

State of California
Division of Workers' Compensation

Additional pages attached

**PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)
AMENDED TO CORRECT INSURANCE AND DOI**

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

<input checked="" type="checkbox"/> Periodic Report (required 45 days after last report)	<input type="checkbox"/> Change in treatment plan	<input type="checkbox"/> Released from care
<input checked="" type="checkbox"/> Change in work status	<input type="checkbox"/> Need for referral or consultation	<input type="checkbox"/> Response to request for information
<input type="checkbox"/> Change in patient's condition	<input type="checkbox"/> Need for surgery or hospitalization	<input checked="" type="checkbox"/> Request for authorization
<input type="checkbox"/> Other:		

Patient:

Last: Johnson (1) First: Marvetta M.I.: _____ Sex: Female
 Address: 1022 W 138th St City: Compton State: CA Zip: 90222
 Date of Injury: 1.01/25/19 2.03/14/19 3.07/29/2019 4.08/18/2019 Date of Birth: 12/11/1967
 Occupation: Detention Service Officer SS #: _____ Phone: 546-19-7076 562-361-3048

Claims Administrator:

Name: Sedgwick Claim Numbers: 1.419-01553-D 2.419-02165-D 3.420-00359-D 4.20-00878-D
 Address: P.O. Box 51350 City: Ontario State: CA Zip: 91761
 Phone: (909) 942-8936 FAX: (909)942-8918
 Employer name: Los Angeles County Probation Dept Employer Phone: (562) 361-3048

Subjective complaints:

Lower Back- Constant/Frequent, severe to moderate, radiating pain – Improving with Chiropractic Care
(Lt.) Thigh – Frequent, severe to moderate pain – Decreasing pain
(Lt.) Hip- Constant/Frequent, moderate to severe pain and stiffness – Slight decrease in pain
(Lt.) Knee – Frequent, severe to moderate pain – Slight improvement

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

Lumbar Spine- Moderate palpable tenderness, ROM- 30/60, Ext- 8/25, R Lat Flex-10/25, L Lat Flex- 10/25, R Rot- 10/25, L Rot- 10/25, +Kemps, +SLR, + (Lt.) Braggards, +Ely's, +Milgrams, +Valsalva, +4/+5 Heel/Toe Walking, Knee Ext., Hip Flex., **(Lt.) Hip-** Moderate to severe palpable tenderness, decreased swelling at the greater trochanter, ROM- Flex- 80/120, Ext- 8/30, Int. Rot- 15/35, Ext. Rot-10/45, Abd.-25/45, Add.- 10/20, +3/+5 Hip Flex, Add., Hip Ext., +Patricks, **(Lt.) Thigh-** Moderate palpable tenderness, **(Lt.) Knee-** Moderate palpable tenderness, ROM- Ext- 125/180, Flex- 105/135, +Mobility, + Valgus, + Varus

Diagnoses:

ICD Codes

Lumbar Spine – Sprain/Strain, with radiculopathy Rule Out Disc Bulges	S33.5XXA, M54.16 Rule Out M51.26
(Lt.) Hip – Sprain/Strain, Contusion	S73.109A, S70.00XA
(Lt.) Thigh (Quads) – Strain	S76.112A
(Lt.) Knee - Sprain/Strain	S83.90XA
Subluxations of the L/S (Initial Encounter)	S33.100A

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

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

Ms. Johnson's response to Chiropractic treatment, Physiotherapy and Therapeutic Exercises, has been satisfactory. She has shown some functional improvement. She has a slight improvement in ranges of motion and reports a slight decrease in pain and the duration of pain. Therefore, I am **requesting authorization for additional Chiropractic care and physiotherapy**, 2 times per week, for 3 weeks, totaling 6 visits, for the next 30 days. A re-evaluation will follow, at the end of 30 days.

I am also requesting authorization for x-rays of her Lumbar Spine and (Lt.)Hip.

Work Status: This patient has been instructed to:

Remain off-work until: 5/28/19

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

Return to full duty on _____ with no limitations or restrictions.

Primary Treating Physician: (original signature, do not stamp)

Date of exam: 5/21/19

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: Kenneth A. Webb, D.C.

Cal. Lic. #: DC 26997

Executed at: Los Angeles, California

Date: 05/21/2019/Amended 11/12/2020

Name (Printed): Kenneth A. Webb, D.C.

Specialty: Chiropractor

Address: 11915 Washington Blvd. Los Angeles, California 90066

Phone: (310) 572 - 1515 Fax (310) 572 - 1522

**State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA**

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

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

Employee Information

Name: Johnson, Marvetta
 Date of Injury : 1. 01/25/2019 2. 03/14/2019 3.07/29/2019 4. 08/18/2019 Date of Birth: 12/11/1967
 Claim Number: 1. 419-01553-D 2. 419-02165-D 3.420-00359-D 4. 20-00878-D Employer: Los Angeles County Probation Department

Requesting Physician Information

Name: Kenneth A. Webb DC
 Practice Name: Westside Health-Chiropractic Contact Name: Beatriz
 Address: 11015 Washington Blvd. City: Los Angeles State: CA
 Zip Code: 90066 Phone: 310-572-1515 Fax Number: 310-572-1522
 Specialty: Chiropractic NPI Number: 1225320817
 E-mail Address: doctors@westsidehealthandchiro.com

Claims Administrator Information

Company Name: Sedgwick Contact Name:
 Address: P.O. Box 51350 City: Ontario State: CA
 Zip Code: 91761 Phone: (909) 942-8936 Fax Number: (909)942-8818
 E-mail Address:

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other information: (Frequency, Duration Quantity, etc.)
Lumbar Spine- Sprain/Strain, with Radiculopathy, Rule Out Disc Bulges	S33.5XXA, M54.16, Rule Out M51.26	Authorization for additional Chiropractic Care and Physiotherapy 2X3 Authorization for x-rays of the Lumbar Spine, (Lt.), (Lt.) Hip		6 visits
(Lt.) Hip- Sprain/Strain, Contusion	S73.109A, S70.00XA			
Thigh (Quads)- Strain(Lt.)	S76.112A			
(Lt.) Knee- Sprain/Strain	S83.90XA			

Subluxations of the L/S- S33.100A (Initial Encounter)

Requesting Physician Signature: *Kenneth A. Webb, D.C.* Date: 05/21/2019/Amended 11/12/20

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:

RE: Marvetta Johnson vs. Los Angeles County Probation Dept.
Claim NO: 1. 419-01553-D 2. 419-02165-D 3. 420-00359-D
4. 20-00878-D

WCAB NO: 1. ADJ12198746 2. ADJ12198788 3. ADJ12430393
4. ADJ12566243

DOI: 1. 01/25/2019 2. 03/14/2019 3. 07/29/2019 4. 08/18/2019

PROOF OF SERVICE BY MAIL/FAX

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am a resident of the county aforesaid, I am over the age of eighteen years, and not a party to the within entitled action; my business address is: 11915 Washington Blvd. Los Angeles, CA. 90066, November 18, 2020, I served the within.

Physicians Progress Report
Request for Authorization for Treatment (RFA)

On the interested parties in said action, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in United States Mail at Los Angeles, California, addressed as follows:

Applicant Attorney:
David H. Black
3201 Pico Blvd
Santa Monica, CA 90405
Fax: 310.315.7353

Sedgwick
P.O. Box 51350
Ontario, CA 90222
Fax: 909-942-8918

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

Executed on November 18, 2020 at Los Angeles, California.


Beatriz Palomino

FAX COVER SHEET

To: 13103157353

From: doctors doctors
<doctors@westsidehealthandchiro.com>

Company:

Date: 11/18/2020 12:16

Fax Number: 13103157353

Pages (Including cover): 7

Re: Marvetta Johnson Amended Initial Report

Notes:

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Westside Health and Chiro

11915 Washington Blvd

Los Angeles, CA 90066

Tel: 310-572-1515 Fax: 310-572-1522

FAX COVER SHEET

To: 13103157353

From: doctors doctors
<doctors@westsidehealthandchiro.com>

Company:

Date: 11/18/2020 12:21

Fax Number: 13103157353

Pages (Including cover): 5

Re: Marvetta Johnson Amended PR2 05/21/2019

Notes:

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Westside Health and Chiro

11915 Washington Blvd

Los Angeles, CA 90066

Tel: 310-572-1515 Fax: 310-572-1522