Proactive Work Health Medical-Urgent Care - PTLA

P.O.Box 17130
Los Angeles CA 90017-0130
Phone: (213) 977-9300
Fax: (213) 977-9600

Facsimile Cover Sheet

Date: 08/31/23
To: Devin Kelsey
Fax:(949) 474-6064
From: Lucero Fernanda

State of California

Division of Workers' Compensation

Request for Authorization

DWC Form RFA - California Code of Regulations, title 8, section9785.

This form must 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.

☐ New Request ☐ Resubmission - Change in Material Facts

☐ Expedited Review: Check box if the patient faces an imminent and serious threat to his or her health

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

Employee Information

Employee Name (Last, First, Middle): MENDELSON JADE			
Date of Injury (MM/DD/YYYY): 07/14/2023		Date of Birth (MM/DD/YYYY): 10/05/1996	
Claim Number: 23G44K810286		Employer: AAA 2601 S. FIGUEROA	

Provider Information

Provider Name: KAYVON YADIDI D.O.			
Practice Name: ProActive Work Health Medical Center		Contact Name:	
Address: 132 S Beaudry St		City: Los Angeles	State: CA
Zip Code: 90012	Phone: 818-528-6766	Fax Number: 213-223-5161	
Provider Speciality: Occupational Med./Internal Med.		NPI Number: 1659452969	
E-mail Address: referrals@proactiveworks.net			

Claims Administrator Information

Claims Administrator: CCMSI		Contact Name: KelseyDevin	
Address: PO BOX 53550		City: IRVINE	State: CA
Zip Code: 92619-3550	Phone: (949) 474-6596	Fax Number: (949) 474-6064	
E-mail Address:			

Requested Treatment: (See the Instructions for guidance; attach additional pages if necessary.)

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. Up to five(5) procedures may be entered; attach additional requests on a separate sheet.

Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS	Other information: (Frequency, Duration, Quantity, Facility, etc)
Strain of muscle, fascia and tendon of lower back, subsequent encounter	S39012D	Acupuncture - Evaluation		2 x 3 Weeks

Special Instructions / Treatments:

Treating Physician Signature: KAYVON YADIDI D.O.

Date: 08/30/23

Claims Administrator 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		
Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

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 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 the report to Department of Industrial Relations, 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

CCMSI PO BOX 53550 IRVINE CA 92619-3550 (866) 985-1595

2. Employer Name

AAA 2601 S. FIGUEROA

3. Address No. and Street	City	Zip Code
2601 S. FIGUEROA	LOS ANGELES	90042

4. Nature of Business (e.g. food manufacturing, building construction, retailer of women's clothes.)

5. Patient Name (First Name, Middle Initial, Last Name)			6. Sex	7. Date of Birth
JADE		MENDELSON	Female	10 / 5 / 1996

8. Address No. and Street	City	Zip Code	9. Phone Number
314W. 6TH ST STE 307	LOS ANGELES	90014	(747) 998-6812

10. Occupation (Specific Job Title)	11. Social Security Number	12. Address No. & Street Where Inj. Occurred
sales	603-96-0336	2601 S. FIGUEROA LOS ANGELES CA 90042

City Where Injury Occ.	County	13. Date and hour of injury or onset of illness
LOS ANGELES	Los Angeles County	7 / 14 / 2023 11:58 am pm

14. Date Last Worked	15. Date and Hour of 1st Exam or Treatment	16. Have you or your office previously rendered treatment?
7 / 14 / 2023	7 / 18 / 2023 11:37 am pm	

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 happended. (Give specific object, machinery or chemical. Use reverse side if more space is required.)

"In front of courtyard walking through exit and seen a car coming my way and i tried to move and my foot got caught in some wood, and while trying to catch my balance my other foot got caught and i lost balance and fell in crates."

