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:	Geroge Soohoo
Employer:	California Institute For Men
Insurance:	SCIF State Employees Santa Ana
Claim Number:	Unavailable
Facsimile:	(800) 371-5905
Applicant Attorney:	Workers Defenders Law Group
Facsimile:	(310) 626-9632

Date Sent:	Sep 28, 2021	Number of Pages:	8
Description:	Dr. Komberg Initial Report & RFA 9/15/2021		

Sent By: Angela D.

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 Street
La Palma, CA. 90623
Ph: (714) 994-1131 / Fax: (714) 994-4415

September 15, 2021

Patient:	Geroge Soohoo 2506 Light lane, Cona Del Mar, CA. 92625 Telephone: (949) 892-8277 D.O.B.: 11/28/1953	**Sex:** SSN:	Male Unknown
Insurance:	SCIF State Employees Santa Ana PO Box 65005, Fresno, CA. 93650 Telephone: (888) 782-8338	 **FAX:**	 **(800) 371-5905**
DOI:	8/16/2021;CT8/1/15-7/6/21		
Employer:	California Institute For Men		
Occupation:	Unknown		
Attorney:	Workers Defenders Law Group 8018 E Santa Ana Cyn Ste 100-215, Anaheim Hills, CA. 92808 Telephone: (714) 948-5054	 **FAX:**	 **(310) 626-9632**
WCAB #:	Unknown		

PRIMARY TREATING PHYSICIAN'S INITIAL COMPREHENSIVE REPORT

Dear Attorney:

In regard to my patient, Mr. Soohoo, I am sending an initial report concerning the work related injury sustained on 8/16/2021;CT8/1/15-7/6/21 while in the performance of his customary and usual work.

HISTORY OF THE INJURY AS RELATED BY THE PATIENT:

Specific Date of injury: 8/16/2021
Body parts: Low back

On August 16, 2021, while at work the patient sustained injuries to his Low Back.

The patient elaborates that he was stooping down while attending a patient and lifting a box when he felt a sharp cracking sensation to his low back. He felt immediate pain and proceeded to report his injury.

The patient **DID** report his injury to his supervisor. An appointment **WAS** made for the patient by his employer.

PREVIOUS WORK RELATED INJURY:

Mr. Sooho 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:	Lorazepam, Metformin 500mg, Gemfibrozil, Amlodipine, Losartan 10mg
.Medical:	high blood pressure, high cholesterol and Diabetes.
Allergies:	No known allergies.

OCCUPATIONAL/SOCIAL HISTORY:

Mr. Soohoo was born on 11/28/53. He is married/single with three children. He denies having served in the military. He states that he does not smoke or drink alcoholic beverages.

JOB DESCRIPTION:

Mr. Soohoo was employed as a Dentis

SUBJECTIVE COMPLAINTS:

Pain Scale:

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

1) He has complaint of occasional moderate 6/10 headache.

2) He complains of activity-dependent to constant moderate 7-8/10 low back pain, stiffness, and weakness.

3) He is complaining of activity-dependent to constant moderate 7/10 right hip pain and stiffness radiating to tinderness.

4) He is complaining of intermittent moderate 6/10 bilateral hand pain and stiffness.

5) Mr. Soohoo presents today complaining of ears radiating to lost of hearing.

OBJECTIVE FINDINGS:

Height: 5'3"

Weight: 190 pounds

Temp.: 97.4º F

B.P.: 150/86

Pulse: 65 bpm

Right-hand dominant

Sensory Exam:

Dermatome sensation is intact and equal bilaterally in both the upper and lower extremities.

Motor Exam:

Motor strength is 5+/5 bilaterally in the upper and lower extremities.

Reflexes:

Deep tendon reflexes are normal and equal bilaterally at 2/2.

Head:

Cranial nerves II through VII and XI through XII were tested, and were within normal limits.

Fingertip-to-fingertip and fingertip-to-nose were performed normally.

Lumbar Spine:

There is no bruising, swelling, atrophy, or lesion present at the lumbar spine.

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

Range of Motion:

The lumbar ranges of motion are decreased.

Orthopedic Tests:

Kemp's causes pain.

Sitting Straight Leg Raise causes pain.

Right Hip:

There is no bruising, swelling, atrophy, or lesion present at the right hip.

There is +3 tenderness to palpation of the posterior hip. There is muscle spasm of the posterior hip.

Range of Motion:

The right hip ranges of motion are decreased.

Orthopedic Tests:

Patrick's FABERE causes pain.

Bilateral Pain:

Examination deferred.

Ears:

Examination deferred.

DIAGNOSES:

Headache [R51]

Lumbar sprain/strain [S33.5XXA, S39.011A]

Rule out lumbar disc [M51.26]

Hip sprain / strain, right [S73.101A]

Hand sprain / strain, right [S66.911A]

Hand sprain / strain, left [S66.912A]

PLAN:

Chiropractic treatment, Physiotherapy, Kinetic Activities 2-3 x per week for 6 weeks.

WORK STATUS:

Mr. Geroge Soohoo is on temporary total disability through October 29, 2021.

CAUSATION:

His presenting complaints and examination findings are consistent with the described history.

Based upon information provided on his initial visit, there were no prior complaints of pain in the affected body parts.

Based upon the provided history and medical evidence as available, Mr. Soohoo's injuries are believed to be attributable to, and the direct result of, the work-related trauma that occurred on 8/16/2021;CT8/1/15-7/6/21.

Thank you for the opportunity to evaluate and treat this individual. If I may be of any further assistance to you, please do not hesitate to contact me personally.

AUTHORIZATION REQUEST:

Authorization for above referenced treatment is requested based upon proposed treatment plan and medically reasonable treatment requirements. This is per Labor Code 4600 and Title 8, Section 9792.6, C.C.R. and Rule 9785(b); therefore, we are requesting written authorization to be sent to us within seven (7) working days as required by 8 C.C.R. 9792.

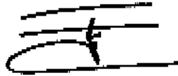
DISCLOSURE STATEMENT:

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,



Sepideh Tarameshloopoor, 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:

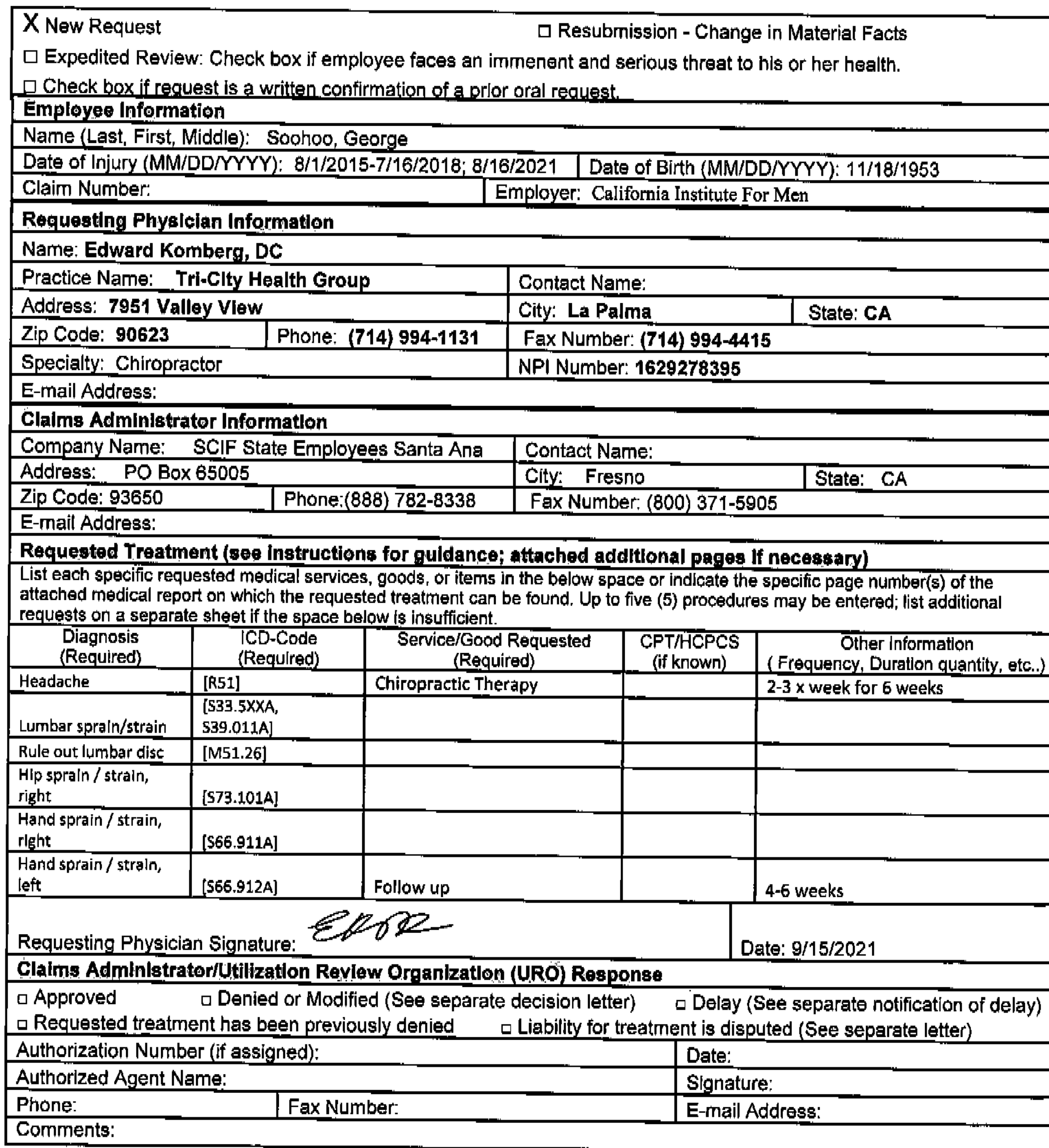
1. A Self assessed penalty of 10% on the total unpaid charges.
2. Interest that will accrue on the balance of the charges at 10% per annum, from the date of service of the billing.

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.

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): Soohoo, George

Date of Injury (MM/DD/YYYY): 8/1/2015-7/16/2018; 8/16/2021 | Date of Birth (MM/DD/YYYY): 11/18/1953

Claim Number: | Employer: California Institute For Men

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: SCIF State Employees Santa Ana | Contact Name:

Address: PO Box 65005 | City: Fresno | State: CA

Zip Code: 93650 | Phone:(888) 782-8338 | Fax Number: (800) 371-5905

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..)
Headache	[R51]	Chiropractic Therapy		2-3 x week for 6 weeks
Lumbar sprain/strain	[S33.5XXA, S39.011A]			
Rule out lumbar disc	[M51.26]			
Hip sprain / strain, right	[S73.101A]			
Hand sprain / strain, right	[S66.911A]			
Hand sprain / strain, left	[S66.912A]	Follow up		4-6 weeks

Requesting Physician Signature: [signature] | Date: 9/15/2021

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: