Southern California
IMMEDIATE MEDICAL CENTER
Specializing in Occupational Medicine

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Tel: 323-726-3212	Tel : 562-633-2273	Tel: 562-802-0208	Tel: 562-616-1166
Fax: 323-726-0942	Fax: 562-633-1796	Fax: 562-802-0999	Fax: 562-616-1141

DAILY PHYSICAL THERAPY REPORT

Patient..: JOHNSON, MARVETTA Date of Exam..: 4/20/2021 Time In : 2:08 PM
Employer.: LOS ANGELES COUNTY PROBATION DEPT. Date of Injury: 11/06/2020 Time Out: 3:15 PM

P.T. Visit Number: 9 Cumulative Total
Missed appointments for the case: 2 visits

Diagnosis: 1. LEFT TRAPEZIUS MUSCLE STRAIN

Subjective:

The patient states better since the cortisone injection last week
Work Status: not working
Patient reports pain level today is 06. on scale of 0 to 10.
The patient feels physical therapy is helping

Objective:
hp w tens burstx15min l shldr,stm,gh joint mob,therapeutic exercise

Range of Motion is Improved

Assessment:
Patient is PROGRESSING SLOWER THAN EXPECTED
Pain: Initial value: 07/10. Today's value 06/10.
Pain is Better
see re-eval

Plan/Recommendations:
Continue with plan of therapist
Other...: progress as tolerated

Treatment included:

RPT RE-EVALUATION	THERAPEUTIC PROC./EXERCISES
JOINT MOBILIZATION BY RPT	MYOFASCIAL RELEASE BY R.P.T.
ELECTRICAL STIMULATION-UN	

Digital Signature
MARJAN TAVAKOLIAN, RPT
License # PT 21509

INC#: 459611

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DAILY PHYSICAL THERAPY REPORT

Patient..: JOHNSON, MARVETTA Date of Exam..: 4/22/2021 Time In : 2:27 PM
Employer.: LOS ANGELES COUNTY PROBATION DEPT. Date of Injury: 11/06/2020 Time Out: 3:30 PM

P.T. Visit Number: 10 Cumulative Total
Missed appointments for the case: 2 visits

Diagnosis: 1. LEFT TRAPEZIUS MUSCLE STRAIN

Subjective:

The patient states feeling about the same
Work Status: not working
Patient reports pain level today is 06, on scale of 0 to 10.
The patient feels physical therapy is helping

Objective:
hp w tens burstx15min 1 shldr,stm,gh joint mob,therapeutic exercise

Range of Motion is Improved

Assessment:
Patient is PROGRESSING SLOWER THAN EXPECTED
Pain: Initial value: 07/10. Today's value 06/10.
Pain is Unchanged
improved shldr mobility

Plan/Recommendations:
Continue with plan of therapist
Other...: progress as tolerated

Treatment included:

THERAPEUTIC PROC./EXERCISES	JOINT MOBILIZATION BY RPT
MYOFASCIAL RELEASE BY R.P.T.	ELECTRICAL STIMULATION-UN

Digital Signature
MARJAN TAVAKOLIAN, RPT
License # PT 21509

INC#: 459611

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 4 weeks, totaling 8 visits, for the next 30 days. A re-evaluation will follow, at the end of 30 days.

I am also requesting authorization for an MRI of the left hip due to the ongoing severity of pain and symptoms.

Work Status: This patient has been instructed to:
X Remain off-work until: 5/23/2021
☐ 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: 4/23/2021

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: 4/23/20212020
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

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
X Change in work status	☐ 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 First: Marvetta M.I: _____ Sex: Female
Address: 1022 W 138th St City: Compton State: CA Zip: 90222
Date of Injury: 11/6/2020 Date of Birth: 12/11/1967
Occupation: Detention Service Officer SS #: 546-19-7076 Phone: 562-361-3048
Claims Administrator:
Name: Sedgwick Claim Numbers: 421-00578-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:

Neck- Constant, moderate to severe pain and stiffness. Pain radiates down to left upper trapezius and left shoulder; improving with treatment.

Left Upper Trapezius-Moderate pain and hypertonicity; improving with treatment.

Left Elbow-no pain today

Left Knee-Frequent, moderate pain with moderate swelling; improving with treatment.

Left Hip-Constant, severe pain.

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

CERVICAL SPINE

Inspection: Normal head carriage, normal color, and contour.

Palpation: Revealed moderate tenderness and hypertonicity of the spleniuscapitus, paraspinal, strenocleidomastoid, left upper trapezius and the suboccipital muscles bilaterally.

Reflexes:	Biceps	RT 2+	LT 2+
	Brachioradialis	RT 2+	LT 2+
	Triceps	RT 1+	LT 1+
		(2+ is normal)	

Sensation: Revealed hypersensitive response to pin-prick and light touch along all dermatomes bilaterally.