18. SUBJECTIVE COMPLAINTS

Allergies:

NKDA

Current Medications:

Past Medical History:

Medical Problems:-
- Hypertension: No
- Heart disease: No
- Diabetes: No
- Asthma: No
- Liver disease: No
- Kidney disease: No
- Gastroentestinal disease: No
- Thyroid disease: No

Date of Hire with Current Employer:: Less than 5 years from DOI

Do you have a second job:: No
Previous Work-Related Injuries: Denies
Previous non work related injuries: Denies
Hospitalizations: None
History of Surgery: No
Social History:-
Smokes: No
Drinks: No
Children: None
Review of Systems:-
HEENT: Normal
Cardiovascular: Normal
Pulmonary: Normal
GastroIntestinal: Normal
Urinary: Normal
(Male) History of Prostate Disease?: No
Musculoskeletal: Normal
Dermatological: Normal
Neurological: Normal
Psychiatric: Normal

Social History:

General -

Problem: Work place injury
History and mechanism of injury: 26 year old call center employee for 19 months presents with pain in her right knee, right ankle and foot, headache and lower back pain. She states while walking to work, she had to get out of the way of a car coming in front of her. She stepped to her left and stepped in to some crates. She tried to balance herself and lost her footing on something left on the ground and fell. She twisted her right ankle/foot and right knee. She struck her head on the ground. She thinks she was out for a few seconds. She was helped by co-workers to sit on the side. She refused transport by EMT and went home with her boyfriend.

19. Objective Findings

A. Physical Examination

Vitals :

B/P 1: 170`/104 Pulse: 106

Ankle - Right

Ankle:-
Inspection: moderate (3+) swelling
Palpation: moderate (3+) tenderness to palpation lateral malleolus
Sensory Exam: Normal
Motor Exam: Normal
Pulses: Normal
ROM Ankle:-
dorsiflexion (NL 20°): 10 degrees
plantarflexion (NL 50°): 30 °
inversion (NL 25°): 15 ° (full inversion 25°)
eversion (NL 10°): Decreased eversion
Achilles Tendon: Thompson's squeeze test is negative Normal continuity and function
Special test::-
Anterior drawer test (anterior talofibular ligament): Negative
Talar Tilt test (calcaneofibular and anterior talofibular ligament): Normal

Foot - Right

Foot evaluation::-
Inspection: Moderate swelling, ecchymosis lateral aspect of the foot
Palpation: severe tenderness to palapation over 5th metatarsal head
Range of motion of foot::-
Forefoot adduction (NL 20 °): Normal
Forefoot abduction (NL 50 °): Normal
Sensory examination:: Normal
Motor examination:: Normal
Toe evaluation::-
Inspection: Normal
Palpation:: No Tenderness

Head / Neuro -

General = Patient is alert and oriented X3 and is talking in full sentences.

HEENT = NC/AT, PERRLA, EOMI, Sclera is clear, TM is patent without any injection or exudate. Pharynx is clear without any exudate or erythema. Neck is supple.

Neuro - Alert and well oriented x 3. Cranial nerves 2-12 grossly intact. Negative Rhomberg sign. Normal finger to nose maneuver. DTR's 2+. Grip 5/5 bilaterally. Gait is normal. There is no focal deficit.

Knee - Right

Inspection: degenerative changes are present
Palpation: Moderate tenderness medial joint margin
Effusion: Not present
Grinding/Crepitation: present with flexion
ROM:-
Flexion (NL 130 °): 90 ° with moderate pain
Extension (NL 180 °): Normal (NL 180 °)
Internal Rotation (NL 10 °): Normal (NL 10 °)
External Rotation (NL 10 °): Normal (NL 10 °)
medial collateral ligament test: Stable
lateral collateral ligament test: Stable
Ant. Drawer's Sign: Negative
Lachman's Sign: Negative
McMurray's Sign: Negative
Vascular: normal
Motor: Normal

Lumbar / Sacral -

Lumbosacral Spine:-
Gait: antalgic gait
Inspection: Normal contour
Palpation: slight (2+) tenderness paralumbar spine
Range of Motion:-
Forward Flexion (NL to toes): 75 degrees, with pain
Extension (NL 30 °): 20 °, with pain

Right Lateral Bend (NL 30 °): Full right lateral bend without pain (Normal 30°), performed freely
Left Lateral Bend (NL 30 °): Full left lateral bend without pain (normal 30°)
Right Rotation (NL 45 °): Full right rotation without pain (normal 45°)
Left Rotation (NL 45 °): Full left rotation without pain (normal 45°)
Straight Leg Raising, Sitting: Negative on the left and right
Kemp's test: Negative
Deep Tendon Reflexes (DTRs): Knee and ankle jerk normal bilaterally (normal 2+/4+).
Motor exam: completely normal
Sensory: Normal to touch
Circulatory: pulses intact, normal skin color

