RE: Benetia Young vs. Star View Adolescent Center

WCAB#: ADJ12620825

(PROOF OF SERVICE BY MAIL - 1013a, 2015.5 C.C.P.)

I am a resident of/employed in the aforesaid county, State of California; I am over the age of eighteen years and not a party to the within action; my business/residence address is: 14531 Hamlin Street, Van Nuys, CA 91411.

On 01-21-20, I served the foregoing

Attending Physician's Report

Applicant Attorney:
Natalia Foley, Esq.
5753 E Santa Ana Cyn Rd., Ste. G#616
Anaheim, CA 92807

Insurance Carrier
Athens Administrators
P.O. Box 696
Concord, CA 94522

On the interested parties in this action by placing the true copy thereof, enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Van Nuys, California, addressed as follows:

I certify (or declare), under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

01-21-20

Date

Signature of Declarant

IRENA E. HAMAMDJIAN

Full name of Declarant

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.

X 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

Young
Patient last name:

Benetia
Patient first name:

MI

20322 S Amantha Ave.
Patient Street Address/PO Box

Carson
Patient City

CA
State

90746
Zip Code

Female
Sex

shift lead
Occupation

[1] 310-415-1029
Phone Number

Date of Birth 1/8/1965

Claims Administrator

Date of Injury CT:
04/18/2019-10/10/2019

Athens Administrators
Claims Administrator Name:

19006760
Claim number:

P.O. Box 696
Claims Administrator Street Address/

Concord
Claims Administrator City

CA
State

94522
Zip Code

[1] 866-482-3535
Phone Number

Fax Number

Star View Adolescent Center
Employer Name

Phone Number

Subjective Complaints (The information below must be provided. You may use this form or you may substitute or append a narrative report):

Continued symptoms of both anxiety and depression.

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

Continued objective functional improvement documented on progress note.

1. Major Depressive Disorder, Single Episode	ICD-10	F32.9
2. Generalized Anxiety Disorder	ICD-10	F41.1
3. Psychological Factors Affecting Medical Condition (stress-intensified headache, neck/shoulder/low back tension/pain, TMJ/dental reaction, nausea, chest pain, shortness of breath, peptic acid reaction, constipation, abdominal pain/cramping, diarrhea and possible stress-aggravated high blood pressure)	ICD-10	F54
4.	ICD-10	

ICD-10

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?

Psychiatric medication (90792)
CBT Psychotherapy (90834)
All as needed and all as requested by RFA in effect according to guidelines.

Work Status: This patient has been instructed to:

☐ Remain off-work_____. **In the initial evaluation of 11-18-19, it was not possible to estimate the return-to-work date for regular or modified work. Defer to 2 to 3 months from today, 01-21-20.**

☐ See P&S evaluation of _____.

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

Ms. Young was found to be temporarily totally disabled on a combined physical and psychological basis.

☐ Return to full duty on_____ with no limitations or restrictions.

Primary Treating Physician: *(original signature, do not stamp)* Date of exam 11-18-19 (Last Treatment).

Physician signature:_____ Cal. License. Number : A23197

Executed at: Van Nuys, CA Date: 01-21-20

Physician Name: Thomas Curtis M.D. Specialty: Psychiatry

Physician address: 14531 Hamlin Street, Van Nuys, CA 91411 Phone Number: (818)780-4409

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.

Re: Benetia Young vs. Star View Adolescent Center
WCAB #: ADJ12620825

(PROOF OF SERVICE BY MAIL - 1013a, 2015.5 C.C.P.)

I am a resident of/employed in the aforesaid county, State of California; I am over the age of eighteen years and not a party to the within action; my business/residence address is: 14531 Hamlin Street, Van Nuys, CA 91411.

On 12/31/2019 , I served the foregoing document described as:

Hamlin Psyche Center Progress Note, Request for Authorization for Medical Treatment Form, and Copy of Prescriptions

On the interested parties in this action by placing the true copy thereof, enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Van Nuys, California, addressed as follows:

WCAB#:ADJ12620825
(Report served upon applicant attorney)

Applicant Attorney:
Natalia Foley, Esq.
5753 E Santa Ana Cyn Rd., Ste. G#616
Anaheim, CA 92807

Insurance Carrier:
Athens Administrators
P.O. Box 696
Concord, CA 94522

Defense Attorney:

I certify (or declare), under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

12/31/2019
Date

Joaquin C Perez
Signature of Declarant

Joaquin Perez
Full Name of Declarant

THOMAS A. CURTIS, M.D.

