employee can perform each activity per day

	No restriction	6 hours	4 hours	2 hours	1 hour	0 hours	COMMENTS
Sitting	☐	☐	☐	☐	☐	☒	
Standing/Walking	☐	☐	☐	☐	☐	☒	
Kneeling/Crawling/ Squatting	☐	☐	☐	☐	☐	☒	
Climbing	☐	☐	☐	☐	☐	☒	
Laying Back/Stomach	☐	☐	☐	☐	☐	☒	
Bending	☐	☐	☐	☐	☐	☒	
Twisting	☐	☐	☐	☐	☐	☒	
Pushing/Pulling	☐	☐	☐	☐	☐	☒	Weight limitations:
HAND/ARM USE:							
Reaching Overhead	☐	☐	☐	☐	☐	☐	
Reaching Above Shoulder	☐	☐	☐	☐	☐	☐	
Fine Manipulation	☐	☐	☐	☐	☐	☐	NA
Keyboard/Mouse Use	☐	☐	☐	☐	☐	☐	
Simple Grasping	☐	☐	☐	☐	☐	☐	
Power Grasping	☐	☐	☐	☐	☐	☐	
LIFTING/ CARRYING:							Specify height limitations for each restriction:
0-10 lbs.	☐	☐	☐	☐	☐	☒	
11-25 lbs.	☐	☐	☐	☐	☐	☒	
26-50 lbs.	☐	☐	☐	☐	☐	☒	
51-75 lbs.	☐	☐	☐	☐	☐	☒	
76+ lbs.	☐	☐	☐	☐	☐	☒	

Can Employee work entire shift?	☐ Yes	☒ No	If no, how many hours?
Does Employee need periodic rest breaks?	☐ Yes	☒ No	If yes, how often?
Can Employee operate/work around moving equipment?	☐ Yes	☒ No	
Can Employee work at heights?	☐ Yes	☒ No	
Is Employee on any medication that affects work ability?	☐ Yes	☒ No	If yes, explain:

PHYSICIAN INFORMATION

[illegible]

☒ Medical ☐ Physical Therapy ☐ Other:

NAME: William Workman SIGNATURE: [signature] DATE: 2-28-11
TELEPHONE: 9259440110 FAX: 9259440960 E-MAIL:

PHYSICIAN: Fax to City of Vallejo, Risk Management Division at (707) 649-5445 AND give completed original to Employee to return to Department Workers' Compensation Contact.

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) 648-4855.

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CITY OF VALLEJO WORKERS' COMPENSATION MANAGEMENT PROGRAM
INITIAL INJURY PACKET

PHYSICIAN COMPLETE

EMPLOYEE STATUS REPORT
CONFIDENTIAL INFORMATION

EMPLOYEE NAME: [redacted]	DATE OF INJURY: 10/3/09	APPT. DATE: 7/14/11	TIME IN: / TIME OUT:
MEDICAL RECORD #:	DATE OF BIRTH: 6/8/1964	NEXT APPT. DATE: 7/22/11	INJURY TYPE: ☐ Recordable ☐ First Aid

Dr. Initial: **"Yes, I have reviewed the Employee's Usual & Customary job description prior to addressing work status."**

INJURY/TREATMENT

TYPE OF INJURY: Both Knees

PHYSICAL THERAPY: ____ sessions per week for NA weeks

SURGERY SCHEDULED?: ☐ NO ☐ YES, DATE: NA

WORK STATUS

☒ A. RELEASED TO USUAL & CUSTOMARY ON *(Date)*:

☐ B. RELEASED TO RESTRICTED DUTY ON *(Date)*:

☐ C. TOTAL TEMPORARY DISABILITY EFFECTIVE *(Date)*:

☐ D. PERMANENTLY DISABLED FROM USUAL & CUSTOMARY EFFECTIVE *(Date)*:

WORK ABILITIES

Maximum hours Employee can perform each activity per day

	No restriction	6 hours	4 hours	2 hours	1 hour	0 hours	COMMENTS
Sitting							
Standing/Walking							
Kneeling/Crawling/ Squatting							
Climbing							
Laying Back/Stomach							
Bending							
Twisting							
Pushing/Pulling							Weight limitations:
HAND/ARM USE:							
Reaching Overhead							
Reaching Above Shoulder							
Fine Manipulation							NA
Keyboard/Mouse Use							
Simple Grasping							
Power Grasping							
LIFTING/ CARRYING:							Specify height limitations for each restriction:
0-10 lbs.							
11-25 lbs.							
26-50 lbs.							
51-75 lbs.							
76+ lbs.							

Can Employee work entire shift?	☒ Yes	☐ No	If no, how many hours?
Does Employee need periodic rest breaks?	☐ Yes	☒ No	If yes, how often?
Can Employee operate/work around moving equipment?	☒ Yes	☐ No	
Can Employee work at heights?	☒ Yes	☐ No	
Is Employee on any medication that affects work ability?	☐ Yes	☒ No	If yes, explain:

PHYSICIAN INFORMATION

I [illegible] penalty of perjury that [illegible] of my information and belief I have not violated California Labor Code Section [illegible] and have not offered, delivered, received or accepted any [illegible] for the referral for examination or evaluation by a physician.

☒ Medical ☐ Physical Therapy ☐ Other:

NAME: William B. Workman	SIGNATURE: [signature]	DATE: 7/14/11
TELEPHONE: 925-944-0110	FAX: 925-944-0960	E-MAIL:

PHYSICIAN: **Fax to City of Vallejo, Risk Management Division at (707) 649-5443**
AND give completed original to Employee to return to Department Workers' Compensation Contact.

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.

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JUL 27 2011
BY

From: 707 6485289 Page: 1/1 Date: 7/27/2011 10:44:15 AM

CITY OF VALLEJO WORKERS' COMPENSATION MANAGEMENT PROGRAM
INITIAL INJURY PACKET

PHYSICIAN COMPLETE

EMPLOYEE STATUS REPORT
CONFIDENTIAL INFORMATION

EMPLOYEE NAME: [redacted]	DATE OF INJURY: 10/3/09	APPT. DATE: 8/22/11	TIME IN:	TIME OUT:
MEDICAL RECORD #:	DATE OF BIRTH: 6/8/1964	NEXT APPT. DATE: NA	INJURY TYPE: ☐ Recordable ☐ First Aid	

Dr. Initial: ______ "Yes, I have reviewed the Employee's Usual & Customary job description prior to addressing work status."

INJURY/TREATMENT

TYPE OF INJURY: Both Knees

PHYSICAL THERAPY: ____ sessions per week for NA weeks

SURGERY SCHEDULED?: ☐NO ☐YES, DATE: NA

WORK STATUS

☒ A. RELEASED TO USUAL & CUSTOMARY ON (Date):

☐ B. RELEASED TO RESTRICTED DUTY ON (Date):

☐ C. TOTAL TEMPORARY DISABILITY EFFECTIVE (Date):

☐ D. PERMANENTLY DISABLED FROM USUAL & CUSTOMARY EFFECTIVE (Date):

WORK ABILITIES

Maximum hours Employee can perform each activity per day

	No restriction	6 hours	4 hours	2 hours	1 hour	0 hours	COMMENTS
Sitting	☐	☐	☐	☐	☐	☐	
Standing/Walking	☐	☐	☐	☐	☐	☐	
Kneeling/Crawling/ Squatting	☐	☐	☐	☐	☐	☐	
Climbing	☐	☐	☐	☐	☐	☐	
Laying Back/Stomach	☐	☐	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	☐	
Pushing/Pulling	☐	☐	☐	☐	☐	☐	Weight limitations:
HAND/ARM USE:							
Reaching Overhead	☐	☐	☐	☐	☐	☐	
Reaching Above Shoulder	☐	☐	☐	☐	☐	☐	
Fine Manipulation	☐	☐	☐	☐	☐	☐	NA
Keyboard/Mouse Use	☐	☐	☐	☐	☐	☐	
Simple Grasping	☐	☐	☐	☐	☐	☐	
Power Grasping	☐	☐	☐	☐	☐	☐	
LIFTING/ CARRYING:							Specify height limitations for each restriction:
0-10 lbs.	☐	☐	☐	☐	☐	☐	
11-25 lbs.	☐	☐	☐	☐	☐	☐	
26-50 lbs.	☐	☐	☐	☐	☐	☐	
51-75 lbs.	☐	☐	☐	☐	☐	☐	
75+ lbs.	☐	☐	☐	☐	☐	☐	

Can Employee work entire shift?	☒ Yes	☐ No	If no, how many hours?
Does Employee need periodic rest breaks?	☐ Yes	☒ No	If yes, how often?
Can Employee operate/work around moving equipment?	☒ Yes	☐ No	
Can Employee work at heights?	☒ Yes	☐ No	
Is Employee on any medication that affects work ability?	☐ Yes	☒ No	If yes, explain:

PHYSICIAN INFORMATION

I declare under penalty of perjury that to the best of my information and belief I have not violated California Labor Code Section 139.3 and have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

☒ Medical ☐ Physical Therapy ☐ Other:

NAME: William B. Workman SIGNATURE: [signature] DATE: 8/22/11

TELEPHONE: 925-944-0110 FAX: 925-944-0960 E-MAIL:

PHYSICIAN: Fax to City of Vallejo, Risk Management Division at (707) 649-5443 AND give completed original to Employee to return to Department Workers' Compensation Contact.

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.

Initial Distribution: Treating Physician Envelope

FAXED BY: ______

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From: 707 6485289 Page: 1/1 Date: 7/27/2011 10:44:15 AM

CITY OF VALLEJO WORKERS' COMPENSATION MANAGEMENT PROGRAM
INITIAL INJURY PACKET

PHYSICIAN COMPLETE

EMPLOYEE STATUS REPORT
CONFIDENTIAL INFORMATION

EMPLOYEE NAME: [redacted]	DATE OF INJURY: 10/3/09
MEDICAL RECORD #:	DATE OF BIRTH: 6/8/1964

APPT. DATE: 7/26/12	TIME IN:	TIME OUT:
NEXT APPT. DATE: NA	INJURY TYPE: ☐ Recordable ☐ First Aid	

Dr. Initial: ____ "Yes, I have reviewed the Employee's Usual & Customary job description prior to addressing work status."

INJURY/TREATMENT

TYPE OF INJURY: Both Knees

PHYSICAL THERAPY: ___ sessions per week for NA weeks

SURGERY SCHEDULED: ☐NO ☐YES, DATE: NA

WORK STATUS

☒ A. RELEASED TO USUAL & CUSTOMARY ON (Date):

☐ B. RELEASED TO RESTRICTED DUTY ON (Date):

☐ C. TOTAL TEMPORARY DISABILITY EFFECTIVE (Date):

☐ D. PERMANENTLY DISABLED FROM USUAL & CUSTOMARY EFFECTIVE (Date):

WORK ABILITIES

Maximum hours Employee can perform each activity per day

	No restriction	6 hours	4 hours	2 hours	1 hour	0 hours	COMMENTS
Sitting	☐	☐	☐	☐	☐	☐	
Standing/Walking	☐	☐	☐	☐	☐	☐	
Kneeling/Crawling/ Squatting	☐	☐	☐	☐	☐	☐	
Climbing	☐	☐	☐	☐	☐	☐	
Laying Back/Stomach	☐	☐	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	☐	
Pushing/Pulling	☐	☐	☐	☐	☐	☐	Weight limitations:
HAND/ARM USE							
Reaching Overhead	☐	☐	☐	☐	☐	☐	NA
Reaching Above Shoulder	☐	☐	☐	☐	☐	☐	
Fine Manipulation	☐	☐	☐	☐	☐	☐	
Keyboard/Mouse Use	☐	☐	☐	☐	☐	☐	
Simple Grasping	☐	☐	☐	☐	☐	☐	
Power Grasping	☐	☐	☐	☐	☐	☐	
LIFTING/ CARRYING:							Specify height limitations for each restriction:
0-10 lbs.	☐	☐	☐	☐	☐	☐	
11-25 lbs.	☐	☐	☐	☐	☐	☐	
26-50 lbs.	☐	☐	☐	☐	☐	☐	
51-75 lbs.	☐	☐	☐	☐	☐	☐	
76+ lbs.	☐	☐	☐	☐	☐	☐	

Can Employee work entire shift?	☒ Yes	☐ No	If no, how many hours?
Does Employee need periodic rest breaks?	☐ Yes	☒ No	If yes, how often?
Can Employee operate/work around moving equipment?	☒ Yes	☐ No	
Can Employee work at heights?	☒ Yes	☐ No	
Is Employee on any medication that affects work ability?	☐ Yes	☒ No	If yes, explain:

PHYSICIAN INFORMATION

[illegible]

☒ Medical ☐ Physical Therapy ☐ Other:

NAME: William B. Workman	SIGNATURE: [signature]	DATE: 7/26/12
TELEPHONE: 925-944-0110	FAX: 925-944-0960	E-MAIL:

PHYSICIAN: Fax to City of Vallejo, Risk Management Division at (707) 648-5443 AND give completed original to Employee to return to Department Workers' Compensation Contact.

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.

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FAXED BY: ____

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

CITY OF VALLEJO WORKERS' COMPENSATION MANAGEMENT PROGRAM
INITIAL INJURY PACKET

PHYSICIAN COMPLETE

EMPLOYEE STATUS REPORT
CONFIDENTIAL INFORMATION

EMPLOYEE NAME: [redacted]	DATE OF INJURY: 10/3/09	APPT. DATE: 10/30/12	TIME IN:	TIME OUT:
MEDICAL RECORD #:	DATE OF BIRTH: [redacted]	NEXT APPT. DATE: NA	INJURY TYPE: ☐ Recordable ☐ First Aid	

Dr. Initial: ____ "Yes, I have reviewed the Employee's Usual & Customary job description prior to addressing work status."

INJURY/TREATMENT

TYPE OF INJURY: Both Knees

PHYSICAL THERAPY: ____ sessions per week for NA weeks

SURGERY SCHEDULED?: ☐NO ☐YES, DATE: NA

WORK STATUS

- ☒ A. RELEASED TO USUAL & CUSTOMARY ON *(Date)*: 10/30/12
- ☐ B. RELEASED TO RESTRICTED DUTY ON *(Date)*:
- ☐ C. TOTAL TEMPORARY DISABILITY EFFECTIVE *(Date)*:
- ☐ D. PERMANENTLY DISABLED FROM USUAL & CUSTOMARY EFFECTIVE *(Date)*:

WORK ABILITIES

Maximum hours Employee can perform each activity per day

	No restriction	8 hours	4 hours	2 hours	1 hour	0 hours	COMMENTS
Sitting	☒	☐	☐	☐	☐	☐	
Standing/Walking	☒	☐	☐	☐	☐	☐	
Kneeling/Crawling/ Squatting	☐	☐	☐	☐	☐	☐	
Climbing	☐	☐	☐	☐	☐	☐	
Laying Back/Stomach	☐	☐	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	☐	
Pushing/Pulling	☐	☐	☐	☐	☐	☐	Weight limitations:
HAND/ARM USE:							
Reaching Overhead	☐	☐	☐	☐	☐	☐	
Reaching Above Shoulder	☐	☐	☐	☐	☐	☐	
Fine Manipulation	☐	☐	☐	☐	☐	☐	
Keyboard/Mouse Use	☐	☐	☐	☐	☐	☐	NA
Simple Grasping	☐	☐	☐	☐	☐	☐	
Power Grasping	☐	☐	☐	☐	☐	☐	
LIFTING/ CARRYING:							Specify height limitations for each restriction:
0-10 lbs.	☒	☐	☐	☐	☐	☐	
11-25 lbs.	☒	☐	☐	☐	☐	☐	
26-50 lbs.	☒	☐	☐	☐	☐	☐	
51-75 lbs.	☒	☐	☐	☐	☐	☐	
76+ lbs.	☒	☐	☐	☐	☐	☐	

Can Employee work entire shift?	☒ Yes	☐ No	If no, how many hours?
Does Employee need periodic rest breaks?	☐ Yes	☒ No	If yes, how often?
Can Employee operate/work around moving equipment?	☒ Yes	☐ No	
Can Employee work at heights?	☒ Yes	☐ No	
Is Employee on any medication that affects work ability?	☐ Yes	☒ No	If yes, explain:

PHYSICIAN INFORMATION

I declare under penalty of perjury that to the best of my information and belief I have not violated California Labor Code Section 139.3 and have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration for any referral for examination or evaluation by a physician.

☒ Medical ☐ Physical Therapy ☐ Other:

NAME: William B Workman MD	SIGNATURE: [signature]	DATE: 10/30/12
TELEPHONE: 925-944-0110	FAX: 925-944-8960	E-MAIL:

PHYSICIAN: Fax to City of Vallejo, Risk Management Division at (707) 649-5443
AND give completed original to Employee to return to Department Workers' Compensation Contact.

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CITY OF VALLEJO WORKERS' COMPENSATION MANAGEMENT PROGRAM
INITIAL INJURY PACKET

PHYSICIAN COMPLETE

EMPLOYEE STATUS REPORT

CONFIDENTIAL INFORMATION

EMPLOYEE NAME: [redacted]	DATE OF INJURY: 10/3/09
MEDICAL RECORD #: —	DATE OF BIRTH: [redacted]

APPT. DATE: 3/5/13	TIME IN:	TIME OUT:
NEXT APPT. DATE: NA	INJURY TYPE: ☐ Recordable ☐ First Aid	

Dr. Initial: ____ "Yes, I have reviewed the Employee's Usual & Customary job description prior to addressing work status."

INJURY/TREATMENT

TYPE OF INJURY: Both Knees

PHYSICAL THERAPY: ____ sessions per week for NA weeks

SURGERY SCHEDULED?: ☐NO ☐YES, DATE: NA

WORK STATUS

☒ A. RELEASED TO USUAL & CUSTOMARY ON (Date): 3/5/13

☐ B. RELEASED TO RESTRICTED DUTY ON (Date):

☒ C. TOTAL TEMPORARY DISABILITY EFFECTIVE (Date): 2a of 3/3/13 and 3/4/13

☐ D. PERMANENTLY DISABLED FROM USUAL & CUSTOMARY EFFECTIVE (Date):

WORK ABILITIES

Maximum hours Employee can perform each activity per day

	No restriction	8 hours	4 hours	2 hours	1 hour	0 hours	COMMENTS
Sitting	☐	☐	☐	☐	☐	☐	
Standing/Walking	☐	☐	☐	☐	☐	☐	
Kneeling/Crawling/ Squatting	☐	☐	☐	☐	☐	☐	
Climbing	☐	☐	☐	☐	☐	☐	
Laying Back/Stomach	☐	☐	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	☐	
Pushing/Pulling	☒	☐	☐	☐	☐	☐	Weight limitations:
HAND/ARM USE:							
Reaching Overhead	☐	☐	☐	☐	☐	☐	
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0-10 lbs.	☐	☐	☐	☐	☐	☐	
11-25 lbs.	☐	☐	☐	☐	☐	☐	
26-50 lbs.	☐	☐	☐	☐	☐	☐	
51-75 lbs.	☐	☐	☐	☐	☐	☐	
75+ lbs.	☐	☐	☐	☐	☐	☐	

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Does Employee need periodic rest breaks?	☐ Yes	☒ No	If yes, how often?
Can Employee operate/work around moving equipment?	☒ Yes	☐ No	
Can Employee work at heights?	☒ Yes	☐ No	
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☒ Medical ☐ Physical Therapy ☐ Other:

NAME: William B. Workman MD SIGNATURE: WBWorkman DATE: 3/5/13

TELEPHONE: 925-944-0110 FAX: 925-944-0960 E-MAIL:

PHYSICIAN: Fax to City of Vallejo, Risk Management Division at (707) 649-5448
AND give completed original to Employee to return to Department Workers' Compensation Contact.

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) 648-4356.

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CITY OF VALLEJO Workers' Compensation Management Program
INITIAL INJURY PACKET

PHYSICIAN COMPLETE

EMPLOYEE STATUS REPORT
CONFIDENTIAL INFORMATION

EMPLOYEE NAME: [redacted]	DATE OF INJURY: 10/3/09
	DATE OF BIRTH: [redacted]

APPT. DATE: 11/4/13	TIME IN:	TIME OUT:
NEXT APPT. DATE: NA	INJURY TYPE: ☐ Recordable ☐ First Aid	

Dr. Initials: "Yes, I have reviewed the Employee's Usual & Customary job description prior to addressing work status."

INJURY/TREATMENT

TYPE OF INJURY: Both Knees

PHYSICAL THERAPY: ____ sessions per week for NA weeks

SURGERY SCHEDULED?
☐ NO ☐ YES, DATE: NA

WORK STATUS

☒ A. RELEASED TO USUAL & CUSTOMARY ON (Date): 11/4/13

☐ B. RELEASED TO RESTRICTED DUTY ON (Date):

☒ C. TOTAL TEMPORARY DISABILITY EFFECTIVE (Date): As of 3/3/13 and 3/4/13

☐ D. PERMANENTLY DISABLED FROM USUAL & CUSTOMARY EFFECTIVE (Date):

WORK ABILITIES

Maximum hours Employee can perform each activity per day

	No restriction	8 hours	6 hours	5 hours	4 hour	0 hours	COMMENTS
Sitting	☐	☐	☐	☐	☐	☐	
Standing/Walking	☐	☐	☐	☐	☐	☐	
Kneeling/Crawling/ Squatting	☐	☐	☐	☐	☐	☐	
Climbing	☐	☐	☐	☐	☐	☐	
Laying Back/Stomach	☐	☐	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	☐	
Pushing/Pulling	☐	☐	☐	☐	☐	☐	Weight limitations:
HAND/ARM USE:							
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Keyboard/Mouse Use	☐	☐	☐	☐	☐	☐	
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11-25 lbs.	☐	☐	☐	☐	☐	☐	
26-50 lbs.	☐	☐	☐	☐	☐	☐	
51-75 lbs.	☐	☐	☐	☐	☐	☐	
75+ lbs.	☐	☐	☐	☐	☐	☐	

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Can Employee operate/work around moving equipment?	☒ Yes	☐ No	
Can Employee work at heights?	☒ Yes	☐ No	
Is Employee on any medication that affects work ability?	☐ Yes	☒ No	If yes, explain:

PHYSICIAN INFORMATION

I declare under penalty of perjury that to the best of my knowledge and belief I have not violated Penal Code Section 550 and have not solicited, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration for any referral for examination or evaluation of a patient.

☒ Medical ☐ Physical Therapy ☐ Other:

NAME: William B. Workman MD SIGNATURE: WBWorkman DATE: 11/4/13

TELEPHONE: 925-944-0110 FAX: 925-944-0960 E-MAIL:

PHYSICIAN: Fax to City of Vallejo, Risk Management Division at (707) 649-5442
AND give completed original to Employee to return to Department Workers' Compensation Contact.

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CITY OF VALLEJO WORKERS' COMPENSATION MANAGEMENT PROGRAM
INITIAL INJURY PACKET

PHYSICIAN COMPLETE

EMPLOYEE STATUS REPORT
CONFIDENTIAL INFORMATION

EMPLOYEE NAME: [redacted]	DATE OF INJURY: 2/15/14
MEDICAL RECORD #:	DATE OF BIRTH: [redacted]

APPT. DATE: 5/22/14	TIME IN:	TIME OUT:
NEXT APPT. DATE: NA	INJURY TYPE: ☐ Recordable ☐ First Aid	

Dr. Initial: ____ **"Yes, I have reviewed the Employee's Usual & Customary job description prior to addressing work status."**

INJURY/TREATMENT

TYPE OF INJURY: LT. hip

PHYSICAL THERAPY: ____ sessions per week for NA weeks

SURGERY SCHEDULED?: ☐NO ☐YES, DATE: ? soon

WORK STATUS

- ☐ A. RELEASED TO USUAL & CUSTOMARY ON *(Date)*:
- ☒ B. RELEASED TO RESTRICTED DUTY ON *(Date)*: 5/22/14
- ☐ C. TOTAL TEMPORARY DISABILITY EFFECTIVE *(Date)*:
- ☐ D. PERMANENTLY DISABLED FROM USUAL & CUSTOMARY EFFECTIVE *(Date)*:

WORK ABILITIES

Maximum hours Employee can perform each activity per day

	No restriction	8 hours	6 hours	4 hours	1 hour	0 hours	COMMENTS
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Kneeling/Crawling/ Squatting	☒	☐	☐	☐	☐	☐	
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Fine Manipulation	☐	☐	☐	☐	☐	☐	
Keyboard/Mouse Use	☐	☐	☐	☐	☐	☐	NA
Simple Grasping	☐	☐	☐	☐	☐	☐	
Power Grasping	☐	☐	☐	☐	☐	☐	
LIFTING/ CARRYING:							Specify height limitations for each restriction:
0-10 lbs.	☒	☐	☐	☐	☐	☐	
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26-50 lbs.	☒	☐	☐	☐	☐	☐	
51-75 lbs.	☒	☐	☐	☐	☐	☐	
76+ lbs.	☒	☐	☐	☐	☐	☐	

Can Employee work entire shift?	☐ Yes	☒ No	If no, how many hours?
Does Employee need periodic rest breaks?	☒ Yes	☐ No	If yes, how often?
Can Employee operate/work around moving equipment?	☐ Yes	☒ No	
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Is Employee on any medication that affects work ability?	☐ Yes	☒ No	If yes, explain:

PHYSICIAN INFORMATION

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☒ Medical ☐ Physical Therapy ☐ Other:

NAME: William B. Workman, MD	SIGNATURE: [signature]	DATE: 5/22/14
TELEPHONE: 925-944-0110	FAX: 925-944-0960	E-MAIL:

PHYSICIAN: Fax to City of Vallejo, Risk Management Division at (707) 649-5443
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Page 5

Initial Evaluation

Patient: [redacted]
Exam Date: 4/6/2010
Visits for problem: 1
Date of b[redacted]4 Sex: M
York 1390
ID: 554806211
Group: 2009095282
Problem: S/P L Knee Partial Lateral menisectomy
Diagnosis: 836.1 Tear lat menisc knee-cur

Benicia Bay Phyiscal Therapy
560 First Street Ste C 103
Benicia, CA 945103266

Phone: (707) 747-9977
Fax: (707) 747-9477

Referred by: William Workman, M.D.
Phone: (925) 944-0110
Fax: (925) 944-0960

Physician Summary for [redacted]

[redacted] 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 [redacted] 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 L 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

Initial Evaluation for [redacted] **4/6/2010**

Referred by: William Workman, M.D.

Measurements & Goals

Left Knee		Measurements	Short Term Goal	Long Term Goal
Manual Muscle Test	Hamstrings	4 /5	5 /5	5 /5
	Quadriceps	4 /5	5 /5	5 /5
ROM-Passive	Knee Extension	-5 degrees	0 degrees	0 degrees *with pain at end range*
	Knee Flexion	110 degrees	130 degrees	130 degrees *with 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 tenderness.

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

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

MILLENNIUM SPORTS CLUB

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

"The Next Step" Physical Repair and Conditioning

PROGRESS REPORT

PATIENT NAME: [redacted] **DATE:** 5/10/10

DOCTOR: Dr. **CLAIM #** [redacted]

PRESCRIPTION: (L) Knee - water therapy progress to land as tolerated

RECOMMENDATION: progress to land

NOTES: [redacted] has just completed his 10th session in aquatic therapy (AWKS). He has full ROM in both leg extension & flexion. But continues to have some swelling & pain behind the (L) knee if he pushes too hard. Standing in one place. Pain & swelling the most. It is apparent that [redacted] has lost Quad mass & strength when compared to his (R) leg - He exhibited a mild antalgic gait when starting water therapy that is now less noticeable. The compensatory behaviors he has from his (L) knee injury are now causing his (R) Hip flexor pain. Water therapy has been ideal for [redacted] as all of his LE issues are being addressed at the same time - We are encouraging [redacted] to begin more land loading activities as tolerated to begin to prepare him for his RTW duties.

Thank you for your referral; He has been a pleasant and "Highly" motivated Client.

Katherine
Next Step Staff

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

MILLS CLUB SPORTS

Vallejo
Phone:(707)644-7788
Fax: (707)644-0906

"The Next Step" Physical Repair and Conditioning

PROGRESS REPORT

PATIENT NAME: [redacted] **DATE:** 7/2/10

DOCTOR: Workman **CLAIM #** [redacted]

PRESCRIPTION: (L) Knee

RECOMMENDATION: Progress to Land → work Hardening for RTW GOALS

NOTES: [redacted] just completed another 4 wks of water therapy foca Duty/ w/t Land functional Training as tolerated. Excessive loading still ↑ pain on (L) Knee and causes swelling. He adapted to a 3x/wk water program balanced w/t a stationary bike, 2x/wk on mech tension for 30 mn. This program has allowed [redacted] to progress comfortably and consistently. He still experiences some (R) Hip pain from compensatory behaviors but this is also improving. [redacted] has full flexion and extension, has ↓ his antalgic gait and has ↑ Quad/Ham strength. His (L) VMO is still weak so we are adding more intense squatting & Lunging to ↑ firing - [redacted] is a "highly" motivated Client and a joy to work with - He Hopes to return to full duty status by August.

Thank you for your referral;

The Next Step Staff

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

Initial Evaluation

Patient Name:	[redacted]		**Date Seen:**	2/21/2011
Referring Physician:	William Workman, MD		**Patient ID:**	9241
Diagnosis:	V67.00	Following surgery, unspecified	**Date of Birth**	[redacted]
	836.2	Other tear of cartilage or meniscus kne		
Time In:	12:00 AM		**Time Out:**	12:00 AM

Subjective

Current Condition

Details

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	Status	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	Outcome
R knee Medial/lateral menisectomy	2/18/2011	Improved
L knee Medial/lateral menisectomy	3/2010	Improved

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

Measurement	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

Measurement	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 (SL calf raise)	5/5 (SL calf raise)
Hamstring	5-/5	5/5
Quadriceps	5-/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	5-/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.

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

Goals

Length	Status	Goal
Long Term	Not Met	1. Independent with Home Exercise Program to continue improvement and prevent future injuries.
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	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 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, 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.

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/STM R ITB, R lateral retinaculum

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

X _____ DPT
Ada Jaureguli License #: 36256

(Document electronically signed by TheraOffice Documentation)
2/21/2011

To Be Completed By Physician:

____ I have no revisions to this plan of care
____ Revise plan of care as follows
____ Discharge Patient

Prognosis: ____ Excellent ____ Good ____ Fair ____ Poor

Continue _____ times per _____ for _____ weeks / months

Physician Signature: WB Workman MD Date _____
In signing this document, physician certifies that prescr[illegible] medical necessity.

APPROVED
By William B. Workman, MD at 9:01 am, Feb 28, 2011

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

Progress Note

Patient Name: [redacted]
Referring Physician: William Workman, *MD*
Diagnosis: V67.00 Following surgery, unspecified
836.2 Other tear of cartilage or meniscus kne

Date Seen: 3/17/2011
Patient ID: 9241
Date of Birth: [redacted])

Subjective

Subjective Findings

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

Functional Status

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 mvmnts 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

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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 Strength**
Gastrocnemius	4+/5 (SL calf raise)	5/5 (SL calf raise)	5/5	5/5 (SL calf 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	4+/5	5/5
Gluteus Maximus	5-/5 (prone)	5-/5 (prone)	5-/5 (prone)	5-/5 (prone)
Peroneus Longus/brevis	5-/5	5-/5	5-/5	5-/5

Knee - Joint Mobility

	3/17/2011	
Joint	**Force Direction**	**End-Feel**
Patellofemoral	lateral/medial Glide	Normal

Knee - Joint Mobility

	2/21/2011	
Joint	**Force Direction**	**End-Feel**
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

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

Plan

Goals

Length	Status	Goal
Long Term	Met	1. Independent with Home Exercise Program to continue improvement and prevent future injuries.
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.

X _____ 1 DPT
Ada Jauregui License #: 36256

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

To be Completed By Physician:

✓ I have no revisions to this plan of care
____ Revise plan of care as follows
____ Discharge Patient

Prognosis: ____ Excellent ____ Good ____ Fair ____ Poor

Continue _____ times per _____ for _____ weeks / months

WB Workman MD

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

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

Progress Note/Discharge Summary

Patient Name: [redacted]
Referring Physician: William Workman, MD
Diagnosis: V67.00 Following surgery, unspecified
836.2 Other tear of cartilage or meniscus kne

Patient ID: 9241
Date of Birth: [redacted] years old)

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

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	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 raise)	5/5 (SL calf raise)	5/5	5/5 (SL calf 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	5/5
Gluteus Maximus	5-/5 (prone)	5-/5 (prone)	5-/5 (prone)	5-/5 (prone)
Peroneus Longus/brevis	5-/5	5-/5	5-/5	5-/5

Knee - Joint Mobility

	4/14/2011	
Joint	**Force Direction**	**End-Feel**
Patellofemoral	lateral/medial Glide	Normal

Knee - Joint Mobility

	2/21/2011	
Joint	**Force Direction**	**End-Feel**
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

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

Goals

Length	Status	Goal
Long Term	Met	1. Independent with Home Exercise Program to continue improvement and prevent future injuries.
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	4. Patient to demonstrate normal gait on multiple surfaces without gait deviations 4 weeks.

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.
End of authorized visits

X_____
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(Document electronically signed by TheraOffice Documentation)
4/18/2011

To Be Completed By Physician:

____ I have no revisions to this plan of care
____ Revise plan of care as follows
____ Discharge Patient

Prognosis: ____ Excellent ____ Good ____ Fair ____ Poor

Continue _____ times per _____ for _____ weeks / months

Physician Signature: _____ Date: _____
In signing this document, physician certifies that prescribed rehabilitation is a medical necessity.