B. X-ray and laboratory results (State if none or pending)

X-Ray		Ankle X-Ray, min. 3v's RIGHT			
X-Ray		Foot X-Ray; 2v's RIGHT			
X-Ray		Knee X-Ray 3V RT			

20. DIAGNOSES (If occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? No

1. S93491A Sprain of right ankle, initial encounter
2. S83411A Sprain of medial collateral ligament of right knee , initial encounter
3. S39012A Strain of muscle, fascia and tendon of lower back, initial encounter
4. F0781 Postconcussional syndrome
5. S0063XA Contusion of other part of head, initial encounter

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? YES If "no", please explain below:

22. Is there any other current condition that will impede or delay patient's recovery? No If "yes", please explain below:

23. TREATMENT RENDERED (Use reverse side if more space is required.)

Medications: 07/18/2023, 3412, *Naproxen (Naprosyn) 500mg #14 (Disp) - 1 BID
Supplies : 07/18/2023, 5079, KNEE WRAP AROUND-HINGED -
Supplies : 07/18/2023, 5157, Ankle Walker Airboot (short) -
Supplies : 07/18/2023, 5174, EDUCATIONAL BOOKLET -
Supplies : 07/18/2023, 5235, COLD/HOT PACK-LARGE DISPENSED -

24. If further treatment required, specify treatment plan/estimated duration.

* Current Plans : patient presents with sprain of the ankle and knee. She is started on medication for pain relief. Knee support and ankle support provided. She will be off of work and be re-evaluated next week for return to modified work.
For face to face evaluation and all or some of the following:
Preparing to see the patient, obtaining and/or reviewing obtained history, performing a medically appropriate examination and evaluation, counseling and educating the patient, ordering medications, tests, or procedures, referring and communicating with other health care professionals, documenting clinical information in the electronic, independently interpreting results and communicating results to the patient and care coordination, 45 minutes was used.

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DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

25. If hospitalized as inpatient, give hospital name and location

	Date Admitted	Estimated length of stay

26. WORK STATUS - Is patient able to perform usual work? ☐ Yes ☒ No

If "no", date when patient can return to

Regular work	Modified work

Specify restrictions

Temporary Disabled

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Physician Signature: *(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 section 139.3.

Physician signature		Cal License Number:	20A6595
Executed at:	132 S Beaudry St Los Angeles CA 90012	Date *(mm/dd/yyy)*	07/18/23
Physician Name:	KAYVON YADIDI D.O.	Specialty:	Occupational Med./Internal Med.
Physician Address:	132 S Beaudry St Los Angeles CA 90012	Phone Number:	(213) 977-9300

Any person who makes or causes to be made any knowingly fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

PRIVACY NOTICE: The Administrative Director is authorized to maintain the records of the Division of Workers' Compensation (DWC). (Cal. Lab. Code § 126.) The Information Practices Act of 1977 and the Federal Privacy Act require the Administrative Director to provide this notice to individuals who submit information to the DWC pertaining to a workers' compensation claim. (Cal. Civ. Code § 1798.17; Public Law 93-579.)
The principal purpose for requesting information from injured workers, dependents, lien claimants, physician, employers or their representatives is to administer the California workers' compensation system. Each form shows which fields are required to be completed for DWC to process the form. If a required field in a form is incomplete or unreadable, the DWC may return the form to the individual for correction or may reject the form. Providing a social security number is required on this form pursuant to Labor Code § 6409. If you do not provide your security number, the DWC may return the form to you for correction or reject the form. If you do not have a social security number, indicate this in the space provided for the injured worker's social security number. As permitted by law, social security numbers are used to help properly identify injured workers and to conduct statistical research as allowed under the Labor Code.

As authorized by law, information furnished on this form may be given to: you, upon request; the public, pursuant to the Public Records Act; a governmental entity, when required by state or federal law; to any person, pursuant to a subpoena or court order pursuant to any other exception in Civil Code § 1798.24.