Circulation: Revealed regular and palpable radial pulses bilaterally with normal color, temperature and no trophic changes noted.

Muscle Strength :		Rt.	Lt.
Deltoids	(C5)	+5	+4**
Biceps	(C6)	+5	+4*
Triceps	(C7)	+5	+4*
Wrist Ext.	(C6)	+4	+4
Wrist Flex.	(C7)	+5	+5
Finger Flex.	(C8)	+5	+5
Finger Add.	(T1)	+5	+5

(5 = normal, 4 = decreased strength, 3 = very weak, Blank = no pain,
* = slight pain, ** = moderate pain, *** = severe pain)

CERVICAL ORTHOPEDIC TESTS

Compression	POSITIVE
Shoulder Distraction	POSITIVE
Foraminal Compression	POSITIVE
Distraction	POSITIVE
Valsalva	NEGATIVE
Adsons	NEGATIVE
Klines	NEGATIVE

CERVICAL ACTIVE RANGE OF MOTION (in degrees)

	Patient	Normal
Flexion	30**	45
Extension	25**	55
Rt. Lat. Flex.	25**	45
Lt. Lat. Flex.	25**	45
Rt. Rotation	60**	90
Lt. Rotation	60**	90

(Blank = no pain, * = slight pain, ** = moderate pain, *** severe pain)

LEFT HIP EXAMINATION

Inspection: Revealed slow and guarded movements in all ranges of motion.

Palpation: Revealed moderate to severe tenderness of the left greater trochanter and moderate pain during both passive and active range of motion.

LEFT HIP ORTHOPEDIC EXAM

Patrick's	POSITIVE
Obere's	POSITIVE

HIP ROM

	Lt. Hip	Normal
Extension:	15*	20
Flexion:	90***	120
Internal Rot.:	20**	45
External Rot.:	20**	45
Adduction:	5**	10
Abduction:	20***	45

SHOULDER & ARM EXAMINATION

Inspection: Revealed normal color and contour.

Palpation: Revealed severe tenderness in THE LEFT A/C joint, supraspinatus tendon and upper trapezius muscle and bicep and triceps muscles.

SHOULDER RANGE OF MOTION:

	Lt. Shoulder	Normal
Extension	30	50
Flexion	150**	180
Int. Rotation	60**	90
Ext. Rotation	60**	90
Abduction	150***	180
Adduction	25 ***	50

(Blank = no pain, * = slight pain, ** = moderate pain, *** severe

SHOULDER ORTHOPEDIC TESTS:

Apley's Scratch Test	POSITIVE
Apprehension Test	POSITIVE

ELBOW EXAM

Inspection: Revealed normal color.

Palpation: No tenderness; medial and lateral side of right elbow.

Orthopedic: Positive Tinel's on bilateral cubital fossa on left elbow.

ELBOW RANGE OF MOTION

	Lt. Elbow	Normal
Extension:	0	0
Flexion:	140	140
Supination:	75	80
Pronation:	75	80

(Blank = no pain, * = slight pain, ** = moderate pain, *** severe pain)

KNEE EXAMINATION

Inspection: Revealed slight swelling and normal color bilaterally.

Palpation: Moderate palpable tenderness; medial and lateral sides.

KNEE RANGE OF MOTION

	Lt. Knee	Normal
Extension:	180	180
Flexion:	135	135

(Blank = no pain, * = slight pain, ** = moderate pain, *** severe pain)

ORTHOPEDIC EXAM OF RIGHT KNEE

Varus Stress: Negative
Valgus Stress Positive
McMurray's: Positive
Mobility: Positive

DIAGNOSIS

Left Hip-Sprain S73.102A

Left Shoulder –Sprain S43.402A, rule out Rotator Cuff Tear M75.102

Left Knee- Sprain S83.92XA, rule out Medial Meniscus Tear S83.242A

Left Elbow-Sprain S53.402A

Cervical Spine- Sprain/Strain-S13.8XXA, Radiculopathy M54.12, spasm M62.838

Subluxations of C/S- S13.100D

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 L.			
Date of Injury: 11/06/2020		Date of Birth:12/11/1967	
Claim Number: 421-00578-D		Employer: County of Los Angeles/Probation	

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	
Address: P.O. Box 51350		City: Ontario	State: CA
Zip Code: 91761	Tel No: (855) 238-4936	Fax Number: (501) 251-2746	
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.)
Left Hip-Sprain	S73.102A	Authorization for additional Chiropractic care inclusive of Physiotherapy and Therapeutic Exercises 2X4 Authorization for MRI of Left Hip		8 Visits
Left Shoulder-Sprain, R/O Rotator Cuff Tear	S43.402A, M75.102			
Left Knee-Sprain R/O Medial Meniscus Tear	S83.92XA, S83.242A			
Left Elbow-Sprain	S53.402A			
C/S Sprain /Strain, Radiculopathy, Spasm	S13.6XXA, M54.12, M62.838			
Subluxations of C/S	S13.100D			

Requesting Physician Signature: Kenneth A. Webb, DC Date: April 23, 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:		

RE: Marvetta Johnson VS COLA/Probation Department
Claim NO: 421-00578-D
WCAB NO: Pending
DOI: 11-06-2020

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 April 23, 2021, I served the within.