§ 9785.5. Request for Authorization

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

Patient Information
Patient Name: [redacted]
Date of Birth:
Date of Injury: 2/19/14
Employer: CITY OF VALLEJO
Claim Number: [redacted]

Claims Administrator Information
Claims Administrator: YORK INSURANCE
Adjustor Name (If known): SCHAUNNA
Address:
City, State, Zip:
Telephone Number:
Fax Number: 866-548-2637

Provider Information
Provider Name: William B. Workman, MD
Practice Name: Walnut Creek Orthopedics
Address: 101 Ygnacio Valley Rd,Ste.400
City, State, Zip Code: Walnut Creek, CA 94598
Telephone Number: 925-944-0110
Fax Number: 925-944-0960
Provider Specialty: Orthopedics
Provider State License Number: A72343
National Provider ID Number: [redacted]

Requested Treatment: (See Instructions for guidance; attach additional pages if more space is required.)
Either state the requested treatment in the below space or indicate the specific page number(s) of the accompanying medical report on which the requested treatment can be found. Include supporting evidence as necessary. More than one treatment request may be included.

Diagnosis:	HIP PAIN, LABRAL TEAR
ICD Code:	843.9, 719.45
Procedure Requested:	LEFT HIP ARTHROSCOPY WITH FEMOROPLASTY, ACETABULOPLASTY AND LABRAL REPAIR
CPT/HCPCS Code:	29914, 29915, 29916, EO218(CTU) (HIP BRACE-L1686 & L2622)
Other Information: (Frequency, Duration Quantity, Facility, etc.)	PHYSICAL THERAPY 3X6, EKG, CBC, FOR PREOP CLEARANCE CPM for 10 day PREMIER SURGERY CENTER

5/27/14
Date of Request

WBWorkman
Provider Signature

Claim Administrator Response Approving Treatment:
You may use this form for approving a treatment request. A request for additional information, or a decision to modify, delay, or deny a request for authorization cannot be made using this form. Please review all timeframes and requirements set forth in California Labor Code section 4610 and California Code of Regulations, title 8, sections 9792.9 and 9792.9.1.

A decision on the requested medical treatment must be made within five (5) working days from receipt of this request for authorization, or 14 calendar days with a timely request for information necessary to render a decision. For an expedited request, one made in a case of imminent or serious health threat, the maximum is 72 hours. Authorization may not be denied on the basis of lack of information without documentation 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

Adjuster/Authorized Agent Name (print)

MAY 27 2014

DWC Form RFA (Version 12/2012)

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

Surgery Authorization Request Form

Date: 03/02/2010

To: UR/Stacy McAfee
Fax: 925-609-9264
Phone:
Re: [redacted]

Claim no:

Dr. Workman is requesting authorization for surgery on [redacted]

See Correction

Surgery: 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

XED
MAR 02 2010

WELLCOMP
Managed Care Services

March 3, 2010

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

[redacted]

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 [redacted]

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. [redacted] worker's comp. treatment (925) 349-3874.

Sincerely,

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

Authorization for Post Operative PT 3x4

[redacted]

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

Provider:
Dr. William Workman, MD
801 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/DWCPropRegs/MedicalTreatmentUtilizationSchedule/MTUS_FinalCleanCopy.doc, § 9792.21. Medical Treatment Utilization Schedule, 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**

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 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

Adjuster: Stacey McAfee (925) 349-3886

Authorization for Left Knee Arthroscopy and partial lateral meniscectomy

[redacted]

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? Left Knee Arthroscopy and partial lateral meniscectomy

Status: Approved.

Guideline (s) Used:
ACOEM:
http://www.acoempracguides.org/secure/Chapter_13_Knee.aspx#_B._Meniscus_TearsB. Meniscus Tears
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

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 meniscectomy . 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 McAfee (925) 349-3886

Knee Injuries
From: [redacted]
To: sports@md.aaos.org
BC:
Date: Wednesday - October 20, 2010 2:55 PM
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.

[redacted]

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: [redacted]

Claim no:

Dr. Workman is requesting authorization for surgery on [redacted].

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,
Tere

Phone: (925) 944-0110 or 944-0475 (This number has voicemail)
Fax: (925) 944-0960

JAN 09 2011

PALADIN
Managed Care Services

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: [redacted]
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 meniscectomy 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 meniscal 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, DWC 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

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

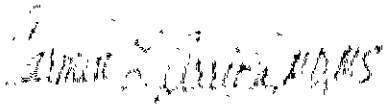
Oakland, CA 94612 1515 Clay Street, 6th floor (510) 622-2861	**Oxnard, CA 93030** 2220 E. Gonzales Road, Suite 100 (805) 485-3528	**Pomona, CA 91768** 732 Corporate Center Drive (909) 623-8568
Redding, CA 96001-2796 2115 Akard, Room 21 (530) 225-2047	**Riverside, CA 92501** 3737 Main Street, Room 300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

cc: [redacted]
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 QME Panel – Send QME 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 QME 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 1-800-736-7401 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 QME 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 QME 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 (Required): _____ Claim Number (required) _____

Specialty Requested *(Required)*

_____
(use 3 letter code only)

Requesting Party *(Check one box only)*:
☐ Unrepresented Injured Employee
☐ Claims Administrator, if none, Employer
☐ Defense Attorney

Reason QME Panel is being requested *(Check one box only)*:
☐ § 4060 (compensability exam)
☐ § 4061 (permanent impairment or disability dispute)
☐ § 4062 Injured employee only (medical treatment determine, UR dispute or other 4062 reason)
☐ § 4062 Claims administrator only (non treatment medical determination or non-UR reason under 4062)
☐ §§ 4061 and 4062 dispute (medical treatment and permanent impairment or disability dispute)

If the Claims administrator is requesting a 4062 panel explain the reason for the request:

_____

Answer each question below:
Has this claim been denied? ☐ Yes ☐ No Has any body part in this claim been accepted? ☐ Yes ☐ No

If yes, indicate the date of the denial _____

Did notice to injured employee state employer requests an evaluation to determine compensability? *(Attach copy of notice)* ☐ Yes ☐ No

Does dispute involved an MPN: ☐ Continuity or transfer of Care ☐ Permanent Disability, Future Medical, UR decision ☐ Diagnosis/Treatment?

Employee Information

First Name, _____ Middle Initial _____ Last Name _____

Street Address. _____

City _____ State _____ Zip Code _____ Daytime Phone No. _____

If you now live out of state, list the California city and zip code of your residence when injured: _____

If you never resided in California, list the California zip code in which you would like to be evaluated _____

Employer and Claims Administrator Information

Employer. _____

Claims Administrator Name: _____

Adjustor name: _____

Street Address or P.O Box: _____

City _____ State. _____ Zip Code _____ Daytime Phone No. _____

Claim Number: _____

Prior QME Panel Information *(Answer all that apply)*

Has the employee ever received 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 settled 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 available now ☐ Yes ☐ No ☐ Unknown

This completed form must be mailed to:
Division of Workers' Compensation – Medical Unit
P.O Box 71010, Oakland, Ca 94612
(510) 286-3700 or (800) 794-6900

Date _____

_____ _____
Print Name of Requestor Signature of Injured 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 QME 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 QME 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 QME'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 QME 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 (Required) _____ **Specialty Requested** *(3 letter code required)*: _____ **Claim Number** (required) _____

Specialty of treating physician _____ Opposing party's specialty preference _____

Requesting Party *(Check one box only)*:
☐ Applicant's Attorney (or injured employee)
☐ Defense Attorney / Claims Administrator

Reason QME Panel is being requested *(Read attachment, 'How to Request a QME') (Check one box only)*:
☐ § 4060 (compensability exam)
☐ § 4061 (permanent impairment or disability dispute)
☐ § 4062 Injured employee only (medical treatment determine, UR dispute or other 4062 reason)
☐ § 4062 Claims administrator only (non treatment medical determination or non-UR reason under 4062)
☐ §§ 4061 and 4062 dispute (medical treatment and permanent impairment or disability dispute)

If the Claims administrator is requesting a 4062 panel explain the reason for the request below

_____

You must attach a copy of your written proposal identifying a disputed issue and naming one or more physicians to be an AME

Answer each question below:
Has this claim been denied? ☐ Yes ☐ No Has any body part in this claim been accepted? ☐ Yes ☐ No

If yes, indicate the date of the denial _____

Did notice to injured employee state employer requests an evaluation to determine compensability? *(Attach copy of notice)* ☐ Yes ☐ No

Does dispute involved an MPN ☐ Continuity or transfer of Care ☐ Permanent Disability, Future Medical, UR decision ☐ Diagnosis/Treatment?

Employee Information

First Name: _____ Middle Initial ____ Last Name: _____

Street Address _____

City. _____ State: _____ Zip Code: _____ Daytime Phone No: _____

If you now live out of state, list the California city and zip code of your residence when injured: _____

If you never resided in California, list the California zip code in which you would like to be evaluated _____

Employee's Attorney

First Name _____ Last Name _____ Firm Number _____

Law Firm Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____ Phone No _____

Claim Number: _____

Employer and Claims Administrator Information

Employer: _____

Claims Administrator Name: _____

Adjustor name: _____

Street Address or P O Box _____

City _____ State _____ Zip Code _____ Phone No _____

Employee's Attorney

First Name _____ Last Name _____ Firm Number _____

Law Firm Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____ Phone No _____

Prior QME Panel Information *(Answer all that apply)*

Has the employee ever received 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 settled 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 available now ☐ Yes ☐ No ☐ Unknown

This completed form must be mailed to:
Division of Workers' Compensation – Medical Unit
P.O Box 71010, Oakland, Ca 94612
(510) 286-3700 or (800) 794-6900

Date _____

Print Name of Requestor _____ Signature _____

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.

For Use with the QME Panel Request Form 106

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 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
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

NON-MD/DO SPECIALTY CODES_

ACA Acupuncture
DCH Chiropractic
DEN Dentistry
OPT Optometry
POD Podiatry
PSY Psychology
PSN Psychology – Clinical Neuropsychology

WELLCOMP™
Managed Care Services

1/25/2011

COPY

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

Re [redacted]
D/Injury: 10/03/2009
Authorization No: 2009095282-

Dear Dr. Workman:

This letter 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 meniscectomy and Post-operative physical therapy x12, 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)

ltrU04/tt

cc: City of Vallejo
James Brunson

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

March 24, 2011

[redacted]

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.

Case Name: [redacted]
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 **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.**

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 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.

Case Name: [redacted]
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.

Case Name: [redacted]
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

E James Greenwald

03/24/2011 21:24:29 GMT
UNITED STATES POSTAL SERVICE. ID:10000yb0tg0
Electronic Postmark Service

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

925 944 0960

WELLCOMP
Managed Care Services

March 28, 2011

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

[redacted]

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 [redacted] 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. [redacted] 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 prompt response.

Sincerely,

Nancy Immer LVN CPUR 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

WELLCOMP™
Managed Care Services

S.O.L.
510-923-1944

3/28/2011

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

[redacted]
Claim No: 2009095282
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.

FAXED
APR 1 2011
BY:

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
[redacted]

WELLCOMP™
Managed Care Services

NOTICE OF AUTHORIZATION Date: 5/2/2011 TOTAL PAGES (inc cover): 2

FAXED TO: 925-944-0960 ATTN: William Workman, MD
FAXED TO: ATTN:

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

RE: [redacted]

Requesting Physician: William Workman, MD
Requesting Provider (if applicable):
Received Date: 04/28/2011
Authorization Date: 04/29/2011
[redacted]

Type of Review: [ ] Expedited/Rush [ ] Concurrent [ ] Retrospective [X] Prospective

Dear Provider:

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 TRX band for home exercise, as per your request.

Please be advised this certification expires on 07/30/2011. 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 immediately at (800) 932-5535. If the treatment is initiated after said date, your billing for services may be subject to retrospective utilization review.

Sincerely,

Laura Keeney

Laura Keeney, Medical Coordinator

ltrU03/ks

cc: City of Vallejo
[redacted]

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

May 3, 2011

Case Name: [redacted]

Employer: [redacted]
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: [redacted]
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 **postoperative physical therapy, three times per week for four weeks is DENIED.**

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

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: [redacted]
Employer:
Claim No:
Date Of Injury: 10/3/2009
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: [redacted]
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

05/03/2011 22:01:07 GMT
UNITED STATES POSTAL SERVICE. ID:10000yb7bpl
Electronic Postmark Service

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

WELLCOMP™
Managed Care Services

5/4/2011

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

Re: [redacted]
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
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 Vallejo
[redacted]

August 9, 2011

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, [redacted] 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,

Tammara Moore, DPT, OCS, Owner (510) 823-7154, cell

Nina Patterson, MPT, OCS, Owner (510) 435-6839, cell

Stephanie Sousa, Patient Care Coordinator (510) 735-7990, cell

Enclosure

WELLCOMP
Managed Care Services

NOTICE OF AUTHORIZATION

[redacted]

Date: May 3, 2012

TOTAL PAGES (inc cover) 1

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

FAXED TO:
ATTN:

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

RE: [redacted]
D/Injury: 10/3/2009

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 explres 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

cc: [redacted]

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

WELLCOMP

NOTICE OF AUTHORIZATION

[redacted]

Date: July 13, 2012

TOTAL PAGES: 1

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

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

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

RE: [redacted]
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: [redacted]
Vallejo, CA 94591

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

StoneRiver Pharmacy Solutions via facsimile

** INBOUND NOTIFICATION : FAX RECEIVED SUCCESSFULLY **

TIME RECEIVED	REMOTE CSID	DURATION	PAGES	STATUS
March 25, 2014 4:45:34 PM EDT	occ med	138	4	Received

2014-03-25 13:18 occ med 7076512955 >> P 1/4

Patient [redacted] MR:01977909 WCAB#: FAC:VAL Contact:(707) 651-1370 Carrier 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.

☒ New Request ☐ Resubmission - Change in Material Facts ☐ Retrospective Review
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request. ☐ Updated Request

Employee Information

Name (Last, First, Middle): [redacted]
Date of Injury (MM/DD/YYYY): 02-15-2014 Date of Birth (MM/DD/YYYY) [redacted]
Claim Number: [redacted] Employer: CITY OF VALLEJO

Requesting Physician Information

Name: TANG, ZILUE
Practice Name: Kaiser Permanente KOJ Contact Name: MARISSA A. BYRNE
Address: 975 Sereno Drive City: Vallejo State: CA
Zip Code: 94589 Phone: (707) 651-1370 Fax Number: (707) 651-2955
Specialty: OCC MED NPI Number: 1205031481
E-mail Address:

Claims Administrator Information

Company Name: YORK INS SVCS Contact Name: SCHAUNNA MCEACHRON
Address: PO BOX 619079 City: ROSEVILLE State: CA
Zip Code: 95661 Phone: (800) 422-7244 Fax Number: [redacted] Box. Cel 8. 1439
E-mail address:

Request for Authorization for Medical Treatment (Attach additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration, Quantity, etc)
SPRAIN OR STRA	843.9	MRI		1 Request MRI L hip

There are 1 request(s) on this form. Note: Above data may be truncated due to insufficient space. See continuation pages.

Requesting Physician Signature: Electronically Signed TANG, ZILUE Date: 03-25-2014

Claims Administrator/Utilization Review Organization Use Only

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)
Authorization Number (If assigned): Date:
Authorized Agent Name: Signature:
Phone: Fax Number: E-mail Address:
Comments:

MRN:01977909 James P Brunson

Patient Name: [redacted]
MRN: 01977909
Gender: Male
Age: 49y 9m
Language: ENGLISH
Contact Phone: (707)558-0432

Requesting Provider: Zhiwe Tang, M.D.
Provider Id: 000067878
Fac/Adm Dept: VAL/OCC
Tie Line/Ext: 8-460-2853
Fax Tie Line:
PCP: Brian D Winter, M.D. - (VAL)MED

Consult Detail

Status: (02) RESPONSE NEEDED
Access Time: 1 days
Date Initiated: 03/18/2014
Response Date:
FAC/SPE: Vallejo/Occupational Medicine
Assigned to for Triage:
Last Modified By: KVAZT1 03/18/2014 9:09 AM
Triage Provider:
Entered By: Zhiwe Tang, M.D. 03/18/2014 9:09 AM

Problem Reason:

Authorization -Work Related Injury

E & M Coding:

None

Referral Workup

1. Facility where referral is generated:
   A: Vallejo
2. Date of Injury (mm/dd/yy):
   A: 02/15/14
3. Type of Consult:
   A:
4. Possible Procedure Needed:
   A: MRI ,
5. Possible Treatment Needed:
   A:
6. Possible Surgery Needed:
   A:
7. This patient is part of a Medical Provider Network (MPN)
   A:
8. Name of provider to whom this patient is being referred:
   A:
9. Reason patient is being referred outside:
   A:
10. Transfer of Care?
   A:
11. For MRI requests the following is required:
   A:
12. Patient History/Comments:
   A: left hip injury. limited progress with PT. evidence of labral tear. request left hip arthrogram study for further evaluation

Response Notes:

Booking Information:

Priority:	Facility:	Dept:	Type:	Provider:
	Vallejo	OCM		

Booking Instructions:

YORK

April 22, 2014

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

RE: [redacted]

WCAB/ADJ#:

Dear Dr. Workman,

You have been designated as the Primary Treating Physician for [redacted]. 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. [redacted] 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

[redacted]
26 Brighton Drive
Vallejo, CA 94591

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 €, (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];

(8) 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 Fom 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

Received 5/22/14 Office visit.

FAX

OURSYSTEM®
Norman Peterson and Associates

526 Washington St, Ste 1 · Ashland OR 97520 · phone 800.497.1368 · fax 541.488.5408

To:	Dr. William Workman	From:	Sharon Rivers
Fax:	9259440960	Pages:	2
Phone:	9259440110	Date:	5/20/14
Re:	[redacted] Vallejo Fire, CVCH-546693	CC:	

x Urgent ☐ For Review ☐ Please Comment X Please 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 Vallejo 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, [redacted]

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. [redacted] 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

WELLCOMP
Managed Care Services

June 4, 2014

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

RE: [redacted]
Authorization No: CVCH-546693-004

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)

cc: [redacted]
Vallejo, CA 94591

City of Vallejo
ATTN: VICKY SCOPESI

WELLCOMP
Managed Care Services

June 4, 2014

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

RE: [redacted]

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 plan, as follows:
Post operative DME rental of CPM machine for seven (7) day rental Cold Therapy Unit for seven (7). Expiration Date: 08/31/2014.

You are also provided the option to discuss this determination with Dr. Gary Taff, MD and or specialty 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/af
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:
Vacaville
Phone: (707)447-8462
Fax: (707)447-8463

"The Next Step"
Physical Repair

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

BRIDGING THE GAP BETWEEN PHYSICAL THERAPY AND FUNCTIONAL INDEPENDENCE

PRESCRIPTION FORM

Patient Name [redacted] Date _____

Injury Rehab Programs

_____Ankle/Foot
_____Knee
_____Hip
_____Back
_____Neck
_____Shoulder
_____Elbow
_____Wrist/Hand

Exercises

_____Strengthening
_____Stretching
_____Aerobic
_____Conditioning
_____Aqua Therapy
_____Lumbar Stabilization

Total Gym X

Other Work Hardening for RTW Requirements

Phase I: _____
Phase II: _____
Phase III: _____

Independent Gym (IEP)_____

Authorization _____

Diagnosis _____

_____

_____

Frequency _____

Duration _____

Remarks _____

_____

Referring Doctor's Signature _____

APPROVED
By James Quintella PA-C at 1:54 pm, Jul 13, 2010

Surgery Information

William B. Workman, MD

Date: 02/26/2010 Patient: [redacted] Age: 45
DOB: [redacted]

Facility: ☑ Premier ☐ JMMC-*Concord* ☐ JMMC-*WC* ☐ Other Facility_____

☑ OUT Patient ☐ AM Admit ☐ 23 Hour Observation

☐ URGENT ☐ Patient requests: _____ ☐ Patient will Call

Procedure: **Left knee arthroscopy and partial lateral menisectomy**

_____ PL #:_____

ANESTHETIC: ☑ General ☐ Femoral Block

☐ OPEN ☑ ARTHROSCOPIC Length of Procedure: 3/4 hr.

Assistant: none PCP Pre-Op:_____ Date/Time: _____

Diagnosis: _____

ICD9: 715.16 - DJD knee 836.1 - Lat. Meniscus tear _____ _____

CPT: _____ 29881 _____ _____

Special Equipment: _____

Misc Equipment: ☐ Mini C-ARM ☐ C-ARM ☐ NO SPIDER

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: _____

☐ CPM Disp by: _____

Surgery Date/Time: 03/31/10 Pre-Op Date/Time: 03/29/10 CONF. No.:_____

☑ Computer ☐ EKG ☐ Sent patient paperwork ■ Post OP PT Faxed: 03/16/10 Faxed Surgery 03/16/10

Post-Operative
Physical Therapy Prescription

WILLIAM B. WORKMAN, M.D.

BW6360387 **A-72343**

Date: 02/26/2010 **Fax #:** 707-747-9477

TO: Benicia Bay

FROM: TERE

Patient Name: [redacted]

Date of Surgery: 03/31/10

Procedure: LEFT KNEE ARTHROSCOPY PARTIAL LATERAL MENISECTOMY.

Please schedule therapy per the prescription below. Surgery is scheduled for the above date. We ask that therapy commence the following office day. Attached is the patient demographic and insurance information. Please contact the patient and, if necessary, the patient's insurance to make the necessary arrangements. Thank you for your excellent care of our patients.

Dx: LMT **ICD-9:** 836.1

3 day(s)/week X 4 week(s) (MD f/u appt. 2 weeks/post-op)

☑ Evaluate and Treat ☐ R ☑ L ☐ Shoulder ☑ Knee ☐ _____

☑ PROM	☑ MODALITIES FOR PAIN & SWELLING
☐ AAROM	☐ RC STRENGTHENING
☐ AROM	☐ SCAPULAR STABILITY
☐ PRE	☐ QUAD/HAMSTRING STRENGTH/FLEXABILITY
☐ HEP	

☐ _____

SIGNED: WB Workman, 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: 03/29/2010

TO WHOM IT MAY CONCERN:

RE: [redacted]

The above patient is:

☐ Released to return to regular work as of _____

☐ Released to return to light duty as of _____ with these restrictions:

_____

_____

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

☑ Unable to return to work for a period of 2months

From: 3/29/10 To: 5/31/10

Due to knee surgery

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

☐ May take physical education as of _____

☐ May NOT take physical education for _____ due to: _____

_____

Signed _____

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

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 Nam [redacted]

Diagnosis(es): s/p knee arthroscopy, partial lateral mnsctmy

☐ RIGHT ● LEFT ☐ BILATERAL

● EVALUATION & TREATMENT

- ● AROM
- ● AAROM
- ● PROM
- ☐ PRE
- ☐ WORK CONDITIONING
- ☐ WORK HARDENING
- ● QUAD STRENGTH
- ● HAMSTRING FLEXIBILITY
- ☐ RTC STRENGTH
- ☐ SCAP STAB STRENGTH

- ● MODALITIES TO REDUCE PAIN AND INFLAMMATION
- ● SOFT TISSUE MOBILIZATION
- ● HOME EXERCISE PROGRAM

Special Instructions:

Frequency: 2 Times / Week Duration: 6 Weeks

Physician's Signature:

William B. Workman, MD - James T. Quintella, PA-C

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: 10/21/2010

Patient Nam [redacted]

☐ **With Contrast**
☑ **Without Contrast**

☑ **Right**
☐ **Left**

☑ Knee	☐ Elbow	☐ C-Spine
☐ Shoulder	☐ Wrist	☐ L-Spine
☐ Hip	☐ Ankle	

☐ Other _____

Diagnosis: medial pain

History: R/O medial meniscus tear

☐ **URGENT**

☐ **ROUTINE**

WBWorkman, MD
William B. Workman, M.D.

Surgery Information

William B. Workman, MD

Date: 01/07/2011 Patien [redacted] Age: 46
DOB [redacted]

Facility: ☑ Premier ☐ JMMC-*Concord* ☐ JMMC-*WC* ☐ Other Facility _____

☑ OUT Patient ☐ AM Admit ☐ 23 Hour Observation

☐ URGENT ☐ Patient requests: _____ ☐ Patient will Call

Procedure: **RIGHT KNEE ARTHROSCOPY PARTIAL MEDIAL & LATERAL MENISECTOMY**

_____ **PL #:** _____

ANESTHETIC: ☑ General ☐ Femoral Block

☐ OPEN ☑ ARTHROSCOPIC Length of Procedure: 1 hr.

Assistant: **NONE** PCP Pre-Op: _____ Date/Time: _____

Diagnosis: _____

ICD9: **836.1 - Lat. Meniscus tear** **836.0 - Med. Meniscus Tear** _____ _____

CPT: **29880** _____ _____ _____

Special Equipment: _____

Misc Equipment: ☐ Mini C-ARM ☐ C-ARM ☐ NO SPIDER

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: _____

☐ CPM Disp by: _____

Surgery Date/Time: **02/18/11** Pre-Op Date/Time: **02/17/11** CONF. No.: _____

☑ Computer ☐ EKG ☐ Sent patient paperwork ■ Post OP PT Faxed: **01/28/11** Faxed Surgery **01/28/11**

WALNUT CREEK
ORTHOPEDICS & SPORTS MEDICINE

Post-Operative
Physical Therapy Prescription

WILLIAM B. WORKMAN, M.D.

BW6360387 A-72343

Date: 01/28/2011 **Fax #:** 510-923-1944

TO: SOL

FROM: TERE

Patient Name: [redacted]

Date of Surgery: 02/18/11

Procedure: RIGHT KNEE ARTHROSCOPY PARTIAL MEDIAL & LATERAL MENISECTOMY

Please schedule therapy per the prescription below. Surgery is scheduled for the above date. We ask that therapy commence the following office day. Attached is the patient demographic and insurance information. Please contact the patient and, if necessary, the patient's insurance to make the necessary arrangements. Thank you for your excellent care of our patients.

Dx: MED/LAT MENISCUS TEARS **ICD-9:** 836.0 & 836.1

_____day(s)/week X _____week(s) (MD f/u appt. _____weeks/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 - SEE ATTACHED.

SIGNED: _____

William B. Workman, 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: 02/24/2011

TO WHOM IT MAY CONCERN:

RE: [redacted] *FAXED TO 707-648-5289

The above patient is:

☐ Released to return to regular work as of _____

☐ Released to return to light duty as of _____ with these restrictions:

_____

_____

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

☑ Unable to return to work for a period of _____

From: 02/18/11 (DAY OF SURGERY) To: 2/28/11(NEXT APPT. DATE)

Due to _____

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

☐ May take physical education as of _____

☐ May NOT take physical education for _____ due to: _____

_____

Signed _____

William B. Workman, MD
101 Ygnacio Valley Road, Suite 400
Walnut Creek, CA 94596
Phone (925) 944-0110 Fax (925) 944-0960

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

Physical Therapy Order Form

Date: 04/28/2011

Patient Name: [redacted]

Diagnosis(es): 836.1 - Lat. Meniscus tear

☐ RIGHT ☐ LEFT ● BILATERAL

● EVALUATION & TREATMENT

- ☐ AROM
- ☐ AAROM
- ☐ PROM
- ☐ PRE
- ☐ WORK CONDITIONING
- ☐ WORK HARDENING
- ☐ QUAD STRENGTH
- ☐ HAMSTRING FLEXIBILITY
- ☐ RTC STRENGTH
- ☐ SCAP STAB STRENGTH

- ☐ MODALITIES TO REDUCE PAIN AND INFLAMMATION
- ☐ SOFT TISSUE MOBILIZATION
- ● HOME EXERCISE PROGRAM

Special Instructions: needs TRX for home program

Frequency: 3 Times / Week Duration: 6 Weeks

Physician's Signature : [signature]

William B. Workman, MD

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

Physical Therapy Order Form

Date: 04/30/2012

Patient Name: [redacted]

Diagnosis(es): 836.1 - Lat. Meniscus tear

❑ RIGHT ❑ LEFT ❑ BILATERAL

● EVALUATION & TREATMENT

- ● AROM
- ● AAROM
- ● PROM
- ● PRE
- ❑ WORK CONDITIONING
- ❑ WORK HARDENING
- ● QUAD STRENGTH
- ● HAMSTRING FLEXIBILITY
- ❑ RTC STRENGTH
- ❑ 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 : WB Workman, MD

William B. Workman, MD

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

Physical Therapy Order Form

Date: 04/30/2012

Patient Name: [redacted]

Diagnosis(es): 836.1 - Lat. Meniscus tear

❑ RIGHT ❑ LEFT ● BILATERAL

● EVALUATION & TREATMENT

- ● AROM
- ● AAROM
- ● PROM
- ● PRE
- ❑ WORK CONDITIONING
- ❑ WORK HARDENING
- ● QUAD STRENGTH
- ● HAMSTRING FLEXIBILITY
- ❑ RTC STRENGTH
- ❑ SCAP STAB STRENGTH

- ● MODALITIES TO REDUCE PAIN AND INFLAMMATION
- ● SOFT TISSUE MOBILIZATION
- ● HOME EXERCISE PROGRAM

Special Instructions: water therapy

Frequency: 3 Times / Week Duration: 6 Weeks

Physician's Signature: William B. Workman, MD

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

Post-Operative Physical Therapy Prescription

WILLIAM B. WORKMAN, M.D.

BW6360387 A-72343

Date: 05/22/2014 Fax #: 707-552-9638

TO: GROVE, ANDERSEN, GHIRINGELLI PT

FROM: TERE

Patient Name: [redacted]

Date of Surgery: 07/09/14

Procedure: LEFT HIP ARTHROSCOPY WITH FEMOROPLASTY, ACETABULOPLASTY AND LABRAL REPAIR

Please schedule therapy per the prescription below. Surgery is scheduled for the above date. We ask that therapy commence the following office day. Attached is the patient demographic and insurance information. Please contact the patient and, if necessary, the patient's insurance to make the necessary arrangements. Thank you for your excellent care of our patients.

Dx: _____ ICD-9: _____

3 day(s)/week X 6 week(s) (MD f/u appt. 2 weeks/post-op)

- [x] Evaluate and Treat
- [ ] R [x] L
- [ ] Shoulder
- [ ] Knee
- [x] hip

- [x] PROM
- [ ] AAROM
- [ ] AROM
- [ ] PRE
- [ ] HEP

- [x] MODALITIES FOR PAIN & SWELLING
- [ ] RC STRENGTHENING
- [ ] SCAPULAR STABILITY
- [ ] QUAD/HAMSTRING STRENGTH/FLEXABILITY

- [ ] _____

SIGNED: WB Workman, MD

William B. Workman, MD

101 Ygnacio Valley Road, Suite 400 - Walnut Creek, CA 94596
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: [redacted] Age: 49
DOB: [redacted]

Facility: ☑ Premier ☐ JMMC-*Concord* ☐ JMMC-*WC* ☐ Other Facility _____

☑ OUT Patient ☐ AM Admit ☐ 23 Hour Observation

☐ URGENT ☐ Patient requests: _____ ☐ Patient will Call

Procedure: **LEFT HIP ARTHROSCOPY WITH FEMOROPLASTY, ACETABULOPLASTY AND LABRAL REPAIR**

PL #: _____

ANESTHETIC: ☑ General ☐ Femoral Block

☐ OPEN ☑ ARTHROSCOPIC Length of Procedure: 3 hr.

Assistant: _____ PCP Pre-Op: _____ Date/Time: _____

Diagnosis: **labral tear, hip pain**

ICD9: **843.9** **719.45** _____ _____

CPT: **29914** **29915** **29916** _____

Special Equipment: _____

Misc Equipment: ☐ Mini C-ARM ☐ C-ARM ☐ NO SPIDER

Post-Op Equipment:

Pain Pump: ☐ 2 Day ☐ 4 Day Disp by: _____

☑ COLD THERAPY Disp by: **NO-RENTAL ONLY**

☐ Cradle Arm Sling Disp by: _____

☑ ROM HIP BRACE Disp by: **PREMIER**

☑ CPM Disp by: **Integrated Health**

Surgery Date/Time: **07/09/14** Pre-Op Date/Time: **07/01/14** CONF. No.: _____

☑ Computer ☑ EKG ☐ Sent patient paperwork ■ Post OP PT Faxed: **06/11/14** Faxed Surgery **06/11/14**

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: [redacted]

Pre-operative Order

- [x] EKG
- [x] BASIC METABOLIC PANEL
- [ ] Other.

Diagnosis: 843.9

Physician's Signature: WB Workman, MD

William B. Workman, MD

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

PHYSICIAN RELEASE FORM

Date: 5/20/14 Claim #: [redacted]

Physician: Dr. William Workman Phone: 9259440110 Fax: 9259440960

Patient Name: [redacted] Employer: Vallejo Fire Dept.

_____ Worker is released to lift, carry, push, pull to 25 – 30 lbs. (please circle):

_____ Worker is released to occasional knee bend tasks (25% of shift)

Return-to-Work Release Date:

✓ Approved with modifications specified below:

desk work

Return-to-Work Release Date:

_____ Disapproved for the following medical reasons:

WB Workman, MD

Attending Physician Date of Signature

APPROVED
By William B. Workman, MD at 11:40 am, May 22, 2014

Estimated date return to full duty:_____

We have read and understand the requirements, including physical capacities, of the temporary Bridge Assignment and all related physician's modifications. We agree to respect the restrictions.

Employer Representative Date

Employee Date

OURSYSTEM®
Norman Peterson and Associates
1.541.488.0162

PLEASE FAX TO : 541.488.5408 - Sharon Rivers

WALNUT CREEK ORTHOPEDICS AND SPORTS MEDICINE

☐ **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

ADDRESS

CITY

DOB GENDER DATE

THIS DOCUMENT CONTAINS VOID PANTOGRAPH MICROPRINTED SIGN LINE REVERSE RX SECURITY ... LERNIT ... DERMO ... SIGNATURE NUMBERING PRINTED ON SAFETY PAPER

℞ 1 ☐ 1-24 ☐ 25-49 ☐ 50-74 ☐ 75-100 ☐ 101 150 ☐ 150 +
☐ Do Not Substitute Refill 0 - 1 - 2 - 3 - 4 - PRN Units

℞ 2 ☐ 1-24 ☐ 25-49 ☐ 50-74 ☐ 75-100 ☐ 101-150 ☐ 150 +
☐ Do Not Substitute Refill 0 - 1 - 2 - 3 - 4 - PRN Units

℞ 3 ☐ 1-24 ☐ 25-49 ☐ 50-74 ☐ 75 100 ☐ 101 150 ☐ 150 +
☐ Do Not Substitute Refill 0 - 1 2 - 3 4 PRN Units

Prescription is void if the number of drugs prescribed is not noted. Void after

☐ Spanish SP01

090316208717 #000449 Signature

WALNUT CREEK ORTHOPEDICS AND SPORTS MEDICINE
☐ **William B. Workman, M.D.** Lic. # A72343 DEA # BW6360387
☐ **James T. Quintelis, P.A.-C.** Lic # PA14994 DEA # MQ0542426
301 Lennon Lane, Suite 100 Walnut Creek, CA 94598
(925) 944-0110 Fax (925) 944-0960

[redacted]

ADDRESS 26 Brighton Dr

CITY Vallejo STATE CA ZIP 94591

DOB 4/12/64 GENDER M DATE 2/17/11

THIS DOCUMENT CONTAINS VOID PANTOGRAPH, MICROPRINTED SIGN LINE, REVERSE RX, SECURITY ... THERMOCHROMIC INK FEATURE, NUMBERING, PRINTED ON SAFETY PAPER

℞ 1 Vicodin #30 1 po q 4hr prn pain
☐ 1-24 ☑ 25-49 ☐ 50-74 ☐ 75-100 ☐ 101-150 ☐ 150 + Units
☐ Do Not Substitute Refill 0 - 1 - 2 - 3 - 4 - PRN

℞ 2 Vistaril 25mg #30 1 po q 4h take c Vicodin
☐ 1-24 ☑ 25-49 ☐ 50-74 ☐ 75-100 ☐ 101-150 ☐ 150 + Units
☐ Do Not Substitute Refill 0 - 1 - 2 - 3 - 4 - PRN

℞ 3
☐ 1-24 ☐ 25-49 ☐ 50-74 ☐ 75-100 ☐ 101-150 ☐ 150 + Units
☐ Do Not Substitute Refill 0 - 1 - 2 - 3 - 4 - PRN

Prescription is void if the number of drugs prescribed is not noted. 2

Void after

☐ Spanish SP01

Signature

00316208717 #000742

WALNUT CREEK
ORTHOPEDICS
&
SPORTS MEDICINE

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

NAME: [redacted] **DATE:** 02/28/2011

Rx Indocin 25mg
#30
Tpo TID x 10 days

SIGNED: _____

May Refill 0 **Times**

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

WALNUT CREEK
ORTHOPEDICS
& SPORTS MEDICINE

William B. Workman, M.D.

BW6360387 A-72343

NAME: [redacted] **DATE:** 05/16/2011

℞

TRX BAND

DX: 836.0

SIGNED: ✖ W B Workman, 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

WALNUT CREEK
ORTHOPEDICS
& SPORTS MEDICINE

WILLIAM B. WORKMAN, M.D.

BW6360387 **A-72343**

NAME: [redacted] **DATE:** 07/10/2012

℞ Voltaren 75mg

Disp: #30 [thirty]

sig: i po qD prn

SIGNED: WB Workman, MD

May Refill ____ Times

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

WALNUT CREEK
ORTHOPEDICS
&
SPORTS MEDICINE

WILLIAM B. WORKMAN, M.D.

BW6360387 **A-72343**

NAME: [redacted] **DATE:** 10/30/2012

℞ Voltaren 75mg

Disp: #30 [thirty]

sig: i po qD prn

SIGNED: _____

May Refill 3 **Times**

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

WALNUT CREEK
ORTHOPEDICS
& SPORTS MEDICINE

William B. Workman, MD
BW6360387 A-72343

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

Patient Name: [redacted] Date: 12/19/2012

℞

ONE YEAR GYM MEMBERSHIP FOR WATER THERAPY

3-4 TIMES A WEEK.

PER PATIENT ADJ. STATES SHE WILL AUTH THIS.

Signed: ✖ WB Workman, MD

May Refill_____Times

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

CVS/pharmacy

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 Authorized as of _____ Denied _____

PRESCRIBER INFORMATION:

Name: WILLIAM WORKMAN

Address: 101 YGNACIO VALLEY ROAD SUITE 40010
WALNUT CREEK, CA 94596

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

PHARMACY INFORMATION:

From: **CVS/pharmacy**
Store Number: 9761
Address: 2100 COLUMBUS PKWY
BENICIA, CA 94510

Phone: 707-747-3453
Fax: 707-747-6022

PATIENT INFORMATION:

Name: [redacted]
DOB: [redacted]
Address: [redacted]
Phone: [redacted]

THIRD PARTY INFORMATION:

Name: WORKER'S COMPENSATION
Cardholder ID: 544806211
Group Number:
Person Code:
Relationship: 1
TP Help Desk Phone: 866-200-8393

NEW PRESCRIPTION:

Medication:

Quantity:
Refills:
SIG:

ORIGINAL PRESCRIPTION:

Rx #: 234073
Drug: DICLOFENAC SOD EC 75 MG TAB

Qty. Prescribed: 30.0 EA
Prescribed Refills: 3 OK
Date Written: 10-30-2012
SIG: TAKE 1 TABLET BY MOUTH EVERY DAY

Pharmacy Comments:

Prescriber Comments: OK

JAN 11 2013

Prescriber's Name (Printed): _____ Prescriber's DEA # _____

Transmitted By: _____ (KS/TX ONLY) DPS # / Oral Code _____
(TX/HI ONLY)

Prescriber's Signature: _____ Date: _____

Massachusetts Only: Interchange is mandated unless Practitioner writes the words "No Substitution"

FOR CVS USE ONLY: PRX1 **2900000000545116590**

CVS/pharmacy

REQUEST FOR A REFILL OR NEW PRESCRIPTION

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

PRESCRIBER:

Name:	WILLIAM WORKMAN	From:	**CVS/pharmacy**
		Store #	9761
Address:	101 YGNACIO VALLEY ROAD SUITE 4 WALNUT CREEK, CA 94596	Address:	2100 COLUMBUS PKWY 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:

PRESCRIBER ACTION REQUIRED:

☐ Authorized this time plus _____ additional refills

☐ Not Authorized

Prescriber Comments:

Prescriber's Name (Printed): _____ Prescriber's DEA # _____

Transmitted by: WB Workman, MD (KS/TX ONLY)

Prescriber's Signature: _____ DPS # / Oral Code _____ (TX/HI ONLY)

Date: _____

Massachusetts Only: Interchange is mandated unless Practitioner writes "No Substitution"

APPROVED
By William B. Workman, MD at 12:20 pm, Dec 27, 2013

FOR CVS USE ONLY: SRX1 29000000000859700925

CVS/pharmacy

REQUEST FOR A REFILL OR NEW PRESCRIPTION

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

PRESCRIBER:

Name:	WILLIAM WORKMAN	From:	**CVS/pharmacy**
		Store #	9761
Address:	101 YGNACIO VALLEY ROAD SUITE 4 WALNUT CREEK, CA 94596	Address:	2100 COLUMBUS PKWY 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: [redacted]
DOB:
Address:
Phone:

FOR ORIGINAL PRESCRIPTION:

CVS Rx#	281690
Medication:	DICLOFENAC SOD DR 75 MG TAB
Qty. Prescribed:	30.0 EA Thirty
Prescribed Refills:	2
Date Written:	12-27-2013
SIG:	TAKE 1 TABLET BY MOUTH EVERY DAY AS NEEDED

Date Last Filled: 02-25-2014

Pharmacy Comments:

PRESCRIBER ACTION REQUIRED:

☑ Authorized this time plus 3 additional refills

☐ Not Authorized

FAXED
APR 01 2014
BY:

Prescriber Comments:

Prescriber's Name (Printed): WORKMAN
Prescriber's DEA #
Transmitted by: (KS/TX ONLY)
DPS # / Oral Code (TX/HI ONLY)
Prescriber's Signature:
Date: 4/1/14

Massachusetts Only: Interchange is mandated unless Practitioner writes the words "No Substitution"

FOR CVS USE ONLY: SRX1 2900000000958411740

REQUEST FOR A REFILL OR NEW PRESCRIPTION

WALNUT CREEK
ORTHOPEDICS
SPORTS MEDICINE

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: [redacted]

Signed X: _____

Date: _____

[redacted]
Patient's Name

C. PERMISSION 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 of Walnut Creek Orthopedics & Sports Medicine.

PARENT/GUARDIAN NAME/SIGNATURE **DATE**

RELATIONSHIP TO MINOR

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 SIGNATURE **DATE**

PARENT/GUARDIAN NAME/SIGNATURE **DATE**

E. PERMISSION TO LEAVE VERBAL DIAGNOSTIC STUDY RESULTS:

I give permission to have Walnut Creek Orthopedics & Sports Medicine leave MRI or diagnostic results on my voicemail at the phone numbers I have listed in the event that I cannot be reached.

x _____ 2/25/2010

PATIENT SIGNATURE **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.

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 *you* and *not* the insurance company.

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WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE
FINANCIAL POLICIES
(updated February 2009)

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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.

[redacted]
Patient Name (Please print)

Parent/Guardian Name, if applicable (Please print) | **Relationship to Patient**

X _____ | 2/25/2010

Patient or Guardian Signature | **Date**

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE
PATIENT CONSENT FORM

[redacted]

Patient's Name

A. **PERMISSION TO GIVE MY HEALTH RELATED INFORMATION TO SPOUSE/SIBLING/CHILD/FRIEND/ETC**:

I, [redacted] hereby authorize Walnut Creek Orthopedics & S[redacted]kman, M.D. to disclose the following protected health/billing information to :

[redacted]

_____ (name/relationship) contact # _____

X _____ 2/25/2010

PATIENT SIGNATURE **DATE**

_____ _____

PARENT/GUARDIAN NAME/SIGNATURE **DATE**

B. **PARTY RESPONSIBLE FOR PAYMENT***:

Assignment and Release: I hereby assign my insurance benefits to be paid directly to Walnut Creek Orthopedics & Sports Medicine and/or William B. Workman, M.D. 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.

X _____ 2/25/2010

PATIENT SIGNATURE **DATE**

_____ _____

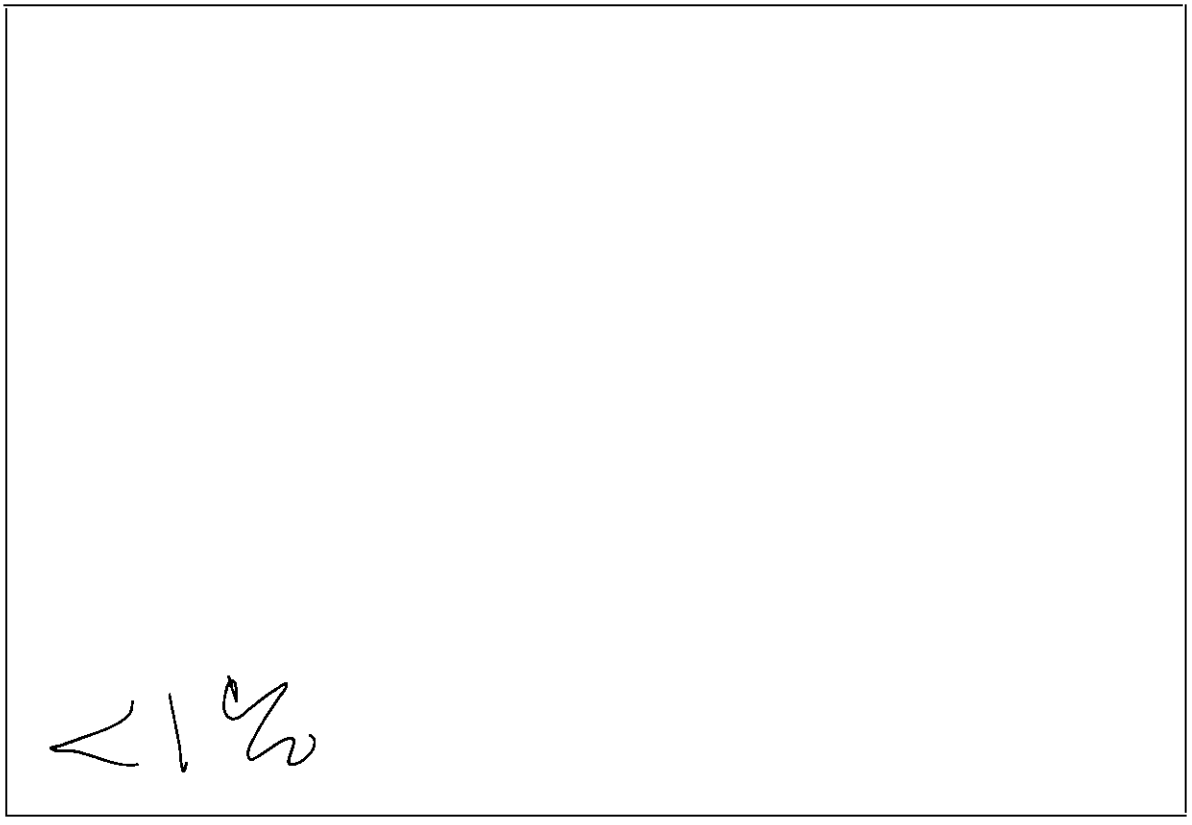
PARENT/GUARDIAN NAME/SIGNATURE **DATE**

***Statements will be sent to patient or Parent/Guardian unless otherwise specified here:**

_____

_____

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 [redacted]

Signed X

Date 3/29/17

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: [redacted]
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 KNEE	11/29/2010 09:45 AM

Notes Sent to the Provider:

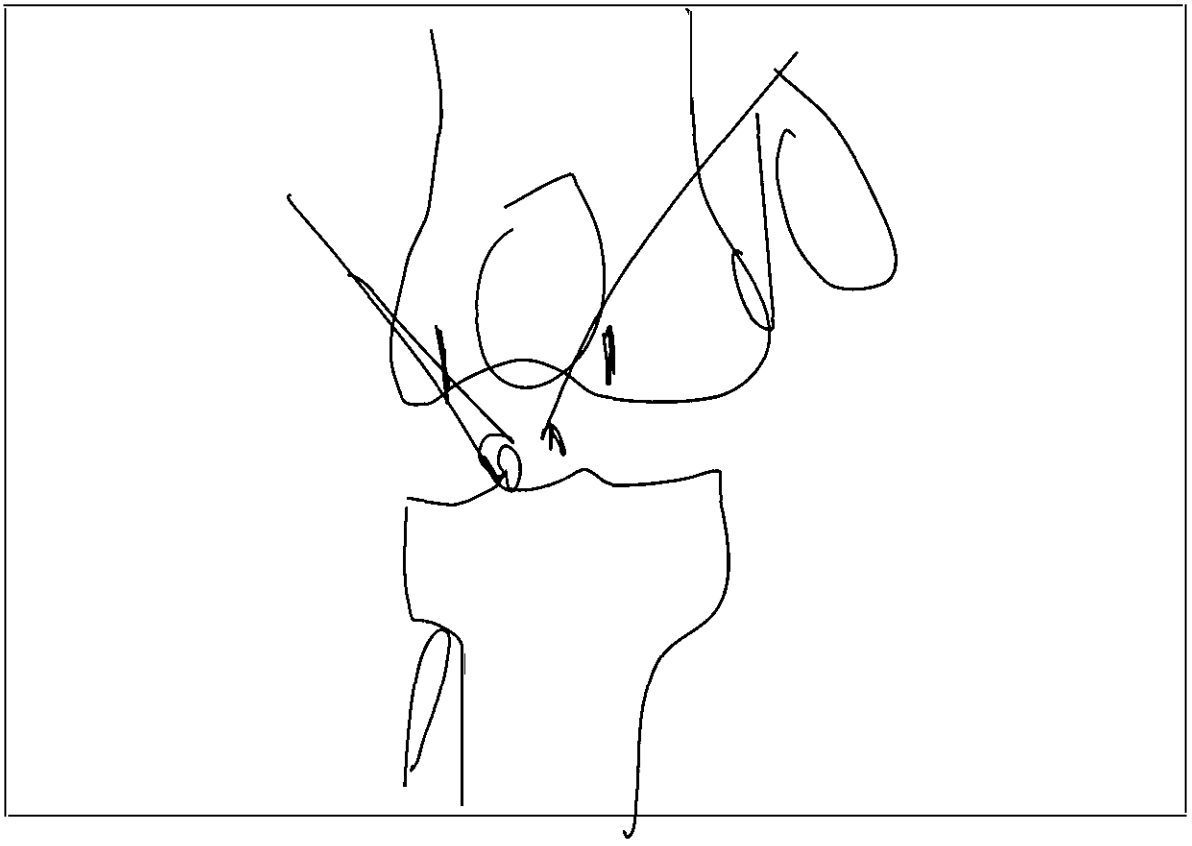
If you have any questions, please contact us at referrals@onecallmedical.com or call us at 800-872-2875, 8AM - 8PM EST.
One Call Medical, Inc. - The Connection to Quality http://www.onecallmedical.com

Sincerely,

ROSINAH
MFARINYA

OCM Service Consultant

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 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 [redacted]

Signed X

Date 2/17/11

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE
PATIENT CONSENT FORM

[redacted]
Patient's Name

A. **PERMISSION TO GIVE MY HEALTH RELATED INFORMATION TO SPOUSE/SIBLING/CHILD/FRIEND/ETC:**

I, [redacted] hereby authorize Walnut Creek Orthopedics & Sports Medicine and/or William B. Workman, M.D. to disclose the following protected health/billing information to :

_____ (name/relationship) contact # _____

_____ (name/relationship) contact # _____

_____ 6/11/12
PATIENT SIGNATURE **DATE**

_____ _____
PARENT/GUARDIAN NAME/SIGNATURE **DATE**

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_____ _____
PATIENT SIGNATURE **DATE**

_____ _____
PARENT/GUARDIAN NAME/SIGNATURE **DATE**

***Statements will be sent to patient or Parent/Guardian unless otherwise specified here:**

_____

_____

[redacted]
Patient's Name

C. **PERMISSION 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 of Walnut Creek Orthopedics & Sports Medicine.

PARENT/GUARDIAN NAME/SIGNATURE _____ DATE _____

RELATIONSHIP TO MINOR _____

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 SIGNATURE _____ DATE 6/11/12

PARENT/GUARDIAN NAME/SIGNATURE _____ DATE _____

E. **PERMISSION TO LEAVE VERBAL DIAGNOSTIC STUDY RESULTS:**

I give permission to have Walnut Creek Orthopedics & Sports Medicine leave MRI or diagnostic results on my voicemail at the phone numbers I have listed in the event that I cannot be reached.