An individual has a right of access to records containing his/her personal information that are maintained by the Administrative Director. An individual may also amend, correct, or dispute information in such personal records. (Cal. Civ. Code §§ 1798.34-1798.3.) You may request a copy of the DWC's policies and procedures for inspection of records at the address below. Copies of the procedures and all records are ten cents ($0.10) per page, payable in advance. (Cal. Civ. Code § 1798.33.) Requests should be sent to: Division of Workers' Compensation - Medical Unit, P.O. Box 71010, Oakland, CA 94612. Tel: (510) 286-3700 or (800) 794.6900. Fax: (510) 622-3467.

State of California

Additional pages attached ☐

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 medical 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 ☐ Release 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

MENDELSON	JADE			
Patient last name:	Patient first name:			MI
314W. 6TH ST STE 307	LOS ANGELES	CA	90014	F
Patient Street Address / PO Box	Patient City	State	Zip Code	Sex
sales	(747) 998-6812	Date of Birth	10/05/96	
Occupation	Phone Number			

Claims Administrator

Date of Injury: 07/14/23

CCMSI	23G44K810286		
Claims Administrator Name	Claim number		
PO BOX 53550	IRVINE	CA	92619-3550
Claims Administrator Street Address	Claims Administrator City	State	Zip Code
(866) 965-1595	(949) 474-6064	AAA 2601 S. FIGUEROA	(213) 741-3404
Phone Number	Fax Number	Employer Name	Phone Number

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

Vitals:

B/P 1: 139/104 Pulse: 104

Subjective Complaints:

General -
Problem: Work place injury
History and mechanism of injury: 26 year old call center employee for 19 months presents with pain in her right knee, right ankle and foot, headache and lower back pain She states while walking to work, she had to get out of the way of a car coming in front of her. She stepped to her left and stepped in to some crates. She tried to balance herself and lost her footing on something left on the ground and fell. She twisted her right ankle/foot and right knee. She struck her head on the ground. She thinks she was out for a few seconds. She was helped by co-workers to sit on the side. She refused transport by EMT and went home with her boyfriend.
Current complaint:
There are no significant changes in her symptoms. She continues to have stiffness of her ankle and pain in the left ankle with burning of the foot and inability to weight bear.
she continues to have pain in her left knee with instability
She continues to have severe pain in her back with pain shooting to her right leg.
Intercurrent history: The intercurrent history was reviewed for today's examination and evaluation.
History of injury to the same body part:
Patient denies any previous work related or non work related injury to the above body part/parts

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

-

Ankle - Right

Ankle:-
Gait: Unable to bear weight
Inspection: No visible abrasions, induratioin, or discoloration
Palpation: moderate (3+) tenderness to palpation lateral malleolus
Sensory Exam: Normal
Motor Exam: Normal
Pulses: Normal

ROM Ankle:-
dorsiflexion (NL 20°): 10 degrees
plantarflexion (NL 50°): 30 °
inversion (NL 25°): 15 ° (full inversion 25*)
eversion (NL 10°): Decreased eversion
Achilles Tendon: Thompson's squeeze test is negative Normal continuity and function

Special test::-
Anterior drawer test (anterior talofibular ligament): Negative
Talar Tilt test (calcaneofibular and anterior talofibular ligament): Normal
Strength testing: Unable to balance on one leg Unable to rise on the toes

Knee - Right

Inspection: degenerative changes are present
Palpation: Moderate tenderness medial joint margin
Effusion: Not present
Grinding/Crepitation: present with flexion

ROM:-
Flexion (NL 130 °): 90 ° with moderate pain
Extension (NL 180 °): Normal (NL 180 °)
Internal Rotation (NL 10 °): Normal (NL 10 °)
External Rotation (NL 10 °): Normal (NL 10 °)
medial collateral ligament test: Stable
lateral collateral ligament test: Stable
Ant. Drawer's Sign: Negative
Lachman's Sign: Negative
McMurray's Sign: Negative
Vascular: normal
Motor: Normal

Lumbar / Sacral -

Lumbosacral Spine:-
Gait: Ambulates with protected gait
Inspection: Normal contour
Palpation: slight (2+) tenderness paralumbar spine

