State of California
Division of Workers' Compensation

Additional pages attached ☐

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

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 or IMC 81556

☐ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Discharged
☐ Change-in work status ☐ Need for referral or consultation ☐ Info. Requested by:
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Other: UR REQUESTED

Patient:

Last Garner First Annette M.I. Sex Female DOB 11/15/1959
Address 1832 W 79th St City Los Angeles State Zip 90047
Occupation SS # 561-25-6071 Phone ( ) (323)229-8544

Claims Administrator:

Name National Interstate Insurance Co. Claim Number CL#: 1341863
Address P.O. Box 549 City Richfield State Zip 44286
Phone ( )(800)929-1500 FAX ( )
Employer name: Mission School Transport Inc Employer Phone: ( )

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

Subjective Complaints:

Ms. Garner reports pain in her back. She experiences difficulty controlling her emotions and impulses. She tends to socially isolate and withdraw from others. She feels sad, irritable, fearful, nervous, restless, anxious, depressed, and helpless. She fears the worst happening. (Continue on 2nd page)

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

Sad, dysphoric, and anxious mood and nervous.

Diagnosis:

1.	Depressive Disorder NOS	ICD-9	F32.9
2.	Generalized Anxiety Disorder	ICD-9	F41.1
3.		ICD-9	

Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture. Use CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?

Cognitive Behavioral Group Psychotherapy 1x week for 6 weeks. Relaxation Training/Hypnotherapy 1x week for 6 weeks. Refer for a medical consultation for psychotropic medication. (Continue on 2nd page).

Work Status: From the psychological standpoint this patient is psychiatrically temporarily totally disabled until 09/04/20.

Restriction: To be determined when patient reaches MMI Status.

Primary Treating Physician: (original signature, do not stamp) Date of exam: July 24, 2020

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Signature:
Executed at: ~~SANTA ANA~~
Name: Nelson L. Flores, PSY.D.
Address: P.O. Box 6299 Laguna Niguel, CA 92607-6299
Next report due no later than

Cal. Lic. # PSY31773
Date: 07/24/2020
Specialty: Psychology
Phone: (714) 972-0040

DWC Form PR-2 (Rev. 1/1/99)

(Use additional pages, if necessary)

Subjective Complaints:

She experiences crying episodes, and at times, she feels like crying. She has difficulty communicating, making decisions, and remembering things. She tends to over-eat and reports she has gained approximately 7 pounds. She has lost interest in her usual activities. She endorses sleep difficulties, including nightmares and distressing dreams. She feels tired and has low energy throughout the day. She experiences intrusive recollections and flashbacks. She has a decreased sexual desire. She is bothered by heart palpitations, headaches, and sweating sensations throughout her hands and body. She reports gastrointestinal disturbances, including diarrhea and nausea. She has shown improvement with the pain in her back.

Treatment Plan:

Referral to Dr. Kim for sleep medication. Follow up in 45 days. Continue with current treatment plan.

Psychological Testing:

Burns Depression Checklist score: **63 (severe depression)** Burns Anxiety Inventory score: **43 (severe anxiety)**

Psychological testing administered today: **31** minutes (testing time includes administration, scoring, and interpretation).

Disclosure:

The patient was informed and consented to the use of telehealth services.

The interview with the patient today and scoring and interpretation of the psychological testing were entirely conducted by this examiner.

I have reviewed the medical records and collateral records. X 15 mins.

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[X] New Request [ ] Resubmission – Change in Material Facts
[ ] Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
[ ] Check box if request is a written confirmation of a prior oral request.

Employee Information

Employee Name (Last, First, Middle): Garner, Annette	
Date of Injury (MM/DD/YYYY): 11/01/2019	Date of Birth (MM/DD/YYYY): 11/15/1959
Claim Number: CL#: 1341863	Employer: Mission School Transport Inc

Provider Information

Provider Name: Nelson L. Flores, PSY.D.	
Practice Name: Psychological Assessment Serv.	Contact Name: Nelson L. Flores, PSY.D.
Address: 2107 N Broadway Ste 207	City: Santa Ana State: CA
Zip Code: 92706 Phone: 714-972-0040	Fax Number: 714-972-0477
Provider Specialty: Psychology	NPI Number: 1598385197
E-mail Address:	

Claims Administrator Information

Claims Administrator Name: National Interstate Insurance Co	Contact Name:
Address: P.O. Box 549	City: Richfield State: OH
Zip Code: 44286 Phone: (800)929-1500	Fax Number: (330)659.8909
E-mail Address:	

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

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Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Depressive Disorder NOS	F32.9	Refer for Medical	99205	Once
Generalized Anxiety Disorder	F41.1	consultation for		
		psychotropic medication		

Treating Physician Signature: Date: 7/31/2020

Claims Administrator Response

[ ] Approved [ ] Denied or Modified (See separate decision letter) [ ] Delay (See separate notification of delay)
[ ] Requested treatment has been previously denied [ ] Liability for treatment is disputed

Authorization Number (if assigned):	Date:
Authorized Agent Name:	Signature:
Phone: Fax Number:	E-mail Address:
Comments:	

State of California
Division of Workers' Compensation

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Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Depressive Disorder NOS	F32.9	Group Medical Psychotherapy	90853	1X WK X 6 WKS, TOTAL 6 SESSIONS
Generalized Anxiety Disorder	F41.1	Group Medical Psychotherapy	90853	" "

Treating Physician Signature: Date: 7/31/2020

Claims Administrator Response

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Phone:	Fax Number:	E-mail Address:
Comments:		

State of California
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Claim Number: CL#: 1341863 | Employer: Mission School Transport Inc

Provider Information

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Practice Name: Psychological Assessment Serv. | Contact Name: Nelson L. Flores, PSY.D.