PATIENT SIGNATURE _____ DATE 6/11/12

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.

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.

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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.

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[redacted]

Parent/Guardian Name, if applicable (Please print)

Relationship to Patient

Patient or Guardian Signature

6/11/12

Date

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE
PATIENT CONSENT FORM

[redacted]

Patient's Name

A. **PERMISSION TO GIVE MY HEALTH RELATED INFORMATION TO SPOUSE/SIBLING/CHILD/FRIEND/ETC:**

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_____ _____
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_____

_____

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N/A _____
PATIENT/GUARDIAN SIGNATURE **DATE**

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[redacted] 5/22/14
PATIENT/GUARDIAN SIGNATURE **DATE**

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WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE
FINANCIAL POLICIES

(updated October 2012)

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[redacted]

Parent/Guardian Name, if applicable (Please print) | **Relationship to Patient**

Patient or Guardian Signature | **Date** 5/22/14

Premier Surgery Center

Name: [redacted]
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

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:ij

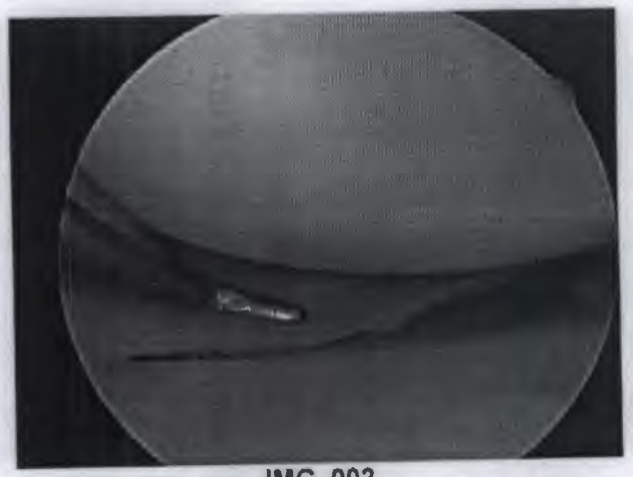
Premier Surgery Center
2222 East St.
Suite 200
Concord, CA 94520

smith&nephew

Patient: [redacted]
MRN: 033110e
[redacted]
Sex: M

Surgeon: William Workman, MD
Procedure: left knee scope w partial lateral menisectomy
Procedure Date: 3/31/2010
Procedure ID: 03302010155014


IMG_001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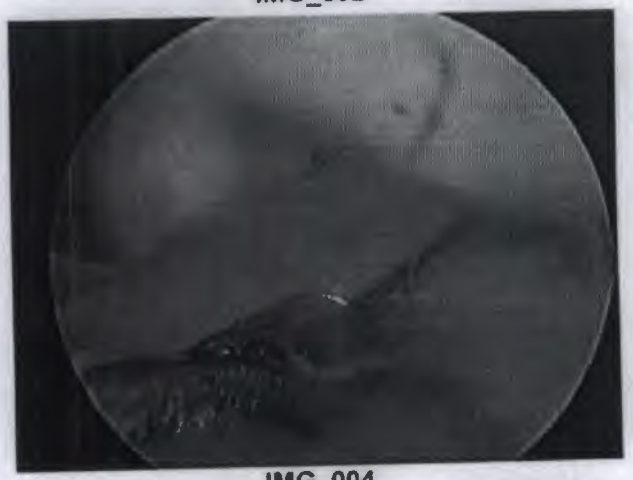
IMG_003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IMG_005


IMG_006

Premier Surgery Center

Name: [redacted]
MR#:
Date of Procedure: 2/18/11
Physician: William Workman, M.D.

Operative Report

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:
Pain in the knee.

Premier Surgery Center

Name: [redacted]
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.

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The patient was then extubated and delivered to the Recovery Room in stable condition.

_____
William Workman, M.D.

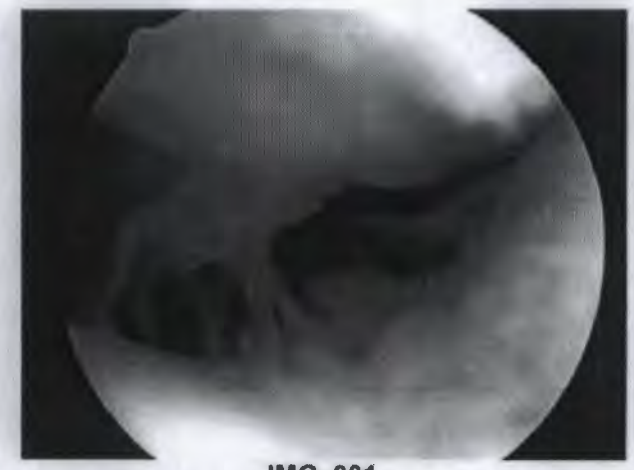
Job # 1339787
D: 2/18/11
T: 2/24/2011
WW:jj

Premier Surgery Center
2222 East St.
Suite 200
Concord, CA 94520

smith&nephew

P[redacted]
M
D
Sex: M

Surgeon: William Workman, MD
Procedure: rt knee scope w medial and lateral menisectomy
Procedure Date: 2/18/2011
Procedure ID: 02182011065607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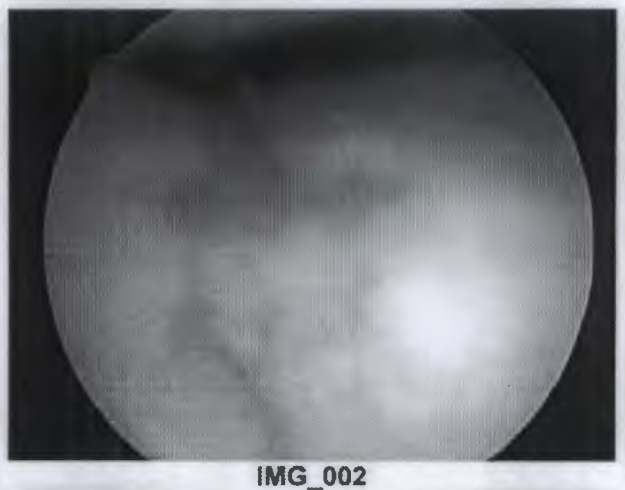
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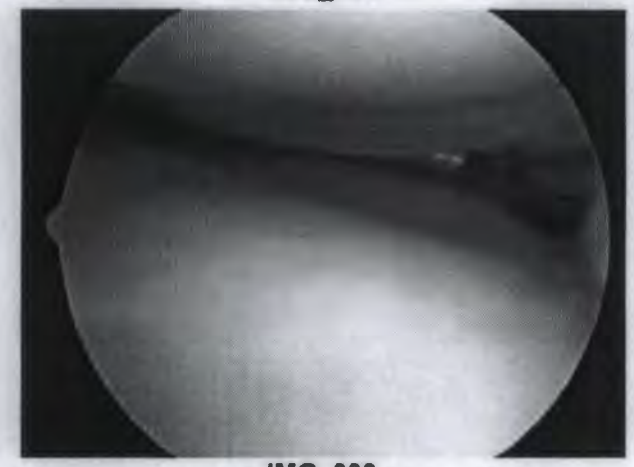
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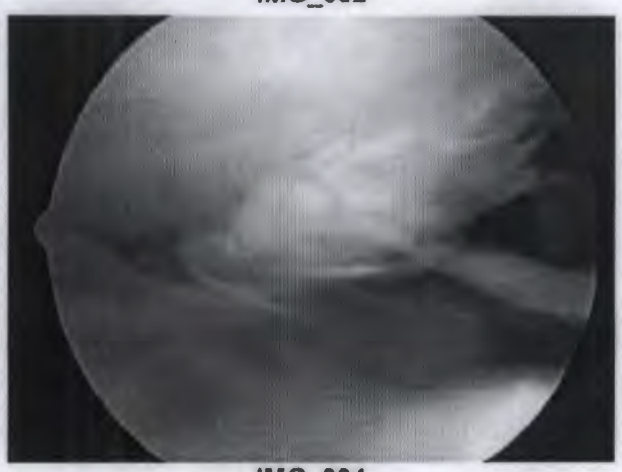
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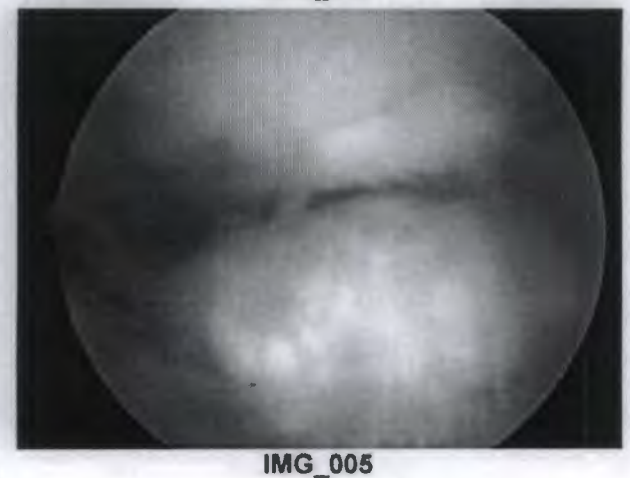
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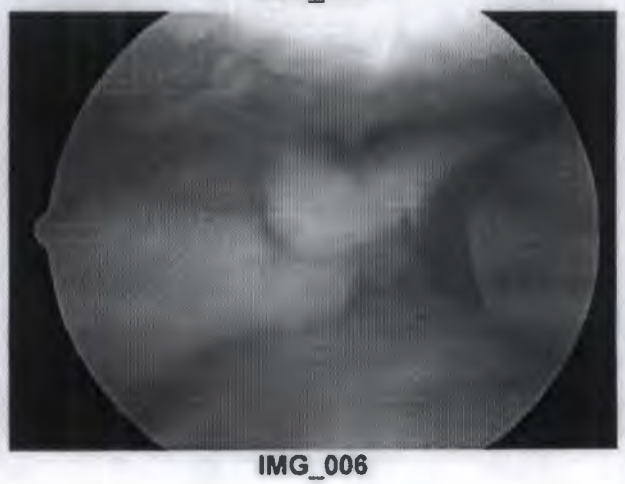
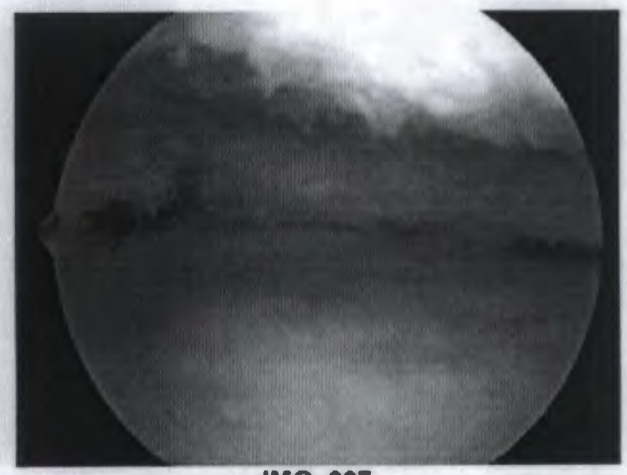

IMG_006

Premier Surgery Center
2222 East St.
Suite 200
Concord, CA 94520

smith&nephew

P[redacted]
M
D
Sex: M

Surgeon: William Workman, MD
Procedure: rt knee scope w medial and lateral menisectomy
Procedure Date: 2/18/2011
Procedure ID: 02182011065607



IMG_007

VALLEJO OPEN MRI

155 GLEN COVE MARINA ROAD, SUITE 101
VALLEJO, CA 94591
Telephone (707) 644-1292 / Fax (707) 644-1362

[redacted] Sex: M

JEFFREY GAO, MD
971 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 injury. 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 tendons 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 anteroinferior aspect of the lateral femoral condyle and the superior aspect of the lateral tibial plateau.

IMPRESSION:

1. Abnormal lateral meniscus. Findings may correspond to extensive lateral meniscal tear involving the posterior and anterior horns. Clinically correlate to exclude previous partial meniscectomy.

2. Mild sprain, medial collateral ligament.

VALLEJO OPEN MRI

155 GLEN COVE MARINA ROAD, SUITE 101
VALLEJO, CA 94591
Telephone (707) 644-1292 / Fax (707) 644-1362

[redacted] ex: M

JEFFREY GAO, MD
975 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

3. 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.

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 Alameda, this 15th day of January 2010.

End of diagnostic report for accession: 17275356

Dictated: 01/18/2010 4:42PM

Dictated By: Foster, Jr, MD
Transcribed By: GG 01/19/2010 2:54AM
Signed By: Roy Foster, MD 01/19/2010 10:09AM
cc: PDM NETWORK

VALLEJO OPEN MRI

155 GLEN COVE MARINA ROAD, SUITE 101
VALLEJO, CA 94591
Telephone (707) 644-1292 / Fax (707) 644-1362

[redacted] 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

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 horn-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.

VALLEJO OPEN MRI

155 GLEN COVE MARINA ROAD, SUITE 101
VALLEJO, CA 94591
Telephone (707) 644-1292 / Fax (707) 644-1362

[redacted] 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 horn-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

NorCal Imaging
A RadNet Imaging Center

NorCal Imaging Walnut Creek
114 La Casa Via
Walnut Creek, CA 94598
Phone: (925) 937-6100
Fax: (925) 938-9940

[redacted]

Copy to:
ADIN Healthcare Inc.
761 Old Hickory Blvd Suite 300
Brentwood TN 37027

FAX: (614) 717-6500

Date of Service: 04-17-2014
Exam: MR Arthrogram Hip [MR701] - Hip - L

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 femoroacetabular impingement. These fibrocystic changes are in the lateral femoral head and neck junction. There is mild sclerosis 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.

