Tri-City Health Group
7951 Valley View
La Palma, CA 90623

Tel: 714 994-1131 **Fax: 714 994-4415**

MEDICAL FACSIMILE COVER SHEET

IF YOU RECEIVE THIS FAX IN ERROR, PLEASE CONTACT THE SENDER IMMEDIATELY, AND THEN DESTROY THE FAXED MATERIALS.

Confidentiality Notice

The information contained in this fax is privileged and confidential information intended for the use of the individuals or entities described below. Health Care Information is personal and sensitive and should only be read by authorized individuals. Failure to maintain confidentiality is subject to penalties under State and Federal Law.

The following fax contains information pertaining to:

Patient Name:	Darlene Walls
Employer:	Kaiser Permanente
Insurance:	AMGUARD
Claim Number:	Unavailable
Facsimile:	(570) 825-0611
Applicant Attorney:	Law Offices Of Natalia Foley
Facsimile:	(310) 626-9632

Date Sent:	Jan 24, 2019	Number of Pages:	9
Description:	Physician Initial Report 1/24/2019		

Sent By: Mayela Jimenez

In the event that any of the above information is incorrect, please contact the front office personnel or office manager to provide correct information.

Tri-City Health Group

7951 Valley View St.
La Palma, CA. 90623
Ph: (714) 994-1131 / Fax: (714) 994-4415

January 24, 2019

Patient:	Darlene Walls	**Sex:**	Female
	16323 Cornuta Ave. Apt 8, Bellflower, CA. 90706		
	D.O.B.: 3/23/1967	SSN:	558-37-5679
Insurance:	AMGUARD		
	P.O. BOX 1368 Wilkes Barre, PA. 18703		
	Telephone: (800) 673-2465	**FAX:**	**(570) 825-0611**
DOI:	CT 1/3/18-1/4/19		
Employer:	Kaiser Permantente Downey Medical Center		
Occupation:	Nurse Assistant		
Attorney:	Law Offices Of Natalia Foley		
	8306 Wilshire Blvd #115, Beverly Hills, CA. 90211		
	Telephone: (323) 306-0818	**FAX:**	**(310) 626-9632**
WCAB #:	Unknown		

PRIMARY TREATING PHYSICIAN'S INITIAL COMPREHENSIVE REPORT

Dear Attorney:

In regard to my patient, Ms. Walls, I am sending an initial report concerning the work-related injury she sustained on CT 1/3/18-1/4/19 while in the performance of her regular and customary duties.

HISTORY OF THE INJURY (AS RELATED BY THE PATIENT):

From 01/03/2018-01/04/2019 during the course of employment as a (Job Title) for Kaiser, she sustained injury to neck, shoulders, wrists, hands, back, hips, and legs.
The patient elaborates to the best of her knowledge that she sustained cumulative trauma injuries while working 8-12 hours a day, and five days per week since January 25, 2008.
Her symptoms developed as a result of her customary job duties which included but are not limited to changing patients, turning, reposition, transferring, toileting, grooming, hygiene, feeding, changing pads, remove soiled linens if necessary. The onset of symptoms began sometime on 2015 approximately.

The patient procured treatment with her physician that placed her off duty two days per month. Every six months she renewed her restrictions. Ms. Walls underwent physical therapy to her right shoulder with temporary benefit. X-ray of the right shoulder was also done. Pain medication was prescribed periodically. Three cortisone injections were administered to her right shoulder. The third injection worsened her pain. Ms. Walls continues working full duty, only restriction is being off two days a month.

The examination was performed with the assistance of an interpreter from S.A.I. Professional Services.

PREVIOUS WORK RELATED INJURY:
Ms. Walls denies having sustained any prior or subsequent work-related injuries or any new injuries to the subject body parts.

PAST MEDICAL HISTORY: (AS RELATED BY THE PATIENT)

Fractures:	None.
Auto Accident:	None.
Surgeries:	None.
Medications:	None.
Medical:	hypertension
Allergies:	Codeine and Keflex

SOCIAL HISTORY:
Ms. Walls was born on 3/23/67. She is single with four children. She denies having served in the military. She states that she has five to six cigarettes daily and consumes occasional alcohol

JOB DESCRIPTION:
Ms. Walls was employed as a Nurse Assistant.

Changing patients, turning, reposition, transferring, toileting, grooming, hygiene, feeding, changing pads, remove soiled linens if necessary. The onset of symptoms began sometime on 2015 approximately.

SUBJECTIVE COMPLAINTS:
Pain Scale:

0	1	2 3	4 5 6 7	8 9 10
None	Minimal	Slight	Moderate	Severe

1) The patient, Ms. Walls, has complaint of frequent severe neck pain.
2) She is complaining of intermittent moderate low back pain radiating to right leg with numbness.
3) The patient, Ms. Walls, presents today complaining of frequent severe right shoulder pain.
4) She complains of intermittent moderate to severe left wrist pain radiating to hand with numbness and tingling.
5) Ms. Walls has complaint of intermittent mild to moderate right wrist pain.

OBJECTIVE FINDINGS:
Height: 5'7"
Weight: 181 pounds
B.P.: 161/96
Pulse: 86 bpm
Left-hand dominant

Girth Measurements:

	Left	Right

Bicep:	25.0 cm24.0 cm
Forearm:	24.0 cm24.0 cm
Thigh:	45.0 cm43.0 cm
Calf:	36.5 cm36.0 cm

JAMAR Grip Strength results, second notch:
Left: 20, 19, 19 Kg
Right: 18, 21, 20 Kg

Cervical Spine:
There is +3 tenderness to palpation of the cervical paravertebral muscles and bilateral trapezii. There is muscle spasm of the cervical paravertebral muscles and bilateral trapezii.

Range of Motion:
The cervical ranges of motion are decreased and painful.

	Range	Normal
Flexion	45°	50°
Extension	45°	60°
Left Lateral Bending	35°	45°
Right Lateral Bending	38°	45°
Left Rotation	70°	80°
Right Rotation	70°	80°

Orthopedic Tests:
Shoulder Depression causes pain.

Lumbar Spine:
There is +3 tenderness to palpation of the lumbar paravertebral muscles, bilateral SI joints, and bilateral gluteus. There is muscle spasm of the lumbar paravertebral muscles and bilateral gluteus.

Range of Motion:
The lumbar ranges of motion are decreased and painful.

	Range	Normal
Flexion	40°	60°
Extension	15°	25°
Left Lateral Bending	23°	25°
Right Lateral Bending	20°	25°

Orthopedic Tests:
Kemp's causes pain.
Straight Leg Raise causes pain on the right.

Right Shoulder:
There is +3 tenderness to palpation of the anterior shoulder, posterior shoulder, and lateral shoulder. There is muscle spasm of the anterior shoulder, posterior shoulder, and lateral shoulder.

Range of Motion:
The right shoulder ranges of motion are decreased and painful.

	Range	Normal

Flexion	160°	180°
Extension	50°	50°
Abduction	145°	180°
Adduction	40°	40°
Internal Rotation	70°	80°
External Rotation	75°	90°

Orthopedic Tests:
Hawkin's causes pain.

Left Wrist:
There is +3 tenderness to palpation of the dorsal wrist and volar wrist. There is muscle spasm of the forearm, thenar, and hypothenar.

Range of Motion:
The left wrist ranges of motion are decreased and painful.

	Range	Normal
Flexion	45°	60°
Extension	50°	60°
Radial Deviation	20°	20°
Ulnar Deviation	25°	30°

Orthopedic Tests:
Tinel's causes pain and tingling.
Phalen's causes pain.
Reverse Phalen's causes pain.

Right Wrist:
There is +3 tenderness to palpation of the dorsal wrist and volar wrist. There is muscle spasm of the forearm, thenar, and hypothenar.

Range of Motion:
The right wrist ranges of motion are decreased and painful.

	Range	Normal
Flexion	42°	60°
Extension	50°	60°
Radial Deviation	20°	20°
Ulnar Deviation	30°	30°

Orthopedic Tests:
Phalen's causes pain.

