Arrowhead Orthopaedics

Treatment Plan Summary

Martinez, Sonia
Patient ID: 00001575894
DOB: 11/07/1968
Age: 54 years **Gender:** F

09/08/2023

Date: 09/08/23 : 04:18pm
Title: Request for Authorization

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

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

[X] New Request		[] Resubmission - Change in Material Facts	
[] Expedited Review: Check box if employee face 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: SoniaMartinez			
Date of Injury: 11/28/16	Date of Birth: 11/07/68		
Claim Number: 124646	Employer: County of San Bernardino		
Requesting Physician Information			
Name: Jason Solomon, MD			
Practice Name: Arrowhead Orthopaedics	Contact Name: Brittany Valadao at 909 557 1600 x 1081		
Address: 15095 Amargosa Rd., Bldg 1 Suite 106	City: Victorville	State: CA	
Zip Code: 92394	Phone: (760) 245-6495	Fax Number: 909 989 4477 **E-MAIL: wcauthorizations@arrowheadortho.com**	
Specialty: Orthopaedics	NPI Number: 1336187475		
Email Address:			
Claims Administrator Information			
Company Name: County of San Bernardino	Contact Name: 909-386-9046		
Address: 222 W Hospitality Lane	City: San Bernardino	State: CA	
Zip Code: 92408	Phone: 19093868711	Fax Number:	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

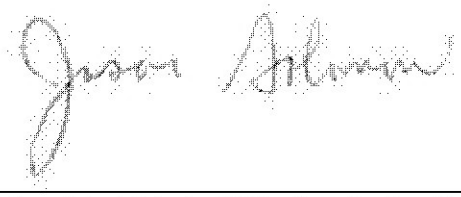
List each specific requested medical services, good, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below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

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
left shoulder pain, ac joint oa left arm numbness	M19.012 M25.512 M54.10	MRI of the LEFT shoulder w/o contrast EMG/NCS of the BILATERAL Upper Extremities, **NOT WITH DR. RONALD LEVIN**		For Peer to Peer Please contact: Brittany Valadao at 909 557 1600 x 1081

09/08/2023

		Doctor Peer to Peer Availability: September 13, 14, 19, 21, from 9:00 to 3:00		

Requesting Physician Signature: *Jason Solomon, MD*



Date: **09/08/23**

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:	Email Address:

Comments:

ARROWHEAD ORTHOPAEDICS

Victorville - Ph: (760) 245-6495

PATIENT INFORMATION:

Patient Name:	**Martinez, Sonia**			ID#:	**00001575894**
Patient Address:	**16548 Silica Dr**			DOB:	**11/07/1968**
Patient City, ST, Zip:	**Victorville**	**CA**	**92395-7838**	Patient Sex:	**F**
Patient Home Ph#:	**(909)322-9475**			Ref. Source:	
Patient Work Ph#:				Ref. Source Ph#:	
Patient Cell Ph#:				Ref. Source Fax#:	

INSURANCE INFORMATION:

Account Type:	**WC**		
Primary Insurance:	**County Of San Bernardino 222**	Secondary Insurance:	**County Of San Bernardino**
ID/Claim #:	**999999999**	ID/Claim #:	**999999999**
Address:	**222 W Hospitality Ln** **Sn Bernrdno CA 924150013**	Address:	**222 W Hospitality Ln** **Sn Bernrdno CA 924150013**
Authorization #:		Authorized by:	
Authorization Date:		NCM Name:	
Adjustor Name:		NCM Phone:	
Adjustor Phone:		NCM Fax:	
Employer:		Employer Ph#:	

TREATMENT REQUEST

Urgency: **ROUTINE**

Height: Weight: BMI:

Treatment Proposed: **mri of the left shoulder w/o contrast**

Treatment CPT:

Diagnostic Test:

Diagnostic CPT:

DME:

HCPCS:

Follow Up Appt.

Follow UP CPT:

Diagnosis: **left shoulder pain, ac joint oa**

ICD-9:

Comments:

Medical Assistant: **lesley a**

Physician Assistant:

Surgeon's Signature: *Jason A. Solomon, MD* Date: **09/08/2023**

(electronically signed)

Risk Management 2023-09-11 8:40AM

ARROWHEAD ORTHOPAEDICS

Victorville - Ph: (760) 245-6495

PATIENT INFORMATION:

Patient Name:	**Martinez, Sonia**			ID#:	**00001575894**
Patient Address:	**16548 Silica Dr**			DOB:	**11/07/1968**
Patient City, ST, Zip:	**Victorville**	**CA**	**92395-7838**	Patient Sex:	**F**
Patient Home Ph#:	**(909)322-9475**			Ref. Source:	
Patient Work Ph#:				Ref. Source Ph#:	
Patient Cell Ph#:				Ref. Source Fax#:	

INSURANCE INFORMATION:

Account Type:	**WC**		
Primary Insurance:	**County Of San Bernardino 222**	Secondary Insurance:	**County Of San Bernardino**
ID/Claim #:	**999999999**	ID/Claim #:	**999999999**
Address:	**222 W Hospitality Ln** **Sn Bernrdno CA 924150013**	Address:	**222 W Hospitality Ln** **Sn Bernrdno CA 924150013**
Authorization #:		Authorized by:	
Authorization Date:		NCM Name:	
Adjustor Name:		NCM Phone:	
Adjustor Phone:		NCM Fax:	
Employer:		Employer Ph#:	

TREATMENT REQUEST

Urgency: **ROUTINE**

Height: Weight: BMI:

Treatment Proposed: **emg / ncv of the bilateral upper extremities**

Treatment CPT:

Diagnostic Test:

Diagnostic CPT:

DME:

HCPCS:

Follow Up Appt.

Follow UP CPT:

Diagnosis: **left shoulder pain, ac joint oa**

ICD-9:

Comments:

Medical Assistant: **lesley a**

Physician Assistant:

Surgeon's Signature: *Jason A. Solomon, MD* Date: **09/08/2023**

(electronically signed)

Risk Management 2023-09-11 8:40AM

09/08/2023

Date: 09/08/23 : 11:19am
Title: PR-2; Jason A. Solomon, M.D.

Additional pages attached: [ ]

ARROWHEAD ORTHOPAEDICS

STATE OF CALIFORNIA
Division of Worker's 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.

[ ] 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: **Martinez**	First: **Sonia**	Middle:	Sex: female
Address: **16548 Silica Dr**	City: **Victorville**	State: **CA**	Zip: **92395-7838**
Date of Injury: **11/28/16**		Date of Birth: **11/07/68**	
Occupation:	SS#: **547-39-1875**	Phone: **(909)322-9475**	

Claims Administrator:

Name: County of San Bernardino	Claim #: 124646		
Address: **222 W Hospitality Lane**	City: **San Bernardino**	State: **CA**	Zip: **92408**
Phone: **19093868711**	FAX:		
Adjustor: **909-386-9046**			
Employer Name: County of San Bernardino	**Employer Phone:**		

Interpreter: N/A

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

HISTORY OF PRESENT ILLNESS

Sonia Martinez is a 54 year-old, left-hand-dominant female who presents for complaints referable to her left shoulder. The patient was last seen on 07/21/2017.

CURRENT COMPLAINTS

Since the patient's last visit she reports worsened symptoms and rates her pain as a 7 on a pain scale from 0-10. Patient is currently taking motrin as needed for pain control. The patient also has complaints of weakness , numbness ,tingling , stiffness in her left shoulder .

Treatment to date has included medication. Diagnostic studies to date include x-rays, an MRI EMG

09/08/2023

CURRENT WORK STATUS

The patient is currently working regular duties.

PHYSICAL EXAMINATION

The patient is 5'3" tall, weighs 172 lbs. Respirations are regular. She is alert and oriented, well-nourished, well-developed, and in no apparent distress. Mood and affect are appropriate.

lue
2+ r/u pulse
ain/pin/m/u/r/mc/ax motor intact
m/u/r/ax sensory intact
elbow 0-140 sp 80/80 wrist ex 70 fx 70 rd 10 ud 40 fdm
sh ff 170 abd 90 er 50 ir l3, pain w resisted ff abd er ir
5/5 ff abd er ir strength
+tinels carpal tunnel

DIAGNOSTIC STUDIES

No x-rays were taken today.

IMPRESSION

left shoulder pain, ac joint oa
left arm numbness

TREATMENT RECOMMENDATIONS

I have explained my diagnosis and treatment recommendations to Sonia and all of her questions were answered. We discussed operative versus nonoperative measures of treatment with the patient. I have not seen this patient since 2017. She needs a left shoulder mri to assess her cuff and a bilateral emg/ncs.

After discussing all the risks and benefits of a cortisone injection, the patient agreed to have an injection to the left shoulder. This was performed to the subacromial space. Using sterile procedure and ethyl chloride for mild anesthesia, I injected (using a 22G needle) a combination of 4cc 1.0% lidocaine without epi, and 1cc Celestone (30mg).. The patient tolerated the procedure well.

We will order a MRI of the LEFT shoulder .

We will request authorization for an EMG/NCS of the BILATERAL Upper Extremities .

FOLLOW UP

The patient will follow up after ordered tests have been completed

WORK STATUS

09/08/2023

Regular Duties

PEER TO PEERS

Utilization Review: In the event that you have questions after reviewing this report and need to speak to me directly please call Mayra H at 909-557-1656 for the Redlands office and Wendy R at 951-977-2430 for the Riverside office.

Patient Education: N

Primary Treating Physician: (original signature, do not stamp) Date of exam: **09/08/23**
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: Electronically signed- *Jason A. Solomon M.D*
11:21 AM

Executed at: Arrowhead Orthopaedics
Name: Jason A. Solomon, M.D.
Address: 15095 Amargosa Road, Suite 106 & 108
Victorville, CA 92394
Phone: 760-245-6495 Fax: 760-493-3223
Reexamination date:

Cal Lic. A129166
Date: 09/08/23
Specialty: Orthopaedic Surgeon

DWC Form PR-2 (Rev. 01.01.05)

Nurse Case Manager:
Phone:
Fax:

Defense Attorney:
Address:

Phone:
Fax:

Applicant Attorney:
Address:

Phone:
Fax:

la

BILLING

County Of San Bernardino 222

09/08/2023

Procedure Codes:

Procedure: New Detailed: 99203

Procedure: PR-2: WC002

Major Joint - Single
Procedure: Inject Major Jt: 20610 (x1)
Procedure: Lidocaine 1%: J2001 (x4cc)
Procedure: Celestone 30mg/5mL (6mg/mL): J0702 (x1cc)

Diagnosis Codes:
Diagnosis: Pain in left shoulder : ICD10 = M25.512 / ICD9 = 719.41 / SNOMED = 267949000
Diagnosis: Osteoarthritis of AC joint : ICD10 = M19.012 / ICD9 = 715.91 / SNOMED = 239865003
Diagnosis: Radiculopathy : ICD10 = M54.10 / ICD9 = 729.2 / SNOMED = 72274001

Progress Note Status:

Action Item: Progress Note Complete - Victorville

#Orders: Treatment Request Form, Treatment Request Form

SIGNED BY Jason A Solomon, MD (JSO) 09/08/2023 11:34A