NorCal Imaging
A RadNet Imaging Center

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.
3. 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
Dictated 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

TOTAL P.01

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: [redacted]

Diagnosis(es): s/p knee arthroscopy, partial lateral mnsctmy

☐ RIGHT ● LEFT ☐ BILATERAL

● EVALUATION & TREATMENT

● AROM	☐ WORK HARDENING
● AAROM	● 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:

Frequency: 2 Times / Week Duration: 6 Weeks

Physician's Signature: [signature]

William B. Workman, MD - James T. Quintella, PA-C

TOTAL P.01

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: [redacted]

Diagnosis(es): s/p knee arthroscopy, partial lateral mnsctmy

☐ RIGHT ● LEFT ☐ BILATERAL

● EVALUATION & TREATMENT

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● MODALITIES TO REDUCE PAIN AND INFLAMMATION
● SOFT TISSUE MOBILIZATION
● HOME EXERCISE PROGRAM

Special Instructions:

Frequency: 2 Times / Week Duration: 6 Weeks

Physician's Signature: [signature]

William B. Workman, MD - James T. Quintella, PA-C

TOTAL P.01

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: [redacted]

Diagnosis(es): s/p knee arthroscopy, partial lateral mnsctmy

☐ RIGHT ● LEFT ☐ BILATERAL

● EVALUATION & TREATMENT

● AROM	☐ WORK HARDENING
● AAROM	● 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:

Frequency: 2 Times / Week Duration: 6 Weeks

Physician's Signature: [signature]

William B. Workman, MD - James T. Quintella, PA-C

KAISER PERMANENTE Did employee notify employer of this injury? Y Inquiry relar to: MR 01977909

KAISER PERMANENTE Claim#: DOI:02-15-2014 Visit:02-15-2014 21:43 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 illness, send two copies of this report to the employer's Workers' Compensation insurance carrier or the self-insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of this report to Division of Labor Statistics and Research, P.O.Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1.	**INSURER NAME AND ADDRESS** YORK INS SVCS PO BOX 619079 ROSEVILLE,CA 95661							Please do not use this column
2.	**EMPLOYER NAME** CITY OF VALLEJO							Case No.
3.	Address No. and Street 555 SANTA CLARA ST	City VALLEJO		CA	Zip 945800000			Industry
4.	Nature of Business (e.g. food manufacturing, building construction, retailer of women's clothes)				(707) 648-4355			County
5.	**PATIENT NAME** (First Name, Middle Initial, Last Name) [redacted]				6. Sex M	7. Date of Birth [redacted] Yr. Mo. Day		Age
8.	Address No. and Street [redacted]	City VALLEJO			Zip [redacted]	9. Telephone Number [redacted]		Hazard
10.	Occupation (Specific Job Title) FIREFIGHTER ENGINEER					11. [redacted]		Disease
12.	Injured at: No. and Street STRUCTURE FIRE				County SOLANO			Hospitalization
13.	Date and hour of injury or onset of illness	Yr. Mo. Day 02-15-2014	Hour 09:15	PM	14. Date last worked	Yr. Mo. Day 02-15-2014		Occupation
15.	Date and hour of first examination or treatment	Yr. Mo. Day 02-15-2014	Hour 09:43	PM	16. Have you (or your office) previously treated patient?			Return

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code

17. Describe how the accident or exposure happened. (Give specific object, machinery or chemical. Use reverse side if more space is required)
PT STATES: WHILE FIGHTING FIRE MY LEFT LEG FELL THROUGH A HOLE IN A BEDROOM FLOOR; STRAINING MY LEFT HIP FLEXOR.

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 fell

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 | Ht 1.753 m (5' 9.02") | Wt 96.255 kg (210 lb) | BMI 31 kg/m2 | 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 843.9
Secondary ICD9 Code

21. Are your findings and diagnosis consistent with the patient's account of injury or onset of illness?
If 'No' please explain:

22. Is there any other current condition that will impede or delay 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 cc to occ med to f/up LEFT GROIN MUSCLE

24. If further treatment required, specify treatment plan, estimated duration.
Z TANG MD. OCC HEALTH 02/18/14

25. If hospitalized as inpatient, give hospital name and location. Date Admitted: Yr.Mo.Day Estimated stay

26. Work Status - Is patient able to perform usual work? Y If 'No', date when patient can return to: Regular work: 02-18-2014
Restrictions: SEE #23. Modified work:

REVIEWED BY:

Doctor's Signature:
Doctor's Name and Degree: SPERANDIO, JENNIFER, MD TREATING MD
Address: 975 Sereno Drive, Vallejo, CA 94589
CA License Number: C504480
IRS Number: 94-2728480
Telephone Number: (707) 651-1370

FORM 5021 (REV.4.5) 1992-06 Any person who makes or causes to be made any knowingly false or fraudulent material statement or material
90362 (Rev.2-93) representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony. v2.5

RECEIVED
MAR 06 2014 A
OSC West

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

17. History continued:

18. Complaints 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 Gastrointestinal: no N/V

19. Findings continued:
A. tachypnea Skin - warm, dry, no rashes Normal gait Perrla, eomi, 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

B.

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

KAISER PERMANENTE Did employee notify employer of this injury? Y Inquiry refer to: MR 01977909

KAISER PERMANENTE Claim#: DOI:02-15-2014 Visit:02-18-2014 15:56 ReportDate:02-19-2014 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, send two copies of this report to the employer's Workers' Compensation insurance carrier or the self-insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of this report to Division of Labor Statistics and Research, P.O.Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1.	INSURER NAME AND ADDRESS YORK INS SVCS PO BOX 619079 ROSEVILLE,CA 95661						Please do not use this column
2.	EMPLOYER NAME CITY OF VALLEJO						Case No.
3.	Address No. and Street 555 SANTA CLARA ST	City VALLEJO		Zip 945900000			Industry
4.	Nature of Business (e.g. food manufacturing, building construction, retailer of women's clothes)			(707) 648-4355			County
5.	PATIENT NAME (First Name, Middle Initial, Last Name) [redacted]			6. Sex M	7. Date of Birth	Yr. Mo. Day [redacted]	Age
8.	Address No. and Street [redacted]	City VALLEJO		Zip 945918322	9. Telephone Number	[redacted]	Hazard
10.	Occupation (Specific Job Title) firefighter				11.	[redacted]	Disease
12.	Injured at: No. and Street STRUCTURE FIRE			County SOLANO			Hospitalization
13.	Date and hour of injury or onset of illness	Yr. Mo. Day 02-15-2014	Hour 09:15 PM	14. Date last worked	Yr. Mo. Day 02-15-2014		Occupation
15.	Date and hour of first examination or treatment	Yr. Mo. Day 02-18-2014	Hour 03:56 PM	16. Have you (or your office) previously treated patient?			Return

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code

17. Describe how the accident or exposure happened. (Give specific object, machinery or chemical. Use reverse side if more space is required)
PT STATES: WHILE FIGHTING FIRE MY LEFT LEG FELL THROUGH A HOLE IN A BEDROOM FLOOR; STRAINING MY LEFT HIP FLEXOR.

18. Subjective Complaints (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 pain

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% Gait: 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 illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? N
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' please explain:

22. Is there any other current condition that will impede or delay patient's recovery? n
If 'Yes' please explain:

23. TREATMENT RENDERED (Use reverse side if more space is required.)
SPRAIN OR STRAIN OF HIP OR THIGH Note: kit, acute Continue icing 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 required, specify treatment plan, estimated duration.
Z TANG MD. OCC HEALTH. 03/04/14

25. If hospitalized as inpatient, give hospital name and location. Date Admitted: Yr.Mo.Day Estimated stay

26. Work Status - Is patient able to perform usual work? N If 'No', date when patient can return to: Regular work:
Restrictions: SEE #23. Modified work: 02-18-2014

Doctor's Signature:
Doctor's Name and Degree: TANG, ZILUE, MD TREATING MD
Address: 975 Sereno Drive, Vallejo, CA 94589
CA License Number: 100762A
IRS Number: 94-2726460
Telephone Number: (707) 651-1370

FORM 5021 (REV.4.5) 1992-05 Any person who makes or causes to be made any knowingly false or fraudulent material statement or material
90362 (Rev.2-93) representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony. v2.5

KAISER PERMANENTE Claim#: DOI:02-15-2014 Visit:02-18-2014 16:56 ReportDate:02-19-2014 Final:Y
[redacted] P MR#:01077909 WCAB#: FAC:VAL Contact:(707) 651-1370 Carrier DOI (if available):

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

Continuation

17. History continued:

18. Complaints continued:
when he flexes his thigh up at the crease in his groin. Chief Complaint: LEG PROBLEM. [redacted] 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/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 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 surgery Relevant Family History: No relevant family history Hobbies/Leisure Activities: Patient denies any relevant recreational/leisure 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

B.

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 event/exposure.

KAISER PERMANENTE Claim#:CVCH-546693 DOI:02-15-2014 Visit:03-04-2014 08:37 ReportDate:03-05-2014 Final:N
Patient [redacted] 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 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

[redacted]

11. ☐	Patient will be permanently precluded from engaging in his/her usual and customary occupation	**If any of these boxes are checked you must use Form PR-3 or narrative report.**
12. ☐	Patient's condition is permanent and stationary with residual disability on:	
13. ☐	Patient will require future medical care	

14. Claims Administrator YORK INS SVCS PO BOX 619079 ROSEVILLE CA 95661	Patient: [redacted]	16. SSN. [redacted] 17. Name 18. Address 19. City V CA Zip 945918322 20. DOI 0 64 22. Sex M 23. Phone (24. Fax 25. Occupat
26. Phone (800) 422-7244 27. Fax (866) 548-2637	28. Claim C CAB	

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:**

[redacted] 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
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 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 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
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:

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

35. **Diagnoses**

1st — ICD-9 843.9
SPRAIN OR STRAIN OF HIP OR THIGH (L)

2nd — 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 ?**

39. Other Physician/Non-Physician Providers:

40. Drugs:

41. Physical Medical Service: 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 full duty on . with no limitations or restrictions.**
48. [X] **Return to modified work on 03-04-2014 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 are deemed permanent.**

State of California Division of Workers' Compensation

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

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 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 KOJ Occupational Health

Executed at _____ Signature Date MAR 05 2014

54. Name TANG, ZILUE MD 55. California Lic# 100782A

56. Address 975 Sereno Drive, Vallejo, CA, 94589 57. Phone (707) 651-1370 Vallejo Facility

v2.9

KAISER PERMANENTE Claim#:CVCH-546693 DOI:02-15-2014 Visit:03-18-2014 08:53 ReportDate:03-19-2014 Final:N
Patien[redacted]N, [redacted] 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

[redacted]

11. ☐ Patient will be permanently precluded from engaging in his/her usual and customary occupation
12. ☐ Patient's condition is permanent and stationary with residual disability on:
13. ☐ Patient will require future medical care

If any of these boxes are checked you must use Form PR-3 or narrative report

14. Claims Administrator	Patient: 15. [redacted]
YORK INS SVCS	17. Name [redacted]
	18. Address [redacted]
PO BOX 619079	19. City [redacted] te CA Zip 945918322
ROSEVILLE	20. DOI [redacted]-1964 22. Sex M
CA 95661	23. Phone [redacted] 24. Fax
	25. Occupat [redacted]
26. Phone (800) 422-7244 27. Fax (866) 548-2637	28. Claim C [redacted] 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:**

[redacted] 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.

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APR 01 2014
OSC West

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 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 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:

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

35. **Diagnoses**

1st — ICD-9 843.9
SPRAIN OR STRAIN OF HIP OR THIGH (L)

2nd — 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, r/o labrum tear
Plan: MRA

I have reviewed the Physical Therapy progress notes. The patient has shown functional gains from therapy, specifically improved range of motion, improvement in activities of daily living and reduction in work restrictions. I am requesting authorization for an additional 4 visits of physical therapy over 3 weeks.
Work Status: Modified duty advanced 3/19/2014 through 4/1/2014 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: 4/1/2014 1:50 PM

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 45. Hospitalization/ Surgery
46. Consult/Other Services:

Work Status: This patient has been instructed to:

47. [ ] **Return to full duty on** **with no limitations or restrictions.**
48. [X] **Return to modified work on** 03-18-2014 **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 are deemed permanent.**

State of California Division of Workers' Compensation

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

Primary Treating Physician: (original signature, do not stamp) 52. Date of exam 03-18-2014

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 KOJ Occupational Health

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 Facility

v2.9

Patient [redacted] N, [redacted] P MR:01977909 WCAB#: PAC:VAL Contact:(707) 651-1370 Carrier 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.

☒ New Request ☐ Resubmission - Change in Material Facts ☐ Retrospective Review
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request. ☐ Updated Request

Employee Information

Name (Last, First, Middle): [redacted]
Date of Injury (MM/DD/YYYY): 02-15-2014 Date of Birth (MM/DD/YYYY): [redacted]
Claim Number: [redacted] Employer: CITY OF VALLEJO

Requesting Physician Information

Name: TANG, ZILUE
Practice Name: Kaiser Permanente KOJ Contact Name: MARISSA A. BURKE
Address: 975 Sereno Drive City: Vallejo State: CA
Zip Code: 94589 Phone: (707) 651-1370 Fax Number: (707) 651-2955
Specialty: OCC MED NPI Number: 1205031481
E-mail Address:

Claims Administrator Information

Company Name: YORK INS SVCS Contact Name: SCHAUNNA MCEACHRON
Address: PO BOX 619079 City: ROSEVILLE State: CA
Zip Code: 95661 Phone: (800) 422-7244 Fax Number: [redacted] Bev. Cal B. 1439
E-mail address:

Requested Treatment (see instructions for guidance; attach additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration, Quantity, etc)
SPRAIN OR STRA	843.9	MRI		1 Request MRI L hip

There are 1 request(s) on this form. Note: Above data may be truncated due to insufficient space. See continuation pages.

Requesting Physician Signature: Electronically Signed TANG, ZILUE Date: 03-25-2014

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)
Authorization Number (If assigned): Date:
Authorized Agent Name: Signature:
Phone: Fax Number: E-mail Address:
Comments:

MRN:01977909 James P Brunson

Patient Name: [redacted]	Requesting Provider: Zilue Tang, M.D.
Mrn:	Provider Id: 000067076
Gender:	Fac/Adm Dept: VAL/OCC
Age:	Tie Line/Ext: 8-460-2853
Language:	Fax Tie Line:
Contact Phone:	PCP: Brian D Winter, M.D. - (VAL)MED

Referral Detail

Status: (02) RESPONSE NEEDED

Access Time: 2 days
Date Initiated: 03/18/2014
Response Date:

FAC/SPE: Vallejo/Occupational Medicine
Assigned to For Triage:
Triage Provider:

Last Modified By: KVAZT1 03/18/2014 9:09 AM
Entered By: Zilue Tang, M.D. 03/18/2014 9:09 AM

Problem Reason:

Authorization -Work Related Injury

E & M Coding:

None

Referral Workup:

1. Facility where referral is generated:
   A: Vallejo
2. Date of injury (mm/dd/yy):
   A: 02/15/14
3. Type of Consult:
   A:
4. Possible Procedure Needed:
   A: MRI ,
5. Possible Treatment Needed:
   A:
6. Possible Surgery Needed:
   A:
7. This patient is part of a Medical Provider Network (MPN)
   A:
8. Name of provider to whom this patient is being referred:
   A:
9. Reason patient is being referred outside:
   A:
10. Transfer of Care?
   A:
11. For MRI requests the following is required:
   A:
12. Patient History/Comments:
   A: left hip injury. limited progress with PT. evidence of labral tear. request left hip arthrogram study for further evaluation

Response Notes:

Booking Information:

Priority:	Facility:	Dept:	Type:	Provider:
	Vallejo	OCM		

Booking Instructions:

KAISER PE[redacted]MANENTE Claim#:CYCH-546693 DOI:02-15-2014 Visit:04-01-2014 13:59 ReportDate:04-02-2014 Final:N
Patien[redacted] 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 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.

[redacted]

11. ☐ Patient will be permanently precluded from engaging in his/her usual and customary occupation
12. ☐ Patient's condition is permanent and stationary with residual disability on:
13. ☐ Patient will require future medical care

If any of these boxes are checked you must use Form PR-3

14. Claims Administrator	Patient: 15. [redacted]
YORK INS SVCS	17. Name [redacted]
	18. Address [redacted]
PO BOX 619079	19. City V[redacted] A Zip 945918322
ROSEVILLE	20. DOI 0[redacted] 22. Sex M
CA 95661	23. Phone ([redacted] 24. Fax
	25. Occupati[redacted]
26. Phone (800) 422-7244 27. Fax (866) 548-2637	28. Claim C[redacted] AB

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:

[redacted] 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
Current complaints: as above.

RECEIVED
APR 15 2014 A
OSC West

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 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 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 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:

State of California Division of Workers' Compensation

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

35. **Diagnoses**

1st SPRAIN OR STRAIN OF HIP OR THIGH (L) ICD-9 843.9

2nd 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, r/o labrum tear

MRA requested. Waiting for appt.
I certify the medical necessity of the care and have reviewed and approve
the Plan of Care. Continue PT
Work Status: Modified duty if available 4/1/2014 through 4/15/2014 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: 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. Drugs:

41. Physical Medical Service: 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 full duty on with no limitations or restrictions.**
48. [X] **Return to modified work on** 04-01-2014 **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 are deemed permanent.**

Primary Treating Physician: (original signature, do not stamp) 52. **Date of exam** 04-01-2014

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 KOJ Occupational Health

Executed at Signature Date APR 02 2014

54. Name TANG, ZILUE MD 55. California Lic# 100782A

56. Address 975 Sereno Drive, Vallejo, CA, 94589 57. Phone (707) 651-1370 Vallejo Facility

v2.9

KAISER PERMANENTE Claim#:CVCH-546693 DOI:02-15-2014 Visit:04-15-2014 14:32 ReportDate:04-16-2014 Final:Y
Patient [redacted] 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)

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**
04.	☐	**Change in work status**	05. ☐ **Need for referral or consultation** 06. ☐ **Response to request for information**
07.	☐	**Change in patient's condition**	08. ☐ **Need for surgery or hospitalization** 09. ☐ **Request for Authorization**
10.	☐	**Other:**	
11.	☐	Patient will be permanently precluded from engaging in his/her usual and customary occupation	**If any of these boxes are checked you must use Form PR-3 or narrative report.**
12.	☐	Patient's condition is permanent and stationary with residual disability on:	
13.	☐	Patient will require future medical care	

14. **Claims Administrator** YORK INS SVCS PO BOX 619079 ROSEVILLE CA 95661	**Patient:** [redacted] 16. [redacted] 17. Name 18. Addres 19. City Zip 945918322 20. DOI 22. Sex M 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 [redacted]

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

32. Subjective Complaints:

[redacted] 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

1st ICD-9 843.9
SPRAIN OR STRAIN OF HIP OR THIGH (L)

2nd ICD-9

State of California Division of Workers' Compensation

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

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.. (primary encounter diagnosis)
Note: left, acute, r/o labrum tear
Plan: 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.