Physicians Progress Report
Request for Authorization

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:

Sedgwick
P.O. Box 51350
Ontario, CA 91761
Fax: (501) 251-2746

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

Executed on April 23, 2021 at Los Angeles, California.

Beatriz Palomino

RE: Marvetta Johnson VS COLA/Probation Department
Claim NO: 21-00578-D
WCAB NO: Pending
DOI: 11-06-2020

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 June 30, 2021, I served the within.

Bill and Supporting Documents

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:

Sedgwick
P.O. Box 51350
Ontario, CA 91761
Fax: (501) 251-2746

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

Executed on June 30, 2021 at Los Angeles, California.

Beatriz Palomino

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Fax: 323-726-0942	Fax: 562-633-1796	Fax: 562-802-0999	Fax: 562-616-1141

DAILY PHYSICAL THERAPY REPORT

Patient..: JOHNSON, MARVETTA Date of Exam..: 5/04/2021 Time In : 2:28 PM
Employer.: LOS ANGELES COUNTY PROBATION DEPT. Date of Injury: 11/06/2020 Time Out: 3:35 PM

P.T. Visit Number: 11 Cumulative Total
Missed appointments for the case: 2 visits

Diagnosis: 1. LEFT TRAPEZIUS MUSCLE STRAIN
2. LEFT ELBOW CONTUSION
3. LEFT KNEE CONTUSION

Subjective:

The patient states feeling ok
Work Status: not working
Patient reports pain level today is 06. on scale of 0 to 10.
The patient feels physical therapy is helping

Objective:
hp w tens burstx15min left shldr.stm.joint mob.therapeutic exercise

Range of Motion is Improved

Assessment:
Patient is PROGRESSING SLOWER THAN EXPECTED
Pain: Initial value: 07/10. Today's value 06/10.
Pain is Unchanged
er wfl, resolving capsular pattern restriction

Plan/Recommendations:
Continue with plan of therapist
Other...: progress as tolerated

Treatment included:
THERAPEUTIC PROC./EXERCISES JOINT MOBILIZATION BY RPT
MYOFASCIAL RELEASE BY R.P.T. ELECTRICAL STIMULATION-UN

Digital Signature
MARJAN TAVAKOLIAN, RPT
License # PT 21509

INC#: 459611

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DAILY PHYSICAL THERAPY REPORT

Patient..: **JOHNSON, MARVETTA** Date of Exam..: 5/06/2021 Time In : 2:32 PM
Employer.: LOS ANGELES COUNTY PROBATION DEPT. Date of Injury: 11/06/2020 Time Out: 3:32 PM

P.T. Visit Number: 12 Cumulative Total
Missed appointments for the case: 2 visits

Diagnosis: 1. LEFT TRAPEZIUS MUSCLE STRAIN
2. LEFT ELBOW CONTUSION
3. LEFT KNEE CONTUSION

Subjective:

The patient states feeling the same
Work Status: not working
Patient reports pain level today is 06, on scale of 0 to 10.
The patient feels physical therapy is helping

Objective:
hp w tens burstx15min 1 shldr.stm.gh joint mob.therapeutic exercise

Range of Motion is Improved

Assessment:
Patient is NOT PROGRESSING
Pain: Initial value: 07/10. Today's value 06/10.
Pain is Unchanged
trigger point left levator scapulae

Plan/Recommendations:
Continue with plan of therapist
Other...: add stretches

Treatment included:

THERAPEUTIC PROC./EXERCISES	JOINT MOBILIZATION BY RPT
MYOFASCIAL RELEASE BY R.P.T.	ELECTRICAL STIMULATION-UN

Digital Signature
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DAILY PHYSICAL THERAPY REPORT

Patient..: JOHNSON, MARVETTA Date of Exam..: 5/11/2021 Time In : 2:17 PM
Employer.: LOS ANGELES COUNTY PROBATION DEPT. Date of Injury: 11/06/2020 Time Out: 3:15 PM

P.T. Visit Number: 13 Cumulative Total
Missed appointments for the case: 2 visits

