IN THE SUPREME COURT OF THE STATE OF NEVADA

CITY OF HENDERSON, and CCMSI, Appellants, v. BRIAN WOLFGRAM, Respondent.	Supreme Court Case No.: 80982 District Court Case No.: A-18-782711-J

APPELLANTS' APPENDIX VOLUME 2

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CERTIFICATE OF MAILING

Pursuant to Nevada Rules of Civil Procedure 5(b), I hereby certify that, on the _____ day of April 2021, service of the attached **APPELLANTS' APPENDIX VOLUME 2** was made this date by depositing a true copy of the same for mailing, first class mail, and/or electronic service as follows:

Jason Mills, Esq.
GGRM
2770 S Maryland Pkwy #100
Las Vegas, NV 89109

City of Henderson
240 South Water Street MSC 122
Henderson, NV 89015

CCMSI
P.O. Box 35350
Las Vegas, NV 89133

_____
An employee of LEWIS, BRISBOIS, BISGAARD & SMITH, LLP

ORIGINAL

NEVADA DEPARTMENT OF ADMINISTRATION

BEFORE THE APPEALS OFFICER

In the Matter of the Contested Industrial Insurance Claim of BRIAN WOLFGRAM 221 LOOKOUT AVENUE HENDERSON, NV 89002, Claimant.	Claim No. : 14C52E546827 Hearing No. : 1710311-SE Appeal No. : Employer : ATTN: SALLY IHMELS CITY OF HENDERSON 240 SOUTH WATER STREET MSC 122 HENDERSON, NV 89015

RECEIVED AND FILED 2017 JUN 21 PM 4:15

EMPLOYER'S MOTION FOR STAY PENDING APPEAL

COMES NOW the Employer, CITY OF HENDERSON (hereinafter referred to as "Employer"), by and through its attorneys, DANIEL L. SCHWARTZ, ESQ., and LEWIS BRISBOIS BISGAARD & SMITH LLP, and moves this Appeals Officer for a Stay of the execution of the Hearing Officer's Decision and Order, dated May 19, 2017, pending decision on the merits of the appeal by Employer to this Appeals Officer, filed separately.

This Motion is made and based upon the attached Points and Authorities and any arguments of counsel on this matter, requested by the Appeals Officer.

DATED this 21 day of June, 2017.

Respectfully submitted,

LEWIS BRISBOIS BISGAARD & SMITH LLP

By: _____
DANIEL L. SCHWARTZ, ESQ.
Nevada Bar No. 5125
2300 West Sahara Avenue, Suite 300, Box 28
Las Vegas, NV 89102
Phone: (702) 893-3383
Fax: (702) 366-9689
Attorneys for the Employer

STATEMENT OF THE CASE

The present appeal stems from a May 19, 2017, Hearing Officer's Decision and Order, Hearing No. 1710311-SE, which reversed Administrator's February 15, 2017 determination to deny reopening. **(Exhibit pp. 76-77.)**

On October 18, 2014, the claimant, BRIAN WOLFGRAM ("claimant"), alleged an injury to both arms/hands due to assisting with loading approximately 1000 feet of hose while training. The physician on the C-4 Form diagnosed bilateral wrist tenosynovitis, cervical strain r/o radiculopathy and bilateral elbow tenosynovitis. (Exhibit p. 1)

Employer completed a C-3 Form. (Exhibit p. 2)

An Incident Report was completed by claimant. (Exhibit p. 3)

A Witness Report was completed by Brandon Bowyer. He noted that on two occasions he witnessed Wolfgram grimace in pain. (Exhibit p. 4)

Claimant presented to Concentra on October 20, 2014. The history noted repetitive use of the hand and lifting fire hoses. The assessment noted sprains and strains of elbow and forearm, wrist tenosynovitis, and cervical strain r/o radiculopathy. Wrist braces were given. Restrictions were also given. (Exhibit pp. 5-7)

On October 21, 2014, Employer advised of claimant's modified duties. (Exhibit p. 8)

On October 21, 2014, claimant accepted a modified duty position. (Exhibit p. 9)

On October 22, 2014, claimant returned to Concentra. The assessment remained the same. Restrictions continued. (Exhibit pp. 10-11)

Claimant completed a medical release and prior history noting no prior conditions. (Exhibit pp. 12-15)

On October 29, 2014, claimant returned to Concentra reporting upper back pain. Claimant was referred to a hand specialist. (Exhibit pp. 16-18) Same was approved. (Exhibit pp. 19-22)

On November 3, 2014, claimant presented for physical therapy. (Exhibit pp. 23-24) Physical therapy continued. (Exhibit pp. 25-31)

On November 10, 2014, claimant presented to Dr. Young. Electrodiagnostic studies were recommended. (Exhibit pp. 32-33)

On November 17, 2014, claimant presented to Dr. Germin for EMG/nerve conduction studies. The results were negative. (Exhibit pp. 34-40)

On November 19, 2014, claimant was advised that his claim had been accepted for a cervical strain. (Exhibit p. 41)

On November 20, 2014, claimant returned to Dr. Young. Claimant reported that his symptoms had dissipated somewhat. Full duty was recommended. (Exhibit pp. 42-45)

On November 25, 2014, Administrator advised claimant that his claim was amended to include bilateral elbows and hands cubital tunnel syndrome. (Exhibit p. 46)

On December 18, 2014, claimant returned to Dr. Young. A strengthening program was recommended. (Exhibit pp. 47-51)

On December 23, 2014, claimant returned to Dr. Young indicating he overdid it the prior day putting the top on his jeep. The assessment noted decreased muscle tightness along the forearm extension. (Exhibit p. 52)

Claimant continued treatment with Dr. Young. (Exhibit pp. 53-55)

On January 15, 2015, claimant reported 100% improvement in the right upper extremity and 95% in the contralateral left. Tingling had resolved. Claimant was found to have reached maximum medical improvement, stable, not ratable. (Exhibit pp. 56-58)

On January 26, 2015, claimant was advised that his claim would close without a rating. (Exhibit p. 59)

On January 30, 2017, claimant returned to Dr. Young. A recurrence of previous symptoms was noted. A request for repeat EMG/NCV studies was made. Reopening was recommended. (Exhibit pp. 60-61)

On February 6, 2017, claimant requested reopening of his industrial claim. (Exhibit p. 62)

On February 15, 2017, claimant was advised that the request for reopening was denied, as same needed to be requested within one year of closing, as he did not miss any time from work, nor receive benefits for a permanent partial disability (PPD). (Exhibit p. 63)

On March 9, 2017, claimant's counsel sent notice of representation. 64-68)

On March 10, 2017, claimant appealed the February 15, 2017 denial of reopening. (Exhibit p. 69)

On April 10, 2017, claimant was advised of his average monthly wage (AMW). (Exhibit pp. 70-75)

A hearing was held on May 9, 2017 regarding reopening. In a written Decision and Order dated May 19, 2017, the Hearing Officer reversed the denial of reopening. (Exhibit pp. 76-77)

Employer has filed a timely appeal of this erroneous Decision and Order of the Hearing Officer ordering the claim reopened. Pending a hearing on the merits of its appeal, Employer moves this Court for a Stay of the Hearing Officer's decision.

POINTS & AUTHORITIES

Jurisdiction

Subsection 3 of NRS 616C.345 provides in part that, "[t]he Appeals Officer may order a Stay, when appropriate, upon the application of a party."

ARGUMENT

The Hearing Officer Erred As a Matter of Law and of Fact

It is the claimant, not the Employer, who has the burden of proving his case by a preponderance of all the evidence. State Indus. Ins. Sys. v. Hicks, 100 Nev. 567, 688 P.2d 324 (1984); Johnson v. State ex rel. Wyoming Worker's Comp. Div., 798 P.2d 323 (1990); Hagler v. Micron Tech., Inc., 118 Idaho 596, 798 P.2d 55 (1990).

In attempting to prove his case, the claimant has the burden of going beyond speculation and conjecture. That means that the claimant must establish all facets of the claim by a preponderance of all the evidence. To prevail, a claimant must present and prove more evidence than an amount which would make his case and his opponent's "evenly balanced." Maxwell v.

SIIS, 109 Nev. 327, 849 P.2d 267 (1993); SIIS v. Khweiss, 108 Nev. 123, 825 P.2d 218 (1992); SIIS v. Kelly, 99 Nev. 774, 671 P.2d 29 (1983); 3, A. Larson, The Law of Workmen's Compensation, §80.33(a).

NRS 616A.010(2) makes it clear that:

> A claim for compensation filed pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS must be decided on its merit and not according to the principle of common law that requires statutes governing workers' compensation to be liberally construed because they are remedial in nature.

The issue is whether the Hearing Officer erred in reversing the denial of reopening. The Employer asserts that the Hearing Officer did so err, as the claimant is not entitled to reopening under the facts presented.

Claimant requested that his claim be reopened more than a year after the claim had been closed.

NRS 616C.390 provides as follows:

> Reopening claim: General requirements and procedure; limitations; applicability. Except as otherwise provided in NRS 616C.392:
> 1. If an application to reopen a claim to increase or rearrange compensation is made in writing more than 1 year after the date on which the claim was closed, the insurer shall reopen the claim if:
> (a) A change of circumstances warrants an increase or rearrangement of compensation during the life of the claimant;
> (b) The primary cause of the change of circumstances is the injury for which the claim was originally made; and
> (c) The application is accompanied by the certificate of a physician or a chiropractor showing a change of circumstances which would warrant an increase or rearrangement of compensation.
> 2. After a claim has been closed, the insurer, upon receiving an application and for good cause shown, may authorize the reopening of the claim for medical investigation only. The application must be accompanied by a written request for treatment from the physician or chiropractor treating the claimant, certifying that the treatment is indicated by a change in circumstances and is related to the industrial injury sustained by the claimant.
> 3. If a claimant applies for a claim to be reopened pursuant to subsection 1 or 2 and a final determination denying the reopening is issued, the claimant shall not reapply to reopen the claim until at least 1 year after the date on which the final determination is issued.
> 4. Except as otherwise provided in subsection 5, if an application to reopen a claim is made in writing within 1 year after the date on

which the claim was closed, the insurer shall reopen the claim only if:

(a) The application is supported by medical evidence demonstrating an objective change in the medical condition of the claimant; and

(b) There is clear and convincing evidence that the primary cause of the change of circumstances is the injury for which the claim was originally made.

5. **An application to reopen a claim must be made in writing within 1 year after the date on which the claim was closed if:**

(a) The claimant did not meet the minimum duration of incapacity as set forth in NRS 616C.400 as a result of the injury; and

(b) The claimant did not receive benefits for a permanent partial disability.

If an application to reopen a claim to increase or rearrange compensation is made pursuant to this subsection, the insurer shall reopen the claim if the requirements set forth in paragraphs (a), (b) and (c) of subsection 1 are met.

6. If an employee's claim is reopened pursuant to this section, the employee is not entitled to vocational rehabilitation services or benefits for a temporary total disability if, before the claim was reopened, the employee:

(a) Retired; or

(b) Otherwise voluntarily removed himself or herself from the workforce, for reasons unrelated to the injury for which the claim was originally made.

7. One year after the date on which the claim was closed, an insurer may dispose of the file of a claim authorized to be reopened pursuant to subsection 5, unless an application to reopen the claim has been filed pursuant to that subsection.

8. An increase or rearrangement of compensation is not effective before an application for reopening a claim is made unless good cause is shown. The insurer shall, upon good cause shown, allow the cost of emergency treatment the necessity for which has been certified by a physician or a chiropractor.

9. A claim that closes pursuant to subsection 2 of NRS 616C.235 and is not appealed or is unsuccessfully appealed pursuant to the provisions of NRS 616C.305 and 616C.315 to 616C.385, inclusive, may not be reopened pursuant to this section.

10. The provisions of this section apply to any claim for which an application to reopen the claim or to increase or rearrange compensation is made pursuant to this section, regardless of the date of the injury or accident to the claimant. If a claim is reopened pursuant to this section, the amount of any compensation or benefits provided must be determined in accordance with the provisions of NRS 616C.425.

[56:168:1947; 1943 NCL § 2680.56] + [57:168:1947; 1943 NCL § 2680.57] — (NRS A 1971, 770; 1981, 1198, 1831; 1983, 285, 1294;

1985, 1547; 1993, 741, 2441; 1995, 2152; 1999, 1787; 2005, 1491; 2015, 1140)
(Emphasis added)

Further, NRS 616C.400 states:

Minimum duration of incapacity.
1. **Temporary compensation benefits must not be paid under chapters 616A to 616D, inclusive, of NRS for an injury which does not incapacitate the employee for at least 5 consecutive days, or 5 cumulative days within a 20-day period, from earning full wages, but if the incapacity extends for 5 or more consecutive days, or 5 cumulative days within a 20-day period, compensation must then be computed from the date of the injury.**
2. The period prescribed in this section does not apply to:
(a) Accident benefits, whether they are furnished pursuant to NRS 616C.255 or 616C.265, if the injured employee is otherwise covered by the provisions of chapters 616A to 616D, inclusive, of NRS and entitled to those benefits.
(b) Compensation paid to the injured employee pursuant to subsection 1 of NRS 616C.477.

Here, the claimant was required to request reopening of his claim *within one year*, as he did not meet the minimum duration of incapacity as described in NRS 616C.400, and did not receive a PPD rating. Claimant requested reopening nearly *two* years after his claim had closed. Therefore, he cannot meet his burden of proving that this claim should be reopened, regardless of the medical reporting he has in support thereof. The denial of reopening was entirely legal and proper under these circumstances.

The Hearing Officer noted that Dr. Young "establishes propriety of claim reopening under the 2015 revisions of 616C.390." This is utterly false, as indicated above. Dr. Young is not privy to the legal implications of NRS 616C.390 and the requirement that the claimant request reopening within one year because he was never taken off of work or "incapacitated" as outlined in NRS 616C.400. **The Hearing Officer has erred as a matter of law.** The Employer certainly has a strong likelihood of prevailing on the merits of its appeal. Therefore, a Stay is needed while this appeal proceeds on the merits.

Employer is the Only Party that Will Suffer Any Harm

In DIR v. Circus Circus, 101 Nev. 405, 411-12, 705 P.2d 645, 649 (1985), the Nevada Supreme Court stated that an Employer's proper procedure when aggrieved by a decision is to seek a Stay. The Nevada Supreme Court has also recognized that a Stay should be granted where it can be shown that the appellant would suffer irreparable injury during the pendency of the appeal, if the Stay is not granted. White Pine Power v. Public Serv. Comm'n, 76 Nev. 263, 252 P.2d 256 (1960). The Supreme Court elaborated upon this requirement in Kress v. Corey, 65 Nev. 1, 189 P.2d 352 (1948):

> As a rule a supersedes or stay should be granted whenever it appears that without it the object of the appeal or writ of error may be defeated or that it is reasonably necessary to protect appellant or plaintiff in error from irreparable or serious injury in the case of reversal and it does not appear that appellee or defendant in error will sustain irreparable or disproportionate injury in case of affirmance. 65 Nev. at 17.

The Nevada Supreme Court held, in Ransier v. SIIS, 104 Nev. 742, 766 P.2d 274 (1988), that an Employer may not seek recoupment of benefits paid to a claimant that were later found to be unwarranted on appeal. The Ransier decision has not been overruled or reversed. Thus, a Stay is the only method of preventing a burdensome and unnecessary cost to Employer pending an appeal.

In the present case, the issue is the reversal of denial of reopening. The Hearing Officer has ordered that Employer reopen claimant's industrial insurance claim, despite the claimant failing to comply with the legal requirements for reopening. The Employer will be irreparably harmed if it is forced to reopen the claim and begin administering benefits to the claimant, even though the claimant has not met his burden of proof. The time, resources and money expended during the pendency of the appeal cannot be recouped by the Employer, *even if it prevails on the merits of the appeal.* Conversely, the claimant cannot establish any irreparable harm as if he somehow prevails on the merits of this appeal, his claim will be reopened at that time and he will be paid retroactive benefits, with interest. There is no harm to claimant if this Stay is granted.

Therefore, it is clear that under these facts, Employer is the only party that will suffer irreparable harm if a Stay is denied. Accordingly, a Stay of the Hearing Officer's decision is appropriate until such time as a hearing can be conducted on the merits of Employer's appeal.

CONCLUSION

Based upon the foregoing points and authorities, Employer, CITY OF HENDERSON, respectfully submits that it has established good cause to grant a Stay of the Hearing Officer's Decision and Order dated May 19, 2017, particularly in light of the clear error of law and fact, which has been established above.

WHEREFORE, Employer, CITY OF HENDERSON, respectfully requests that the Appeals Officer grant its Motion for Stay Pending Appeal until such time as a hearing can be conducted on the merits of the underlying appeal.

AFFIRMATION PURSUANT TO NRS 239B.030

The undersigned does hereby affirm that the attached exhibits do not contain the personal information of any person.

DATED this 21 day of June, 2017.

Respectfully submitted,

LEWIS BRISBOIS BISGAARD & SMITH LLP

By: _____

DANIEL L. SCHWARTZ, ESQ.
Nevada Bar No. 5125
2300 West Sahara Avenue, Suite 300, Box 28
Las Vegas, NV 89102
Phone: (702) 893-3383
Fax: (702) 366-9689
Attorneys for the Employer

CERTIFICATE OF MAILING

Pursuant to Nevada Rules of Civil Procedure 5(b), I hereby certify that service of the foregoing **EMPLOYER'S MOTION FOR STAY PENDING APPEAL** was made this date by depositing a true copy of the same for mailing, first class mail, at Las Vegas, Nevada, addressed as follows:

Jason Mills, Esq.
Neeman & Mills
1201 South Maryland Parkway
Las Vegas, NV 89104

Attn: Sally Ihmels
City of Henderson
240 South Water Street MSC 122
Henderson, NV 89015

Attn: Susan Riccio
Cannon Cochran Management Services, Inc.
P.O. Box 35350
Las Vegas, NV 89133

DATED this 21 day of June, 2017.

An employee of LEWIS BRISBOIS BISGAARD & SMITH LLP

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

First Name	Last Name	Birthdate	Sex	Claim Number (Insurer's Use Only)
BRIAN M K	WOLFGRAM	10/10/1967	☒M ☐F	

Home Address	Age	Height	Weight	Social Security Number
221 LOOKOUT AVE	47	6	190	

City	State	Zip	Telephone
HENDERSON	NV	89002	702 858-4813

Physical Address	City	State	Zip	Primary Language Spoken
221 LOOKOUT AVE	HENDERSON	NV	89002	ENGLISH

INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred
		FIRE CAPTAIN

Employer's Name/Company Name	Telephone
CITY OF HENDERSON FIRE DEPT.	702 267-2222

Office Mail Address (Number and Street): 240 WATER ST

Date of Injury (if applicable)	Hours Injury (if applicable)	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
10/18/2014	am 3 (pm)	10/19/2014	10/19/14	ARBOGAST

Address or Location of Accident (if applicable): GREEN VALLEY PARKWAY AND HORIZON RIDGE MESA

What were you doing at the time of the accident? (if applicable): LOADING HOSE AFTER TRAINING

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary): ASSISTED WITH LOADING APPROX. 1000 FT OF HOSE WHILE TRAINING.

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?

Witnesses to the Accident (if applicable): FF BOWYER

Nature of Injury or Occupational Disease: BILATERAL ARM & HAND PAIN

Part(s) of Body Injured or Affected: BOTH ARMS / HANDS

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER, OR OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date 10/20/14 Place _____ Employee's Signature _____

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place: CONCENTRA MEDICAL CENTERS Name of Facility: CMC-HENDERSON

Date	Diagnosis and Description of Injury or Occupational Disease	Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident?
10/20/14	Bilateral wrist tenosynovitis; Cervical strain rule out radiculopathy; Bilateral elbow tenosynovitis	☒ No ☐ Yes (if yes, please explain)
Hour		

Treatment: PE FU ICE PT Rest

Have you advised the patient to remain off work five days or more?
☐ Yes Indicate dates: from _____ to _____
☒ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty
If modified duty, specify any limitations/restrictions: _____

X-Ray Findings:

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☒ Yes ☐ No

Is additional medical care by a physician indicated? ☒ Yes ☐ No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☒ No (Explain if yes)

Date	Print Doctor's Name	I certify that the employer's copy of this form was mailed to the employer on:
10/20/14	B Hardwick	

Address	Provider's Tax I.D. Number	Telephone	INSURER'S USE ONLY
149 N GIBSON RD STE H	75-2014828	(702) 558-6275	RECEIVED 10/21/2014 CCMSI
HENDERSON, NV 89014			

Doctor's Signature _____ Degree MD

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev.01/00)

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM.