CA Lic. #A23197 DEA #AC4289460

☐ **VAN NUYS - 818-780-4409 - MAIN OFFICE**
14531 Hamlin Street, Van Nuys, CA 91411

BATCH #VP011459J

☑ **LONG BEACH - 562-513-3435**
4300 Long Beach Blvd., Suite 240, Long Beach, CA 90807

☐ **LOS ANGELES - 213-352-1397**
3251 W 6th St., Holmes Center, Suite B2, Los Angeles, CA 90020

No. 1036 Serial#VLP191001A01236

hepps

DESCRIPTION OF SECURITY FEATURES ON REVERSE SIDE

Name Benetia Young D.O.B. 1/8/65

Address _____ Phone _____

Wellbutrin 100mg #60
1am/1noon
depression

Quantity: ☐1-24 ☐25-49 ☒50-74 60
☐75-100 ☐101-150 ☐151 and over Units_____
Refills ☒0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐ Do not substitute

Buspar 10mg #60
1bid
anxiety

Quantity: ☐1-24 ☐25-49 ☒50-74 60
☐75-100 ☐101-150 ☐151 and over Units_____
Refills ☒0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐ Do not substitute

Ambien 5mg #14
1ahs
sleep

Quantity: ☒1-24 ☐25-49 ☐50-74 14
☐75-100 ☐101-150 ☐151 and over Units_____
Refills ☒0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐ Do not substitute

Quantity: ☐1-24 ☐25-49 ☐50-74
☐75-100 ☐101-150 ☐151 and over Units_____
Refills ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐ Do not substitute

3

Prescription is VOID if the number of drugs prescribed is not noted. _____ ☐1 ☐2 ☒3 ☐4

SP 02 X _____ Date 11/18/19

HAMLIN PSYCHE CENTER PROGRESS NOTE

PATIENT: BENETIA YOUNG
DATE: 11/18/2019
DATE OF INJURY: CT:04/18/2019 - 10/10/2019
DOB: 1/8/1965
CLAIMS ADMINISTRATOR: ATHENS ADMINISTRATORS
ADJUSTER: TIMOTHY CHAPIN
CLAIM NUMBER: 19006760

TOTAL # OF CBT SESSIONS: _____ **EXPIRY DATE:** _____

TODAY'S SESSION #: _____

I. SERVICES PROVIDED

PSYCHE DIAGNOSTIC EVAL (USE FOR DISABILITY FORMS, DISABILITY EXTENSIONS, SSD, RTW, ETC.)

☑ Med Management ☐ e-Rx ☐ Initial SDI Form ☐ SDI Extension ☐ FMLA form
☐ LTD/Ret Form ☐ SSD Form ☐ RTW/Disability Form ☐ Other Form ☐ Referral

E/M SERVICE: DO NOT USE WITH PSYCHE DIAGNOSTIC EVAL

☐ 15 MIN ☐ 25 MIN ☐ 40 MIN

PSYCHOTHERAPY

☐ Ind. Therapy ☐ Biofeedback ☐ Group Therapy ☐ Telephone Therapy

II. PRESENTING COMPLAINTS—HISTORY OF DEPRESSION

☑ Depression ☑ Decreased energy ☐ Pessimism
☑ Changes in appetite ☑ Changes in weight (up or down) ☐ Diminished self-esteem
☑ Lack of motivation ☑ Difficulty thinking ☐ Emptiness and inadequacy
☑ Difficulty getting to sleep ☑ Difficulty staying asleep ☐ Early morning awakening

II. PRESENTING COMPLAINTS—HISTORY OF ANXIETY

☑ Excessive worry ☑ Panic attacks ☐ Shaking
☑ Restlessness ☑ Feeling "keyed up" or on edge ☐ Chest pain
☑ Jumpiness ☑ Inability to relax ☐ Palpitations
☑ Tension ☑ Pressure ☐ Nausea
☑ Agitation ☑ Agoraphobia ☐ Shortness of breath

II. PRESENTING COMPLAINTS—HISTORY OF PTSD

☑ Disturbing memories ☑ Reliving of the trauma ☑ Flashbacks ☐ Intrusive recollections

II. PRESENTING COMPLAINTS --HISTORY OF CONFUSION:

☐ Hearing voices ☐ Seeing things ☐ Paranoia ☐ Conspiracy

II. PRESENTING COMPLAINTS—HISTORY OF STRESS-RELATED MEDICAL COMPLAINTS

☑ Tension headache ☑ Increased Pain ☑ Peptic acid reaction
☑ Muscle tension ☑ Sexual dysfunction ☑ Abdominal pain/cramping
☑ TMJ/jaw clenching ☑ Dermatological reaction ☐ Constipation or diarrhea (circle)