DIAGNOSES:
Cervical musculoligamentous injury [S13.8XXA]
Cervical muscle spasm [M62.838]
Rule out cervical disc [M50.20]
Rule out cervical radiculitis versus radiculopathy [M54.12]
Lumbar musculoligamentous injury [S33.5XXA, S39.012A]
Lumbar muscle spasm [M62.830]

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I have received from others. Examination was performed by a staff physician or myself, and information was tabulated and transcribed by a staff member. As to that information, I declare under penalty of perjury that the information accurately described the information provided to me, except as noted herein, that I believe it to be true.

I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Should you have any further questions or comments, please do not hesitate to contact this office.

Sincerely,

Kurt Cline, DC

Edward Komberg, D.C.

ADDENDUM:
It is requested that the insurance carrier/defendant pay any uncontested amount of the billing, within the 60-day period, pursuant to Labor Code, Section 4603.2 and Section 4622. If all or part of the claim is denied, then we are to receive an objective notice, in writing, within the 60-day time frame. Absent denial of payment of any or all of the itemized billing within those time parameters and in writing, all payments shall be increased by:

1. A self-assessed penalty of 10% on the total unpaid charges.
2. Interest that will accrue on the balance of the charges at 10% per annum, from the date of billing.

Attached are our report or billing and lien.

In accordance with Foley vs. State Compensation Insurance Fund 73-OAK-49138 as well as the DIA/WCAB Procedures and the Procedures Manual Index #6.6.10, and Labor Code Section 4621 and 4622 effective July 19, 1984, we are requesting full payment of our billing.

PLEASE NOTE:
1. Federal and State laws require that a sufficient amount of time be spent reviewing documentation prior to rendering an adverse determination on medical necessity.

2. In accordance with LC 4610(e), we request that all documentation received be forwarded to a licensed health provider of the same profession, with sufficient level of training and experience in the care in question, so that a proper review may be performed.
3. Please note that Labor Code 4600(a) states that: "Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer". This is detailed in Labor Code 4610(f)(4).
4. Should this claim be denied, you are required to provide specific and clinical reasons utilized in the decision making, within specified time frames, as documented in 4610(g)(1). In addition, you must provide a recommendation of appropriate care and the reasoning used to determine such care, as required by Labor Code 4610(g)(4). In this regard, I would like to call your attention to possible consequences of failure to meet timeframe requirements, noted in Labor Code 4610(i): "If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure"
5. All patient care rendered will be done so in accordance with current California Workers' Compensation Law and regulations.

State of California, Division of Worker's Compensation
REQUEST FOR AUTORIZATION
DCW Form RFA

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

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

Employee Information			
Name (Last, First, Middle): Darlene Walls			
Date of Injury (MM/DD/YYYY): CT 1/3/18-1/4/19		Date of Birth (MM/DD/YYYY): 3/23/1967	
Claim Number:		Employer: Kaiser Permantente Downey Medical Center	
Requesting Physician Information			
Name: Edward Komberg DC			
Practice Name: Tri-City Health Group		Contact Name:	
Address: 7951 Valley View		City: La Palma	State: CA
Zip Code: 90623	Phone: 714-994-1131	Fax Number: 714-994-4415	
Specialty: chiropractor		NPI Number: 1629278395	
E-mail Address:			

Claims Administrator Information			
Company Name: AMGUARD		Contact Name:	
Address: P.O. BOX 1368		City: Wilkes Barre,	State: PA.
Zip Code: 18703	Phone:(800) 673-2465	Fax Number: **(570) 825-0611**	
E-mail Address:			

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

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

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS (if known)	Other Information (Frequency, Duration quantity, etc..)
Cervical musculoligamentous injury	[S13.8XXA]	Chiropractic treatment, Physiotherapy, Kinetic Activities		2-3 x per week for 5 weeks 2-3x per week for 6 weeks
Lumbar musculoligamentous injury	[S33.5XXA, S39.012A]	Home Exercise Program		
Shoulder sprain / strain, right	[S43.401A, S46.911A]	Referrals: FCE, Pain Management.		
Wrist strain, bilateral Wrist sprain, bilateral	[S63.502A] [S66.912A] [S63.501A] [S66.911A]	X-Rays of cervical spine, lumbar spine, right shoulder, left wrist, and right wrist.		
		Follow up		4-6 weeks

Requesting Physician Signature: Date: 1/24/2019

Claims Administrator/Utilization Review Organization (URO) Response

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

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