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
CITY OF HENDERSON	Municipality	886000720	E546827

Office Mail Address	Location . . . If different from mailing address	Telephone
240 WATER STREET MSC 137		702-267-1921

City	State	Zip	INSURER	THIRD-PARTY ADMINISTRATOR
HENDERSON	NV	89015	City of Henderson	CCMSI, Inc.

EMPLOYEE

First Name	M.I.	Last Name	Social Security	Birthdate	Age	Primary Language Spoken
Brian	K	Wolfgram		10/10/1967	47	English

Home Address (Number and Street)	Sex	Marital Status
221 Lookout Ave	☑ Male ☐ Female	☐ Single ☑ Married ☐ Divorced ☐ Widowed

City	State	Zip	Was the employee paid for the day of injury? (if applicable)	How long has this person been employed by you in Nevada?
Henderson	NV	89002	☑ Yes ☐ No	07/09/1990

In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:
Nevada	Fire Captain	2000 FIRE

Telephone	Is the injured employee a corporate officer? . . . sole proprietor? . . . partner?	Was employee in your employ when injured or disabled by occupational disease (O/D)?
702-858-4823	☐ Yes ☑ No ☐ Yes ☑ No ☐ Yes ☑ No	☑ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
10/18/2014	15:00	10/19/2014	Arboreen

Address or location of accident (Also provide city, county, state) (if applicable): Green Valley & Horizon Ridge, Henderson, Clark, Nevada

Accident on employer's premises? (if applicable) ☐ Yes ☑ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)
Loading hose after trng/Bilateral Arm & Hand Pain

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.
While picking up and loading hose after manipulative drills felt pain and burning sensation in both arms. Noticed reduced grip strength in both hands

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable): unknown

Witness: n/a

Was there more than one person injured in this accident? (if applicable) ☐ Yes ☑ No

Part of body injured or affected	If fatal, give date of death
cervial; bilateral wrist/hand; bilateral elbows	n/a

Witness:

Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)
Bilateral wrist tenosynovitis; Cervical strain; Bilateral elbow tenosynovitis

Witness:

Did employee return to next scheduled shift after accident? (if applicable) ☑ Yes ☐ No

Will you have light duty work available if necessary? ☑ Yes ☐ No

If validity of claim is doubted, state reason: n/a

Location of Initial Treatment: Concentra Medical Center,149 N Gibson Ste H,Henderson

Treating physician/chiropractor name: Hunwick

Emergency Room ☐ Yes ☑ No

Hospitalized ☐ Yes ☑ No

IMPORTANT LOST TIME INFO

IMPORTANT: How many days per week does employee work? varies

From 08:00 To 08:00

Last day wages were earned: 10/18/14

Scheduled days off: S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☑

Are you paying injured or disabled employee's wages during disability? ☑ Yes ☐ No

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
07/09/1990	10/18/2014	10/19/14	0

Was the employee hired to work 40 hours per week? ☐ Yes ☑ No If not, for how many hours a week was the employee hired? 56

Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☑ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☑ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI

Employee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☑ BI-WKLY ☐ SEMI-MONTHLY

On the date of injury or disability the employee's wage was: $ 35.48 per ☑ Hr ☐ Day ☐ Wk ☐ Mo

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title: [signature]

Date: 10.21.14

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No. 14C52E546827	Class Code
Claims Examiner's Signature	Date	Status Clerk	RECEIVED 10/21/2014

Form C-3 (rev.11/05) ORIGINAL – EMPLOYER PAGE 2 – INSURER/TPA CCMSI PAGE 3 – EMPLOYEE

2

00224

FIRST AID ☐ BBP ☐ W/C ☑

CITY OF HENDERSON
Human Resources
A Place To Call Home

First Notice of Injury or Occupational Disease

SSN# | Employee # 11056

Brian K. Wolfgram
Name of employee

Fire | Fire Captain
Department | Job title

Arboreen
Supervisor to whom reported

Arboreen
Supervisor on duty at time of accident/injury

Employee on overtime? YES ◯ NO ◉

No. of days worked per week 56hr week

10/18/2014 | 03.00 p.m.
Date of accident/injury | Time

Did injury occur on employer premises? YES ◯ NO ◉

Parking lot behind Fresh and Easy GV PKWY/Horizon Ridge
Accident/injury location - address

10/19/2014 0645 Thought pain would subside
Date/Time reported: (Explain if not reported immediately)

Brandon Bowyer
Witness(es) Name

Firefighter Schedule | 0800 to 0800
Scheduled days off: (Not # of days) | Reg. Working Hours

Describe accident/injury in detail beginning with what you were doing when it occured.*

While picking up and loading hose after manipulative drills I felt pain and a burning sensation in both of my arms. I also noticed reduced grip strength in both of my hands. I stretched and shook my arms and hands and felt some relieve and was able to continue work. Upon returning to the station Firefighter Bowyer said he noticed me shaking out my arms and asked if I was alright. I indicated to him that I was going to wait and see if they continued to get better and if not I may file a C1 and have him complete a witness statement. Several times as I slept through the night I awoke to pain, numbness and tingling in my arms and hands.

Equipment, tools furniture, etc., connected with accident/injury: 1 3/4",2 1/2" and 5" hose

Unsafe conditions or practice involved: none

What can be done to prevent reoccurence? unknown

Did the accident happen in the normal course of work? YES ◉ NO ◯

Was anyone else involved? YES ◯ NO ◉ Names

BODY PART INJURY (be specific)

- ☐ 01 Face (explain)
- ☐ 02 Toe or foot R ☐ L ☐
- ☐ 03 Internal organs (not lungs)
- ☐ 04 Fingers
- ☑ 05 Hands R ☑ L ☑
- ☑ 06 Arms R ☑ L ☑
- ☐ 07 Trunk
- ☐ 08 Lungs
- ☐ 09 Back
- ☐ 10 Eyes ☐R ☐L
- ☐ 11 Leg ☐R ☐L
- ☐ 12 Knee ☐R ☐L
- ☐ 13 Ankles ☐R ☐L
- ☐ 14 Shoulders ☐R ☐L
- ☐ 15 Head
- ☐ 16 Neck
- ☐ 17 Groin
- ☐ Other

NATURE OF INJURY

- ☐ 01 Wounds (cuts)
- ☐ 02 Hernia
- ☐ 03 Fracture
- ☐ 04 Dermatitis
- ☑ 05 Strain
- ☐ 06 Sprain
- ☐ 07 Contusion (bruise)
- ☐ 08 Burns
- ☐ 09 Foreign body
- ☐ 10 Infection
- ☐ 11 Dislocation
- ☐ 12 Chemical Exposure (Attach MSDS)
- ☐ 13 Infectious Exposure (explain)
- ☐ 14 Other

ACTION TAKEN

- ☐ Hospitalized
- ☐ Emergency hospital care
- ☐ First Aid Provided by whom:
- ☐ Doctor's care
- ☐ Time loss
- ☐ Same day time loss
  Time left work
- ☑ No time loss
- ☐ Employee return to work?
  YES ◯ NO ◯
  Date
  Time

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City of Henderson
Risk Management Division

Treating Physician Name | Hospital

Physician's Address | Doctor's instructions | Physician's Phone #

Any person who willfully makes a false statement or representation for the purpose of obtaining any benefit or payment under the provisions of this chapter, either for himself or any other person, shall be guilty of a felony. (N.R.S. 616.575)

Employee's signature 10/19/14 Date

Supervisor's Investigation*

Supervisor's signature 10-19-14 Date

Safety Rep's comments* | Safety Rep's signature | Date

*Use additional sheets if necessary.

*Reports shall be completed and distributed in accordance to Safety & Health Procedures Manual, Chapter 1-Safety Administration, SHP-115 Occupational Injury/Illness Reporting

My Employer/insurer may have made arrangements to direct me to a Health Care Provider for medical treatment of my industrial injuries. I have been notified of these arrangements. To file a claim for compensation, see "Claim for Compensation (Form C-4)" on reverse side.

Reset Form

Submit

For assistance with Workers' Compensation issues you may contact the Office of the Governor Consumer Health Assistance
TOLL FREE: 1-888-333-1597 Website http://govcha.state.nv.us E-mail: cha@govcha.state.nv.us

C-1 (11/05) WHITE - Human Resources YELLOW - Department PINK - Employee

3

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00225 10/21/2014
CCMSI

Human Resources Department

City of Henderson
Witness Report
Occupational Injury or Illness

Instructions: Have all witnesses complete a witness report and forward to the City of Henderson, Human Resources Department, Risk Management Division, 240 Water Street, MSC #137, City Hall, 3rd Floor, Henderson NV 89015 within 3 working days from the date of the incident.

Name of Injured Party: BRIAN WOLFGRAM

Date of Injury: 10/18/14 Time: 3:00 AM or PM

Witness Name (Your Name)
BRANDON BOWYER
Address
510 LARIAT LN . HENDERSON NV 89014
Phone Number(s)
(609) 949-2921

Where were you in relation to the accident? ***(List exact location)***

ON TWO OCCATIONS ON 10/18/2014 I WITNESSED CAPT WOLFGRAM GRIMACE IN PAIN. ONCE IN THE APP BAY AT STATION 97 AND ONCE WHILE TRAINING LOADING HOSE.

Describe in DETAIL what happened, how the incident evolved, name(s) of person(s) involved, etc.:

WHILE IN THE APP BAY AT STATION 97, CAPT WOLFGRAM CLIMBED DOWN FROM THE ENGINE AND GRIMACED IN PAIN AND SHOOK BOTH OF HIS ARMS.
WHILE LOADING HOSE DURING A TRAINING EXCERCISE HE DID IT AGAIN AND WAS UNABLE TO HELP DUE TO THE PAIN.

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City of Henderson
Risk Management Division

Additional comments/observations:

I ASKED CAPT WOLFGRAM ABOUT THE INCIDENT AND HE SAID HE WAS HAVING SHARP SHOOTING PAIN IN BOTH ARMS W/ REDUCED GRIP STRENGTH

BRANDON BOWYER
Print Name

Signature

RECEIVED
10/21/2014
CCMSI

10-19-2014
Date

HRRM-0153, RM&EB, Rev. (4/10)

4

00226

149 N Gibson HENDERSON, NV 89014 (702) 558-6275

Patient:	Wolfgram, Brian K	**Service Date:**	10/20/2014
Soc. Sec. #		**Injury Date:**	10/18/2014
Date of Birth:	10/10/1967 **Age:** 47	**Employer:**	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson		240 S Water St
Service ID #:	1201391363		MSC 137
Claim #:			Henderson, NV 89015
Dictator:	Bernard B Hunwick, MD		
Diagnosis:	847.0 Cervical Strain		

Notes: CHIEF COMPLAINT:
Patient is a 47 year old male employee of City of Henderson-Non Regulated who complains about his Arm which was injured on 10/18/2014.

PATIENT STATEMENT:
Patient states :"Assisted with loading hose about 100lbs and felt sharp pain in both hands"

Vital Signs: BP: 144/88. P: 72. R: 14. T: 98.6 degrees F orally. The patients height is 6 ft. 1 in. (185.4 cm)
The vitals were taken at: 12:15 PM by: J E H.

HISTORY OF PRESENT ILLNESS:
The mechanism of injury was repetetive use of the hand and lifting fire hoses. The pain began gradually. The pain is located on both wrists and both elbows. The pain is described as acute, moderate and aching. Pain Intensity Level: 4/10. Pain radiates down both artms to the hands and fingers. He complains of numbness and tingling in the fingers and hands as well as decreased grip strength.

PMHx: None
PSHx: None
Current Medications: None.
Allergies: Denies known medication allergies.

ROS: All review of systems negative per concentra comprehensive questionaire except as above.

PE: APPEARANCE: Well nourished, well developed, in no acute distress.
VITAL SIGNS: See nurses notes.
SKIN: Normal. No lesions.
NEUROLOGIC: Neurologically intact.
PERIPHERAL VASCULAR: No cyanosis. No clubbing. Extremities warm. Circulation distal to injury intact. Good cap refill <2 seconds.
MUSCULOSKELETAL:
Bilateral Wrists: Mild to moderately decreased ROM with pain. No bruising. Tender to palpation over the dorsal wrists. Opposite side unremarkable.
Bilateral Hands: Decreased grip strength. FROM with pain. No bruising. Opposite side unremarkable.
Bilateral elbows: FROM with pain. Tender overlateral elbows. Increased pain with resisted flexion/extension. Opposite side unremarkable.
Cervical: Bilateral shoulder range of motion normal. Strength normal. Spurlings negative.

ASSESSMENT:
1. Sprains and strains of elbow and forearm. 841.
2. Wrist tenosynovitis. 727.05.
3. Cervical strain. 847.0. R/O cervical radiculopathy

PLAN:
It is more likely from his PE that the patient has tenosynovitis of the wrists and elbows 2ary to 25 years of lifting fire hoses; but cannot yet rule out cervical impingement

Dictated By: Bernard B Hunwick, MD

Dictated On: Oct 20 2014 2:22PM

Patient:	Wolfgram Brian K	**Service Date:**	10/20/2014
Soc. Sec. #		**Injury Date:**	10/18/2014
Date of Birth:	10/10/1967 **Age:** 47	**Employer:**	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson		240 S Water St
Service ID #:	1201391363		MSC 137
Claim #:			Henderson, NV 89015
Dictator:	Bernard B Hunwick, MD		
Diagnosis:	847.0 Cervical Strain		

Notes: as a root cause.

Bilateral wrist braces given
Biofreeze

Voltaren Gel 2-3g to affected areas QID prn pain.
Ibuprofen 600mg PO QID prn pain
Ice Q1 hours x 15 mins
Modified Work Activity
RTC in 2-3 days
Gel pack small x2

Return to clinic or ER if symptoms recur, worsen, new symptoms develop, any increase in pain or any signs of infection.

This patient has the above listed injuries for which a structured program of Physical Therapy is medically necessary due to Limited ROM, Decrease strength and Functional deficits. This condition limits the patients ability to perform the essential functions of the job. Management will include in conjunction with therapeutic exercises, with a focus on functional outcomes and return to regular work.

The program is anticipated to require 6 visits, or less if recovery occurs earlier. The patient may require additional visits but only if objective improvement can be demonstrated.

Diagnosis, treatment plan and expectations were discussed with the patient. The patient was given an opportunity to ask questions regarding the diagnosis and treatment plan. The patient acknowledged understanding the diagnosis and treatment plan and had no further questions. Patient is instructed to return to the clinic immediately if symptoms worsen or new symptoms develop.

Dictated By: Bernard B Hunwick, MD

Dictated On: Oct 20 2014 2:22PM

Claim Number:

Concentra Medical Centers

149 N Gibson HENDERSON, NV 89014
Phone: (702) 558-6275 Fax: (702) 856-3198

Service Date: 10/20/2014
Case Date: 10/18/2014

Physician Work Activity Status Report

Patient: Wolfgram, Brian K.
SSN:
Address: 221 Lookout Ave
HENDERSON, NV 89002
Home: (702) 858-4823
Work: **Ext.:**

Employer Location: City of Henderson-Non Regul **Contact:** Mary Sexton
Address: 240 S Water St, MSC 137 **Role:** Primary Contact
Henderson, NV 890157227 **Phone:** (702) 267-1922 **Ext.:**
Auth. by: Arbortan **Fax:** (702) 267-1902

This Visit: **Time In:** 10:45 am **Time Out:** 01:36 pm **Recordable:** N/A **Visit Type:** New

Treating Provider: Bernard B. Hunwick, MD

Diagnosis:
847.0 Cervical Strain
727.05 Tenosynovitis, Wrist/Hand
727.09 Elbow Tenosynovitis

Medications:
☐ Dispensed Prescription Medication to Patient
☐ Dispensed Over-The-Counter Prescription
☒ Written Prescription given to Patient

Patient Status:

Modified Activity - Returning for follow-up visit

Restricted Activity (In effect until next physician visit):

Return to work on 10/20/2014 with the following restrictions
No lifting over 15 lbs.
No pushing and/or pulling over 15 lbs. of force

Remarks:

Employer Notice: The prescribed activity recommendations are suggested guidelines to assist in the patient's treatment and rehabilitation. Your employee has been informed that the activity prescription is expected to be followed at work and away from work.

Anticipated Date of Maximum Medical Improvement: **Actual Date of Maximum Medical Improvement:**

Next Visit(s): **Patient Notice:** It is essential to your recovery that you keep your scheduled appointments, but should you need to reschedule or cancel your appointment, please contact the clinic. Thank you for your cooperation.

Visit Date: Wednesday October 22, 2014 11:15 am
Provider/Facility: Bernard B. Hunwick, MD

RECEIVED
10/21/2014
CCMSI

7

Mary Sexton

From: Scott Vivier
Sent: Tuesday, October 21, 2014 7:09 AM
To: FD 6 BCs; FD CHIEFS
Cc: Brenda Sambol; Cheer McHardy; Mary Sexton; Brian Wolfgram
Subject: Brian Wolfgram - 56 Hour Modified Duty Assignment

Chiefs,

Brian saw the doctor yesterday for an injury that occurred on 10-19-14. The doctor has placed him on modified duty effective 10-20-14. Brian accepted the modified duty offer. Brian will be on a 56 LD assignment, however no changes to his T-staff will occur until he sees the doctor again on Wednesday the 22nd (he may be released to full duty prior to his next shift on the 24th). Thanks

Scott Vivier
Division Chief - EMS
City of Henderson Fire Department
702-267-2292 (Office)

CITY OF HENDERSON
240 Water Street
P.O. Box 95050
Henderson, NV 89009-5050

October 21, 2014

Brian Wolfgram
221 Lookout Ave
Henderson, NV 89002

RE: Light-Duty Offer for Workers' Compensation Injury Dated 10/18/14

Dear Brian,

This letter is being sent in compliance with NRS 616C.475, which requires the employer (the City of Henderson) confirm an offer of temporary light-duty employment in writing. Therefore, this letter will confirm that as of the date your physician released you to modified duty, October 20, 2014, temporary light-duty employment is immediately available and has been offered to you.

Your physician has indicated that you can return to work with restriction. You are responsible for notifying your physician of any discomfort or pain associated with your injury while performing your assigned duties. You are also responsible for notifying us immediately, if your treating physician makes changes to your restrictions or releases you to full-duty.

If your supervisor for your modified-duty assignment differs from your regular supervisor, you are required to notify both supervisors of any change in restrictions and/or any absence you may have due to illness, etc.

Please sign and date this letter, along with your supervisor, and return it to Mary Sexton via fax 267-1902, e-mail, or interoffice mail MSC 137. If you have any questions regarding this offer, please contact your HRBP, Amy Wong, at 267-1943.

Please code your light-duty *working time* to WD (hours worked under modified/restricted duty).

Injured Worker Signature — Date: 10/24/14

Supervisor Signature — Date: 10.28.14

RECEIVED
OCT 28 2014
City of Henderson
Risk Management Division

Sincerely,

Mary Sexton
Risk Management Analyst

cc: CCMSI
Brian Arboreen
Scott Vivier

Received
10/28/14
CCMSI

Concentra Medical Centers
149 N Gibson HENDERSON, NV. 89014
Phone: (702) 558-0275 Fax. (702) 856-3198

Transcription

Patient:	Wolfgram, Brian K.	**Service Date:**	10/22/2014
Soc. Sec. #:		**Injury Date:**	10/18/2014
Date of Birth:	10/10/1967 **Age:**	**Employer:**	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson	**Dictated By:**	Bernard B Hunwick, MD
Service ID # :	1201393049	**Diagnosis:**	847.0 Cervical Strain

Notes:

********** PROGRESS NOTE **********
Vital Signs: BP: 120/82. P: 68. R: 12. T: 98.1 degrees F orally.
The vitals were taken at: 11:47 AM by: T L R.
HISTORY OF PRESENT ILLNESS:
He feels the pattern of symptoms is stable. Patient has not been working normal days off. Patient has been taking their medications some improvement. Therapy is pending insurance approval. Pain is subsiding slowly. The pain is located on bilateral wrists and palams of both hands. The pain is described as acute, mild, aching and numbness and tingling. Pain Intensity Level: 3/10. The symptoms are exacerbated by grasping, lifting, pushing, pulling or activity.
Past Medical Hx Reviewed, No changes.
PE: APPEARANCE: Well nourished, well developed, in no acute distress.
VITAL SIGNS: See nurses notes.
SKIN: Normal. No lesions.
NEUROLOGIC: Neurologically intact.
PERIPHERAL VASCULAR: No cyanosis. No clubbing. Extremities warm. Circulation distal to injury intact. Good cap refill <2 seconds. Bilateral Wrists: Mild to moderately decreased ROM with pain. No bruising. Tender to palpation over the dorsal wrists. Opposite side unremarkable.
Bilateral Hands: Decreased grip strength. FROM with pain. No bruising. Opposite side unremarkable.
Bilateral elbows: FROM with pain. Tender over lateral elbows. Increased pain with resisted flexion/extension. Opposite side unremarkable.
Cervical: Bilateral shoulder range of motion normal. Strength normal.
ASSESSMENT:
1. Sprains and strains of elbow and forearm. 841.
2. Wrist tenosynovitis. 727.05.
3. Cervical strain. 847.0. R/O cervical radiculopathy

PLAN:
MEDICATIONS:Patient instructed to continue their previous medications as prescribed.
Home Exercise program as instructed.
ACTIVITY STATUS:Modified activity
Return if symptoms recur, worsen, new symptoms develop, any increase in pain or any signs of infection.
RETURN FOR EVALUATION: In 1 week
Diagnosis, treatment plan and expectations were discussed with the patient. The patient was given an opportunity to ask questions regarding the diagnosis and treatment plan. The patient acknowledged understanding the diagnosis and treatment plan and had no further questions. Patient is instructed to return to the clinic immediately if symptoms worsen or new symptoms develop.

Dictated By: Bernard B Hunwick, MD

Dictated On: 10/22/2014 1:27 PM

Claim Number:

Concentra Medical Centers

149 N Gibson HENDERSON, NV 89014
Phone. (702) 558-6275 Fax: (702) 856-3198

Service Date: 10/22/2014
Case Date: 10/18/2014

Physician Work Activity Status Report

Patient: Wolfgram, Brian K.
SSN:
Address: 221 Lookout Ave
HENDERSON, NV 89002
Home: (702) 858-4823
Work: Ext.:

Employer Location: City of Henderson-Non Regul
Address: 240 S Water St, MSC 137
Henderson, NV 890157227
Auth. by: Arbortan

Contact: Mary Sexton
Role: Primary Contact
Phone: (702) 267-1922 Ext.:
Fax: (702) 267-1902

This Visit: Time In: 10:57 am Time Out: 12:48 pm Recordable: N/A Visit Type: Recheck

Treating Provider: Bernard B. Hunwick, MD

Diagnosis: 847.0 Cervical Strain
727.05 Tenosynovitis, Wrist/Hand
727.09 Elbow Tenosynovitis

Medications:
- ☐ Dispensed Prescription Medication to Patient
- ☐ Dispensed Over-The-Counter Prescription
- ☐ Written Prescription given to Patient

Patient Status:

Modified Activity - Returning for follow-up visit

Restricted Activity (In effect until next physician visit):

Return to work on 10/22/2014 with the following restrictions
No lifting over 15 lbs.
No pushing and/or pulling over 15 lbs. of force

Remarks:

Employer Notice: The prescribed activity recommendations are suggested guidelines to assist in the patient's treatment and rehabilitation. Your employee has been informed that the activity prescription is expected to be followed at work and away from work.

Anticipated Date of Maximum Medical Improvement: **Actual Date of Maximum Medical Improvement:**

Next Visit(s): Patient Notice: It is essential to your recovery that you keep your scheduled appointments, but should you need to reschedule or cancel your appointment, please contact the clinic. Thank you for your cooperation.

Visit Date: Wednesday October 29, 2014 1:00 pm
Provider/Facility: Bernard B. Hunwick, MD

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OCT 24 [illegible]

11

Request for Additional Medical Information And Release Form

(Pursuant to NRS 616C.490(3))

Injured Employee's Name: BRIAN K. WOLFGRAM

Claim Number: 14C526546827 Social Security Number: ____

Injured Employee's Address: 221 LOOKOUT AVE HENDERSON NV 89002

Injury/Occupational Disease Date: 10/18/14 Date this Notice Printed: 10/27/14

Insurer's Name: CITY OF HENDERSON Employer: CITY

Insurer's Address: ____ Employer's Address: 240 WATER ST

Please provide the information requested below, sign and date the form, and return it to your insurer. Your signature on this form also acts as a release to acquire information affecting your claim from other entities. This renews the release you signed on your C-4 form at the time your claim was submitted to your insurer. Failure to fully complete and return this form to your claims agent in a timely manner could affect your benefits or delay the resolution of your claim.

Prior History Information

Please check the appropriate box below and provide the information requested.

☑ I have no prior conditions, injuries or disabilities of which I am aware, that might affect the disposition of the claim referenced above. (If you checked this box, no further information is needed at this point)

☐ I have a prior condition, injury or disability that could affect the disposition of the claim referenced above. This can include birth defects, prior surgeries, injuries, etc., whether work related or not. (If you checked this box, indicating a pre-existing condition, please explain in detail in the space below. Please attach additional sheets of paper to this form if necessary to fully explain the condition)

I certify that the above is true and correct to the best of my knowledge and that I have provided this information in order to obtain the benefits of Nevada's industrial insurance and occupational diseases acts (NRS 616A to 616D, inclusive or chapter 617 of NRS). I hereby authorize any physician, chiropractor, surgeon, practitioner, or other person, any hospital, including veterans administration or governmental hospital, any medical service organization, any insurance company, or other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to diagnosis, treatment and/or counseling for aids, psychological conditions, alcohol or controlled substances, for which I must give specific authorization. A photostat of this authorization shall be as valid as the original.

Signature 10/27/14 Date

D-38 (Rev. 03)

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OCT 28 2014

CCMSI – LAS VEGAS

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Injured Worker Name Brian Wolfgram
Claim Number 14C52C546827

LIST ALL PRIOR RELATIVE CLAIMS FILED FOR ACCIDENTS/INJURIES -- WHETHER INDUSTRIAL OR NON-INDUSTRIAL, WHICH YOU HAVE FILED THROUGHOUT YOUR LIFETIME.

Claim No: ____________________ Date of Injury: ____________________

Employer: ____________________ Body Part(s) : ____________________

☐ Industrial ☐ Non-Industrial Settlement/Amount Received: $ __________

____

Attending Physician's Name/Address for above-captioned injury

Claim No: ____________________ Date of Injury: ____________________

Employer: ____________________ Body Part(s) : ____________________

☐ Industrial ☐ Non-Industrial Settlement/Amount Received: $ __________

____

Attending Physician's Name/Address for above-captioned injury

Claim No: ____________________ Date of Injury: ____________________

Employer: ____________________ Body Part(s) : ____________________

☐ Industrial ☐ Non-Industrial Settlement/Amount Received: $ __________

____

Attending Physician's Name/Address for above-captioned injury

Claim No: ____________________ Date of Injury: ____________________

Employer: ____________________ Body Part(s) : ____________________

☐ Industrial ☐ Non-Industrial Settlement/Amount Received: $ __________

____

Attending Physician's Name/Address for above-captioned injury

[signature] 10/27/14

Signature Date

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OCT 28 2014
CCMSI ~ LAS VEGAS

 B

Have you ever filed a workers' compensation claim in this state or any other before?

Yes____ No_✓_

If yes, have you ever received a settlement or buyout for the claim?

Yes____ No____

Please list the body part(s) and the amount of the settlement or buyout and the employer under whom the award was received.

_____

_____

_____

Thank you for your cooperation.

_____ 10/27/14

(Injured Worker's Signature) (Date)

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OCT 28 2014

CCMSI ~ LAS VEGAS

Injured Worker Name _____
Claim Number _____
Page 5 of 5

DECLARATION OF MEDICAL PROVIDERS

I, Brian Winfree, have received treatment, had medication prescribed, or
Print Your Name
been evaluated by the following doctors, chiropractors, dentists or other practitioners during the last five (5) years.

List names and addresses and phone	Dates of Treatment
Dr. Scott Tran 1776 W Horizon Ridge Pkwy (702) 313-3288	unknown
Dr. Bacardo 9165 S. Eastern (702) 254-7200	annual physicals
Dr. Benson DDS 2421 W Horizon Ridge Pkwy 702 456-1147	last 20 years

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OCT 28 2014
CCMSI ~ LAS VEGAS

15

Concentra Medical Centers
148 N Gibson HENDERSON, NV 89014
Phone: (702) 558-6275 Fax: (702) 856-3199

Transcription

Patient:	Wolfgram, Brian K.	**Service Date:**	10/29/2014
Soc. Sec. #:		**Injury Date:**	10/18/2014
Date of Birth:	10/10/1967 Age: 47	**Employer:**	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson	**Dictated By:**	BERNARD HUNWICK
Service ID # :	1201397572	**Diagnosis:**	847.0 Cervical Strain

Notes:

Reason For Visit
Chief Complaint: The patient presents today with Upper back pain. Self reported.

Vitals
Vital Signs [Data Includes: Current Encounter]
Recorded by : Smith, Sherry at 29Oct2014 01:57PM
Temperature: 97.6 F, Tympanic
Blood Pressure: 120 mm Hg
Blood Pressure: 88 mm Hg
Heart Rate: 62
Respiration: 14
Height: 6 ft
Weight: 190 lb
BMI Calculated: 25.77 kg/m2
BSA Calculated: 2.08 m2
Pain Scale: 3

Review of Systems

Constitutional: Reviewed and found to be negative.
Head and Face: Reviewed and found to be negative.
Eyes: Reviewed and found to be negative.
ENT: Reviewed and found to be negative.
Cardiovascular: Reviewed and found to be negative.
Respiratory: Reviewed and found to be negative.
Gastrointestinal: Reviewed and found to be negative.
Genitourinary: Reviewed and found to be negative.
Musculoskeletal: back pain , neck pain and night pain, but no joint pain, no muscle pain, no joint swelling, no joint stiffness, no muscle weakness and no limping.
Integumentary and Breasts: Reviewed and found to be negative.
Neurological: Reviewed and found to be negative.
Psychiatric: Reviewed and found to be negative.
Endocrine: Reviewed and found to be negative.
Hematologic and Lymphatic: Reviewed and found to be negative.

History of Present Illness

Patient is returning for a recheck of injuries stated below:
Complaint of neck pain.
Complaint of elbow pain. Symptoms are located in the elbows bilaterally and ulnar

Dictated By: BERNARD HUNWICK

Dictated On: 10/29/2014 3:11 PM

Concentra Medical Centers
149 N Gibson HENDERSON, NV 89014
Phone: (702) 558-6276 Fax: (702) 858-3199

Transcription

Patient:	Wolfgram, Brian K.	Service Date:	10/29/2014
Soc. Sec. #:		Injury Date:	10/18/2014
Date of Birth:	10/10/1967 Age: 47	Employer:	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson	Dictated By:	BERNARD HUNWICK
Service ID # :	1201397572	Diagnosis:	847.0 Cervical Strain

Notes:

aspects of the elbows. The symptoms occur present with activity. The patient describes the pain as tingling and numbness. He describes this as moderate in severity. The pain radiates to the forearms bilaterally and wrists bilaterally. unchanged Associated symptoms include arm/hand numbness and elbow tenderness, but no bruising in the elbow area, no elbow deformity and no elbow instability. Exacerbating factors include motion at the elbow and Lifting. Relieving factors include arm rest.

Complaint of wrist pain. The pain is located in both wrists. The symptoms occur with activity. He describes his pain as tingling and numbness in hands and fingers in nature. He describes this as moderate in severity, a current pain level of 3/10. Symptoms are unchanged. Associated symptoms include numbness in the hand, but no grip weakness.

Complaint of back pain. The pain is located in the mid back bilaterally. The pain is intermittent. He describes his pain as dull and aching in nature. He describes this as mild, a current pain level of 2/10. Symptoms are unchanged. Associated symptoms include back stiffness.

Patient is taking the medication(s) as prescribed and is tolerating well
Patient has been referred to physical therapy: And has attended 1 number of therapy visits since the last visit.

Physical Exam

Constitutional: Well appearing and well nourished.

Head/Face: Normocephalic, atraumatic, and no tenderness.
Eyes: Conjunctiva and lids with no swelling, erythema or discharge.
Pulmonary: No increased work of breathing or signs of respiratory distress.
Musculoskeletal: Normal gait.
Skin: Normal without rashes or lesions. Normal turgor.
Psychiatric: Oriented to person, place, and time.Speech is appropriate in content and delivery.

ASSESSMENT
1. Tenosynovitis of hand or wrist (727.05)
2: Elbow tendinitis (727.09)
3: Cervical strain (847.0)

Plan
1. Hand Specialist Referral Physician Referral Consult. Tingling and numbness in the

Dictated By: BERNARD HUNWICK

Dictated On: 10/29/2014 3:11 PM

Concentra Medical Centers
149 N Gibson HENDERSON, NV 89014
Phone: (702) 558-6275 Fax: (702) 850-3198

Transcription

Patient:	Wolfgram, Brian K.	**Service Date:**	10/29/2014
Soc. Sec. #:		**Injury Date:**	10/18/2014
Date of Birth:	10/10/1967 **Age:** 47	**Employer:**	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson	**Dictated By:**	BERNARD HUNWICK
Service ID # :	1201397572	**Diagnosis:**	847.0 Cervical Strain

Notes:

hands, forearms and elbows with activity, worsening over last 2 years. Status: Complete
Done: 29Oct2014 03:10PM
Ordered;For: Elbow tendinitis, Tenosynovitis of hand or wrist; Ordered By: HUNWICK, BERNARD Performed: Due: 12Nov2014 Marked Important

1. Amended By: HUNWICK, BERNARD; Oct 29 2014 5:10 PM CST

The diagnoses and treatment plan were discussed with the patient. The patient expressed understanding and was told to keep their scheduled appointments for follow-up and/or to return to Concentra as needed.

Activity Status and Restrictions

Treatment Status:
Returning for follow-up: 1 week
Activity Status
Return to modified work/activity today:
Restrictions: Occasionally = up to 3 hrs/day, Frequently = up to 6 hrs/day, Constantly = up to 8 hours or greater per day

May lift up to 15 lbs.
May push/pull up to 15 lbs. Avoid combat or fire fighting situations.

Signatures
Electronically signed by : BERNARD HUNWICK, M.D.; Oct 29 2014 5:05PM CST - Author
Electronically signed by : BERNARD HUNWICK, M.D.; Oct 29 2014 5:10PM CST - Author

Dictated By: BERNARD HUNWICK

Dictated On: 10/29/2014 3:11 PM

FAX

Concentra

To: Sue Riccio
Company: CCMSI
Fax: (217) 477-8034
Phone:

From: Carol Gonzales
Fax: (702) 515-6657
Phone: (702) 677-3544

NOTES:

RE: Wolfgram, Brian REFERRAL: Ortho Hand
Requesting Dr. Vahey/ Dr .Grabow. Thank You, Carol :)

Approved 11/3/14
Sue Riccio
CCMSI WC
Schedule Appt
Thank you

Date and time of transmission: Thursday, October 30, 2014 7:48:50 PM
Number of pages including this cover sheet: 06

P.01

TRANSACTION REPORT

NOV-03-2014 MON 11:32 AM

FOR:

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FAX

Concentra

To: Sue Riccio
Company: COMS
Fax: (217) 477-5934
Phone:

From: Carol Gonzales
Fax: (702) 515-6557
Phone: (702) 617-3544

NOTES:

RE: Wolfgram, Brian REFERRAL, Ortho Hand
Requesting Dr. Varney/ Dr. Grabow. Thank You, Carol :)

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Service Date: 10/29/2014

Concentra Medical Centers
149 N Gibson HENDERSON, NV 89014
Phone: (702) 558-0275 Fax: (702) 856-3188

Patient Referral

Patient Information:

Patient:	Wolfgram, Brian K.	Home Phone:	(702) 858-4823
SSN:		Work Phone:	Ext:
Address:	221 Lookout Ave HENDERSON, NV 89002	DOI:	10/18/2014
		DOB:	10/10/1967

Employer Contact:

Employer Location:	City of Henderson-Non Regul	Contact:	Mary Sexton
Address:	240 S Water St, MSC 137 Henderson, NV 890157227	Role:	Primary Contact
		Phone:	(702) 267-1922 Ext.:
Auth. by:	Arbortan	Fax:	(702) 267-1902

Program:

Billing Information:

Carrier:	CCMSI	Billing:	CCMSI
Address:	PO Box 35350 Las Vegas, NV 891335350	Address:	PO Box 35350 Las Vegas, NV 891335350
Phone:	(702) 933-4800	Claim #:	14C52E546827
Fax:	(702) 933-4861		

Notes:

**NOTE TO THE ABOVE FACILITY OR PHYSICIAN:
Please send a copy of all reports on this patient to the payer and the center.

Concentra Medical Centers
140 N Gibson HENDERSON, NV 89014
Phone: (702) 558 8275 Fax: (702) 856 3198

Service Date: 10/29/2014

Patient Referral

Patient Information:

Patient:	Wolfgram, Brian K.	Home Phone:	(702) 858-4823
SSN:		Work Phone:	Ext:
Address:	221 Lookout Ave HENDERSON, NV 89002	DOI:	10/18/2014
		DOB:	10/10/1967

Provider Referral Information:

Referral Status: Pending
Evaluation: Referral for Treatment
Priority: Routine

REFERRAL PRESCRIPTION

Recommended Provider:
Provider Type: Specialist
Specialty: Hand Surgeon

Referral Purpose

Referral Focus	Hemisphere
Other - arm	Bilateral

Diagnosis

Code	Description
727.05	Tenosynovitis, Wrist/Hand
727.09	Elbow Tenosynovitis

Additional Notes:

Date: 10/29/2014

Referring Provider: Bernard Hunwick, MD
*** Provider Signature on File ***

THIS SECTION TO BE COMPLETED BY THE AUTHORIZING PARTIES

Authorization Details:

Authorized By:

Other - arm ☐ Approve ☐ Decline Name: _____ Initials: ____ Date: _____

**NOTE TO THE ABOVE FACILITY OR PHYSICIAN:
Please send a copy of all reports on this patient to the payer and the center.

00244 22

Concentra

Transcription

149 N Gibson HENDERSON, NV 89014 (702) 558-6275

Patient:	Wolfgram, Brian K	**Service Date:**	11/03/2014
Soc. Sec. #		**Injury Date:**	10/18/2014
Date of Birth:	10/10/1967 **Age:** 47	**Employer:**	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson		240 S Water St
Service ID #:	1201400013		MSC 137
Claim #:	14C52E546827		Henderson, NV 89015
Dictator:	JAMES HORROCKS		
Diagnosis:	847.0 Cervical Strain		

Notes: Visit History

Total visit(s) (cumulative total):6
Current episode visit # :2
Missed Previous Appointments: 0

Current Meds
1. IBU 600 MG TABS;
Therapy: (Recorded:29Oct2014) to Recorded

History of Present Condition

Patient Status: Pt reports feeling better.

Activity Status and Restrictions

Treatment Status: Not Applicable
Activity Status
Return to modified work/activity today.
Restrictions: Occasionally = up to 3 hrs/day, Frequently = up to 6 hrs/day, Constantly = up to 8 hours or greater per day

May lift up to 15 lbs.
May push/pull up to 15 lbs.

Tests and Measures

Left Elbow: WNL
Right Elbow: WNL
Left Wrist/Hand:
Wrist flexion: Muscle performance 5/5.
Wrist extension: Muscle performance 5-/5.
Grip Strength (Dynamometer): Grip Position - II
Trial 1 Left: 94.
Trial 1 Right: 106.
Ligament/Tendon Comment: DeQuarvain s: Neg
Impairment Goals
PAIN: Initial Value: 2/10. Goal: 1/10. Current Value: Pain Free. , WNL
Right Wrist/Hand:
Wrist flexion: Muscle performance 5/5.
Wrist extension: Muscle performance 5/5.
Ligament/Tendon Comment: DeQuarvain s: Neg.
Impairment Goals
PAIN: Initial Value: 2/10. Goal: 1/10. Current Value: Pain Free. , WNL
Cervical Spine:

Dictated By: JAMES HORROCKS

Dictated On: Nov 3 2014 12:36PM

Printed Date: 11/05/2014

149 N Gibson HENDERSON, NV 89014 (702) 558-6275

Patient:	Wolfgram, Brian K	**Service Date:**	11/03/2014
Soc. Sec. #		**Injury Date:**	10/18/2014
Date of Birth:	10/10/1967 **Age:** 47	**Employer:**	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson		240 S Water St
Service ID #:	1201400013		MSC 137
Claim #:	14C52E546827		Henderson, NV 89015
Dictator:	JAMES HORROCKS		
Diagnosis:	847.0 Cervical Strain		

Notes: SPECIAL TESTS:
Spurling Test: Negative.
Essential Function/ADL Goals
Lift : Initial Value: Unable Goal: 100 lbs Current Value: Unable Goal Status: Not measured in this visit
Push/Pull : Initial Value: Unable Goal: 200 lbs Current Value: Unable Goal Status: Not measured in this visit

Evaluation
1. Cervical strain (847.0)
2. Elbow tendinitis (727.09)
3. Tenosynovitis of hand or wrist (727.05)

Therapy Assessment
Overall Progress: As Expected
Response to current treatment: The patient tolerated the current treatment well with no adverse reaction.
Treatment Progression: Continue therapy per treatment plan.

Intervention/Charges

Wrist/Hand Procedures
Therapeutic Exercises:
Wrist Extension Stretch:
Wrist Flexion Stretch:
Foam roll
Tricep curls 3x15 20 lbs.
Rows, 3x15, 20 lbs
Bench press, stand. 3x15 blue.
Therapeutic Activities:
Dynamic UE multidirectional pull, plum
Bean bucket 3 items, (B).
Neuromuscular Reeducation:
WB on ball 4x15 sec.

* included as: Home Exercise Program

Modalities:
Moist Hot Pack

Visit Type:
Procedure Charges:
Therapeutic Exercises: 3 units , 45 minutes
Therapeutic Activities: 1 units , 15 minutes
Neuromuscular Reeducation: 1 units ; 5 minutes

Signatures
Electronically signed by : JAMES HORROCKS, PT; Nov 3 2014 2:36PM CST - Author

Dictated By: JAMES HORROCKS

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Dictated On: Nov. 3 2014 12:36PM

Printed Date: 11/05/2014

Concentra Transcription

149 N Gibson HENDERSON, NV 89014 (702) 558-6275

Patient:	Wolfgram Brian K	**Service Date:**	11/04/2014
Soc. Sec. #		**Injury Date:**	10/18/2014
Date of Birth:	10/10/1967 **Age:** 47	**Employer:**	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson		240 S Water St
Service ID #:	1201400654		MSC 137
Claim #:	14C52E546827		Henderson, NV 89015
Dictator:	JAMES HORROCKS		
Diagnosis:	847.0 Cervical Strain		

Notes: Visit History

Total visit(s) (cumulative total):6
Current episode visit # :3
Missed Previous Appointments: 0

Current Meds
1. IBU 600 MG TABS;
Therapy: (Recorded:29Oct2014) to Recorded

History of Present Condition

Patient Status: Today feeling good w/o the meds..

Activity Status and Restrictions

Treatment Status:
Returning for follow-up:
Activity Status
Return to modified work/activity today.
Restrictions: Occasionally = up to 3 hrs/day, Frequently = up to 6 hrs/day, Constantly = up to 8 hours or greater per day

May lift up to 15 lbs.
May push/pull up to 15 lbs.

Tests and Measures

Left Elbow: WNL
Right Elbow: WNL
Left Wrist/Hand::
Wrist flexion: Muscle performance 5/5.
Wrist extension: Muscle performance 5-/5.
Grip Strength (Dynamometer): Grip Position - II
Trial 1 Left: 94.
Trial 1 Right: 106.
Ligament/Tendon Comment: DeQuarvain s: Neg
Impairment Goals
PAIN: Initial Value: 2/10. Goal: 1/10. Current Value: Pain Free. , WNL
Right Wrist/Hand:
Wrist flexion: Muscle performance 5/5.
Wrist extension: Muscle performance 5/5.
Ligament/Tendon Comment: DeQuarvain s: Neg.
Impairment Goals
PAIN: Initial Value: 2/10. Goal: 1/10. Current Value: Pain Free. , WNL

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Dictated By: JAMES HORROCKS

Dictated On: Nov 4 2014 10:00AM

149 N Gibson HENDERSON, NV 89014 (702) 558-6275

Patient:	Wolfgram Brian K	**Service Date:**	11/04/2014
Soc. Sec. #		**Injury Date:**	10/18/2014
Date of Birth:	10/10/1967 **Age:** 47	**Employer:**	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson		240 S Water St
Service ID #:	1201400654		MSC 137
Claim #:	14C52E546827		Henderson, NV 89015
Dictator:	JAMES HORROCKS		
Diagnosis:	847.0 Cervical Strain		

Notes: Cervical Spine:
SPECIAL TESTS:
Spurling Test: Negative., Spurling s Test: Neg.
Essential Function/ADL Goals
Lift : Initial Value: Unable Goal: 100 lbs Current Value: Unable Goal Status: Not measured in this visit
Push/Pull : Initial Value: Unable Goal: 200 lbs Current Value: Unable Goal Status: Not measured in this visit

Evaluation
1. Cervical strain (847.0)
2. Elbow tendinitis (727.09)
3. Tenosynovitis of hand or wrist (727.05)

Therapy Assessment
Overall Progress: As Expected
Response to current treatment: The patient tolerated the current treatment well with no adverse reaction. Mild sxs after bicep curls.
Treatment Progression: Continue therapy per treatment plan.

Intervention/Charges

Visit Type:
Procedure Charges:
Therapeutic Exercises: 3 units , 45 minutes
Therapeutic Activities: 1 units , 15 minutes
Neuromuscular Reeducation: 1 units , 5 minutes

Wrist/Hand Procedures
Therapeutic Exercises:
Recumbent stationary bike: UE s. 10 min.
Wrist Extension Stretch:
Wrist Flexion Stretch:
Foam roll
Pectoral, bicep stretch, (B).
Tricep curls 3x15 25 lbs.
Rows, 3x15, 25 lbs
Bench press, stand. 3x15 plum
Bicep curls, 3x15, 20 lbs
Therapeutic Activities:
Dynamic UE multidirectional pull, plum
Bean bucket 4 items, (B).
Neuromuscular Reeducation:
WB on ball 4x15 sec.

* included as Home Exercise Program

Signatures
Electronically signed by : JAMES HORROCKS, PT; Nov 4 2014 12:00PM CST - Author

Dictated By: JAMES HORROCKS

Dictated On: Nov 4 2014 10:00AM

149 N Gibson HENDERSON, NV 89014 (702) 558-6275

Patient:	Wolfgram, Brian K	**Service Date:**	11/05/2014
Soc. Sec. #		**Injury Date:**	10/18/2014
Date of Birth:	10/10/1967 **Age:** 47	**Employer:**	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson		240 S Water St
Service ID #:	1201401604		MSC 137
Claim #:	14C52E546827		Henderson, NV 89015
Dictator:	JAMES HORROCKS		
Diagnosis:	847.0 Cervical Strain		

Notes: Visit History

Total visit(s) (cumulative total):6
Current episode visit # :4
Missed Previous Appointments: 0

Current Meds
1. IBU 600 MG TABS;
Therapy: (Recorded:29Oct2014) to Recorded

History of Present Condition

Patient Status: Continues to feel good.

Activity Status and Restrictions

Treatment Status:
Returning for follow-up:
Activity Status
Return to modified work/activity today.
Restrictions: Occasionally = up to 3 hrs/day, Frequently = up to 6 hrs/day, Constantly = up to 8 hours or greater per day

May lift up to 15 lbs.
May push/pull up to 15 lbs.

Tests and Measures

Left Elbow: WNL
Right Elbow: WNL
Left Wrist/Hand:
Wrist flexion: Muscle performance 5/5.
Wrist extension: Muscle performance 5-/5.
Grip Strength (Dynamometer): Grip Position - II
Trial 1 Left: 94.
Trial 1 Right: 106.
Ligament/Tendon Comment: DeQuarvain s: Neg
Impairment Goals
PAIN: Initial Value: 2/10. Goal: 1/10. Current Value: Pain Free. , WNL
Right Wrist/Hand:
Wrist flexion: Muscle performance 5/5.
Wrist extension: Muscle performance 5/5.
Ligament/Tendon Comment: DeQuarvain s: Neg.
Impairment Goals
PAIN: Initial Value: 2/10. Goal: 1/10. Current Value: Pain Free. , WNL

Dictated By: JAMES HORROCKS

Dictated On: Nov 5 2014 12:29PM

Concentra

Transcription

149 N Gibson HENDERSON, NV 89014 (702) 558-6275

Patient:	Wolfgram, Brian K	**Service Date:**	11/05/2014
Soc. Sec. #		**Injury Date:**	10/18/2014
Date of Birth:	10/10/1967 **Age:** 47	**Employer:**	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson		240 S Water St
Service ID #:	1201401604		MSC 137
Claim #:	14C52E546827		Henderson, NV 89015
Dictator:	JAMES HORROCKS		
Diagnosis:	847.0 Cervical Strain		

Notes: Cervical Spine:
SPECIAL TESTS:
Spurling Test: Negative., Spurling s Test: Neg.
Essential Function/ADL Goals
Lift : Initial Value: Unable Goal: 100 lbs Current Value: Unable Goal Status: Not making progress toward goal
Push/Pull : Initial Value: Unable Goal: 200 lbs Current Value: Unable Goal Status: Not making progress toward goal

Evaluation
1. Cervical strain (847.0)
2. Elbow tendinitis (727.09)
3. Tenosynovitis of hand or wrist (727.05)

Therapy Assessment
Overall Progress: Slower than Expected
Response to current treatment: No change.
Treatment Progression: Continue therapy per treatment plan.

Intervention/Charges

Visit Type:
Procedure Charges:
Therapeutic Exercises: 3 units , 45 minutes
Therapeutic Activities: 1 units , 15 minutes
Neuromuscular Reeducation: 1 units , 5 minutes

Wrist/Hand Procedures
Therapeutic Exercises:
Recumbent stationary bike: UE s. 10 min.
Wrist Extension Stretch:
Wrist Flexion Stretch:
Foam roll
Pectoral, bicep stretch, (B).
Tricep curls 3x15 30 lbs.
Rows, 3x15, 30 lbs
Bench press, stand. 3x15 plum
Bicep curls, 3x15, 15 lbs
Therapeutic Activities:
Dynamic UE multidirectional pull, plum
Bean bucket 4 items, (B).
Neuromuscular Reeducation:
WB on ball 4x15 sec.

* included as Home Exercise Program

Signatures
Electronically signed by : JAMES HORROCKS, PT; Nov 5 2014 2:29PM CST - Author

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Dictated By: JAMES HORROCKS

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Dictated On: Nov 5 2014 12:29PM
Printed Date: 11/15/2014

Concentra

Transcription

149 N Gibson HENDERSON, NV 89014 (702) 558-6275

Patient:	Wolfgram, Brian K	**Service Date:**	11/06/2014
Soc. Sec. #		**Injury Date:**	10/18/2014
Date of Birth:	10/10/1967 **Age:** 47	**Employer:**	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson		240 S Water St
Service ID #:	1201402204		MSC 137
Claim #:	14C52E546827		Henderson, NV 89015
Dictator:	JAMES HORROCKS		
Diagnosis:	847.0 Cervical Strain		

Notes: Visit History

Total visit(s) (cumulative total):6
Current episode visit # :5
Missed Previous Appointments: 0

Current Meds
1. IBU 600 MG TABS;
Therapy: (Recorded:29Oct2014) to Recorded

History of Present Condition

Patient Status: Pt reports he awoke with tingling in the (B) wrists.

Activity Status and Restrictions

Treatment Status:
Returning for follow-up:
Activity Status:
Return to modified work/activity today.
Restrictions: Occasionally = up to 3 hrs/day, Frequently = up to 6 hrs/day, Constantly = up to 8 hours or greater per day

May lift up to 15 lbs.
May push/pull up to 15 lbs.

Tests and Measures

Left Elbow: WNL
Right Elbow: WNL
Left Wrist/Hand:
PAIN:
Pain Rating: 2/10
Wrist flexion: Muscle performance 5/5.
Wrist extension: Muscle performance 5-/5.
Grip Strength (Dynamometer): Grip Position - II
Trial 1 Left: 94.
Trial 1 Right: 106.
Ligament/Tendon Comment: DeQuarvain s: Neg
Impairment Goals
PAIN: Initial Value: 2/10. Goal: 1/10. Current Value: Pain Free. , WNL
Right Wrist/Hand:
PAIN:
Pain Rating: 2/10
Wrist flexion: Muscle performance 5/5.

Dictated By: JAMES HORROCKS

Dictated On: Nov 6 2014 11:55AM

Printed Date: 11/15/2014

149 N Gibson HENDERSON, NV 89014 (702) 558-6275

Patient:	Wolfgram, Brian K	**Service Date:**	11/06/2014
Soc. Sec. #		**Injury Date:**	10/18/2014
Date of Birth:	10/10/1967 **Age:** 47	**Employer:**	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson		240 S Water St
Service ID #:	1201402204		MSC 137
Claim #:	14C52E546827		Henderson, NV 89015
Dictator:	JAMES HORROCKS		
Diagnosis:	847.0 Cervical Strain		

Notes: Wrist extension: Muscle performance 5/5.
Ligament/Tendon Comment: DeQuarvain s: Neg.
Impairment Goals
PAIN: Initial Value: 2/10. Goal: 1/10. Current Value: Pain Free. , WNL
Cervical Spine:
PAIN:
Pain Rating: /10
SPECIAL TESTS:
Spurling Test: Negative., Spurling s Test: Neg.
Essential Function/ADL Goals
Lift : Initial Value: Unable Goal: 100 lbs Current Value: Unable Goal Status: Not making progress toward goal
Push/Pull : Initial Value: Unable Goal: 200 lbs Current Value: Unable Goal Status: Not making progress toward goal

Evaluation
1. Cervical strain (847.0)
2. Elbow tendinitis (727.09)
3. Tenosynovitis of hand or wrist (727.05)

Therapy Assessment
Overall Progress: Slower than Expected
Response to current treatment: The patient reported benefit from the current treatment as noted by a reduction in symptoms. Min/no tingling/pain in the (B) hands/wrists or elbows.
Treatment Progression: Continue therapy per treatment plan.

Intervention/Charges

Visit Type:
Procedure Charges:
Therapeutic Exercises: 3 units , 40 minutes
Therapeutic Activities: 1 units , 15 minutes
Neuromuscular Reeducation: 1 units , 5 minutes

Wrist/Hand Procedures
Therapeutic Exercises:
Recumbent stationary bike: UE s. 10 min.
Wrist Extension Stretch:
Wrist Flexion Stretch:
Foam roll
Pectoral, bicep stretch, (B).
Tricep curls 3x15 30 lbs.
Rows, 3x15, 30 lbs
Bench press, stand. 3x15 plum
Bicep curls, 3x15, 15 lbs
Therapeutic Activities:
Dynamic UE multidirectional pull, plum
Bean bucket 4 items, (B).
Neuromuscular Reeducation:

Dictated By: JAMES HORROCKS

Dictated On: Nov 6 2014 11:55AM

Printed Date: 11/15/2014

149 N Gibson HENDERSON, NV 89014 (702) 558-6275

Patient:	[illegible]gram, Brian K	**Service Date:**	11/06/2014
Soc. Sec. #	[illegible]	**Injury Date:**	10/18/2014
Date of Birth:	10/10/1967 **Age:** 47	**Employer:**	City of Henderson-Non Regulated
Service Location:	CMC - LVG Henderson		240 S Water St
Service ID #:	1201402204		MSC 137
Claim #:	14C52E546827		Henderson, NV 89015
Dictator:	JAMES HORROCKS		
Diagnosis:	847.0 Cervical Strain		

Notes: WB on ball 4x15 sec.

* included as Home Exercise Program

Signatures
Electronically signed by : JAMES HORROCKS, PT; Nov 6 2014 1:54PM CST - Author

Dictated By: JAMES HORROCKS

Dictated On: Nov 6 2014 11:55AM

Printed Date: 11/15/2014

Hand Surgery Specialists of Nevada

Colby P. Young, M.D. Jedediah W. Jones, M.D. David M. Fadell, D.O.

Date of Service:	11/10/2014
Patient Name:	Brian Wolfgram
Gender:	Male
Date of Birth	10/10/1967 47 Years 1 Month
Referral Name:	NCM Sally

REASON FOR VISIT:	Loading 1000ft hose onto fire truck, instant pain, numbness and tingling to bilateral elbows and hand
HISTORY OF INJURY:	Affected body part: bilateral arm and hand Date of Injury: 10/18/14

Prescriptions			
Medications			
Ibuprofen 200MG Tablet Oral, Ref: 0			
Social History		Allergies	
Alcohol - Occasionally Tobacco: Non Smoker		No Known Drug Allergies	
Surgical History		Past Medical History	
Spine		NONE PROVIDED	
		Family History	
		None listed	
Smoking Status	Hand Dominance	Height:	Weight in lbs:
Unknown if ever smoked	Right	6'0"	190

HISTORY OF PRESENT ILLNESS: Brian Wolfgram is a 47-year-old right-hand-dominant male who is a fire captain with the City of Henderson. He presents to the office with progressive numbness and tingling involving the bilateral hands. He reports that this is also associated with some tenderness radiating from the elbow. He describes all of the fingers having had these symptoms. He reports that his symptoms have been present for over a year but most recently he was loading a 1000 foot hose onto a truck when he began to notice instant pain, numbness and tingling in the hand.

With further questioning, he reports that this is an activity that he has been doing for several years and his symptoms have been present but have gotten progressively worse. He describes the last episode of moving 1000 foot hose as essentially his body moving to fatigue. He reports that he was seen at Concentra Medical Center where he was given a course of Ibuprofen, as well as Occupational Therapy. He was given a wrist brace. These did not alleviate his symptoms. He describes nocturnal, as well as intermittent paresthesias for which he is presenting to the office today. In addition, he is also describing some hand cramping.

PHYSICAL EXAMINATION

GENERAL: Age appropriate and in no apparent distress.

SKIN: No abnormal markings, swelling, wounds or discoloration.

LYMPHATIC: No erythema, cellulitis, abscesses, lymphangitis or any signs to suggest infection.

VASCULAR: Brisk capillary refill, normal turgor, digits warm, no signs of chronic ischemia.

NEUROLOGIC: Sensation is normal. No signs of atrophy, anhidrosis or trophic changes.

Musculoskeletal: Clinically he has the ability to flex and extend the digits, as well as the elbow. I do not appreciate any findings of positive elbow flexion test of Tinel's at the level of the elbow. He has equivocal findings for carpal tunnel syndrome today. His 2-point discrimination is 5 mm throughout.

Diagnosis	354.0 CARPAL TUNNEL SYNDROME 354.2 Cubital Tunnel Syndrome
99203	OFFICE OUTPT NEW 30 MIN
76000	FLUOR SPX ≤1 HR PHYS TM OTH/THN 71023/71034

PLAN: Today I have recommended that he proceed with electrodiagnostic studies. I do believe that as his symptoms of numbness and tingling are associated with his occupation, as he does utilize vibratory objects, as well as the repetitive pulling, lifting and grasping on a constant and consistent basis.