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 45. Hospitalization/ Surgery
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** 04-15-2014 **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 are deemed permanent.**

State of California Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2) Page 3

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	REMOTE CSID	DURATION	PAGES	STATUS
April 18, 2014 4:43:08 PM EDT	Fax Server	88	4	Received

Fax Server 4/18/2014 4:41:43 PM PAGE 3/004 Fax Server

4/17/2014 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

[redacted]

Copy to:
ADIN Healthcare Inc.
761 Old Hickory Blvd Suite 300
Brentwood TN 37027

FAX: (614) 717-6500

Date of Service: 04-17-2014
Exam. MR Arthrogram Hip [MR701] - Hip - L

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 femoroacetabular impingement. These fibrocystic changes are in the lateral femoral head and neck junction. There is mild sclerosis 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.

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.
3. 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
Dictated 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

Surgical Benefit Verification

Carrier Name		Phone#
Insured's Name	ID#	Group#
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

Out of Pocket Max In $_____ Out $_____ Facility __in network __out of network

Out of Pocket Met In $ Out $

DME Benefit Verification

Effective Date		Deductible $		Deductible Met $	
Out Of Pocket Max $		Ins Pays _____% Pt Pays %			Pre-cert?
CPM	E0935		Covered	Not-covered ___days	Y N
Cold Therapy	E0218		Covered	Not-covered	Y N
ROM Knee Brace	L1832		Covered	Not-covered	Y N
Slingshot	L3670		Covered	Not-covered	Y N
Pain Pump	A4306		Covered	Not-covered	Y N
Custom Brace	L1846		Covered	Not-covered	Y N
OTS Brace	L1845		Covered	Not-covered	Y N
Other:			Covered	Not-covered	Y N

PRECERTIFICATION

Phone#	Fax#	Spoke With
Precert/Auth#	Expiration Date	Date Completed / / by

Deposit

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_____

Surgical Benefit Verification

Carrier Name		Phone#
Insured's Name	ID#	Group#
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

Out of Pocket Max In $_____ Out $_____ Facility __in network __out of network

Out of Pocket Met In $ Out $

DME Benefit Verification

Effective Date		Deductible $		Deductible Met $	
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Custom Brace	L1846		Covered	Not-covered	Y N
OTS Brace	L1845		Covered	Not-covered	Y N
Other:			Covered	Not-covered	Y N

PRECERTIFICATION

Phone#	Fax#	Spoke With
Precert/Auth#	Expiration Date	Date Completed / / by

Deposit

Total Estimated Surgical Fee $ Deposit: Ded $ + Co-ins = Total $

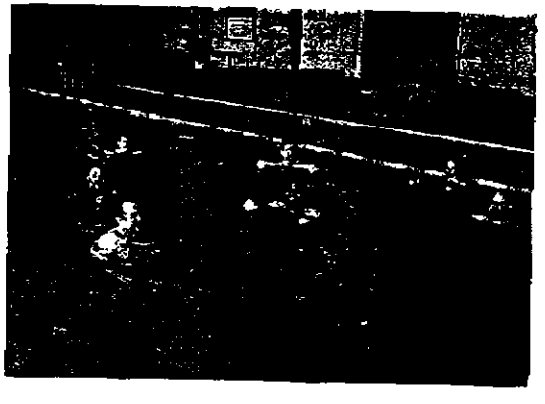
Total Estimated DME Fee $ Deposit: Ded $ + Co-ins = Total $

Total Deposit $

Patient Notified of deposit on / / by

Progressive Phases of The Next Step program

Each client receives an initial evaluation completed by our Physical Therapist upon request. The evaluation includes client history and client goals along with prescription adherence and then determines the level at which the client will initiate the program. For those who require a non-weight bearing environment, we initiate the client into our water therapy.

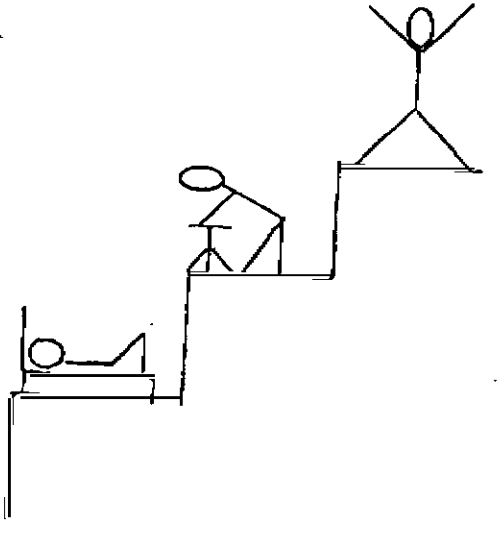


For others who might be more functional, the program initiates with our functional restoration program to include; core strengthening, stabilization, and ROM to the affected area with emphasis on proprioception and increased proper body mechanics.

Reassessments are completed at 4,8, and 12 week intervals. If the client has not progressed as expected, they will be referred back to the prescribing health care provider for further assessment. If the client is on target with the initial assessment, they will be progressed to the next phase in their rehabilitation program or progressed out of "The Next Step" program into either a home exercise program or an independent program in a health club.

"THE NEXT STEP" Physical Repair

Bridging the Gap Between Physical Therapy and Functional Independence



MILLENNIUM SPORTSCLUB

Millennium Vacaville
3446 Browns Valley Rd.
Vacaville, CA 95688
(707)447-8462
Fax:(707)447-8463

Millennium Rancho Solano
3250 Rancho Solano Pkwy
Fairfield, CA 94533
(707)438-2582
Fax:(707)438-2581

Millennium Vallejo
124 Lincoln Rd East
Vallejo, CA 94591
(707)644-7013
Fax (707)644-7014

WHAT IS THE NEXT STEP?

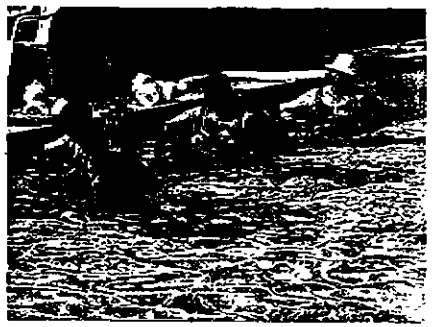
The Next Step is a multi-disciplinary staff that consists of a Physical Therapist, Exercise Physiologist, Physical Therapy Assistant and Certified Athletic Trainers, all who, out of a passion for wellbeing, have made physical rehabilitation and functional training their areas of expertise.

WHAT IS OUR ROLE?

"The Next Step" is an efficacious, progressive, comprehensive and cost-containing program that specializes in functional restoration of the client in a group setting. Our multi-disciplinary approach guides the patient toward maximal results while minimizing time and costs. Our primary goal in this group setting is to progress the client expeditiously to return to pre-injury status in order to improve quality of life at home and/or to maximize functional ability within their current job requirements.

WATER THERAPY
(Phase 1)

Aquatic immersion has profound biologic effects, extending across essentially all homeostatic systems. These effects are both immediate and delayed, and they allow water to be used with therapeutic efficacy for a great variety of rehabilitative problems. Aquatic therapies are beneficial in the management of patients with musculoskeletal problems, neurologic problems, cardiopulmonary diseases and many other conditions. In addition, the margin of therapeutic safety is wider than that of almost any other treatment milieu.



Our group water sessions are designed with CORE trunk stabilization, strengthening, gait training, and ROM as its foundation. Because of the decreased amount of weight bearing on the body, water is an environment where early entry is possible with those clients experiencing high pain levels preventing them from tolerating land based exercises . In addition, water is appropriate for those with muscle imbalances, arthritic issues, gait imbalances, and general deconditioning,

Many of our clients are those that have not had success in a land therapy setting In water, we are able to help these clients build a better foundation insuring a more effective progression in their overall rehabilitation needs

FUNCTIONAL RESTORATION
(Phase 2)

Phase 2 is designed to transition the client from a non weight bearing environment into a weight bearing environment. The transition to a weight bearing environment is an essential part of the progression of care. Appropriate land exercises aid in the progression of overall function by increasing the overload principal to the body in addition to increasing overall proprioception. To accomplish this progression we are incorporating theraball exercises, dynaband, Pilates mat and medicine balls. This functional approach to overall conditioning through balance, ROM, flexibility, and strength helps the client to achieve a more safe and effective recovery.

We also work on proper body mechanics in sitting, lowering and rising to and from the floor, proper lifting techniques and postural awareness.

Our group dynamic continues to aid in compliance and increased learning potential through others.

With managed care reducing rehabilitation time and pushing independent or home exercise at the outcome of therapy, our ultimate committment is to empower our clients to take responsibility for continuing their own care by providing affordable tools and effective exercises that can be done at home **or in a gym.**

WALNUT CREEK ORTHOPEDICS & SPORTS MEDICINE

Name _____

Date _____

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

DATE OF ONSET/INJURY: _____

CAUSE: (If injury, please explain.)

☐ 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.

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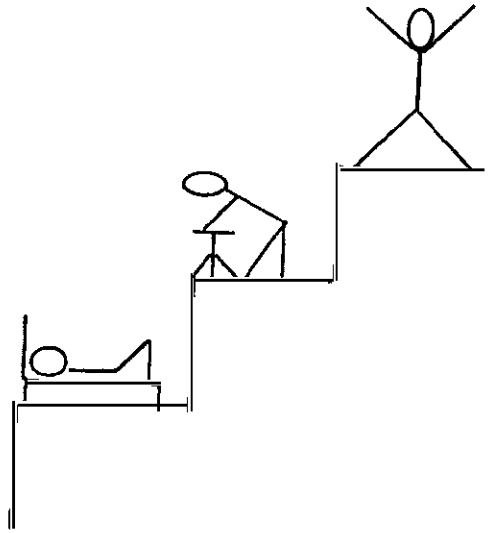

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WELLCOMP™

Managed Care Services

To: William Workman, MD From: Linda Keeney

Company: Date:

Fax: 925-944-0960 Senders Phone Number:

Alternate Fax: Total Number of Pages Including Cover: 2

Regarding: You're Reference Number:

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply

Notes/Comments:

Surgical Benefit Verification

Carrier Name		Phone#
Insured's Name	ID#	Group#
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

Out of Pocket Max In $_____ Out $_____ Facility __in network __out of network

Out of Pocket Met In $_____ Out $_____

DME Benefit Verification

Effective Date		Deductible $		Deductible Met $	
Out Of Pocket Max $		Ins Pays _____% Pt Pays _____%			Pre-cert?
CPM	E0935		Covered	Not-covered ___days	Y N
Cold Therapy	E0218		Covered	Not-covered	Y N
ROM Knee Brace	L1832		Covered	Not-covered	Y N
Slingshot	L3670		Covered	Not-covered	Y N
Pain Pump	A4306		Covered	Not-covered	Y N
Custom Brace	L1846		Covered	Not-covered	Y N
OTS Brace	L1845		Covered	Not-covered	Y N
Other:			Covered	Not-covered	Y N

PRECERTIFICATION

Phone#	Fax#	Spoke With
Precert/Auth#	Expiration Date	Date Completed / / by

Deposit

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

For Use with the QME Panel Request Form 105

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 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
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

NON-MD/DO SPECIALTY CODES

ACA Acupuncture
DCH Chiropractic
DEN Dentistry
OPT Optometry
POD Podiatry
PSY Psychology
PSN Psychology – Clinical Neuropsychology

CITY OF VALLEJO
Revision Date: Jun 5, 2007

Fire Fighter/Engineer

Class Code: 04115

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 Guidelines
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.

WELLCOMP™
Managed Care Services

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Dr. Workman	Shelley Jones RN, BSN (925) 349-3874
COMPANY:	DATE:
	MARCH 3, 2010
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
925-944-0960	9
PHONE NUMBER:	SENDER'S REFERENCE NUMBER:
[redacted]	YOUR REFERENCE NUMBER:

☐ URGENT ☑ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

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

Benicia Bay Phyiscal 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

[redacted]

"The Next Step"
Physical Repair

Main Office:
Vacaville
Phone: (707)447-8462
Fax: (707)447-8463

At
MILLENNIUM SPORTS CLUB

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

Fairfield
Phone:(707)438-2582
Fax: (707)438-2581

FAX COVER SHEET

DATE: 5/11/10 **TIME:** 12:25pm **FAX#:** 925-944-0960

Main Office Street Address: ***3446 Browns Valley Road***
Vacaville, CA 95688

Phone: ***Main Office: (707) 447-8462*** cell.(707)592-8774

Fax: ***Main Office: (707) 447-8463***

From: Kathie Kimsey

To: Dr Workman

# of pages (including cover): 4

COMMENTS: [redacted]

Report + info on "Next Step"
for your information!
Thank You
Kathie

"The Next Step"
Physical Repair
At
MILLS CLUB SPORTSMEN

Main Office:
Vacaville
Phone: (707)447-8462
Fax: (707)447-8463

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

Fairfield
Phone:(707)438-2582
Fax: (707)438-2581

FAX COVER SHEET

DATE: 7/9/10 **TIME:** 2:00pm **FAX#:** 925-944-0960

Main Office Street Address: *3446 Browns Valley Road Vacaville, CA 95688*

Phone: *Main Office: (707) 447-8462* / Please use: CELL: 707-592-8774

Fax: *Main Office: (707) 447-8463*

From: Kathi Kimsey

To: Dr Workman

# of pages (including cover): 6

COMMENTS: [redacted]

Attached is script for CANS therapy only and functional-work hardening for RTW duties* (four duties)

Additionally, would you be okay w/ adding water therapy to the script dated 6/2/10 as the case mgr has ok'd continue water for progression to CANS in June before leaving on maternity leave - Please fax ck 6/2/10 script and current script so they can be forwarded to the adjuster. Thx.

1901 E. Alton Ave. Suite 200
Santa Ana CA92705
800-559-5556 phone
866-409-1957 fax

Paladin Managed Care Services

FAX

011811 10a
Dear Adjuster,
Added more information about patient's symptoms in last PR-2.
Thanks!
WBWorkman

To: William Workman, M.D.

Fax: 925-944-0960

Phone: 925-944-0110

Date: Wednesday, January 12, 2011

Re: [redacted]

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

FAX COVER SHEET

SPORTS + ORTHOPEDIC LEADERS PHYSICAL THERAPY
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

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 [redacted], from Ada Juaregui DPT. If you agree with the plan of care, please sign and date and fax back to our office.

Thank you!

FAX COVER SHEET

SPORTS + ORTHOPEDIC LEADERS PHYSICAL THERAPY
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, 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

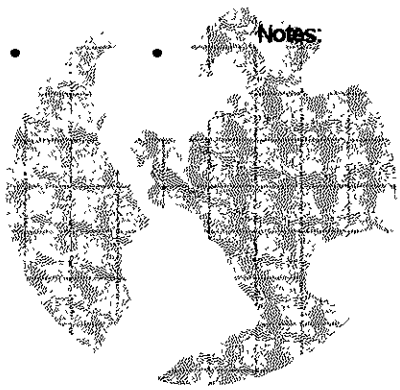
Attached is my progress report for your patient [redacted] from Ada Jauregui, DPT. If you agree with the plan of care, please sign and date and fax back to our office.
Thank you!

facsimile transmittal

To:	William Workman MD	**Fax:**	19259440960
From:	Ada Jauregui	**Date.**	Apr 18, 2011
Re:		**Pages:**	5

Urgent **For Review** **Please Comment** **Please Reply** **Please Recycle**

Notes:



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

FAX

To:	William Workman MD	**From:**	Ada Jauregui
Fax:	(925) 944-0960	**Pages:**	2
Phone:	(925) 944-0110	**Phone:**	(510) 547-1630
Re:	[redacted]	**Date:**	4/18/2011

Comments:

YORK

YORK RISK SERVICES GROUP, INC.

FACSIMILE TRANSMITTAL SHEET

TO: Dr. Workman	FROM: Erika Perry
COMPANY: Walnut Creek Orthopedics	DATE: AUGUST 25, 2011
FAX NUMBER: (925) 944-0960	TOTAL NO. OF PAGES INCLUDING COVER: 3
PHONE NUMBER: (925) 944-0110	SENDER'S REFERENCE NUMBER:
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NOTES/COMMENTS:

Dear Dr. Workman,

I have attached a job desription on Mr. [redacted]n for your records.

please call our office if you require additional information.

Thank you,

Erika Perry
Claims Assistant

P.O. BOX 619079, ROSEVILLE, CA 95661-9079 PHONE: (925) 349-3880 FAX: (866) 548-2637