Diagnosis: 1. LEFT TRAPEZIUS MUSCLE STRAIN
2. LEFT ELBOW CONTUSION
3. LEFT KNEE CONTUSION

Subjective:

The patient states feeling the same
Work Status: not working
Patient reports pain level today is 06, on scale of 0 to 10.
The patient feels physical therapy is helping

Objective:
hp w tens burstx15min 1 shldr,stm,gh joint mob,therapeutic exercise

Range of Motion is Improved

Assessment:
Patient is PROGRESSING SLOWER THAN EXPECTED
Pain: Initial value: 07/10. Today's value 06/10.
Pain is Unchanged
prom 1 shldr wfl

Plan/Recommendations:
Continue with plan of therapist
Other...: progress exercises

Treatment included:
THERAPEUTIC PROC./EXERCISES
MYOFASCIAL RELEASE BY R.P.T.
JOINT MOBILIZATION BY RPT
ELECTRICAL STIMULATION-UN

Digital Signature
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DAILY PHYSICAL THERAPY REPORT

Patient..: JOHNSON, MARVETTA Date of Exam..: 5/13/2021 Time In : 2:41 PM
Employer.: LOS ANGELES COUNTY PROBATION DEPT. Date of Injury: 11/06/2020 Time Out: 3:40 PM

P.T. Visit Number: 14 Cumulative Total
Missed appointments for the case: 2 visits

Diagnosis: 1. LEFT TRAPEZIUS MUSCLE STRAIN
2. LEFT ELBOW CONTUSION
3. LEFT KNEE CONTUSION

Subjective:

The patient states feeling the same
Work Status: not working
Patient reports pain level today is 06. on scale of 0 to 10.
The patient feels physical therapy is helping

Objective:
hp w tens burstx15min left shldr.stm.gh joint mob.therapeutic exercise

Range of Motion is Improved

Assessment:
Patient is PROGRESSING SLOWER THAN EXPECTED
Pain: Initial value: 07/10. Today's value 06/10.
Pain is Unchanged
post capsule tightness. poss trigger points ?. ttp lhbt

Plan/Recommendations:
Continue with plan of therapist
Other...: progress as tolerated

Treatment included:
THERAPEUTIC PROC./EXERCISES JOINT MOBILIZATION BY RPT
MYOFASCIAL RELEASE BY R.P.T. ELECTRICAL STIMULATION-UN

Digital Signature
MARJAN TAVAKOLIAN, RPT
License # PT 21509

INC#: 459611

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 4 weeks, totaling 8 visits, for the next 30 days. A re-evaluation will follow, at the end of 30 days.

I am also requesting authorization for an MRI of the left hip due to the ongoing severity of pain and symptoms.

Work Status: This patient has been instructed to:

X Remain off-work until: **TTD, Upon Evaluation, 6/23/2021**

☐ 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: 5/19/2021

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: 5/19/2021

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

Additional pages attached ☐

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

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 First: Marvetta M.I: _____ Sex: Female
Address: 1022 W 138th St City: Compton State: CA Zip: 90222
Date of Injury: 11/6/2020 Date of Birth: 12/11/1967
Occupation: Detention Service Officer SS #: 546-19-7076 Phone: 562-361-3048
Claims Administrator:
Name: Sedgwick Claim Numbers: 421-00578-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:

Left Hip-Constant, severe pain & intermittent "clicking", 8/10 pain level - Ongoing.

Neck- Frequent, moderate to severe pain and stiffness. Pain radiates down to left upper trapezius and left shoulder; 6/10 - Improving with treatment.

Left Upper Trapezius- Severe pain and hypertonicity, 9/10 - Ongoing

Left Elbow-no pain today

Left Knee-Intermittent, moderate pain with moderate swelling, 5-6/10; Improving with treatment.

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

CERVICAL SPINE

Inspection: Normal head carriage, normal color, and contour.

Palpation: Revealed moderate tenderness and hypertonicity of the spleniuscapitus, paraspinal, strenocleidomastoid, left upper trapezius and the suboccipital muscles bilaterally.

Reflexes:	Biceps	RT 2+	LT 2+
	Brachioradialis	RT 2+	LT 2+
	Triceps	RT 1+	LT 1+
		(2+ is normal)	

Sensation: Revealed hypersensitive response to pin-prick and light touch along all dermatomes bilaterally.

Circulation: Revealed regular and palpable radial pulses bilaterally with normal color, temperature and no trophic changes noted.

Muscle Strength :		Rt.	Lt.
Deltoids	(C5)	+5	+4**
Biceps	(C6)	+5	+4*
Triceps	(C7)	+5	+4*
Wrist Ext.	(C6)	+4	+4
Wrist Flex.	(C7)	+5	+5
Finger Flex.	(C8)	+5	+5
Finger Add.	(T1)	+5	+5

(5 = normal, 4 = decreased strength, 3 = very weak, Blank = no pain,
* = slight pain, ** = moderate pain, *** = severe pain)

CERVICAL ORTHOPEDIC TESTS

Compression	POSITIVE
Shoulder Distraction	POSITIVE
Foraminal Compression	POSITIVE
Distraction	POSITIVE
Valsalva	NEGATIVE
Adsons	NEGATIVE
Klines	NEGATIVE

CERVICAL ACTIVE RANGE OF MOTION (in degrees)

	Patient	Normal
Flexion	35**	45
Extension	25**	55
Rt. Lat. Flex.	25**	45
Lt. Lat. Flex.	25**	45
Rt. Rotation	60**	90
Lt. Rotation	60**	90

(Blank = no pain, * = slight pain, ** = moderate pain, *** severe pain)

LEFT HIP EXAMINATION

Inspection: Revealed slow and guarded movements in all ranges of motion.

Palpation: Revealed moderate to severe tenderness of the left greater trochanter and moderate pain during both passive and active range of motion.

LEFT HIP ORTHOPEDIC EXAM

Patrick's	POSITIVE
Obere's	POSITIVE

HIP ROM

	Lt. Hip	Normal
Extension:	15*	20
Flexion:	90***	120
Internal Rot.:	20**	45
External Rot.:	20**	45
Adduction:	5**	10
Abduction:	20***	45

SHOULDER & ARM EXAMINATION

Inspection: Revealed normal color and contour.

Palpation: Revealed severe tenderness in THE LEFT A/C joint, supraspinatus tendon and upper trapezius muscle and bicep and triceps muscles.

SHOULDER RANGE OF MOTION:

	Lt. Shoulder	Normal
Extension	30	50
Flexion	150**	180
Int. Rotation	60**	90
Ext. Rotation	60**	90
Abduction	150***	180
Adduction	25 ***	50

(Blank = no pain, * = slight pain, ** = moderate pain, *** severe

SHOULDER ORTHOPEDIC TESTS:

Apley's Scratch Test	POSITIVE
Apprehension Test	POSITIVE

ELBOW EXAM

Inspection: Revealed normal color.

Palpation: No tenderness; medial and lateral side of right elbow.

Orthopedic: Positive Tinel's on bilateral cubital fossa on left elbow.

ELBOW RANGE OF MOTION

	Lt. Elbow	Normal
Extension:	0	0
Flexion:	140	140
Supination:	75	80
Pronation:	75	80

(Blank = no pain, * = slight pain, ** = moderate pain, *** severe pain)

KNEE EXAMINATION

Inspection: Revealed slight swelling and normal color bilaterally.

Palpation: Moderate palpable tenderness; medial and lateral sides.

KNEE RANGE OF MOTION

	Lt. Knee	Normal
Extension:	180	180
Flexion:	135	135

(Blank = no pain, * = slight pain, ** = moderate pain, *** severe pain)

ORTHOPEDIC EXAM OF RIGHT KNEE

Varus Stress:	Negative
Valgus Stress	Positive
McMurray's:	Positive
Mobility:	Positive

DIAGNOSIS

Left Hip-Sprain S73.102A

Left Shoulder –Sprain S43.402A, rule out Rotator Cuff Tear M75.102

Left Knee- Sprain S83.92XA, rule out Medial Meniscus Tear S83.242A

Left Elbow-Sprain S53.402A

Cervical Spine- Sprain/Strain-S13.8XXA, Radiculopathy M54.12, spasm M62.838

Subluxations of C/S- S13.100D

ACTIVITIES OF DAILY LIVING

After the injuries, she indicated constant moderate to severe pain and impairment of activities involving self-care/personal hygiene, driving, standing, sitting, climbing stairs, bending, stooping, kneeling, squatting, lifting and carrying.
After Chiropractic Care, she indicates slight improvement and moderate to severe pain and impairment of activities involving self-care/personal hygiene, driving, standing, sitting, climbing stairs.

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 L.	
Date of Injury: 11/06/2020	Date of Birth: 12/11/1967
Claim Number: 21-00578-D	Employer: County of Los Angeles/Probation

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	
Address: P.O. Box 51350		City: Ontario	State: CA
Zip Code: 91761	Tel No: (855) 238-4936	Fax Number: (949) 942-8918	
E-mail Address:			

Requested Treatment (See Instructions for Guidance; Attach 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.)
Left Hip-Sprain	S73.102A	Authorization for additional Chiropractic care inclusive of Physiotherapy and Therapeutic Exercises 2X4 Authorization for MRI of Left Hip		8 Visits
Left Shoulder-Sprain, R/O Rotator Cuff Tear	S43.402A, M75.102			
Left Knee-Sprain R/O Medial Meniscus Tear	S83.92XA, S83.242A			
Left Elbow-Sprain	S53.402A			
C/S Sprain /Strain, Radiculopathy, Spasm	S13.8XXA, M54.12, M62.838			
Subluxations of C/S	S13.100D			

Requesting Physician Signature: Kenneth A. Webb, DC Date: May 19, 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:

Sedgwick Unit D 07/07/2021 13:52

Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

RE: Marvetta Johnson VS COLA/Probation Department
Claim NO: 21-00578-D
WCAB NO: Pending
DOI: 11-06-2020

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 May 19, 2021, I served the within.

Physicians Progress Report
Request for Authorization

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:

Sedgwick
P.O. Box 51350
Ontario, CA 91761
Fax: (501) 251-2746

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

Executed on May 19, 2021 at Los Angeles, California.

Beatriz Palomino

RE: Marvetta Johnson VS COLA/Probation Department
Claim NO: 21-00578-D
WCAB NO: Pending
DOI: 11-06-2020

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 June 30, 2021, I served the within.

Bill and Supporting Documents

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:

Sedgwick
P.O. Box 51350
Ontario, CA 91761
Fax: (501) 251-2746

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

Executed on June 30, 2021 at Los Angeles, California.

Beatriz Palomino

BACK-TO-WORK
ORTHOPEDIC MEDICAL GROUP

☐	☒	☐
6538 Telegraph Road Commerce, CA 90040 Tel: 323.726.3212 Fax: 323.726.0942	5203 Lakewood Blvd. Lakewood, CA 90712 Tel: 562.633.2273 Fax: 562.633.1796	15330 Valley View Ave. St. 1 La Mirada, CA 90638 Tel: 562.802.0208 Fax: 562.802.0999

May 26, 2021

ORTHOPEDIC RE-EVALUATION

PATIENT.....: JOHNSON, MARVETTA
CLAIM NUMBER: 21-00578-D
DATE OF INJ : November 6, 2020
DATE OF EXAM: May 26, 2021
EMPLOYER....: LOS ANGELES COUNTY PROBATION DEPT.
INCIDENT NO.: 915543

CHIEF COMPLAINT:

The patient presents for a follow-up visit for left shoulder pain. She continues to be symptomatic. The injection was not helpful.

PHYSICAL EXAMINATION:

Left Shoulder: Positive impingement syndrome and positive Hawkin's test. There is painful arc of motion. She has weak external rotation.

Range of Motion: Forward elevation is 120 degrees and abduction is 100 degrees. Internal rotation is 70 degrees and external rotation is 80 degrees.

DIAGNOSIS:

1. Left shoulder adhesive capsulitis/impingement syndrome.

TREATMENT PLAN:

This patient continues to be symptomatic. The injection was not helpful. In my opinion, this patient has tried and failed with conservative treatment consisting of numerous sessions of physical therapy, medication, as well as local injection with no improvement. With her continued symptoms, she would be a candidate for left shoulder arthroscopic evaluation and manipulation in order to improve her symptomatology. We will be requesting for an authorization for the procedure. Follow-up in one month for re-assessment.

DISABILITY STATUS:

Temporary partial disability.

ASSESSMENT/CONDITION:

Same

WORK STATUS:

Modified duty with limited use of the left hand. No forceful gripping, grasping, or twisting. No lifting above left shoulder height. No lifting above 20 pounds.

DISCLOSURE:

Labor code section 4628 (J) I declare under penalty of perjury that the information contained in this report and its attachment, if any, is true and correct to the best of my knowledge and belief except as to information that I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information provided to me and, except as noted herein, that I believe it to be true.

Dated this 26th day of May,2021,in Los Angeles County,California

Sincerely,

KEVIN PARK, M.D.
Diplomate American Board of Orthopedic Surgery

KP/rn

sedgwick

UR Referral Form

☐ Non Carve-Out
☐ Fire Carve-Out

Date UR Referral Form sent to UR June 01, 2021	Date treatment request received by Sedgwick 06/01/2021
Claimant/Patient Name Marvetta Johnson	Claims Examiner Rowney, Christine
Street Address 1022 WEST 138TH ST	Company or Agency **Sedgwick - D**
City, State, Zip Code COMPTON CA 90222	Address/City/State/Zip P.O. Box 51350 Ontario, CA 91761

Phone Number	Date of Birth	WCIS#	EAMS# (if applicable)	Date of Injury
(562)361-3048	12/11/1967	202011121511147919948 4		11/06/2020

Claim Number	Social Security #	Type of Review Requested
2100578D	546197076	☒ Prior to Services ☐ Retro Review ☐ Concurrent Review ☐ Appeal ☐ Peer Review

Primary Diagnosis with ICD-9 Code	Accepted Body Parts left elbow, left trapezius, left knee
Treating Physician/Hospital (Name, address, phone) KEVIN S PARK, MD 11411 BROOKSHIRE AVE STE 200 DOWNEY, CA 90241 5628694421	Treating Physician/Hospital Fax# 7149488868
Claimant's Attorney (Name, address, phone)	Claimant's Attorney Fax#
Defense Attorney (Name, address, phone)	Defense Attorney Fax#
Occupation 8655-DETENTION SERVICES OFFICER	Employer Name **County of Los Angeles** - Probation

Is the claims administrator disputing liability for the requested medical treatment besides the question of medical necessity? ☐ Yes ☐ No *If Yes, indicate why liability is being disputed:*	*Has any part of this request been approved by the claims examiner?* ☐ Yes ☐ No *If yes, what treatments have been approved?* # of PT sessions approved to date by claims examiner:

SPECIAL INSTRUCTIONS/REASON FOR ASSIGNMENT: LEFT SHOULDER ARTHROSCOPY MANIPULATION UNDER ANESTHESIA SUBACROMIAL DECOMPRES, EKG, CHEST XRAY, LABORATORY WORKUP, CBC W DIFF, COMP METABOLIC PANEL, PT INR, PTT, CULTURE URINE ROUTINE, COVID TEST, SHOULDER IMMOBILIZER COLD THERAPY UNI 7 DAY RENTAL, PHYSICAL THERAPY. RFA DATED 06/01/2021

State of California
Division of Workers' Compensation
REQUEST FOR AUTHORIZATION

DWC Form RFA – California Code of Regulations, title 8, section

This form must accompany the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a T Report, DWC Form PR-2, or narrative report substantiating the requested treatm

☒ **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): JOHNSON< MARVETTA

Date of Injury (MM/DD/YYYY11/6/20	**Date of Birth (MM/DD/YYYY)12/11/**
Claim Number:21 -00578 D	**Employer:Los angeles county probat**

Provider Information

Provider Name: **Kevin S. Park MD INC**

Practice Name: Greater L.A. Orthopedics		**Contact Name:** Denise (714) 232
Address: 11411 Brookshire Ave Ste 200		**City:** Downey
Zip Code: 90241	**Phone:** 562-869-4421	**Fax Number:** 714 948 8868
Provider Specialty: Orthopedic surgery		**NPI Number:** **1093823494**
E-mail Address: parkorthosurgery@gmail.com		

SEDGWICK		**Contact NameNoelle Dobrinski**
Address: po boX 14440		**City: Lexington**
Zip Code:40512	**Phone 925 275 5493**	**Fax Number859 280 4805 833-875**
E-mail Address:		

Requested Treatment (see Instructions for guidance; attach additional pages if necessary)

Either state the requested treatment in the below space or indicate the specific page number(s) of the acco which the requested treatment can be found. Up to five (5) procedures may be entered; attach additional r

Diagnosis	ICD-Code	Procedure Requested	CPT/HCPCS Code
L shoulder adhesive capsulitis L shoulder impingement	M 75.02, M 75.42, M 67.212	L shoulder arthroscopy manipulation under	23700 29826 29822

		routine, COVID TEST	
		Shoulder immobilizer Cold therapy uni 7 day rental	
		Physical Therapy	97001
			97110

lab workup(cbc with diff, pt inr, ptt, comp met panel, urinalysis culture routine,Covid test

Treating Physician Signature: Kevin Park	Date: 6/1/2021

Claims Administrator Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notificatic

☐ 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:

BACK-TO-WORK
ORTHOPEDIC MEDICAL GROUP

Commerce	Lakewood	La Mirada	Paramount
6538 Telegraph Rd	5203 Lakewood Bvd Ste.B	15330 Valley View Ave # 1	7300 Alondra Blvd Ste. 100
Commerce, CA 90040	Lakewood, CA 90712	La Mirada, CA 90638	Paramount, CA 90723
P: (323) 726-3212	P: (562) 633-2273	P: (562) 802-0208	P: (562) 616-1166
F: (323) 726-0942	F: (562) 633-1796	F: (562) 802-0999	F: (562) 616-1141

May 26, 2021

ORTHOPEDIC RE-EVALUATION

PATIENT: Marvetta Johnson
CLAIM #: 21-00578-D
DATE OF INJURY: November 6, 2020
DATE OF EXAM: May 26, 2021
EMPLOYER: Los Angeles County Probation Department

The above named patient is being seen today for re-evaluation.