I will see him in the office after his studies have been completed so we can discuss treatment options at that time. We will, again, perform a clinical examination. I have recommended that he participate in limitations in his repetitive motion until he returns to see me after the electrodiagnostic studies.

Colby P. Young MD

CLINICAL NEUROLOGY SPECIALISTS

Leo Germin, M.D., FAANEM
Medical Director

Tera Beaird, PA-C

Henderson Location:
1691 W. Horizon Ridge Pkwy. Ste. 100
Henderson, NV 89012
Phone: 702-804-1212
Fax: 702-804-1273

Las Vegas Location:
7751 W. Flamingo Rd., Ste. A-100
Las Vegas, NV 89147
Phone: 702-804-6555
Fax: 702-804-1273

Services:
Consulting Services
Legal and Worker's Compensation
Case Evaluations
Electrodiagnostic Lab
Neurophysiology Lab
Neurosonology Lab
Outpatient Hyperbaric Oxygen Therapy
Inpatient Services at Spring Valley Hospital

Helping Adults With:
Dizziness
Headaches
Numbness/Tingling
Memory/Concentration Loss
Blackouts/Seizures
Muscle Weakness/Pain
Unsteadiness
Tremor/Twitches
Slurred Speech
Neck and Back Pain
Carpal Tunnel Syndrome
Neuralgias
TIAs and Strokes
Traumatic Brain Injury

DATE: November 17, 2014

PATIENT: Wolfgram, Brian

DOB: 10/10/1967

REFERRED BY: Dr. Colby Young

Date of injury: 10/18/2014

IMPRESSION:
1. No electrodiagnostic evidence for overt axonal loss C5 through T1 radiculopathy bilaterally.
2. No electrodiagnostic evidence for carpal tunnel syndrome bilaterally.
3. No electrodiagnostic evidence for ulnar neuropathy at the elbow bilaterally.
4. No electrodiagnostic evidence for axonal or demyelinating sensory or motor peripheral neuropathy.
5. The results of these tests are based on the electrophysiological study only. Please correlate with the clinical examination and the results of the imaging studies.

REASON FOR VISIT: EMG/Nerve Conduction Study.

At your kind request, I had the privilege of seeing Mr. Brian Wolfgram on November 17, 2014, for the neurophysiological consultation for the assessment of pain in both arms.

UPPER EXTREMITIES:

REPORT:
Median and ulnar motor distal latencies, CMAP amplitudes, and nerve conduction velocities are within the range of normal bilaterally.

Median, radial, and ulnar sensory nerve responses are within the range of normal bilaterally.

Median and ulnar minimal F-wave latencies are within the range of normal bilaterally.

EMG:

Monopolar needle examination was performed sampling C5 through T1 innervated muscles and paraspinals bilaterally. Following muscles have been tested: Deltoid, biceps brachii, brachioradialis, triceps, extensor digitorum communis, extensor indicis proprius, first dorsal interosseous, abductor pollicis brevis, and cervical paraspinal muscles bilaterally. Motor unit action potential firing pattern and configuration is within range of normal in all the muscles tested.

Leo Germin, M.D., FAANEM.

Received
11/19/14
CCMSI

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Clinical Neurology Specialists
1691 W. Horizon Ridge Pkwy, #100
Leo Germin, M.D., FAANEM

Patient: Wolfgram, Brian
Sex: Male
Age: 47
Height: 72 inches
Weight: 195 lbs
Temperature:
I.D.#:
Ref. M.D.: Colby Young , M.D.

Address: 221 LookOut Ave
Address:
City: Henderson
State: NV
ZIP: 89002
Phone:
Physician: Leo Germin, M.D.
Test Date: 11/17/14

EMG Study

Name	Ins Act	Fibs	PSW	Fascics	Polyph	MU Amp	MU Dur	Config	Pattern	Recruit
L. Biceps Brachi.	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Brachialis	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Brachioradialis	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Triceps	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Ext.Dig.Com	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Ext.Ind.Pro.	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Abd.Pol.Br.	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Dors.Int.1	norm	none	none	none	none	norm	norm	norm	norm	norm
L. Paraspinals	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Biceps Brachi.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Brachialis	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Brachioradialis	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Triceps	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Ext.Dig.Com	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Ext.Ind.Pro.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Dors.Int.1	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Abd.Pol.Br.	norm	none	none	none	none	norm	norm	norm	norm	norm
R. Paraspinals	norm	none	none	none	none	norm	norm	norm	norm	norm

Received
11/19/14
CCMSI

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Clinical Neurology Specialists
1691 W. Horizon Ridge Pkwy
Leo Germin, M.D., FAANEM

Patient: Wolfgram, Brian
Sex: Male
Age: 47
Height: 72 inches
Weight: 195 lbs
Temperature 33.0 C
I.D.#: Myra
Ref. M.D.: Colby Young, M.D.

Address: 221 LookOut Ave
Address:
City: Henderson
State: NV
ZIP: 89002
Phone:
Physician: Leo Germin, M.D.
Test Date: 11/17/14

Motor Nerve Study

Median Nerve

Rec Site: APB / Stim Site	Lat (ms) L	Lat (ms) R	Dur (ms) L	Dur (ms) R	Amp (mV) L	Amp (mV) R	Area (mVms) L	Area (mVms) R	Dist (mm) L	Dist (mm) R	C.V. (m/s) L	C.V. (m/s) R
Wrist	3.8	3.9	6.1	5.8	9.0	6.7	30.1	20.3				
Elbow	8.0	8.6	6.3	6.1	8.3	6.2	27.9	19.8	230	240	54.1	51.4

Ulnar Nerve

Rec Site: ADM / Stim Site	Lat (ms) L	Lat (ms) R	Dur (ms) L	Dur (ms) R	Amp (mV) L	Amp (mV) R	Area (mVms) L	Area (mVms) R	Dist (mm) L	Dist (mm) R	C.V. (m/s) L	C.V. (m/s) R
Wrist	2.8	2.7	5.8	4.9	9.6	10.1	28.1	27.7				
B.Elbow	6.6	6.4	6.3	5.1	9.4	9.9	27.7	26.5	220	220	58.7	58.7
A.Elbow	8.6	8.3	6.8	5.5	8.8	9.2	25.4	24.3	100	100	50.0	52.2

Sensory Nerve Study

Med/Uln/Rad Nerve

Stim Site: Wrist / Rec Site	Lat (ms) L	Lat (ms) R	Pk Lat (ms) L	Pk Lat (ms) R	Amp (uV) L	Amp (uV) R	Dist (mm) L	Dist (mm) R	C.V. (m/s) L	C.V. (m/s) R
R Thumb	2.0	2.0	2.8	2.6	11.7	9.7	100	100	50.0	50.8
Index	2.8	2.8	3.9	4.2	19.0	12.3	140	140	50.0	50.0
5th dig	2.8	2.5	3.5	3.5	9.3	13.7	140	140	50.3	56.0

F-Wave Study

Median Nerve
Rec Site: APB
Stim Site: Wrist

	Latency ms L	Latency ms R	Amplitude mV L	Amplitude mV R
M wave	4.17	4.58	11.833	9.333
F wave	29.00	29.50	1.497	1.497
F-M	24.83	24.92		

Received
11/19/14
CCMSI

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Patient: Wolfgram, Brian Test Date: 11/17/14

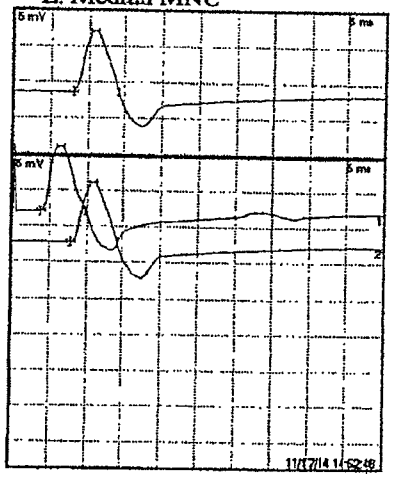
F-Wave Study

Ulnar Nerve
Rec Site: ADM
Stim Site: Wrist

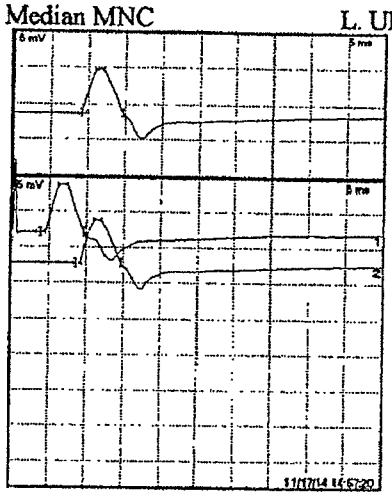
	Latency ms		Amplitude mV	
	L	R	L	R
M wave	3.00	2.67	14.167	13.583
F wave	29.92	29.75	1.497	1.500
F-M	26.92	27.08		

Patient: Wolfgram, Brian Test Date: 11/17/14

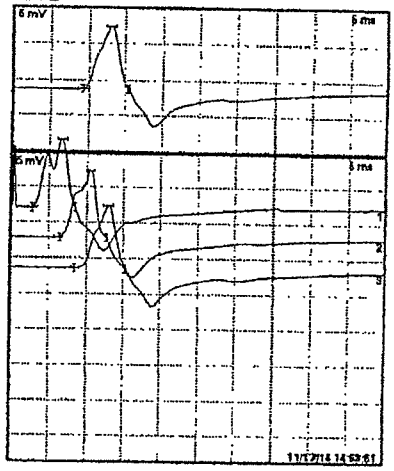
L. Median MNC



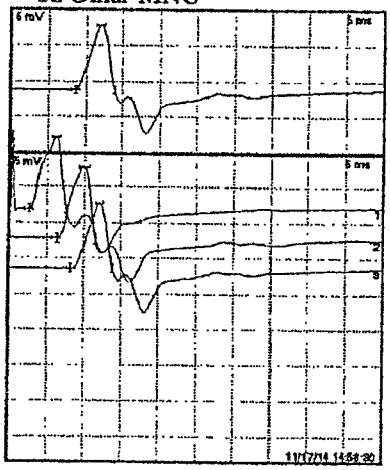
R. Median MNC



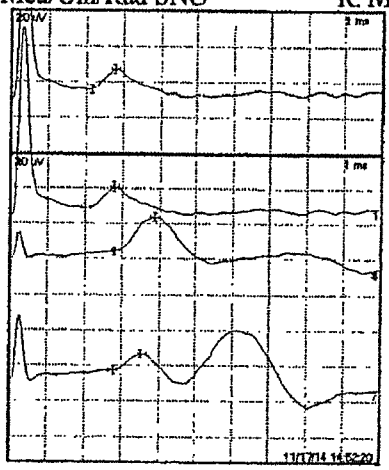
L. Ulnar MNC



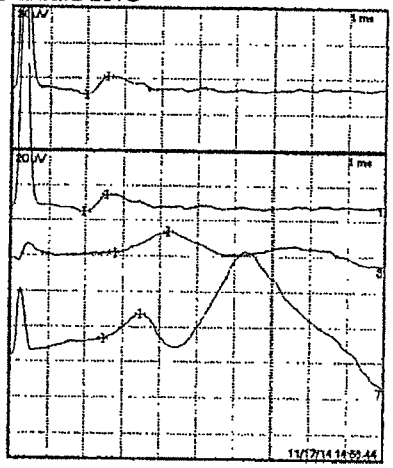
R. Ulnar MNC



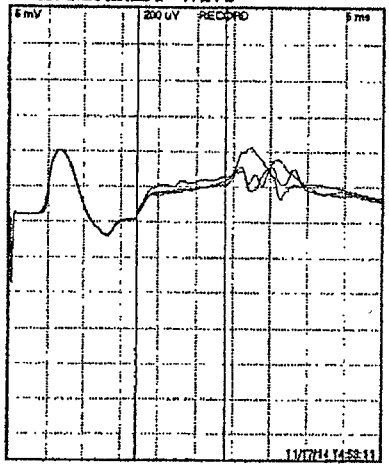
L. Med/Uln/Rad SNC



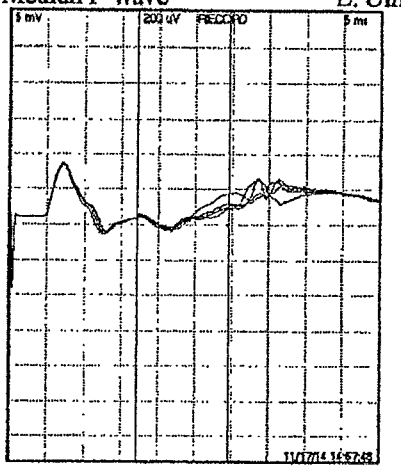
R. Med/Uln/Rad SNC



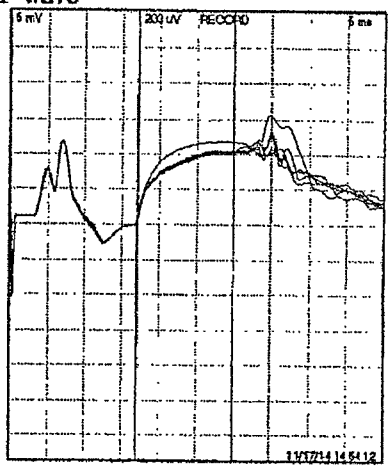
L. Median F-wave



R. Median F-wave



L. Ulnar F-wave



Received
11/19/14
CCMSI

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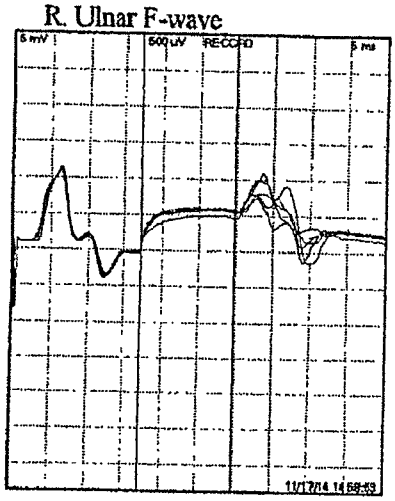
Patient: Wolfgram, Brian Test Date: 11/17/14

R. Ulnar F-wave



Received
11/19/14
CCMSI

40

Brian Wolfgram
221 Lookout Ave
Henderson, NV 89002

Re:

Claim No: 14C52E546827
Employer: City of Henderson
TPA: CCMSI
Date of Injury: 10/18/2014
Date of Notice: 11/19/2014
Body Part: Cervical strain

NOTICE OF CLAIM ACCEPTANCE
(Pursuant to NRS 616C.065)

Dear Mr. Wolfgram:

The above referenced claim has been accepted on your behalf by CCMSI. Please check the information contained in this notice. If you find any of the information to be incorrect, please notify the insurer handling the claim.

If you disagree with the above determination, you do have the right to appeal by requesting a hearing before a Hearing Officer by completing the bottom portion of this notice and sending it to the State of Nevada, Department of Administration, Hearings Division. Your appeal must be filed within seventy (70) days after the date on which the notice of this determination was mailed.

Department of Administration
Hearings Division
1050 E. William Street, Ste. 400
Carson City, NV 89710
(775) 687-8440

OR

Department of Administration
Hearings Division
2200 S. Rancho Drive, Suite 210
Las Vegas, NV 89102
(702) 486-2525

Very truly yours,

Susan Riccio
Claims Representative

Reason for appeal: _____

RECEIVED
MAY 09 2017
CCMSI - LAS VEGAS

Signature

Date

Retain a copy for your records
cc: File/Employer
(rev. 05/10)

D-30

...Risk Management Division

Workers' Compensation Accident/Injury Treatment Report (T-1)

EMPLOYEE TO COMPLETE

Employee's Name: Brian Norfleet Employee Number: 11156

Date of Injury: 10/11/14 Date of Current Visit: 11/20/14

Is this a scheduled work day? [x] Yes [ ] No CURRENT WORK STATUS: [ ] Full Duty [x] Modified Duty [ ] Off Work

PHYSICIAN'S FINDINGS (to be completed by Treating Physician Only)

Diagnosis ICD9 Code (No Narrative): 354.0

• Released to Full-Duty on 11/20/14

• Released to Modified-Duty on __/__/__ with the following restrictions (*check all applicable*):

[ ] No: _Bending _Pushing _Pulling [ ] No Fire Suppression, Rescue or Paramedic Activities (Firefighters)

[ ] No Repetitive Motion to Injured Part: [ ] No Combat Situations

Body Part ______ [ ] Medication May be used while Working

[ ] No Reaching/Working above Shoulder [ ] No Operating a Motor Vehicle or Machinery

[ ] No Climbing: _Ladders _Stairs _Steep Terrain [ ] Other: _Eye Patch _Keep Injury Clean _Must Wear Splint/Sling

[ ] No Lifting over: _5 lbs. _10 lbs. _20 lbs. _35 lbs. _50lbs. # __ lbs.

Comments/Other: ______

Employee's restrictions are: [ ] Temporary [ ] Permanent

• Employee is OFF WORK (TTD) from __/__/__ to __/__/__
(These dates should not start before this treatment date or extend past next appointment date.)

Discharged? [ ] Yes [x] No Medically Stable? [ ] Yes [x] No Ratable? [ ] Yes [ ] No [x] TBD

Condition: [ ] Same [x] Improved [ ] Worsened

Request Referral? [ ] Yes [x] No Referral For/To: ______

Objective Findings/Treatment/Prognosis: ______

REHABILITATION (Physical Therapist / Occupational Therapist)

NOTE FOR PT APPOINTMENTS: Therapist may complete and sign only the portions below.

Job Description Provided: [ ] Yes [ ] No Employee is: [ ] Improving [ ] Maintaining [ ] Regressing [ ] PT/OT Complete

SIGNATURES (Provider, Employee, Supervisor)

TIME IN: 09:?? TIME OUT: 10:30 NEXT APPOINTMENT: Date 12/18/14 Time 8:50am

Physician or Clinician Signature ______ Date 11/20/14

Dr. Craig Young
Physician or Clinician Print Name ______ Phone

4530 S. Eastern Las Vegas NV
Address ______ City/State/ZIP

Employee Signature ______ Supervisor Signature ______

ORIGINAL: HR-Risk Management Division, MSC 137 (Fax 702-287-1631) PLEASE RETAIN A COPY: Department Employee Physician

Adj. Sue Ricicio-(817)477-3034 ncm Salli Cyeskiewicz (866)728-8277.

HRRM-0177, RV&EB (Rev. 01/2014)

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Hand Surgery Specialists of Nevada

Colby P. Young, M.D. Jedediah W. Jones, M.D. David M. Fadell, D.O.

Date of Service:	11/20/2014
Patient Name:	Brian Wolfgram
Gender:	Male
Date of Birth	10/10/1967 47 Years 1 Month
Referral Name:	NCM Sally Dr. Colby Young

REASON FOR VISIT:	NCV EMG results
HISTORY OF INJURY:	Affected body part: bilateral arm and hand Date of Injury: 10/18/14

Current Medications

Ibuprofen 200MG Tablet Oral, Ref: 0

Social History	Allergies
Alcohol - Occasionally Tobacco: Non Smoker	No Known Drug Allergies
Past Surgical History	Past Medical History
Spine	NONE PROVIDED
Family History	Previous Diagnosis
None listed	354.0,354.2,719.43

Smoking Status	Hand Dominance	Height:	Weight in lbs:
Unknown if ever smoked	Right	6'0"	190

SUBJECTIVE: Mr. Wolfgram returns to the office for follow up. He reports that his symptoms have dissipated somewhat. He has completed his electrodiagnostic studies and he is presenting for evaluation.

GENERAL: Age appropriate Male in no apparent distress.

SKIN: The skin is clean and dry. There are no abnormal markings, swelling, or discoloration.

LYMPHATIC: No erythema, cellulitis, abscesses, lymphangitis nor any signs to suggest infection.

VASCULAR: Brisk capillary refill, normal turgor, digits warm, no signs of chronic ischemia.