Address: 2107 N Broadway Ste 207 | City: Santa Ana | State: CA

Zip Code: 92706 | Phone: 714-972-0040 | Fax Number: 714-972-0477

Provider Specialty: Psychology | NPI Number: 1598385197

E-mail Address:

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Claims Administrator Name: National Interstate Insurance Co | Contact Name:

Address: P.O. Box 549 | City: Richfield | State: OH

Zip Code: 44286 | Phone: (800)929-1500 | Fax Number:

E-mail Address:

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Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Depressive Disorder NOS	F32.9	Medical Hypnotherapy/Relaxation Tra	90880	1X WK X 6 WKS, TOTAL 6 SESSIONS
Generalized Anxiety Disorder	F41.1	Medical Hypnotherapy/Relaxation Tra	90880	" "

Treating Physician Signature: | Date: 7/31/2020

Claims Administrator Response

[ ] Approved [ ] Denied or Modified (See separate decision letter) [ ] Delay (See separate notification of delay)
[ ] Requested treatment has been previously denied [ ] Liability for treatment is disputed

Authorization Number (if assigned): | Date:

Authorized Agent Name: | Signature:

Phone: | Fax Number: | E-mail Address:

Comments:

State of California
Division of Workers' Compensation

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Claim Number: CL#: 1341863	Employer: Mission School Transport Inc

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Zip Code: 92706	Phone: 714-972-0040	Fax Number: 714-972-0477	
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E-mail Address:			

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Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Depressive Disorder NOS	F32.9	Phone call, intermediate	99442	ONCE IN 45 DAYS
Generalized Anxiety Disorder	F41.1	Phone call, intermediate	99442	" "

Treating Physician Signature: [signature] Date: 7/31/2020

Claims Administrator Response

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Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

Gmail **Collections Department <collections@drnelsonflores.com>**

Message Sent: 37620016

1 message

ShoreTel Fax <noreply@shoretelfax.com> Tue, Oct 13, 2020 at 3:57 PM
To: collections@drnelsonflores.com

Delivery Information:

Message #:	37620016
Sender Name:	Fax 3
Sender Company:	
Sender Phone:	
Remote CSID:	National Interstate
Total Pages:	7
Start Time:	10/13/2020 6:47:18 PM EDT
Duration:	9 min 29.329 sec
Delivery Count:	1

Recipient List:
13306598909 - 13306598909

Document.PDF
838K

Fax Transmission

To: 13306598909

From: Fax 3

Fax: 13306598909

Date: 10/13/2020

RE: Garner, Annette

Pages: 7

Comments:

07/24/2020 PR-2 and RFAs

Collections
*Psychological Assessment Services *
Ph. 714-972-0040
Fax 714-972-0477

https://www.avast.com/sig-email?utm_medium=email&utm_source=link&utm_campaign=sig-email&utm_content=webmail&utm_term=icon>
Virus-free.
www.avast.com

https://www.avast.com/sig-email?utm_medium=email&utm_source=link&utm_campaign=sig-email&utm_content=webmail&utm_term=link>
<#DAB4FAD8-2DD7-40BB-A1B8-4E2AA1F9FDF2>

Mail out to Vanliner Ins.

State of California
Division of Workers' Compensation

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Provider Specialty: Psychology	NPI Number: 1598385197
E-mail Address:	

Claims Administrator Information

Claims Administrator Name: Vanliner Insurance	Contact Name:
Address: One Premier Dr. Mail Stop Y29	City: Fenton State: MO
Zip Code: 63026 Phone:	Fax Number:
E-mail Address:	

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

Either state the requested treatment in the below space or indicate the specific page number(s) of the accompanying medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; attach additional requests on a separate sheet.

Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Depressive Disorder NOS	F32.9	Refer for Medical Consultation for psychotropic medication	99205	Once
Generalized Anxiety Disorder	F41.1			

Treating Physician Signature: [signature] Date: 7/31/2020

Claims Administrator Response

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E-mail Address:			

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Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code	Other Information: (Frequency, Duration Quantity, Facility, etc.)
Depressive Disorder NOS	F32.9	Group Medical Psychotherapy	90853	1X WK X 60 WKS, TOTAL 60 SESSIONS
Generalized Anxiety Disorder	F41.1	Group Medical Psychotherapy	90853	" "

Treating Physician Signature: Date: 7/31/2020

Claims Administrator Response

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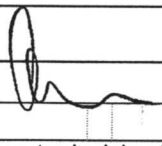
Treating Physician Signature:  Date: 7/31/2020

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Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

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

STATE OF CALIFORNIA, COUNTY OF ORANGE

I am employed in the county aforesaid; I am over the age of eighteen years and not a party to the within entitled action; my business address is 2107 N. Broadway, Suite 207, Santa Ana, CA 92706.

On10/14/2020, I served the within progress report(s) dated 7/24/20 , 7/31/20 and bill regarding **Annette Garner**

on the appropriate parties in said action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Santa Ana, California, addressed as follows:

Workers Defenders Law Group
8018 E.Santa Ana Cyn #100-215
Anaheim Hills, CA 92808

Nelson J. Flores PH.D, QME
2107 N. Broadway
Santa Ana, CA 92706

Claim #:
Attn.

National Interstate Insurance Co.
P.O. Box 549
Richfield, OH 44286
CL#: 1341863
Attn.: Diane McClellan

Michael Sullivan & Assoc.LLP
P.O. Box 85059
San Diego, CA 92186-5059

Vanliner Insurance
One Premier Dr. Mail Stop Y 29
Fenton, MO 63026
Claim #:
Attn.

I declare under penalty of perjury, that the foregoing is true and correct.

Executed on 10/14/202(, at Santa Ana, California.

By: Valeria Rocha
Valeria Rocha

cc: File