Concentra Health Systems

Patient Chart Copy for Luis Quintanilla
MRN: 102-493-924
DOB: 04-Sep-1972
Data accurate as of: 02/06/2023 06:32 PM Central Standard Time

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
☐ 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.

Employee Information

Name (Last, First, Middle): **Quintanilla, Luis**			
Date of Injury (MM/DD/YYYY): **06/12/2022**		Date of Birth (MM/DD/YYYY): **09/04/1972**	
Claim Number: **4A2206G16DP0001**		Employer: **Hilton Worldwide Inc**	

Requesting Physician Information

Name: **Barry Meskin, DPM**			
Practice Name: **CMC-Potrero Hill**		Contact Name:	
Address: **2 Connecticut Street**		City: **San Francisco**	State: **CA**
Zip Code: **94107**	Phone: **415-621-5055**	Fax Number: **Referral Team Fax#: (866)-513-1291**	
Specialty: **Podiatrist**		NPI Number: **1588699532**	
E-mail Address:			

Claims Administrator Information

Company Name: **Sedgwick 14447**		Contact Name: **W/C CLAIMS**	
Address: **PO Box 14447**		City: **Lexington**	State: **KY**
Zip Code: **40512**	Phone: **8664957844**	Fax Number: **2627896691**	
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.)
Strain of ankle and foot, right, initial encounter	**S96.911A**	**Aspir &/Inj; Intermediate joint/bursa w/o ultrasound guid - 20605**		Body Part 1: Ankle, Laterality 1: Right

Supervising Provider Name: **Eli Hurowitz, M.D.**

Requesting Physician Signature: Eli J Hurowitz, MD Date: **12/05/2022**

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:		

PHYSICIAN PROGRESS REPORT

DATE OF INJURY: 06/12/2022

Dear Claims Examiner/Adjuster:

I personally reviewed the patient's Past Medical, Family, and Social History as reported on the initial visit, and it remains unchanged other than the exceptions otherwise noted.

The patient is being re-evaluated with respect to a work-related injury sustained while working for Hilton Worldwide Inc on 06/12/2022.

CHIEF COMPLAINT:
Bilateral feet.

RECORD REVIEW - ANGELINA CASERTA, NP; JUN 15 2022:
49 yo M presents with bilateral Achilles and heel pain sustained last week when he was pushing heavy wall partitions. Of note, he saw his PCP at Kaiser 4 months ago with similar sx and was diagnosed with heel spurs (without x-ray). He was told the injury was likely due to prolonged walking with his job but told him to ice and do stretches. Went to Kaiser yesterday and was seen by a podiatrist (Dr. Sally Pham) via WC at Kaiser. Was recommended to wear a cast and given work restrictions. However, no x-rays done. He was also told to wear work boots instead of his normal shoes. Sx are brought on after he has been resting and stands up to walk - same with first step of the day. Eager to return to playing/coaching soccer. X-RAY bilateral heels and ankles with large heel spurs of superior heel bilaterally. Likely some plantar fasciitis as well. Start PT. Silicone heel cups. Mod duty, meds dispensed. RTC 2-3 days or earliest available. Consider early Podiatry if no better with PT as patient inquires about cortisone injection. 1. Strain of ankle and foot, right, initial encounter (S96.911A) 2. Strain of ankle and foot, left, initial encounter (S96.912A) 3. Bilateral calcaneal spurs (M77.31,M77.32)

RECORDS REVIEWED - DANIEL CHAN, PA-C:
11/2/22 he states his Achilles and ankle pain is improving with new orthotics and new shoes he purchased. He says surgery for Achilles was denied due to no MRI of ankle/foot. He is here for MRI order of both feet since he has pain in both Achilles tendon area. PLAN. RFA for bilateral MRI. RTC 6 weeks. Meds ordered via Vectra. TAC 0.1% 454 G. ASSESSMENT: 1. Bilateral calcaneal spurs (M77.31,M77.32) 2. Strain of ankle and foot, left, initial encounter (S96.912A) 3. Strain of ankle and foot, right, initial encounter (S96.911A)

10/5/22 patient saw Dr. Meskin who is requesting surgery for Achilles injury. He is here because he continues to have pain. He has completed 12/12 PT sessions. He is working modified duty at hotel.

8/26/22 patient has seen PT and feels that last time he saw therapist they made some break thru in his Achilles pain. He has podiatry pending auth. Has been working modified duty.