NEUROLOGIC: Sensation is normal and intact to light touch. No signs of atrophy, anhidrosis or trophic changes.

MUSCULOSKELETAL: Clinically he has the ability to fully flex and extend the arms. He has equivocal provocative findings for cubital tunnel syndrome today.

Diagnosis	354.0 CARPAL TUNNEL SYNDROME 354.2 Cubital Tunnel Syndrome

	719.43 PAIN IN JOINT FOREARM
99213	OFFICE OUTPT EST15 MIN
E0191	Protector heel or elbow

PLAN: We discussed the electrodiagnostic studies which did not demonstrate evidence of cubital tunnel syndrome. We also discussed that electrodiagnostics of the cubital tunnel are less sensitive than those of the carpal tunnel. There is a 75% correlation with clinical findings with cubital electrodiagnostic studies. We discussed that we would place him in an elbow pad for nighttime use and have him follow up in one month. He will participate in full duty activity. At that time, we will have a conversation regarding the treatment options which would consist of continued observation versus discussion regarding in situ decompression.

Colby P. Young MD
Board Certified Orthopaedic Hand and Upper Extremity Specialist
Certified Independent Medical Examiner

Workers' Compensation Accident/Injury Treatment Report (T-1)

EMPLOYEE TO COMPLETE

Employee's Name: Brian Wallgren Employee Number: 11056

Date of Injury: 10/18/14 Date of Current Visit: 11/20/14

Is this a scheduled work day? ☒ Yes ☐ No CURRENT WORK STATUS: ☒ Full Duty ☐ Modified Duty ☐ Off Work

PHYSICIAN'S FINDINGS (to be completed by Treating Physician only)

Diagnosis ICD9 Code (No Narrative): 354.2

- **Released to Full-Duty on** 12/18/14 Original release 11/20/14
- **Released to Modified-Duty on** ___/___/___ with the following restrictions *(check all applicable)*:

☐ No: ___Bending ___Pushing ___Pulling
☐ No Repetitive Motion to Injured Part:
Body Part _____
☐ No Reaching/Working above Shoulder
☐ No Climbing: ___Ladders ___Stairs ___Steep Terrain
☐ No Lifting over: ___5 lbs. ___10 lbs. ___20 lbs. ___35 lbs. ___50lbs. ___# _____lbs.
☐ No Fire Suppression, Rescue or Paramedic Activities (Firefighters)
☐ No Combat Situations
☐ Medication May be used while Working
☐ No Operating a Motor Vehicle or Machinery
☐ Other: ___Eye Patch ___Keep Injury Clean ___Must Wear Splint/Sling

Comments/Other: _____

Employee's restrictions are: ☐ Temporary ☐ Permanent

- **Employee is OFF WORK (TTD) from** ___/___/___ **to** ___/___/___
(These dates should not start before this treatment date or extend past next appointment date.)

Discharged? ☐ Yes ☐ No Medically Stable? ☐ Yes ☐ No Ratable? ☐ Yes ☐ No ☒ TBD

Condition: ☐ Same ☒ Improved ☐ Worsened

Request Referral? ☒ Yes ☐ No Referral For/To: OT 1x4

Objective Findings/Treatment/Prognosis: _____

REHABILITATION (Physical Therapist / Occupational Therapist)

NOTE FOR PT APPOINTMENTS: Therapist may complete and sign only the portions below.

Job Description Provided: ☐ Yes ☐ No Employee is: ☐ Improving ☐ Maintaining ☐ Regressing ☐ PT/OT Complete

SIGNATURES (Provider, Employee, Supervisor)

TIME IN: 8:30 TIME OUT: 9:30 **NEXT APPOINTMENT: Date** 1/15/15 **Time** 940am

Physician or Clinician Signature Date 12/18/14

Colby Yonker MD Physician or Clinician Print Name Phone 702 645.7800

4530 S Eastern Address LV, NV City/State/ZIP

Employee Signature Supervisor Signature

ORIGINAL: HR-Risk Management Division, MSC 137 (Fax: 702-267-1961) PLEASE RETAIN A COPY: Department Employee Physician

HRRM-0103, RM&EB, (Rev. 09/2014)

Received
12/18/14
CCMSI

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November 25, 2014

Brian K Wolfgram
221 Lookout Ave
Henderson, NV 89002

Re: Claim Number : 14C52E546827
Date of Loss : 10/18/2014
Employer : City of Henderson
Accepted body parts : Bilateral elbows and hands cubital tunnel syndrome

Dear Mr. Wolfgram:

This letter is to inform you that the scope of your claim acceptance has been amended as stated above. Please check the information in this letter. If you feel that anything is incorrect, please contact this office.

If you disagree with this determination you have the right to appeal by completing the enclosed "Request for Hearing" form and returning it to the Nevada Department of Administration within seventy (70) days of the date of this determination.

Sincerely,

Susan Ricclo
Claim Representative

Enclosure

cc: employer
File

RECEIVED
MAY 09 2017
CCMSI - LAS VEGAS

Hand Surgery Specialists of Nevada

Colby P. Young, M.D. Jedediah W. Jones, M.D. David M. Fadell, D.O.

Date of Service:	12/18/2014
Patient Name:	Brian Wolfgram
Gender:	Male
Date of Birth	10/10/1967 47 Years 2 Months
Referral Name:	NCM Sally Dr. Colby Young

REASON FOR VISIT:	4wk follow up
HISTORY OF INJURY:	Affected body part: bilateral arm and hand Date of Injury: 10/18/14

Current Medications			
Ibuprofen 200MG Tablet Oral, Ref: 0			
Social History		Allergies	
Alcohol - Occasionally Tobacco: Non Smoker		No Known Drug Allergies	
Past Surgical History		Past Medical History	
Spine		NONE PROVIDED	
Family History		Previous Diagnosis	
None Listed		354.0,354.2,719.43	
Smoking Status	Hand Dominance	Height:	Weight in lbs:
Unknown if ever smoked	Right	6'0"	190

SUBJECTIVE: Mr. Wolfgram returns to the office for follow up. He reports continued improvement in the arm and diminished numbness and tingling. He reports that he still has some mild weakness in the right upper extremity. He describes this as occurring with 25 pounds of lifting remaining.

GENERAL: Age appropriate Male in no apparent distress.

SKIN: The skin is clean and dry. There are no abnormal markings, swelling, or discoloration.

LYMPHATIC: No erythema, cellulitis, abscesses, lymphangitis nor any signs to suggest infection.

VASCULAR: Brisk capillary refill, normal turgor, digits warm, no signs of chronic ischemia.

NEUROLOGIC: Sensation is normal and intact to light touch. No signs of atrophy, anhidrosis or trophic changes.

MUSCULOSKELETAL: Clinically I have evaluated the bilateral arms with full flexion and extension, as well as pronation and supination. I do not appreciate any abnormalities. He has the ability to flex and extend the arm. There does not appear to be a Tinel's and there is not a positive elbow flexion test.

Diagnosis	354.2 Cubital Tunnel Syndrome
99213	OFFICE OUTPT EST15 MIN

PLAN: Today I have discussed options. I believe a short strengthening program would be beneficial This would include onetime per week for the next four weeks. He may resume his normal activities. We will assess him in one month.

Colby P. Young MD
Board Certified Orthopaedic Hand and Upper Extremity Specialist
Certified Independent Medical Examiner

Adjuster: Sue Riccio
Case Manager:
Claim: 4C52E546827
D.O.I: 10-18-14
Fax: 217-477-8034
Next Appt:
From: Danesha

Adjuster: NCM: Salli Choskiewicz
Case Manager:
Claim:
D.O.I:
Fax:
Next Appt: 866-728-8277
From:

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Initial Evaluation

EASTERN THERAPY DEPARTMENT
4530 SOUTH EASTERN AVE SUITE 3
LAS VEGAS, NV 89119

Patient:	Brian Wolfgram	Phone / Fax:	702-645-7800 702-216-3146
Acct #:	10003724	Therapist:	Jody Wait
DOB:	10/10/1967	Date of Service:	12/18/2014
SSN:		Referred By:	Colby Young
		PCP:	
		Diagnosis:	354.20 - Cubital Tunnel, 354.0 - CARPAL TUNNEL SYNDROME, 719.43 - PAIN IN JOINT FOREARM
Phone:		Injured Date:	10/18/2014
Insurance:	88222 - CCMSI	Init Eval Date:	12/18/2014
Authorization/Claim #:		Total Visits/CXL/NS:	0/0/0

Assessment
Pt is a 47 year old, RHD, male with left cubital tunnel syndrome. He works as a fireman and was pulling a large hose at work on 10/18/14 when he felt a sudden loss of grip strength. He returned to work the next day, but continued to have a significant strength deficit and tingling sensation to both arms. He sent to Concntra by his work and started therapy. He also had an EMG test which came back normal. He had no injections and wore an elbow brace that provided no relief. He has been working full duty for the last month.

Social History
Primary Language: English
Occupation: Fireman
Work Status: Full Time/ Full Duty

History of Injury/Illness
Mechanism of injury/illness: Work Injury
Comment: Pulling a long hose

Symptoms(s) / Pain Assessment - Area 1
Area: Left arm
Best: 1/10
Worst: 4/10
Nature of symptom(s) / pain: tingling, muscle tightness
Symptom(s) / pain worsens: sleep with elbow in flexed position
Symptom(s) / pain reduction: Ibuprofen as needed

Functional Activity Index
Sleeping: 0 No pain at night
Personal Care: 0 Independent
Lifting: 1 Can lift heavy weights but it causes extra pain

Patient Goals
Decrease pain. Return to prior function.

Rehab Potential
Patient is likely to achieve goals provided that the patient follows the plan of care prescribed by the doctor.

ROM / MMT - Hand

	ROM degrees		MMT	
	Left	Right	Left	Right
Grip strength, Jamar:	107.9#	123.2#		
Comment:	Jamar with arm extended: R: 133.6# L:108.8#			

Assessment Narrative
Pt is approximately 9 weeks post left cubital tunnel injury. His elbow ROM is WFL. However, grip strength is mildly limited with outstretched arm. He presents with pain when gripping and complains of pain along extensor and flexor origins with heavy lifting and palpation. He has increased pain with resisted wrist extension. Plan to tx 1x a week for 4 weeks for pain management.

Problem List	Comments
Decreased functional activity tolerance	
Activities are limited due to pain	
Difficulty carrying and moving objects	heavy objects
Pt has minimal strength deficit	

Short Term Goals	Time Frame
Independent with HEP	1 day
Decrease pain by 1-2 grades during functional activities	3 weeks
Increase strength by 5-10lbs	3 weeks
Long Term Goals	**Time Frame**
Independent management of pain:	4 weeks
Independent with carrying,moving and handling objects	4 weeks

Treatment Plan	Comments
Evaluation	
MHP/CP(circulation/healing)	
Ultrasound(scar tissu/promote healing)	
Manual therapy(ROM,edema,jt mobilization)	
TE for grip(func.activity,tool use)	
Instructed in and reviewed HEP	forearm stretches, use of heat and massage

Today's Treatment
Evaluation. MHPx10. US, Soft tissue mobilization and icing over lateral epicondyle. Instruction on HEP.

Next Session
Schedule next session with
Therapist:

MD Certification
☐ I agree with the above plan of care and certify that it is medically necessary.
☐ I disagree with the above plan of care and request it be modified as follows.

Dr.Colby Young **Date**

Jody E. Wait, OTR/L, CHT (electronically signed: 12/18/2014)

HAND SURGERY SPECIALISTS OF NEVADA

COLBY P. YOUNG, MD • JEDEDIAH W. JONES, MD
DAVID M. FADELL, DO

9321 WEST SUNSET ROAD
LAS VEGAS, NV 89148

4530 SOUTH EASTERN AVE # 1
LAS VEGAS, NEVADA 89119

(702) 645-7800 • FAX (702) 650-0865

20920

Name: Brian Murphy Date: 12/18/14

Dx: 354.2 DOS: DOI: 10/18/14

Rx: ☒ Evaluate and Treat (Determine appropriate exercise, splinting & wound care program based on evaluation)

EXERCISE

- ☐ AROM ☐ AAROM ☐ PROM
- ☐ Strengthening Program
- ☐ _____

SPLINTING

Splint(s) _____

DRESSINGS/WOUND CARE

- ☐ Dressing Change(s)
- ☐ Sterile dry dressing
- ☐ Wet -> dry dressing
- ☐ Non-adherent dressing
- ☐ Soaks
- ☐ Debridement
- ☐ Desensitization
- ☐ _____

EDEMA CONTROL

- ☐ Edema Control Techniques
- ☐ Coban ☐ Jobst Sleeve
- ☐ Isotoner ☐ DigiSleeve
- ☐ _____

EVALUATIONS

- ☐ ROM ☐ Dexterity
- ☐ Sensory ☐ ADL's
- ☐ Strength ☐ MMT

EQUIPMENT/SUPPLIES

- ☐ Scar Remodeling
- ☐ Putty ☐ Hand helper
- ☐ AVG ☐ Elbow pad
- ☐ Gel sleeve ☐ Elastomer
- ☐ Thermaband ☐ Pulleys
- ☐ Aircast armband

MODALITIES

- ☐ Hot/Cold packs ☐ NMES
- ☐ Iontophoresis ☐ TENS
- ☐ Phonophorasis ☐ Whirlpool
- ☐ Ultrasound

Work Conditioning Program
__ 2 wks __ 3 wks __ 4 wks

Functional Capacity Evaluation
__ PPI rating
__ Determine ability to return to former job
__ Determine appropriate job skills
__ Job site analysis
__ Ergonomic instruction/Patient education
__ Upper extremity strength building

Therapy for ____ times a week ____ weeks
Yes No
Social/Vocational Assessment Needed

Comments/Precautions: _____

Received
12/18/14
CCMSI

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Progress/Daily Notes

EASTERN THERAPY DEPARTMENT
4530 SOUTH EASTERN AVE SUITE 3
LAS VEGAS, NV 89119

Patient:	Brian Wolfgram
Acct #:	10003724
DOB:	10/10/1967
SSN:	
Phone:	
Insurance:	88222 - CCMSI
Authorization/Claim #:	

Phone / Fax:	702-645-7800 702-216-3146
Therapist:	Jody Wait
Date of Service:	12/23/2014
Referred By:	Colby Young
PCP:	
Diagnosis:	354.20 - Cubital Tunnel, 354.0 - CARPAL TUNNEL SYNDROME, 719.43 - PAIN IN JOINT FOREARM
Injured Date:	10/18/2014
Init Eval Date:	12/18/2014
Total Visits/CXL/NS:	0/0/0

Subjective
Pt states that he thinks that he overdid it yesterday because he is sore today. He states that he put the top on his Jeep.

Objective
MHP, US along lateral epicondyle area at 1.0, 1 mhz, 100%. Soft tissue mobilization along extensor wad. Ice massage x 8'

Assessment
Decreased muscle tightness along the forearm extensors today.

Plan
Continue 1x a week.

Jody E. Wait, OTR/L, CHT (electronically signed: 12/23/2014)

Progress/Daily Notes

EASTERN THERAPY DEPARTMENT
4530 SOUTH EASTERN AVE SUITE 3
LAS VEGAS, NV 89119

Patient:	Brian Wolfgram
Acct #:	10003724
DOB:	10/10/1967
SSN:	
Phone:	
Insurance:	68222 - CCMSI
Authorization/Claim #:	

Phone / Fax:	702-645-7800 702-216-3146
Therapist:	Jody Walt
Date of Service:	12/30/2014
Referred By:	Colby Young
PCP:	
Diagnosis:	354.20 - Cubital Tunnel, 354.0 - CARPAL TUNNEL SYNDROME, 719.43 - PAIN IN JOINT FOREARM
Injured Date:	10/18/2014
Init Eval Date:	12/18/2014
Total Visits/CXL/NS:	0/0/0

Subjective
Pt reports decreased pain of the elbow.

Objective
MHP to left elbow. US to lateral epicondyle area. Soft tissue mobilization and forearm stretches. Cold pack.

Assessment
Decreased tightness noted along the forearm musculature. Decreased frequency of pain throughout the day.

Plan
Continue with current tx to manage pain.

Jody E. Walt, OTR/L, CHT (electronically signed: 12/30/2014)

Re-Evaluation

EASTERN THERAPY DEPARTMENT
4530 SOUTH EASTERN AVE SUITE 3
LAS VEGAS, NV 89119

Patient:	Brian Wolfgram
Acct #:	10003724
DOB:	10/10/1967
SSN:	
Phone:	
Insurance:	88222 - CCMSI
Authorization/Claim #:	

Phone / Fax:	702-645-7800 702-216-3146
Therapist:	Jody Walt
Date of Service:	01/06/2015
Referred By:	Colby Young
PCP:	
Diagnosis:	354.20 - Cubital Tunnel, 354.0 - CARPAL TUNNEL SYNDROME, 719.43 - PAIN IN JOINT FOREARM
Injured Date:	10/18/2014
Init Eval Date:	12/18/2014
Total Visits/CXL/NS:	0/0/0

RECEIVED
JAN 09 2015
CCMSI ~ LAS VEGAS

Pain Status - Area 1

	On Initial Evaluation (12/18/2014)	On Re-Evaluation
Area:	Left arm	L arm
Best:	1/10	0/10
Worst:	4/10	0/10
Nature of symptom(s) / pain:	tingling, muscle tightness	
Symptom(s) / pain worsens:	sleep with elbow in flexed position	
Symptom(s) / pain reduction:	Ibuprofen as needed	No meds

Functional Activity Index

		On Re-Evaluation
Sleeping:	0 No pain at night	0 No pain at night
Personal Care:	0 Independent	0 Independent
Lifting:	1 Can lift heavy weights but it causes extra pain	0 Can lift heavy weights without extra pain

Rehab Potential

Patient is likely to achieve goals provided that the patient follows the plan of care prescribed by the doctor.

Fist	On Initial Evaluation (12/18/2014)			On Re-Evaluation		
	Left	Right	Centimeters	Left	Right	Centimeters

ROM / MMT - Hand

	IE ROM degrees		Re-Eval ROM		IE MMT		Re-Eval MMT	
	Left	Right	Left	Right	Left	Right	Left	Right
Grip strength, Jamar:	107.9#	123.2#	110#	124.4#				
Comment:	Initial: Jamar with arm extended: R: 133.6# L:108.8#; Re-eval: Jamar with arm extended R: 136.8#, L: 112.8#							

Assessment Narrative

Pt is approximately 11.5 weeks post left cubital tunnel injury. His pain has decreased moderately and he is able to perform work duties with no complaints of pain. There is less muscle tightness along the forearm extensor wad. Pt is independent with managing the pain and HEP. Recommend discharge.

Problem Status

On Initial Evaluation (12/18/2014)	On Re-Evaluation
Decreased functional activity tolerance	Resolved
Activities are limited due to pain	Resolved
Difficulty carrying and moving objects	Goals met.
Pt has minimal strength deficit	Partially Resolved

Treatment Plan
Re-evaluation
MHP/CP(circulation/healing)
Ultrasound(scar tissu/promote healing)
Manual therapy(ROM,edema,jt mobilization)
TE for grip(func.activity,tool use)
Instructed in and reviewed HEP

Comments

Today's Treatment
ReEvaluation. MHPx10. US along extensor origin, Soft tissue mobilization and long extensor stretch. Instruction on body mechanics. Cold pack.

Next Session
Schedule next session with
Therapist:

MD Certification
☐ I agree with the above plan of care and certify that it is medically necessary.
☐ I disagree with the above plan of care and request it be modified as follows.

Dr.Colby Young **Date**

Jody E. Wait, OTR/L, CHT (electronically signed: 01/06/2015)

Hand Surgery Specialists of Nevada

Colby P. Young, M.D. Jedediah W. Jones, M.D. David M. Fadell, D.O.

Date of Service:	01/15/2015
Patient Name:	Brian Wolfgram
Gender:	Male
Date of Birth	10/10/1967 47 Years 3 Months
Referral Name:	NCM Sally Dr. Colby Young

REASON FOR VISIT:	4wk follow up
HISTORY OF INJURY:	Affected body part: bilateral arm and hand Date of Injury: 10/18/14

Current Medications	
Ibuprofen 200MG Tablet Oral, Ref: 0	
Social History	Allergies
Alcohol - Occasionally Tobacco: Non Smoker	.No Known Drug Allergies
Past Surgical History	Past Medical History
Spine	.NONE PROVIDED
Family History	Previous Diagnosis
.None listed	354.0,354.2,719.43

Smoking Status	Hand Dominance	Height:	Weight in lbs:
Unknown if ever smoked	Right	6'0"	190

SUBJECTIVE: Mr. Wolfgram returns to the office for follow up. He reports 100 percent improvement in the right upper extremity and 95 percent in the contralateral left. Clinically he has full rule out bilaterally He has no tenderness to palpation over the medial or lateral aspect of the right elbow. He has some mild tenderness over the lateral aspect of the right elbow. He has some mild tenderness over the lateral aspect of the left elbow. He has full flexion and extension, as well as pronation and supination. The tingling is now near completely resolved.

GENERAL: Age appropriate Male in no apparent distress.

SKIN: The skin is clean and dry. There are no abnormal markings, swelling, or discoloration.

LYMPHATIC: No erythema, cellulitis, abscesses, lymphangitis nor any signs to suggest infection.

VASCULAR: Brisk capillary refill, normal turgor, digits warm, no signs of chronic ischemia.

NEUROLOGIC: Sensation is normal and intact to light touch No signs of atrophy, anhidrosis or trophic changes.

MUSCULOSKELETAL:

Diagnosis	354.0 CARPAL TUNNEL SYNDROME 354.2 LESION OF ULNAR NERVE 719.43 PAIN IN JOINT FOREARM
99213	OFFICE OUTPT EST15 MIN

PLAN: Today I have recommended that he resume activities as tolerated. I did discuss for him to follow up if need be if any of his symptoms recur. At this point, he has reached maximum medical improvement. He is stable. There is no residual rating or PPI.

Colby P. Young MD
Board Certified Orthopaedic Hand and Upper Extremity Specialist
Certified Independent Medical Examiner

Adjuster: Sue Ricco
Case Manager:
Claim: KC52E5416627
D.O.I: 10.18.14
Fax:
Next Appt: 217.477.3034
From: Danasha

Adjuster: NCM: Sally Chaskiewicz
Case Manager:
Claim:
D.O.I:
Fax:
Next Appt: 866.728.8277
From:

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Risk Management Division

Workers' Compensation Accident/Injury Treatment Report (T-1)

EMPLOYEE TO COMPLETE

Employee's Name: Brian Wolfgram Employee Number: 11056

Date of Injury: 10-18-14 Date of Current Visit: 1-15-15

Is this a scheduled work day? ☐ Yes ☒ No CURRENT WORK STATUS: ☒ Full Duty ☐ Modified Duty ☐ Off Work

PHYSICIAN'S FINDINGS (to be completed by Treating Physician Only)

Diagnosis ICD9 Code (No Narrative): 954.8

- Released to Full-Duty on 1/15/15
- Released to Modified-Duty on __/__/__ with the following restrictions *(check all applicable)*:

☐ No: __Bending __Pushing __Pulling
☐ No Repetitive Motion to Injured Part:
Body Part ______
☐ No Reaching/Working above Shoulder
☐ No Fire Suppression, Rescue or Paramedic Activities (Firefighters)
☐ No Combat Situations
☐ Medication May be used while Working
☐ No Operating a Motor Vehicle or Machinery
☐ No Climbing: __Ladders __Stairs __Steep Terrain ☐ Other: __Eye Patch __Keep Injury Clean __Must Wear Splint/Sling
☐ No Lifting over: __5 lbs. __10 lbs. __20 lbs. __35 lbs. __50lbs. #__ lbs.
Comments/Other: ______

Employee's restrictions are: ☐ Temporary ☐ Permanent

- Employee is OFF WORK (TTD) from __/__/__ to __/__/__
(These dates should not start before this treatment date or extend past next appointment date.)

Discharged? ☒ Yes ☐ No Medically Stable? ☒ Yes ☐ No Ratable? ☐ Yes ☒ No ☐ TBD

Condition: ☐ Same ☐ Improved ☐ Worsened

Request Referral? ☐ Yes ☐ No Referral For/To: ______

Objective Findings/Treatment/Prognosis: ______

REHABILITATION (Physical Therapist / Occupational Therapist)

NOTE FOR PT APPOINTMENTS: Therapist may complete and sign only the portions below.

Job Description Provided: ☐ Yes ☐ No Employee is: ☐ Improving ☐ Maintaining ☐ Regressing ☐ PT/OT Complete

SIGNATURES (Provider, Employee, Supervisor)

TIME IN: 9:45 TIME OUT: 10:30 NEXT APPOINTMENT: Date N/A PRN Time ____

[signature]
Physician or Clinician Signature Date

Colby Young MD Date: [illegible]
Physician or Clinician Print Name Phone

9321 W. Sunset Road Las Vegas, NV 89148
Address City/State/ZIP

[signature]
Employee Signature Supervisor Signature

ORIGINAL: HR-Risk Management Division, MSC 137 (Fax: 702-267-1951) PLEASE RETAIN A COPY: Department Employee Physician

HRRM-0103, Risk [illegible] (Rev. 05/2014)

Adj: Sue Rivera
Phone: 702-477-3041

Nom Salvio
Fax 866-728-8277

58

00280

January 26, 2015

Brian K Wolfgram
221 Lookout Ave
Henderson, NV 89002

Re		
	Claim No:	14C5ZE546827
	Employer:	City of Henderson
	TPA:	CCMSI
	Date of Injury:	10/18/2014

NOTICE OF INTENTION TO CLOSE CLAIM
(Pursuant to NRS 616C.235)

After a careful and thorough review of your workers' compensation claim, it has been determined that all benefits have been paid and your claim will be closed effective seventy (70) days from the date of this notice. Based on the available medical information, the claim will be closed without a Permanent Partial Disability (PPD) evaluation as there is no possibility of a permanent impairment of any kind.

Your file reflects that you are not presently undergoing any medical treatment; however, if you are scheduled for future medical appointments, please advise this office immediately.

Nevada Revised Statute (NRS) 616C.390 defines your right to reopen your claim. You must make a written request for reopening and your doctor must submit a report relating your problem to the original industrial injury. The report must state that your condition has worsened since the time of claim closure and that the condition requires additional medical care. Reopening is not effective prior to the date of your request for reopening unless good cause is shown. Upon such showing by your doctor, the cost of emergency treatment shall be allowed.

If you disagree with the above determination, you do have the right to appeal. If your appeal concerns "accident benefits" (medical treatment or supplies) and your insurer has contracted with an organization for managed care, complete the bottom portion of this notice and send it to your insurer no later than fourteen (14) days after the date of this notice.

If your appeal concerns "compensation benefits," or if no organization for managed care is involved in your claim, complete the bottom portion of this notice and send it to the State of Nevada, Department of Administration, Hearings Division. Your appeal must be filed within seventy (70) days after the date on which the notice of the insurer's final determination was mailed.

Department of Administration
Hearings Division
1050 E. William Street, Ste. 400
Carson City, NV 89710
(775) 687-8440

OR

Department of Administration
Hearings Division
2200 S. Rancho Drive, Suite 210
Las Vegas, NV 89102
(702) 486-2525

From: Susan Ricclo, Claims Representative Susan Ricclo

Reason for appeal:

_____

_____

_____ _____

Signature Date

Retain a copy of this notice for your records.
Cc: File/Employer
Enclosure

D-31 (rev. 10/10)

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14C52E546827

Hand Surgery Specialists of Nevada

Colby P. Young, M.D. Jedediah W. Jones, M.D. David M. Fadell, D.O.

Date of Service:	01/30/2017	
Patient Name:	Brian Wolfgram	
Gender:	Male	
Date of Birth	10/10/1967	49 Years 3 Months
Referral Name:	NCM Sally Dr. Colby Young	

REASON FOR VISIT:	
HISTORY OF INJURY:	Affected body part: bilateral arm and hand Date of Injury: 10/18/14

Prescriptions			
Medications			
Ibuprofen 200MG Tablet, Ref: 0			
Social History		Allergies	
Alcohol - Occasionally Tobacco: Non Smoker		.No Known Drug Allergies	
Surgical History		Past Medical History	
Spine		.NONE PROVIDED	
		Family History	
		.None listed	
Smoking Status	Hand Dominance	Height	Weight in lbs
Unknown if ever smoked	Right	6'0"	200

SUBJECTIVE: Brian Wolfgram returns to the office for followup. He returns as a previous patient that was last seen approximately two years ago. He, on last evaluation, was diagnosed with cubital tunnel, as well as carpal tunnel syndrome and we had treated him with expectant management. He reports that during the course of participating in his normal work-related activities over the last two years, he began having progressive numbness and tingling that has recurred in the hand.

He has not changed any of his outside activities. He states that he had observed this after our conversation on his last evaluation, however subsequently began having worsening symptoms. He states that his symptoms are worse with elbow flexion for a period of time or pressure along the elbow. Computer use, bike riding and sleeping makes his symptoms worse. He states that he had taken a short course of prednisone for unrelated injury and this improved his symptoms temporarily however after he had been taken off the prednisone, his symptoms recurred. He is here to discuss reopening of his claim.

GENERAL: Age appropriate Male in no apparent distress.

SKIN: The skin is clean and dry. There are no abnormal markings, swelling, or discoloration.

LYMPHATIC: No erythema, cellulitis, abscesses, lymphangitis nor any signs to suggest infection.

VASCULAR: Brisk capillary refill, normal turgor, digits warm, no signs of arterial insufficiency.

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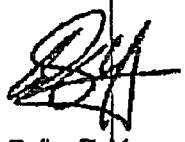
NEUROLOGIC: Sensation is normal and intact to light touch. No signs of atrophy, anhidrosis or trophic changes.

MUSCULOSKELETAL: He has full flexion and extension of the elbows. There is no clicking or catching. He has sensation that is intact to light touch with 2-point discrimination being 5 mm over the radial and ulnar aspect of the thumb and small finger. He has a equivocal Tinel's. He has negative Froment's, Earl's or Wartenberg's tests today.

Diagnosis	G56.21 Lesion of ulnar nerve, right upper limb G56.22 Lesion of ulnar nerve, left upper limb
99203	OFFICE OUTPT NEW 30 MIN

PLAN: I believe he has recurrence of his previous symptoms. I would like to obtain repeat electrodiagnostic studies to evaluate. I do recommend reopening of his claim for evaluation and possible treatment if necessary. I recommended that he have elbow pads during the day and recommended rotating these at night to minimize pressure on the ulnar nerve.



Colby P. Young MD

14C52E5408827

Brian K Wolfgram
221 Lookout Avenue
Henderson, NV 89002

February 6, 2017

Attn: Candice Egan

This letter is to request reopening of my 2014 claim where I was diagnosed with bi-lateral cubital tunnel syndrome. Since 2014, I have had reoccurring symptoms, most recently the beginning of December 2016 to present. Because the symptoms continue to worsen, I scheduled an appointment with Dr. Young for evaluation. I had an appointment with Dr. Young on January 30th and he indicated that since my symptoms had worsened he would assist me with reopening the claim and order a nerve study to assist with the evaluation.

I have not been schedule as of yet for the nerve study but I am scheduled for another appointment with Dr. Young, March 9th. Please let me know if there are any further steps I need to take to expedite this process.

Thank you,

Brian K. Wolfgram

CCMSI

February 15, 2017

Brian K Wolfgram
221 Lookout Ave
Henderson, NV 89002-3339

Re: Claim Number : 14C52E546827
Date of Injury : 10/18/2014
Insurer : City of Henderson

Dear Mr. Wolfgram:

This letter is to inform you that CCMSI has received your request to reopen your above-referenced claim. Please be aware that NRS 616C.390 (5) states:

5. An application to reopen a claim must be made in writing within 1 year after the date on which the claim was closed if:
(a) The claimant was not off work as a result of the injury; and
(b) The claimant did not receive benefits for a permanent partial disability.

Based on the fact that your claim was closed more than one year prior to your request to reopen, you did not lose time from work, and you did not sustain a permanent disability as a result of your claim our office is unable to consider your request for reopening. A copy of NRS 616C.390 is enclosed for your review.

If you disagree with this decision, you may appeal by completing and submitting the attached "Request for Hearing" form to the Department of Administration, Hearings Division within seventy (70) days of the date of this letter.

If you have any questions regarding this matter, please contact this office.

Sincerely,

Candise Egan
Claims Representative

Enclosures: NRS 616C.390
"Request for Hearing" form

cc: City of Henderson
File

RECEIVED
MAR 16 2017
CCMSI - LAS VEGAS

63

Neeman & Mills, PLLC

Attorneys at Law

Jeffrey S. Neeman, Esq.*
Jason D. Mills, Esq.

1201 South Maryland Pkwy.
Las Vegas, NV 89104
Office: (702) 822-4444
Fax: (702) 822-4440

*Also Admitted in California

March 9, 2017

VIA FACSIMILE/ (702) 933-4861
AND REGULAR MAIL

CCMSI
PO Box 35350
Las Vegas, NV 89133

Attn: Candice Egan

Re: Claimant: WOLFGRAM, Brian
Claim No.: 14C52E546827
DOI: 10/18/2014
Employer: City of Henderson

Dear Ms. Egan:

Please be advised that law office of Neeman & Mills, PLLC, has been retained in association with the industrial insurance claim of the above-referenced claimant. Accordingly, please do not have any *ex parte* communication with my client regarding this industrial insurance claim regardless of who initiates the contact. Also at this time I formally request that your office:

1. Issue and provide a copy of the compensability determination pursuant to NRS 616C.065.

2. Provide a complete, current, and unredacted copy of your entire provider list for the **State of Nevada**; and that such list is to be provided within 3 days as required by NAC 616C.030.

3. Provide a complete, current, and unredacted copy of my client's *file of employee's claim* as defined by NAC 616C.088. Prompt submission of the entire file is imperative, as it is my intent to appeal any/all adverse determinations that may have been issued without my knowledge.

4. Provide an average monthly wage calculation, along with supporting documentation used to make the calculations, for both 84 days and 12 months (or the entire period of employment if less than 12 months) as required by NAC 616C.435.

5. Provide a copy of the call log of all oral communication with my client's treating physician(s)/chiropractor(s) pursuant to NRS 616D.330; if a copy is not provided this office will assume that no such communication has taken place.

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6. Provide a copy of any/all light duty job offer(s) extended to my client by the employer pursuant to NRS 616C.475; if a copy is not provided this office will assume that no light duty job offer has been extended by the employer.

Please consider the above mentioned requests to be ongoing in nature throughout the entire period of this claim and continue to supplement the above mentioned requests as the information and/or documentation becomes available.

Also, please be advised that I do not allow any contact between nurse case managers and my client and I do not allow nurse case managers to enter the examination rooms with my client during visits with any physician. Rather, the nurse case manager is to contact my office with any questions and the scheduling of any future appointments. Additionally, pursuant to NAC 616C.109, notice is hereby given that at the time of the PPD examination a member, employee, or representative of this firm will be present at the time of the examination.

Attached hereto is a copy of an Authorization and a Special Power of Attorney signed by my client allowing the release of the above requested information.

Your prompt response is appreciated.

Best Regards,

NEEMAN & MILLS, PLLC

Jason D. Mills, Esq.
Dictated but not read.

JDM:vs
Enclosures

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Neeman & Mills, PLLC

Attorneys at Law

Jeffrey S. Neeman, Esq.*
Jason D. Mills, Esq.

1201 South Maryland Pkwy.
Las Vegas, NV 89104
Office: (702) 822-4444
Fax: (702) 822-4440

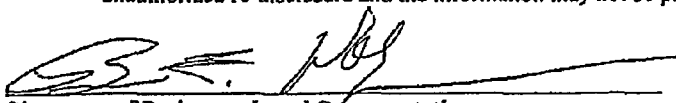
*Also Admitted in California

HIPAA AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: Brian Wolfgram Date of Loss: 10/18/2014

DATE OF BIRTH 10/10/1967 SS# _____

1. I authorize the use or disclosure of my health information as described below:
2. The following individual or organization is authorized to make the disclosure:
   CCMSI & All medical providers
3. The type and amount of information to be used or disclosed is as follows:
   ☑ ENTIRE RECORD From (date)_____To(date) _____
   ☐ Other _____
4. This Information may be disclosed to and used by the following individual or organization:
   NEEMAN & MILLS, PLLC, 1201 South Maryland Pkwy., Las Vegas, NV 89104
   For the purpose of: PERSONAL INJURY AND/OR WORKMAN'S COMPENSATION CASE.
5. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health provider and/or this law firm. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. Unless otherwise revoked this authorization will expire on the following date, event or condition: Claim Closure. If I fail to specify and expiration date, event or condition. This authorization will expire in six months.
8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to insure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.



Signature of Patient or Legal Representative 3/2/17 Date

Under N.R.S. 629.061 you are **REQUIRED, BY LAW,** to furnish all applicable records within **THIRTY (30) DAYS.** Please forward all correspondence to our office as soon as possible. We are preparing the file for settlement.

Regards,

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Neeman & Mills, PLLC

SPECIAL POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that I, Brian Wolfgram a resident of the State of Nevada, desiring to execute a Special Power of Attorney, have made, constitute and appointed, and be these presents do make, constitute and appoint **NEEMAN & MILLS, PLLC**, my attorneys-in-fact, to act as follows:

GIVING AND GRANTING unto my said attorney full power to execute any and all documents necessary for the pursuit and protection in my workman's compensation case and to receive and endorse my name on my behalf to all check which are due from the Employers Insurance Company of Nevada or the self-insured employer.

FURTHER, I do authorize my aforesaid attorney-in-fact to receipt, reaffirmation of lump sum and other documents necessary to obtain said checks and accept any and all checks which are due the private insurer, and/or the self-insured employer.

PROVIDED HOWEVER, that all business transacted hereunder for me or for my account shall be transacted in my name, and that all endorsements and instruments executed by my said attorney for the purposes of carrying out the foregoing powers shall contain my name followed by that of said attorney and the designation "Attorney-in-Fact".

FURTHER, that this Special Power of Attorney shall be carried out in accordance with the Retainer Agreement execute by the parties herein.

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IN WITNESS WHEREOF, I have hereunto set my hand and seal this 3 day of March, 2017.

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

On this 3 day of March, 2017 then and there personally appearing before me, the undersigned, a Notary Public in and for said County and State BRIAN WOLFRAM known to me to be the person described in and who executed the foregoing instrument and who acknowledge to me that s/he executed the same freely and voluntarily and for the uses and purposes therein mentioned.

WITNESS my hand and official seal.

NOTARY PUBLIC, in and of said county and State.

M. DIAZ
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 05-20-18
Certificate No: 14-13831-1

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ORIGINAL

FILED
MAR 10 2017
HEARINGS OFFICE

Nevada Department of Administration
Hearings Division
2200 S. Rancho Drive, Ste. 210 & 220
Las Vegas, NV 89102
(702)486-2525
(702) 486-2527

REQUEST FOR HEARING

CLAIMANT INFORMATION:
Claimant: Brian K. Wolfgram
Address: 221 Lookout Ave.
Henderson, NV 89002
Telephone No.: n/a

EMPLOYER INFORMATION:
Claim No: 14C52E546827
Employer: City of Henderson
Address: 240 Water St. MSC 127
Henderson, NV 89009
Telephone No.: (702) 267-7914

PERSON REQUESTING APPEAL: **CLAIMANT**
I WISH TO APPEAL THE DETERMINATION DATED: February 15, 2017

YOU MUST ATTACH A COPY OF THE DETERMINATION LETTER PER NRS 616C.315(a)(b)

BRIEFLY EXPLAIN THE REASON FOR YOUR APPEAL: Denial of reopening.

