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.

X Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Released from care
Change in work status X Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization X Request for authorization
☐ Other

Patient:
Last: Johnson (5) 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 #: 546-19-7076 Phone: 562-361-3048
Claims Administrator:
Name: Sedgwick Claim Number: 1.419-01553-D 2. 419-02165-D 3. 420-00359-D 4. 20-00878-D
Address: P.O. Box 51320 City: Ontario State: CA Zip: 91761
Phone: 909.942.8936 FAX: 909.942.8918
Employer name: Los Angeles County Probation Dept. Employer Phone: (1562) 361-3048

Subjective complaints:

(Lt.) Hip- Constant/Frequent, severe to moderate pain and stiffness – Increasing pain
(Lt.) Thigh – Intermittent, moderate pain – Improved
Lower Back - Frequent, severe to moderate, radiating pain – Slight improvement
(Lt.) Knee – Frequent/Intermittent, moderate pain – Slight improvement

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

(Lt.) Hip- Severe palpable tenderness, slight swelling, ROM- **Flex**- 80/120, Ext- 10/30, Int. Rot.- 15/35, Ext. Rot-15/45, Abd.- 25/45, Add.- 10/20, +3/+5 Hip Flex, Add., Hip Ext., +Patricks, **(Lt.) Thigh**- Mild palpable tenderness, **(Lt.) Knee**- Mild palpable tenderness, ROM- Ext- 130/180, Flex- 110/135, +Mobility, + Valgus, + Varus **Lumbar Spine**- Severe to moderate palpable tenderness, ROM- 30/60, Ext- 5/25, 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, +3/+5 Heel/Toe Walking, Knee Ext.,Hip Flex.,

Diagnoses:	**ICD Codes**
(Lt.) Hip – Enthesopathy, Contusion	M70.70, S70.00XA
Lumbar Spine – Discitis, with radiculopathy Rule Out Disc Bulges	M46.47, M54.16 Rule Out M51.26
(Lt.) Thigh (Quads) – Strain	S76.112D
(Lt.) Knee - Tendonitis	M76.51
Subluxations of the L/S (Subsequent Encounter)	S33.100D

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.

She underwent an AME evaluation, last week. We are awaiting the report.

I am also requesting authorization for MRI scans of her Lumbar Spine and (Lt.) Hip.

I am also requesting authorization for an NCV/EMG study of her lower extremities.

Work Status: This patient has been instructed to:
Remain off-work until: _____
☐ Return to *modified* work on: _____ with the following limitations or restrictions
(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):
X Return to full duty on: 2/21/2020 with no limitations or restrictions.

Primary Treating Physician: (original signature, do not stamp) Date of exam: 2/21/2020

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: Kenneth A. Webb, D.C. Cal. Lic. # : DC 26997

Executed at: Los Angeles, California Date: 02/21/2020/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: 11915 Washington Blvd.		City: Los Angeles	State: CA
Zip Code: 90066	Phone: 310-572-1515	Fax Number: 310-572-1522	
Specialty: Chiropractic		NPI Number: 1225320617	
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) 942-8918	
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 Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Lumbar Spine- Discitis, with Radiculopathy, Rule Out Disc Bulges	M46.47, M54.16, Rule Out M51.26	Authorization for additional Chiropractic Care and Physiotherapy Authorization 2X3, Authorization for EMG/NCV Lower Extremities , MRI L/S		6 visits
Subluxations of the L/S (Subsequent Encounter)	S33.100D			
(Lt.) Hip- Enthesopathy, Contusion	M70.70, S70.00XA	MRI Left Hip		
(Lt.) Thigh (Quads)- Strain	S76.112D			
(Lt.) Knee- Tendonitis	M76.51			

Requesting Physician Signature: Kenneth A. Webb, D.C. Date: 02/21/2020/Amended 11/18/20

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 12:31

Fax Number: 13103157353

Pages (Including cover): 6

Re: Marvetta Johnson Amended PR2 02-21-2020

Notes:

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Westside Health and Chiro

11915 Washington Blvd

Los Angeles, CA 90066

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