CHIEF COMPLAINT:

The patient presents for a follow-up visit for left shoulder pain. She continues to be symptomatic. The injection was not helpful.

PHYSICAL EXAMINATION:

Left Shoulder: Positive impingement syndrome and positive Hawkin's test. There is painful arc of motion. She has weak external rotation.

Range of Motion: Forward elevation is 120 degrees and abduction is 100 degrees. Internal rotation is 70 degrees and external rotation is 80 degrees.

DIAGNOSES:

1. Left shoulder adhesive capsulitis/impingement syndrome.

TREATMENT PLAN:

This patient continues to be symptomatic. The injection was not helpful. In my opinion, this patient has tried and failed with conservative treatment consisting of numerous sessions of physical therapy, medication, as well as local injection with no improvement. With her continued symptoms, she would be a candidate for left shoulder arthroscopic evaluation and manipulation in order to improve her symptomatology. We will be requesting for an authorization for the procedure. Follow-up in one month for re-assessment.

DISABILITY STATUS:

Temporary partial disability.

ASSESSMENT/CONDITION:

Same

WORK STATUS:

Modified duty with limited use of the left hand. No forceful gripping, grasping, or twisting. No lifting above left shoulder height. No lifting above 20 pounds.

DISCLOSURE:

Labor code section 4628 (J) I declare under penalty of perjury that the information contained in this report and its attachment, if any, is true and correct and to the best of my knowledge and belief except as to information that I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Dated this 26th day of May 2021 in Los Angeles County, California

Sincerely,

Kevin Park, M.D.
Diplomate American Board of Orthopedic Surgery

KP/rn
DD: 05/26/21
DT: 05/29/21

KEVIN S. PARK M.D. INC

BOARD CERTIFIED ORTHOPEDIC SURGERY

11411 Brookshire Avenue Suite 200, Downey CA 90241

PATIENT: _____**Marvetta Johnson**_____

CLAIM # __ 21 -00578 D____ **DOI #** ___11/6/20____ **DOB:** ___12/11/67___

CPT: 23700 29826, 29822

ICD: M 75.02, M 75.42, M 67.212

DIAGNOSIS: L SHOULDER adhesion capsulitis/ impingement

REQUEST : SURGERY REQUIRED:

L ___x___ SHOULDER ARTHROSCOPY

___x___ MANIPULATION UNDER ANESTHESIA

___x___ SUBACROMIAL DECOMPRESSION

2.LABS REQUIRED:

__x__ CBC __x___ PT ___x___ PTT __x___COMPREHENSIVE MET Panel

___x__ CULTURE URINE ROUTINE _x___ COVID TEST

3. _____ MEDICAL CLEARANCE:

99205 Office visit, 8100 UA, 93000 EKG, 80050 CMP, 85025 CBC, 85610 PT, 85730 PPT, 86510 SED, 36415 venipuncture, 71020 Chest xray

with Dr. Shirish Patel 5220 Clark Ave, Suite 125 ; Lakewood, Ca 90712 Tel: 562 925 7401

email: multi5220@verizon.net

Dr. Patel requires letter indicating authorization for their facility.

KEVIN S. PARK M.D. INC

BOARD CERTIFIED ORTHOPEDIC SURGERY

11411 Brookshire Avenue Suite 200, Downey CA 90241

4. DME's Required:

_x__ Shoulder immobilizer

____ ACL Brace

__x__ Cold therapy unit 7 day rental

Provider: PROGRESSIVE MOTION INC . Tax ID: 95 435 7988 TEl: 310 465 1810

5. PHYSICAL THERAPY REQUIRED:

___x___	97001 x 1
_____	97110 3x4
___x____	97110 3x8

Facility: **Physicians' Surgery Center of Downey**, PO Box 4430 Downey, CA 90241 Tel: (562) 869 0500, Fax: 562 569 0505, Tax ID : 20 5170962

and

Sun Surgical Center 7801 Center avenue Suite 203, Huntington Beach CA 92647 Tel: 714 709 8552 Fax: 657 227 7273 Tax ID: 82-2387200

Authorization specifies surgical procedure to be completed IN-network. As both surgery centers are not in Network, we kindly request authorization stating facilities are allowed to perform surgery on this patient according to (MPN) FEE SCHEDULE.

Both facilities accept California's ASC Workers' Comp Fee Schedule. This will ensure cost contracted control of medical fees and expectations of treatment outcome. **Kindly enclose authorization for both facilities.** Due to COVID-19, we are attempting to schedule the patient at the facility that can accommodate them at the earliest convenience for the patient.

For **Peer to Peer,** kindly contact Denise at 714 232 2527 or email parkorthosurgery@gmail.com so that we can forward the message to our physician to complete the peer to peer.