If you are represented by an attorney or other agent, please print the name and address below:

ATTORNEY/REPRESENTATIVE:

Jason D. Mills, Esq.
NEEMAN & MILLS, PLLC
1201 S. Maryland Pkwy
Las Vegas, NV 89104
702-822-4444

INSURANCE COMPANY:

CCMSI
PO Box 35350
Las Vegas, NV 89133
(702) 933-4800

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Signature

March 09, 2017
Date

A COPY OF THE DETERMINATION LETTER MUST BE SUBMITTED

NRS 616C.315 Request for hearing; forms for request to be provided by Insurer; appeals; expeditious and informal hearing required; direct submission to Appeals Officer.

2. Except as otherwise provided in NRS 616C.305, a person who is aggrieved by:
   (a) a written determination of an Insurer; or
   (b) The failure of an Insurer to respond within 30 days to a written request mailed to the Insurer by the person who is aggrieved, may appeal from the determination or failure to respond by filing a request for a hearing before a Hearing Officer.

SCHEDULED ON
MAR 10 2017

17 10311-5E 69

0029

CCMSI

April 10, 2017

Brian Wolfgram
221 Lookout Ave
Henderson, NV 89002

Re: Claim Number : 14C52E546827
Date of Injury : 10/18/2014
Employer : City of Henderson

Dear Mr. Wolfgram:

We are in receipt of your requested wages and have verified calculations in the amount of $33,297.77 for the time period of 07/21/2014 through 10/12/2014. Pursuant to state calculations the allowable average monthly maximum rate which is $5,356.23 and a daily rate of $117.31.

We have enclosed a copy of the Explanation of Wage Calculation Form for your review.
Compensation benefits are based on 66-2/3 percent of your average monthly wage, subject to a maximum limit set by the state.

Nevada Revised Statute (NRS) 616C.425, paragraph 1 states:

"The amount of compensation and benefits and the person or persons entitled thereto must be determined as of the date of the accident or injury to the employee, and their rights thereto become fixed as of that date."

The Nevada Administrative Code requires that the following be included in computing the average monthly wage: All wages and salaries, including overtime, commissions, incentive pay, all leave and holiday pay, bonuses, termination pay, tips (under special circumstances), tool allowances, piecework, and travel pay. Any contribution made by your employer toward the cost of health insurance is not included. If you have additional income which has not been included in the verified amount, please submit documentation to this office as soon as possible. Following a review of the information, you will be notified whether there is an adjustment to your benefits.

If you disagree with this decision, you may appeal by completing the attached "Request for Hearing" Form and submitting it to the Department of Administration, Hearing Division within seventy (70) days of the date of this letter.

If you have any questions regarding this matter, please contact this office.

Sincerely,

Susan Riccio
Claims Representative

Encl: D-7, D-8, D-12a
cc: COH/Jason Mills, Esq.

P.O. Box 35350
Las Vegas, NV 89133-5350
702 933 4800 phone
702 933 4861 fax

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EXPLANATION OF WAGE CALCULATION
(Pursuant to NAC 616C.520(1))

The amount of disability compensation payable to an injured employee is based on his average monthly wage at the time of the accident. The compensation due is calculated on a calendar day basis, and paid at the rate of 66 2/3% of the average monthly wage, subject to the statutory limitation that creates a maximum average monthly wage benefit that is 150% of the state-calculated average monthly wage. If disabled for at least five consecutive days, or five cumulative days within a 20-day period, each day of disablement, including and following the five days, is compensable. When a doctor releases the injured employee to work or he returns to work on his own, the eligibility for disability ceases.

ITEMS INCLUDED IN THE AVERAGE MONTHLY WAGE
(Pursuant to NAC 616C.423)

The calculation of your average monthly wage includes the following: wages or salary; commissions which are prorated over the period used to calculate the AMW; incentive pay; payment for sick leave; bonuses which are prorated over the period used to calculate the average monthly wage; termination pay; tips which are collected and disbursed by the employer and are not paid at the discretion of the customer; tips you report pursuant to NRS 616B.227; payment for piecework, tool allowance, vacation, holidays, overtime, and travel time; and value of room and/or board. Concurrent employment with another employer may be included.

Items which cannot be included are: employment not subject to coverage under NRS 616A to 616D, inclusive or chapter 617 of NRS, or elective employment which has not been elected; reimbursement for job related expenses, including per diem and travel, and allowances for laundry or uniforms.

In certain instances, wages are determined by statute. Compensation will be based on that wage.

If your average monthly wage exceeds the State Average Monthly Wage, compensation will be based on the State Average Monthly Wage.

CALCULATION OF THE AVERAGE MONTHLY WAGE

A wage history of a period of 12 weeks must be used to calculate the average monthly wage. If a 12-week period is not representative of your average monthly wage, the following methods are to be used.

A period of one year, or the full period of employment if less than one year, may be used. It **must** be used if the average monthly wage would be increased; or pursuant to NAC 616C.435(3), if employee is a member of a labor organization and regularly employed by referrals from that office, wages from all employers for one year must be used if the average monthly wage would be increased.

If employed less than 12 weeks, but for a period not less than four weeks, wages are averaged for the available period; or earnings based on piecework or a period of less than four weeks must be based on the rate of pay and projected working schedule, or on an average equal to other employees doing the same work.

The period used to calculate the AMW must consist of consecutive days immediately preceding your accident. Each day must be counted, with the following exceptions: A certified illness or disability; institutionalized in a hospital, or other; enrollment as a full-time student and not employed on days of attendance; military service other than weekend duty; an officially sanctioned strike; or absence due to approved leave pursuant to the Family and Medical Leave Act of 1993.

Concurrent wages for employment by two or more employers may also apply. NAC 616C.447 provides that the insurer shall advise an injured employee in writing of his eligibility for compensation for concurrent employment at time of the initial payment of compensation.

IF IT APPEARS THAT AN ERROR HAS BEEN MADE IN THE WAGE DETERMINATION, PLEASE CONTACT YOUR CLAIMS AGENT. AN EXPLANATION OF THE CALCULATION WILL BE PROVIDED. THE WAGE WILL BE REVISED UPON PRESENTATION OF DOCUMENTATION (CHECK STUBS, INCOME TAX FORM W-2, WAGE STATEMENT FROM THE EMPLOYER) WHICH SHOWS THE ORIGINAL WAGE DETERMINATION TO BE IN ERROR. A REVISED WAGE WILL BE USED TO RECALCULATE AND ADJUST COMPENSATION FOR PERIODS ALREADY PAID, AS WELL AS FUTURE COMPENSATION.

D-7 (rev. 7/99)

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WAGE CALCULATION FORM FOR CLAIMS AGENT'S USE

RE:	Injured Employee:	Brian Wolfgram	Date of Injury:	10/18/14
	Social Security No.:		Claim No.:	14C52E546827
	Employer:	City of Henderson	Insurer:	Self-Insured
	Third-Party Administrator:	CCMSI		

Average Monthly Wage is defined in NAC 616C.420 through 616C.447.
The priorities for determining wage history are:

1. A 12-week history of earnings (84 days).
2. If a 12-week period of earnings is not representative of the injured employee's average monthly wage, a period of one year or the full period of employment, if it is less than one year, may be used. A period of one year or the full period of employment must be used if the average monthly wage would be increased. Divide by the number of days in the period.
3. If period of employment is more than four weeks, but less than twelve weeks, earnings from the date of hire will be used. Divide by the number of days in the period.
4. If period of employment is less then four weeks, average monthly wage will be calculated by multiplying rate of pay on the date of the accident or disease, by hours in employee's projected working schedule, divide by 7 and multiply by 30.44.

If other circumstances apply, see NAC 616C.435.

AVERAGE MONTHLY WAGE - Calculate AMW in the following manner:

Period of earnings: beginning date 07/21/14 through end date 10/12/14

Gross earning $33,297.77 + tips $0.00 / by number of days

In wage history 84 x 30.44 ---------- = Average Monthly Wage: $12,066.48

HOURLY RATE - Hourly rate of pay _____ X number of hours

projected to work per week _____ / 7 x 30.44 --- = Average Monthly Wage: $0.00

VALUE FOR ROOM AND/OR BOARD

Room (Monthly Value) _____ ---------- $0.00

Board (Monthly Value) _____ ---------- $0.00

VALUE OF MEALS - If meals are provided by the employer, see NAC 616C.423(1)(p) and use the following formula:

Amount for meals per day $0.00 x number of days hired

to work per week _____ = $0.00 / 7 x 30.44 ----- = Meals per Month: $0.00

ADD applicable lines to obtain total ---------- = Average Monthly Wage: $12,066.48

DAILY RATE - is to be calculated in the following manner:

Calculated Average Monthly Wage $12,066.48 x 8 / 12 / 30.44 ---------- Daily Rate: $264.27

Maximum Average Monthly Wage $5,356.23 x 8 / 12 / 30.44 ---------- Daily Rate: $117.31

Average Monthly Wage $5,356.23 x 8 / 12 / 30.44 ---------- Daily Rate: $117.31

Date 04/07/17 Signature Susan Riccio

Date 4/7/17 Signature

D-5 (rev. 7/99)

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WAGE CALCULATION FORM FOR CLAIMS AGENT'S USE

Claimant:	Brian Wolfgram	DOI:	10/18/14
Claim No.:	14C52E546827		

PERIOD BEGIN	PERIOD END		CHECK DATE	GROSS PAY
7/21/14	8/3/14			$6,803.56
8/4/14	8/17/14			$5,250.59
8/18/14	8/31/14			$6,527.76
9/1/14	9/14/14			$5,491.84
9/15/14	9/28/14			$5,250.60
9/29/14	10/12/14			$3,973.42
				$33,297.77

14C52EE34U827

EMPLOYER'S WAGE VERIFICATION FORM

(Pursuant to NRS 616C.045(2)(d))

Please provide the following information for the employee named below by completing this form. The information is needed so that the amount of disability compensation to which your employee is entitled may be calculated. Prompt completion and return of this form will ensure the timely payment of any compensation due this injured worker. Please answer all questions and sign the form where indicated.

EMPLOYER: PLEASE PROVIDE THE FOLLOWING INFORMATION ANSWERING ALL QUESTIONS

Date: 4/3/17 Injured Employee's Name (Last/First/M.I.): Wolfgram, Brian K Social Security # _____

Claim No.: E546827 Date of Injury: 10/18/14 Date of Hire: 7/9/90

Was employee hired to work 40 hours per week: [ ] Yes [X] No If no, # of hours per week: 56 # of days per week: varies

On the date of injury, the employee's wage was: $ 35.48 per [X] Hour [ ] Day [ ] Week [ ] Month Date the wage became effective: 6/23/14

Was vacation paid during the applicable twelve week period? Yes If so, during what pay period? 8/3, 8/17, 9/14, 9/28, 10/12

Was sick leave paid during the applicable twelve week period? No Was the injured employee paid for any holidays during the applicable twelve week period? Yes Did employee receive payment for overtime during the applicable twelve week period? Yes Did employee receive termination pay during the applicable twelve week period? No

Provide prior wage if current wage was in effect less than 12 weeks prior to date of injury: $ _____ per [ ] Hour [ ] Day [ ] Week [ ] Month

During this 12-week period did employee change to a job with different (1) duties, (2) hours of employment, (3) rate of pay? [ ] Yes [ ] No

If so, date: _____ Explain: _____

Does the employee receive commissions? [ ] Yes [X] No Period of commission earned _____ to _____.

Indicate the amount of commission received over the last 6 months, or since date of hire: $ _____

Does the employee receive bonuses/incentive pay? [ ] Yes [X] No Period of bonuses/incentive pay earned _____ to _____.

Indicate the amount of bonuses received over last 12 months, or since date of hire: $ _____

Are the commission and bonus amounts included in GROSS EARNINGS below? [ ] Yes [X] No

Does the employee declare tips for the purpose of worker's compensation? [ ] Yes [X] No **See payroll declaration below. Attach declaration forms.**

Does the employee receive meals or lodging (excluding reimbursement for travel per diem)? [ ] Yes [X] No **(Do not include in gross earnings)**

How many meals per day? _____ Monetary value of meals $ _____ per [ ] Day [ ] Week [ ] Month

Lodging $ _____ per [ ] Day [ ] Week [ ] Month

TWELVE WEEK VERIFICATION FROM PAYROLL RECORDS. Report GROSS EARNINGS, include overtime payment and any other remuneration (except reimbursement for expenses). (See NAC 616C.423)

Give payroll information from 7/21/14 through 10/12/14. If employed less than twelve weeks, give gross earnings from date of hire to date of injury.

If absent from work for the following reasons, please specify the date(s) absent and the number code for the reason of absence.

1. Certified illness or disability; 2. Institutionalized in a hospital, or other institution; 3. Enrolled as full-time student, not employed on days of attendance; 4. In military service other than training duty conducted on weekends; 5. Absent because of officially sanctioned strike; 6. Absence because of leave approved pursuant to Family and Medical Leave Act.

Payroll Period Beginning	Payroll Period Ending	Gross Salary (Excluding Tips)	Declared Tips	Payroll Period Beginning	Payroll Period Ending	Gross Salary (Excluding Tips)	Declared Tips
7/21	8/3/14	6,803.56					
8/4	8/17/14	5,250.59					
8/18	8/31/14	6,527.76					
9/1	9/14/14	5,491.84					
9/15	9/28/14	5,250.60					
9/29	10/12/14	3,973.42					

Dates of Absence Begin	Dates of Absence End	Reason	Dates of Absence Begin	Dates of Absence End	Reason	Dates of Absence Begin	Dates of Absence End	Reason

Pay period ends on (check one) [X] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday

Employee is paid: [ ] Weekly [X] Bi-Weekly [ ] Semi-Monthly [ ] Monthly [ ] Other

Employee scheduled day(s) off: [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday [ ] Other

Explain "other":

Date the employee last worked AFTER injury occurred: _____ Date returned to work: _____

This information is true and correct as taken from the employee's payroll records. Print Name: Mary Sexton Signature: Mary Sexton

Date: 4/3/17 Employer: City of Henderson

Insurer: City of Henderson Third-Party Administrator: CCMSI D-8

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PeopleSoft

Report ID: COHPAY14
Company COH City of Henderson
GROSS PAY ANALYSIS
From: 21-JUL-2014 To: 12-OCT-2014

Run Date04/03/2017
Run Time06:54:54

Emp#	Pay End	Employee Name	DEPTID	TYPE	HOURS	RATE	EARNING
11056	03-AUG-2014	Wolfgram,Brian K	2003	Uniform Allowance	0	0.00	72.50
11056	03-AUG-2014	Wolfgram,Brian K	2003	Fire Hours Adjustment	-8	35.48	-283.82
11056	03-AUG-2014	Wolfgram,Brian K	2003	Regular Pay	24	35.48	851.45
11056	03-AUG-2014	Wolfgram,Brian K	2003	Vacation	96	35.48	3,405.79
11056	03-AUG-2014	Wolfgram,Brian K	2003	Bonus	0	0.00	2,830.14
				Pay Period Totals	112		6,876.06
11056	17-AUG-2014	Wolfgram,Brian K	2003	Uniform Allowance	0	0.00	72.50
11056	17-AUG-2014	Wolfgram,Brian K	2003	Overtime Pay	24	53.22	1,277.17
11056	17-AUG-2014	Wolfgram,Brian K	2003	Vacation	19	35.48	674.05
11056	17-AUG-2014	Wolfgram,Brian K	2003	Regular Pay	77	35.48	2,731.73
11056	17-AUG-2014	Wolfgram,Brian K	2003	Fire Hours Adjustment	16	35.48	567.63
				Pay Period Totals	136		5,323.09
11056	31-AUG-2014	Wolfgram,Brian K	2003	Uniform Allowance	0	0.00	72.50
11056	31-AUG-2014	Wolfgram,Brian K	2003	Overtime Pay	48	53.22	2,554.34
11056	31-AUG-2014	Wolfgram,Brian K	2003	Union Leave Paid	6	35.48	212.86
11056	31-AUG-2014	Wolfgram,Brian K	2003	Regular Pay	114	35.48	4,044.38
11056	31-AUG-2014	Wolfgram,Brian K	2003	Fire Hours Adjustment	-8	35.48	-283.82
				Pay Period Totals	160		6,600.26
11056	14-SEP-2014	Wolfgram,Brian K	2003	Uniform Allowance	0	0.00	72.50
11056	14-SEP-2014	Wolfgram,Brian K	2003	Vacation	24	35.48	851.45
11056	14-SEP-2014	Wolfgram,Brian K	2003	Regular Pay	96	35.48	3,405.79
11056	14-SEP-2014	Wolfgram,Brian K	2003	Fire Hours Adjustment	-8	35.48	-283.82
11056	14-SEP-2014	Wolfgram,Brian K	2003	Holiday Off	16	35.48	567.63
11056	14-SEP-2014	Wolfgram,Brian K	2003	Holiday Contract 1x PERS	16	30.16	482.49
11056	14-SEP-2014	Wolfgram,Brian K	2003	Holiday Contract 1x PERS	8	58.54	468.30
				Pay Period Totals	152		5,564.34
11056	28-SEP-2014	Wolfgram,Brian K	2003	Fire Hours Adjustment	16	35.48	567.63
11056	28-SEP-2014	Wolfgram,Brian K	2003	Uniform Allowance	0	0.00	72.50
11056	28-SEP-2014	Wolfgram,Brian K	2003	Overtime Pay	24	53.22	1,277.17
11056	28-SEP-2014	Wolfgram,Brian K	2003	Vacation	48	35.48	1,702.90
11056	28-SEP-2014	Wolfgram,Brian K	2003	Regular Pay	48	35.48	1,702.90
				Pay Period Totals	136		5,323.10
11056	12-OCT-2014	Wolfgram,Brian K	2003	Uniform Allowance	0	0.00	72.50
11056	12-OCT-2014	Wolfgram,Brian K	2003	Fire Hours Adjustment	-8	35.48	-283.82
11056	12-OCT-2014	Wolfgram,Brian K	2003	Regular Pay	108	35.48	3,831.52
11056	12-OCT-2014	Wolfgram,Brian K	2003	Vacation	12	35.48	425.72
				Pay Period Totals	112		4,045.92
				Employee TOTAL	808		33,732.77
				Grand TOTAL	808		33,732.77
				Grand Total By Earnings			
				Regular Pay	467		16,567.77
				Overtime Pay	96		5,108.68
				Fire Hours Adjustment	0		-0.02
				Union Leave Paid	6		212.86
				Uniform Allowance	0		435.00
				Bonus	0		2,830.14
				Vacation	199		7,059.92
				Holiday Off	16		567.63
				Holiday Contract 1x PERS	24		950.79

End of Report

STATE OF NEVADA
DEPARTMENT OF ADMINISTRATION
HEARINGS DIVISION

In the matter of the Contested Industrial Insurance Claim of:

BRIAN K WOLFGRAM
221 LOOKOUT AVE
HENDERSON, NV 89002-3339

Hearing Number: 1710311-SE
Claim Number: 14C52E546827

ATTN SALLY IHMELS
CITY OF HENDERSON
240 S WATER ST MSC 122
HENDERSON, NV 89015-7227

The Claimant's request for hearing was filed on March 10, 2017 and a hearing was scheduled for May 9, 2017. The hearing was held on May 9, 2017, in accordance with Chapters 616 and 617 of the Nevada Revised Statutes.

The Claimant was present. The Claimant was represented by Jason Mills, Esq., for Neeman & Mills, Ltd. The Administrator was represented by Julie Vacca, Claim Supervisor for CCMSI.

ISSUE

The Claimant appealed the determination of CCMSI dated February 15, 2017.

The issue before the Hearing Officer is INSURER'S DENIAL OF CLAIM REOPENING.

DECISION AND ORDER

The burden-of-proof to reopen the claim has been met. Dr. Colby Young establishes propriety of claim reopening under the 2015 revisions of 616C.390. Accordingly, the claim shall be reopened as recommended by the physician.

The determination of the Insurer is hereby **REMANDED**.

IT IS SO ORDERED this 19 day of May, 2017.

Steven Evans
Hearing Officer

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APPEAL RIGHTS

Pursuant to NRS 616C.345(1), should any party desire to appeal this final decision of the Hearing Officer, a request for appeal must be filed with Appeals Officer within thirty (30) days after the date of the decision by the Hearing Officer.