8/12/22 patient states he has been having bilateral ankle and Achilles pain. He is unable to stand for prolong period of time. He has been feeling pain in both feel and ankles from the time he wakes up. He is working modified duty and tolerating it ok. He does take Advil from time to time.

07/13/2022 recheck heel and ankle pain, tolerating mod duty. 5/6 PT completed. PT has helped tremendously and would benefit from more. The Pt would like to return to full duty except for the only issue he has is when he has to pull out the 200lb risers or stomp on the floor when installing the dance floor.

06/22/2022 recheck heel and ankle pain tolerating modified duty. 1/6 PT completed.

SUBJECTIVE COMPLAINTS:

A 50-year-old Hispanic male, we could communicate enough in English, given the history and findings.

His surgery was not certified, but he was encouraged to get MRI studies initially, see reports below.

He continues with insertional Achilles tendinopathy/bursitis, right greater than the left, he is interested in having an injection.

He has had a second opinion and an MRI, I did not have the MRI or the second opinion reporting as such. He does, however, state that the second opinion reviewed the MRI and has recommended a steroid, he wants to try this today. At length we discuss the risks and complications, I explained this quite clearly to him, but explained the injection would mostly be directed to the bursa, see MRI below.

His pain is 3 out of a scale of 10, it is sharp, intermittent, worse with pushing and improved with rest.

He has had 12/12 physical therapy, and continues in a modified capacity at work.

WORK HISTORY:
Type of job / Job title: Houseman
Major job functions: Houseman
Length of time at this job: 25 year(s). Average weekly work hours: 40.

PAST MEDICAL HISTORY:
Medical History: Testicular pain, left. Contusion of left groin.
Surgical History: The patient has no previous history of surgical procedures.
Allergies: The patient has no known allergies to medications.
Medications: He relies on Advil.

REVIEW OF SYSTEMS:
A complete review of systems was performed and was all negative except for the systems as documented on the initial visit and those systems associated with the injury.

OBJECTIVE FINDINGS:
General Appearance: The patient is a well-developed, well-nourished male appearing stated age and in no acute distress.

Gait: The patient has a heel lift, stable supportive shoes and arch supports.

Psyche: Alert and oriented to time, place and person. Mood and affect are appropriate.

Respiratory: There are no apparent signs of respiratory distress.

Vascular: Popliteal, DP and PT arterial pulses are rated as 3/4 bilateral. The digital capillary filling times to all digits is less than 3 seconds.

Palpation: At the right side, there is a prominent bursa, appears small, mild swelling. Otherwise, he is limited with range of motion. Manual muscle strength is maintained.

Neurological: Light touch sensation is intact in both feet. Protective threshold is maintained. I do not appreciate any atrophy and there is normal muscle tone.

Dermatological: The skin temperature, texture and turgor in both feet are within normal limits for the patient's stated age.

Lymphatic System: Lymphangitis, lymphadenitis or cellulitis not present upon examination in either lower extremity.

Musculoskeletal: The patient's muscle strength of the foot and ankle dorsiflexors, plantarflexors, inverters and (supinator) everters (pronators) are rated as 5/5.

Range of Motion
1st MPJ dorsiflexion (normal 60 degrees) 60 degrees
1st MPJ plantarflexion (normal 10 degrees) 10 degrees
Sub-talar (inversion) (normal 15 degrees) 15 degrees
Sub-talar (eversion) (normal 5 degrees) 5 degrees
Ankle dorsiflexion (normal 10 degrees) 10 degrees
Ankle plantarflexion (normal 40 degrees) 40 degrees

Special Tests:
Babinski sign both feet: Negative
Homans sign both calves: Negative
Clonus: Negative
Anterior drawer: Negative
Inversion talus tilt: Negative
Squeeze test: Negative
Cotton test: Negative
Impingement sign: Negative

Tinel sign both feet: Negative
Patellar reflex: Normal
Achilles reflex: Normal
Thompson test: Negative

DIAGNOSTIC IMAGING:
11/22/2022, MRI left ankle, RAVI ALAGAPPAN MD;
Insertional Achilles tendon tendinosis and peritendinitis with mild retrocalcaneal bursitis. Degenerative enthesophyte with reactive marrow edema at the Achilles insertion. No evidence of Achilles tendon disruption.

11/22/2022, MRI right ankle, RAVI ALAGAPPAN MD;
1. Insertional distal Achilles tendon tendinosis and peritendinitis with retrocalcaneal bursitis. Prominent posterior superior calcaneal enthesophyte with reactive bone marrow edema and adjacent soft tissue edema. Combination of findings are compatible with a Haglund syndrome. No evidence of Achilles tendon disruption. 2. Mild distal posterior tibial tendon tendinosis, peritendinitis and tenosynovitis. 3. Moderate flexor hallucis longus tendon tenosynovitis.

06/15/2022 PRICE, MARTIN MD, right ankle x-ray 3 views, there is no evidence of acute fracture, dislocation or bony destructive lesion. The ankle mortise and talar dome appear normal. The adjacent soft tissues appear unremarkable. Incidental note is made of calcaneal spur formation. Impression: No acute osseous changes noted but calcaneal spur.

06/15/2022 FISH, JON MD, left ankle x-ray three views, bones and joints of the ankle proper are unremarkable in appearance. The lateral view shows the posterior calcaneal spur, described on the report of the heel examination done contemporaneously. Impression: Negative examination of the left ankle proper.

06/15/2022 FISH, JON MD, left heel x-ray two views, there is an approximately 15 mm posterior calcaneal 'spur'. A transverse lucency is seen in the distal aspect of the spur. Appearance of the calcaneus is otherwise unremarkable. Impression: Posterior calcaneal spur.

06/15/2022 FISH, JON MD, right heel, two views, there is a 14 mm posterior calcaneal 'spur' showing an apparent lucency within its distal aspect. The calcaneus is otherwise unremarkable. Impression: Posterior calcaneal spur, as noted.

ASSESSMENT:
1. Strain of bilateral feet and ankle, right greater than the left.
2. Pending surgery certification for his right side initially given insertional Achilles tendinopathy, x-ray with.....an approximate 14 mm posterior calcaneal spur showing an apparent lucency within its distal aspect.
3. MRI right side.....insertional distal Achilles tendon tendinosis and peritendinitis with retrocalcaneal bursitis, prominent posterior superior calcaneal enthesophyte with reactive bone marrow edema and adjacent soft tissue edema. Combination of findings are compatible with a Haglund syndrome.
4. MRI left side..... ..insertional Achilles tendon tendinosis and peritendinitis with mild retrocalcaneal bursitis. Degenerative enthesophyte with reactive marrow edema at the Achilles insertion.

RECOMMENDATIONS:
We reviewed the MRI's today line for line item.

We will request retro authorization for a steroid injection.

I suggest he bring me the 2nd opinion report that he refers to having had.

RFA - RETRO REQUEST FOR AUTHORIZATION - CPT 20605:
The patient wants to have a steroid injection, however a strongly cautioned him with regard to using this at/near the Achilles tendon, but assured him that I would direct this toward the busa.....MRI withretrocalcaneal bursitis. The decision to perform the steroid injection was made to relieve pain and inflammation. The benefits and alternatives of the steroid injection were discussed with the patient. The procedure risks and limitations, including cartilage damage, death of nearby bone, joint infection, nerve damage, temporary facial flushing, temporary flare of pain and inflammation in the joint, temporary increase in blood sugar, tendon weakening or rupture, thinning of skin and soft tissue around the injection site, whitening or lightening of the skin around the injection site, were discussed with the patient and all questions answered. The patient's specific medical history risks associated with the proposed procedure were discussed and all questions answered. The patient stated they have had no prior adverse reactions to local anesthesia. The patient verbalized consent. The patient was given the opportunity to answer any questions about any complications that I discussed with the patient. The technique and what to expect from the procedure itself was explained, and all questions were answered. Post-injection care and follow-up treatment options were discussed, and the patient understands the treatment plan.

From a lateral approach, I injected the right side, retrocalcaneal bursa with 0.25 cc of Kenalog 40 mixed with lidocaine plain. The patient was completely relieved of the symptoms with walking and standing, he wants to consider this at the left side at the next encounter also given.....mild retrocalcaneal bursitis

FOLLOWUP:
I can see him back in 2 weeks and re-evaluate this for him.

WORK STATUS:
The patient will continue with work modification, restrictions.

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

Barry Meskin, DPM
Podiatry

This document is electronically signed by: Barry Meskin, DPM on 12/09/2022 11:04:06

BM/AQuity
DD: 12/05/2022 11:54:12
DT: 12/05/2022 13:13:33
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