

Nataly McClain

From: Cavazos, Christine <Christine.Cavazos@sedgwick.com>
Sent: Monday, August 14, 2023 4:21 PM
To: HiltonUR
Subject: RE: UR Referral: DEHARO DE SEGURA, BERTHA: 4A2303X58L0-0001: DOI: 3/16/23
Attachments: NGSIR_server_SGKFTN1VWEB01N-1692055137-11.tif

Hell MedEx, Please find the attached 8/14/23 RFA w/ 8/11/23 Kaiser PR2. Please issue approval for Orthopedic Consultation within Hilton MPN link as follows: www.medexadvantage.com/plus/hilton. DCN: 5220230814010350.

Thank you in advance.

Sincerely,

Christine Cavazos | Senior Claims Examiner WCCA, SIP
Sedgwick Claims Management Services, Inc., CA
DIRECT 925.975.1930 | FAX 888.488.9559
EMAIL Christine.Cavazos@sedgwick.com
sedgwick.com | caring counts



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TIME RECEIVED
August 14, 2023 at 11:56:25 AM EDTREMOTE CSID
ttys6DURATION
144PAGES
6STATUS
Received

From ttys6

Mon 14 Aug 2023 08:53:47 AM PDT

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Kaiser Permanente Occupational Health Fax Cover Sheet

Recipient's Name:	Sedgwick/Embassy Suites
Recipient's Fax Number:	(877) 922-7236
Recipient's Phone Number:	

Recipient's Address:	Attn: UR/Current Adjuster UR Fax: 925-933-9559 / 877-922-7236
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Sender's Name:	LINDSAY A OROZCO
Sender's Fax Number:	(707) 258-4914
Sender's Phone Number:	(707) 258-4909

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Comments:

RFA New Request / PR2 for DEHARO DESEGURA, BER MR 16155942 CL # 4A2303X58L0-0001 for 08-11-2023 Visit EMBASSY SUITES BY HILTON NAPA *Request for auth for Ortho 2nd Opinion (OUTSIDE KAISER PROVIDER)

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.

<input checked="" type="checkbox"/> New Request	<input type="checkbox"/> Resubmission - Change in Material Facts	<input type="checkbox"/> Retrospective Review
<input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health		
<input type="checkbox"/> Check box if request is a written confirmation of a prior oral request. <input type="checkbox"/> Updated Request		

Employee Information:

Name (Last, First, Middle): DEHARO DESEGURA, BER	Date of Birth (MM/DD/YYYY): 04-08-1974
Date of Injury (MM/DD/YYYY): 03-16-2023	Claim Number: 4A2303X58L0-0001
Employer: EMBASSY SUITES BY HILTON NAPA	

Requesting Physician Information:

Name: SPRINKLE, THOMAS	Contact Name: LINDSAY A OROZCO
Practice Name: Kaiser Permanente KOJ	
Address: 3285 Claremont Way 2nd Fl	City: Napa State: CA
Zip Code: 94558	Phone: (707) 258-4909
Fax Number: (707) 258-4914	
Specialty:	NPI Number: 1881680312

E-mail Address:

Claims Administrator Information:	Contact Name: Christine Cavazos
Company Name: SEDGWICK CLAIM MGMT SVCS INC	
Address: PO BOX 14421	City: LEXINGTON State: KY

Zip Code: 40512 Phone: (800) 705-9423

Fax Number:

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)
RIGHT SHOULDER	S43.401A	Orthopedic Consult		I RFA ortho consult 2nd opinion for rotator

There are 1 request(s) on this form.

**Note: Above data may be truncated due to insufficient space.
See continuation pages.**

Requesting Physician Signature: Physician's Electronic Signature on File in Medical Record Date: 08-14-2023
SPRINKLE, THOMAS

Claims Administrator/Utilization Review Organization (URO) Response:	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied or Modified (See separate decision letter)
<input type="checkbox"/> Requested treatment has been previously denied	<input type="checkbox"/> Delay (See separate notification of delay)
<input type="checkbox"/> Liability for treatment is disputed (See separate letter)	
Authorization Number (if assigned):	Date:
Authorized Agent Name:	Signature:
Phone:	Fax Number:
Comments:	E-mail Address:

**State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA**

Diagnosis: RIGHT SHOULDER SPRAIN, INIT (primary encounter diagnosis)
ICD Code: S43.401A
Procedure: Orthopedic Consult
CPT/HCPCS:
Other Info: 1 RFA ortho consult 2nd opinion for rotator cuff tear reconstruction, doi 3/16/23 **OUTSIDE KAISER PROVIDER - REQUIRES WRITTEN AUTH**

KAISER PERMANENTE Claim#: 4A2303X58L0-0001 DOI:03-16-2023 Visit:08-11-2023 09:10 ReportDate:08-11-2023 Final:X
 Patient:DEHARO DESEGURA, BER MR: 16155042 WCAB#: FACNAP Contact:(707) 651-2069 Carrier DOR (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.

<input type="checkbox"/>	Temporary Report - Patient is still receiving treatment from me.
<input type="checkbox"/>	Patient is recovering from an injury or condition.
<input type="checkbox"/>	Patient is recovering from an illness.
<input type="checkbox"/>	Patient is recovering from an operation.
<input type="checkbox"/>	Patient is recovering from an accident.
<input type="checkbox"/>	Patient is recovering from an infection.
<input type="checkbox"/>	Patient is recovering from an exposure.
<input type="checkbox"/>	Patient is recovering from an environmental condition.

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

15. MR 16155942	16. SSN XXX-XX-XXXX
17. Name DEHARO DESEGURA, BER	
18. Address 2881 KELLER CT	
19. City NAPA	State CA
20. DOY 03-16-2023	21. DOB 04-08-1974
22. Sex F	
23. Phone (707) 812-9670	24. Fax
25. Occupation Housekeeper	
26. Phone (800) 705-9423	27. Fax (888) 488-9559
28. Claim 4A2303X58L0-0001	29. WCAB

30. Employer Name: EMBASSY SUITES BY HILTON NAPA 31. Employer Phone: (707) 253-9540

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

32. Subjective Complaints:

Bertha Deharo Desegura is a 49 Y right hand dominant female.

Patient still has some pain in right shoulder with extension and flexion.
 Not currently working.

Review of Systems:

Musculoskeletal: negative for generalized myalgias/arthritis/

Relevant Medications: see list.

Allergies: Patient has no known allergies.

Social History: reports that she has never smoked. She has never used smokeless tobacco.

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

Physical Exam: no apparent distress

Right shoulder:-

Right shoulder has decent range of motion and gets to almost 160 degrees before she has to use some other muscles to reach full range. Cap refill less than 2 seconds. Equal grips. Mild weakness with empty beer can test.

Additional Information Reviewed

Radiology Results:

MRI Results:

5/17/23 MRI right shoulder without contrast from Norcal imaging outside facility: 1. Full thickness tear of supraspinatus and infraspinatus tendons with torn tendon fibers retracted to the level of the glenoid rim. There is mild atrophy of the supraspinatus infraspinatus muscles is suggestive of chronic rotator cuff tears. 2. Small to moderate joint effusion with mild degenerative synovitis, fluid communicates with the subacromial/subdeltoid bursa through the rotator cuff tear. 3. Mild tendinosis of the intra-articular biceps tendon. Fraying versus degenerative tearing of the superior labrum. 4. Mild degenerative changes of the acromioclavicular joint.

Encounter Assessment
 (S46.011D) TRAUMATIC RIGHT ROTATOR CUFF TEAR, SUBSEQ (primary encounter diagnosis)

KAISER PERMANENTE Claim# 4A2303X58L0-0001 DOI:03-16-2023 Visit:08-11-2023 09:10 ReportDate:08-11-2023 Final;Y
 Patient:DEHARO DESEGURA, BER MR:16155042 WCAB#: PACNAP Contact:(707) 651-2849 Carrier DOI: (if available):

State of California Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)
(M25.511) RIGHT SHOULDER JOINT PAIN

34. Diagnostic Studies Ordered:

35. Diagnoses

Diagnosis

1. RIGHT SHOULDER SPRAIN, INIT (primary encounter diagnosis)
- 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.)

TRAUMATIC RIGHT ROTATOR CUFF TEAR, SUBSEQ (primary encounter diagnosis)

Note: not working currently. Pain with rom mild. Ortho rec surgery. Need 2nd opinion after denial.

RFA ortho consult 2nd opinion for rotator cuff tear reconstruction, doi 3/16/23

RIGHT SHOULDER JOINT PAIN

Note: see above

RFA ortho consult 2nd opinion for rotator cuff tear reconstruction, doi 3/16/23

Next Appointment: 9/12/2023 9:10 AM

OTHER NEEDS/RESTRICTIONS: No lifting/carrying/pushing/pulling more than 10 lbs with right upper extremity. No overhead or repetitive work with the right arm.

ADDITIONAL COMMENTS: Employer:Embassy Suites Contact:Jenny P-320-9512 Sec F.No DOI:03/16/23 CL# 4A2303X58L0-0001/r ARM/SHOULDER

WC Carrier: Sedgwick P-800-597-7677

Adj:Christine Cavazos Dir P: 925-975-1930 F:925-933-9559

*Interp Svcs: ProCare P: 866-941-7878

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 08-11-2023 with the following limitations or restrictions.

49. Limitations:

Modified Activity (Applies to work and home)

This patient is placed on modified activity at work and at home from 8/11/2023 through 9/12/2023.

If modified activity is not accommodated by the employer then this patient is considered temporarily and totally disabled from their regular work for the designated time and a separate off work order is not required.

KAISER PERMANENTE Claim#:4A2303X58L0-0001 DOI:03-16-2023 Visit:08-11-2023 09:10 ReportDate:08-11-2023 Final:Y
Patient:DEHARO DESEGURA, BER MR:16155942 WCAB#: FACNAP Contact:(707) 651-2969 Carrier DOD (if available):

State of California Division of Workers' Compensation

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

Other needs and/or restrictions:

No lifting/carrying/pushing/pulling more than 10 lbs with right upper extremity. No overhead or repetitive work with the right arm.

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 08-11-2023
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 which prohibits referral to a physician or entity with whom the physician has an unlawful financial interest.

53. IRS Number 94-2728480

Signature _____ Electronic Signature on File in Medical Record _____

Executed at _____

54. Name SPRINKLE, THOMAS

56. Address 3245 Claremont Way 2nd Fl, Napa, CA, 94558

Signature Date _____

55. California Lic# 084150A

57. Phone (707) 651-2969

Specialty _____

v3.0