Range of Motion:-
Forward Flexion (NL to toes): 75 degrees, with pain
Extension (NL 30 °): 20 °, with pain
Right Lateral Bend (NL 30 °): Full right lateral bend without pain (Normal 30*), performed freely
Left Lateral Bend (NL 30 °): Full left lateral bend without pain (normal 30*)
Right Rotation (NL 45 °): Full right rotation without pain (normal 45*)
Left Rotation (NL 45 °): Full left rotation without pain (normal 45*)
Straight Leg Raising, Sitting: Negative on the left and right
Kemp's test: Negative
Deep Tendon Reflexes (DTRs): Knee and ankle jerk normal bilaterally (normal 2+/4+).
Motor exam: completely normal
Sensory: Normal to touch
Circulatory: pulses intact, normal skin color

Diagnoses:

1	F0781	Postconcussional syndrome
2	S0083XD	Contusion of other part of head, subsequent encounter
3	S83411D	Sprain of medial collateral ligament of right knee, subsequent encounter
4	S93491D	Sprain of right ankle, subsequent encounter

5 S39012D Strain of muscle, fascia and tendon of lower back, subsequent encounter

X-Ray & Lab Results:

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?

Current Plans: MRI is authorized and will be scheduled for the lower back, knee and ankle. She is referred for pool therapy given her weight and the multiple areas of injury. She is referred for acupunture.
I will consider ortho referral.
For face to face evaluation and all or some of the following:
Preparing to see the patient, obtaining and/or reviewing obtained history, performing a medically appropriate examination and evaluation, counseling and educating the patient, ordering medications, tests, or procedures, referring and communicating with other health care professionals, documenting clinical information in the electronic, independently interpreting results and communicating results to the patient and care coordination, 25 minutes was used.

Future Plans:

* pool/aquatic therapy TREATMENT * ACUPUNCTURE TREATMENT 2 X 3 WEEKS

Special Instructions:

Next Office Visit : 09/20/23 9:00:00 AM

Work Status: This patient has been instructed to:

[X] Remain off-work until 09/20/23

[ ] Return to *modified* work on _____ with the following limitations or restrictions. (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

08/30/23	Temporary Disabled	08/30/23	09/20/23	**WC-RE-CHECK INJURY** * pool/aquatic therapy TREATMENT * ACUPUNCTURE TREATMENT 2 X 3 WEEKS

[ ] Return to full duty on with no limitations or restrictions.

Primary Treating Physician: *(Original signature, Do not stamp)* Date of Exam 08/30/2023

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

Electronically Signed By KAYVON YADIDI D.O.

Signature **State Lic. #** 20A6595

Executed at Los Angeles CA **Date** 08/30/2023

Name KAYVON YADIDI D.O. **Speciality**

Address 132 S Beaudry St **City** Los Angeles **State** CA **Zip** 90012

PRIVACY NOTICE: A statement of current data collection and use policies and certain privacy rights of injured workers may be found at the following website: http://www.dir.ca.gov/od_pub/privacy.html.

SPECIALTY REFERRAL FORM

Date:	08/30/23 12:00:00AM		
Patient:	MENDELSON JADE	**DOI:**	07/14/23
Address:	314W. 6TH ST STE 307	**DOB:**	10/05/96
	LOS ANGELES CA 90014	**SSN:**	XXX-XX-0336
Phone:	(747) 998-6812	**Account #:**	341186
Employer:	AAA 2601 S. FIGUEROA	**Contact:**	SHELLY BOLDS
Address:	2601 S. FIGUEROA	**Phone:**	(213) 741-3404
	LOS ANGELES CA 90042		
Insurance:	CCMSI	**Adjuster**	Devin Kelsey
Address:	PO BOX 53550	**Phone:**	(866) 965-1595
	IRVINE CA 92619-3550	**Claim #:**	23G44K810286

NCM/UR:
Phone: **Ext:** **FAX:**

Diagnosis:

Bodyparts:

Head / Neuro	
Lumbar / Sacral	
General	
Knee	Right
Ankle	Right
Foot	Right

Specialty: **ACUPUNCTURE**
Requested Date: 08/30/23 **Status:**
Authorized by:
Authorized on:
Received by:
Pre Cert #:
Referring Phys: KAYVON YADIDI D.O. **Signature :**
Referred to:

Appointment Date:
Consult Only: **Consult & Treat ONE time only:**

Comments:

Special Instructions: