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Jan 27, 2015 11:39 Front Desk
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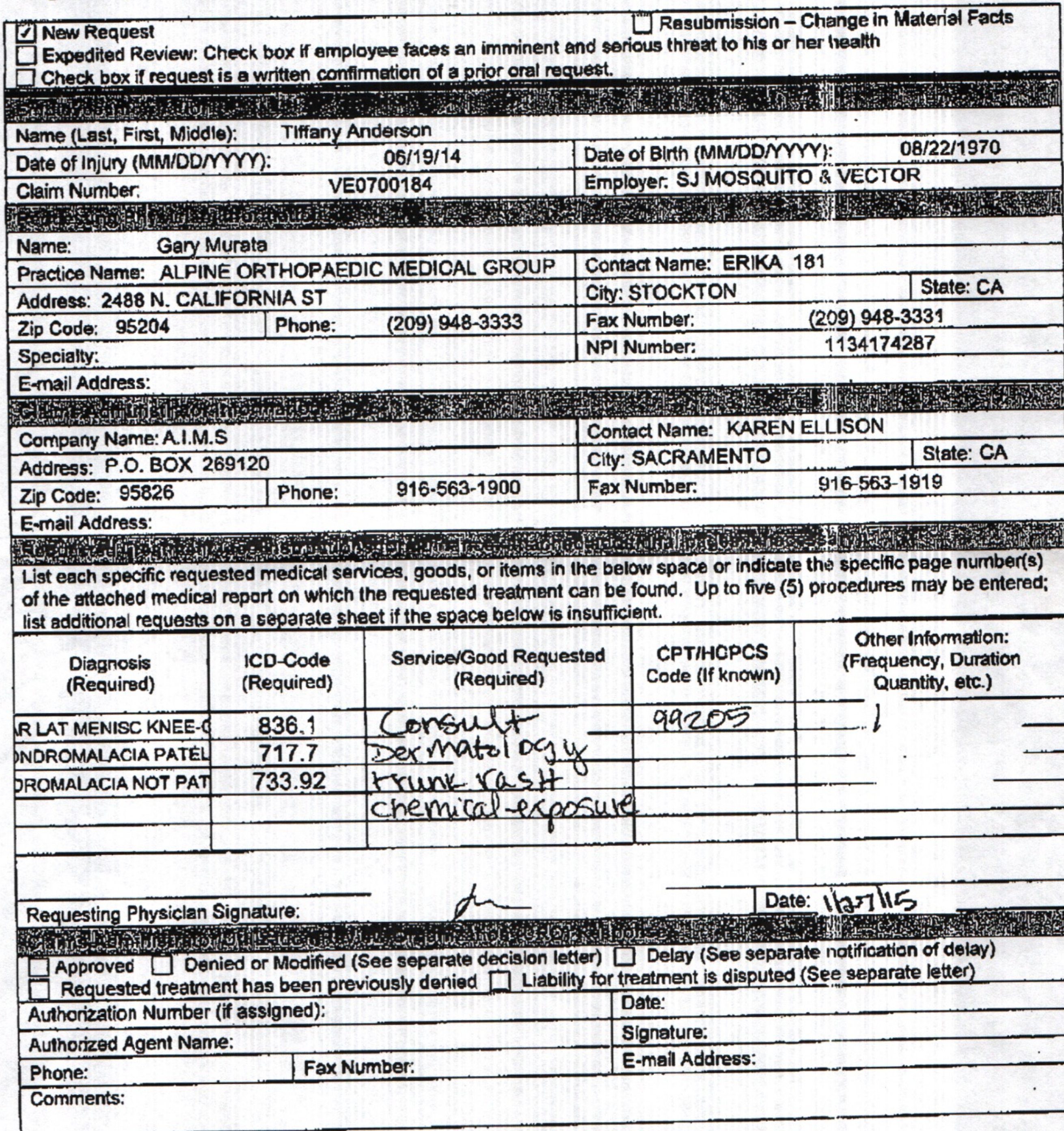
State of California, Division of Workers' Compensation

# 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): Tiffany Anderson
Date of Injury (MM/DD/YYYY): 06/19/14 | Date of Birth (MM/DD/YYYY): 08/22/1970
Claim Number: VE0700184 | Employer: SJ MOSQUITO & VECTOR

**Requesting Physician Information**

Name: Gary Murata
Practice Name: ALPINE ORTHOPAEDIC MEDICAL GROUP | Contact Name: ERIKA 181
Address: 2488 N. CALIFORNIA ST | City: STOCKTON | State: CA
Zip Code: 95204 | Phone: (209) 948-3333 | Fax Number: (209) 948-3331
Specialty: | NPI Number: 1134174287
E-mail Address:

**Claims Administrator Information**

Company Name: A.I.M.S | Contact Name: KAREN ELLISON
Address: P.O. BOX 269120 | City: SACRAMENTO | State: CA
Zip Code: 95826 | Phone: 916-563-1900 | Fax Number: 916-563-1919
E-mail Address:

**Requested Treatment (see instructions for guidance; attached 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.) |
|---|---|---|---|---|
| R LAT MENISC KNEE-C | 836.1 | Consult | 99205 | 1 |
| NDROMALACIA PATEL | 717.7 | Dermatology | | |
| DROMALACIA NOT PAT | 733.92 | trunk rash | | |
| | | chemical exposure | | |
| | | | | |

Requesting Physician Signature: [signature] | Date: 1/27/15

**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:



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Additional pages attached ☑

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

☑ 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:

Last ANDERSON First TIFFANY M.I. Sex F
Address 2 N Avena Ave City Lodi State CA Zip 95240
Date of Injury Date of Birth 8/22/1970
Occupation SS # 549-23-5133 Phone (209) 625-8587

**Claims Administrator:**
Name A.I.M.S. Claim Number VE0700184
Address City State Zip
Phone ( ) FAX ( )

**Employer name:** Employer Phone

**Work Status:** This patient has been instructed to:

☐ Remain off-work until ____.
☐ Return to *modified* work 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.

**Date of exam:** 1/21/2015
**Subjective complaints:**

Ms. Anderson continues to have pain and weakness as well as catching about her right knee. In the past she has had improvement with these symptoms with physical therapy. She is interested in another course of physical therapy. She also notes improvement with over-the-counter topical essential oils as well as ingested oils. She brought in a number of her records outlining exposures and different types of complaints. Apparently in June of 2004, she had a first exposure with a rash. On January 25 th, she had a second exposure. On October 1 st, she had a third exposure where she fell into a ditch with water. She documents injuries to her right knee in June of 2006, March 2009, and July 2009. On November 17, 2009, she noted a whistle blower complaint. She states she had a fourth injury on June 29, 2011, with another exposure. She contacted OSHA from December 9, 2009, to April 4, 2014, noting no training, problems with gaining access to properties, no MSDS for all chemicals being applied, poor training, and working around water without a floatation device. She states there are other violations from March of 2004 to January of 2013. She also wanted me to be aware that she was ill in 2012 for six months. She apparently had a room mate who had clostridium difficile and died from aspiration pneumonia. She had exposure to this person.

The above history was reviewed. No fever or chills. She went to PT with good improvement. She is feeling better from the PT and from the last visit. She is interested in more PT and requesting for the PT again. Today she states that she feels more pain and a rash about her trunk and head secondary to toxic exposure from her most recent knee injury.

**Diagnoses:**

1. TEAR LAT MENISC KNEE-CUR — ICD-9 836.1
2. CHONDROMALACIA PATELLAE — ICD-9 717.7
3. CHONDROMALACIA NOT PATELLAR — ICD-9 733.92



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