III. IMPROVEMENTS IN SYMPTOMS AND FUNCTIONS

☐ Concentrate better ☐ Gets along better ☐ Less headache ☐ Less sad mood
☐ Comprehend TV ☐ Less time in bed ☐ Fewer GI complaints ☐ Less yelling
☐ Can sleep better ☐ Goes out more ☑ Less irritable ☐ Less nervous
☐ Less sexual dysfunction ☐ More outgoing ☐ Less panicky ☐ Less pain

IV. OBJECTIVE BEHAVIORS—MENTAL STATUS EXAMINATION

Physical Appearance:
☑ Casually dressed ☐ Formally dressed ☐ Unkempt ☐ Inappropriately dressed

Initial Presentation:
☑ Depressed ☐ Visibly Anxious ☐ Defensive ☐ Agitated ☐ Suicidal ☐ Homicidal

Cognition:
☑ Distracted ☐ Rambling ☐ Defective Recall ☐ Slow In Thinking

Judgment And Motivation:
☑ Judgment Unimpaired ☐ Judgment Impaired ☐ Interested In TXT ☐ Not Interested In TXT

HAMLIN PSYCHE CENTER PROGRESS NOTE

V. DISABILITY STATUS

☐ TTD ☐ TPD ☐ Permanent and Stationary ☐ Future Award

Remain off work until:→

Return to work on:→

No Restrictions→

Restrictions→

See 45-day PR-2 Form, Return to Work Form or Special or Other Report

VI. DIAGNOSES

1	Major Depressive Disorder, Single Episode	ICD-10	F32.9
2	Generalized Anxiety Disorder	ICD-10	F41.1
3	Psychological Factors Affecting Other Medical Conditions	ICD-10	F54
4		ICD-10	
5		ICD-10	
6		ICD-10	
7		ICD-10	
8		ICD-10	
9		ICD-10	
10		ICD-10	

VII. TREATMENT PLAN

☐ Patient advised of proper sleep hygiene
☐ Patient advised of benzodiazepene risks

CHANGES IN TREATMENT OR MEDICATIONS, IF NEEDED EXPLAIN IN BOX

☐ No change
☐ Add (list to right)
☐ Discontinue (list to right)
☐ Increase (list to right)
☐ Decrease (list to right)

See pt4

THERAPIST SIGNATURE:		**PHYSICIAN SIGNATURE:**	
MA SIGNATURE:		**INTERPRETER**	
THOMAS A. CURTIS, MD		**PATIENT SIGNATURE:**	

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): **Young, Benetia**	
Date of Injury (MM/DD/YYYY): **CT:04/18/2019 - 10/10/2019**	Date of Birth (MM/DD/YYYY): **1/8/1965**
Claim Number: **19006760**	Employer: **Star View Adolescent Center**

Requesting Physician Information

Name: **Thomas Curtis, M.D.**			
Practice Name: **Hamlin Psyche Center**		Contact Name: **Stella Natelli**	
Address: **14531 Hamlin Street**		City: **Van Nuys**	State: **CA**
Zip Code: **91411**	Phone: **(818) 780-4409**	Fax Number: **(818) 780-4472**	
Specialty: **Psyche**		NPI Number: **1952516601**	
E-mail Address:			

Claims Administrator Information

Company Name: **Athens Administrators**		Contact Name: **Timothy Chapin**	
Address: **P.O. Box 696**		City: **Concord**	State: **CA**
Zip Code: **94522**	Phone: **[1] 866-482-3535**	Fax Number:	
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.)
Major Depressive Disorder, Single Episode Generalized Anxiety Disorder Psychological Factors Affecting Other Medical Conditions	F32.9 F41.1 F54	Prescription of Medications	90862	☑ no refills ☐ 1 refill Wellbutrin 100mg #60 tam/noon depression Buspar 10mg #60 tbid anxiety. Ambien 5mg #14 tam/prn sleep.
		Prescriptions to be filled by a pharmacist	99605	
		☐ Needs interpreter Please provide or authorize a certified interpreter for all medication and psychological evaluations	N/A	Medical necessity and clinical rationale: To improve depression, anxiety, sleep problems, stress-intensified medical symptoms and the related functional impairment. See prior UR Reconsideration report and/or medication management reports (Please provide a copy of the decision to this office at 14531 Hamlin Street, Van Nuys, Ca 91411)

Requesting Physician Signature: Date: 11/18/2019

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:		