Tri-City Health Group

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

April 16, 2021

Patient:	Martin Lugo PO Box 12512, Costa Mesa, CA. 92627 Telephone: (949) 609-9888 D.O.B.: 7/30/1964	**Sex:** Male SSN: 561-71-1451	
Insurance:	**Per CCR §9780.1 & §9781 please provide carrier information**		
DOI:	1/1/19-4/5/20;3/23/21;		
Employer:	Westpac Labs Inc 10200 Pioneer Blvd 500, Santa Fe Springs, CA. 90670 Telephone:	 **FAX:**	
Occupation:	Medical Courier		
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 AND REQUEST FOR AUTHORIZATION

Dear Attorney

In regard to my patient, Mr. Lugo, I am sending an initial report concerning the work related injury sustained on 1/1/19-4/5/20;3/23/21; while in the performance of his customary and usual work.

HISTORY OF THE INJURY AS RELATED BY THE PATIENT:

On June 4, 2020 during the course of employer he suffered a car accident. He was finishing his shift and driving in the company car. He was at a red light when he was suddenly rear-ended by a drunk female driver. Upon the impact he noticed pain to his neck and back.

A police report was done. The patient **DID** report his injury to his employer. An appointment **WAS** made for the patient by their employer or insurance carrier for medical treatment.

MEDICAL TREATMENT TO DATE:

He went to Urgent Care on his own after the accident. He was examined and had x-rays of his neck; he was given medication for the pain and diagnosed with inflammation.
The following day he was seen by the company doctor at Concentra. He was examined had x-rays done of his back and was diagnosed with inflammation, arthritis and degenerative disease. He has started on physical therapy and subsquently stopped treatment. However, he noticed persisting neck pain that began to radiate to his right arm.
He continued working in despite of his persisting pain.

Specific Date of injury: 3/23/2021
Body parts: low back, hips and left side

The patient reports that during the course of employment he began to experience pain to his low back, hips and left side. He reports that he noticed the pain after getting in and out of the care from 25-35 times a day to deliver supplies and pick up lab work.

On March 23, 2021 he noticed increasing while getting inside the small company car that he was provided. He is 6 feet tall and the care small. He reports he had to sit back and rest to catch his breath due to the increasing back, hip and left side pain.
He reported his injury to his employer who made an appointment to see the company doctor. However, he had to re-schedule the appointment because the way was too long and he was in pain.
On March 29, 2021 he was seen an Urgent Care Center was examined. He was administered pain injection (toridol) and prescribed Norco to help him with his sleep disturbance due to the pain.
On or about April 2, 2021 he was seen at Concentra Medical Group in the city of Santa Ana, Ca He was examined , had x-rays done of his hips and MRI studies of his low back and pelvis. He was placed on TTD and started a course of physical therapy. He was placed on TTD.

Cumulative date of injury date: 1/1/2019-4/5/2021
Body parts: neck, back, hips, left side of leg, sleep disturbance.

From 1/1/2019-4/5/2021 during the course of employment as a Medical Courier for West Pack Labs Inc. he neck, back, hips, left side of leg, sleep disturbance .

The patient elaborates to the best of his knowledge that he sustained a cumulative trauma injuries while working 8 ½ hours a day, and 5-6 days per week since November 2028.
His symptoms developed as a result of his customary job duties. He is responsible for the transportation of medical items among labs, hospitals, clinics, and other healthcare facilities. Manage pickups and deliveries, take orders, and send invoices to medical clients.
The onset of symptoms began sometime on 1/1/2019. He was required to get in and out of the care up to 25-30 times a day. The company car is very small and he is 6 feet tall.
The patient **DID** report his injury to his employer. An appointment **WAS NOT** made for the patient by their employer or insurance carrier for medical treatment.
The patient remains off work and his symptoms have remained unchanged.

PREVIOUS WORK RELATED INJURY:

Mr. Lugo denies having sustained any prior or subsequent injuries or any new injuries to the subject body parts.

PAST MEDICAL HISTORY AS RELATED BY THE PATIENT:

Fractures:	None.
Auto Accident:	None.

Surgeries: 2010 Two feet of colon removed due cancer.
2005 Gallbladder.
Medications: None.
Medical: The patient has a history of Colon Cancer and Diabetes.
Allergies: No known allergies.

His family medical history is non-contributory.

OCCUPATIONAL/SOCIAL HISTORY:

Mr. Lugo was born on 7/30/64. The patient is single with one child. He denies having served in the military. He does not smoke or drink alcoholic beverages.

JOB DESCRIPTION:

Mr. Lugo was employed as a Medical Courier: He is responsible for the transportation of medical items among labs, hospitals, clinics, and other healthcare facilities. Manage pickups and deliveries, take orders, and send invoices to medical clients.

SUBJECTIVE COMPLAINTS:

Pain Scale:

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

1) Mr. Lugo has complaint of frequent 10/10 neck pain. has trouble tilting his head to the left.

2) Mr. Lugo complains of frequent 6-7/10 low back pain.

3) He presents today complaining of frequent 6-7/10 left shoulder pain.

4) The patient, Mr. Lugo, has complaint of right shoulder with numbness.

5) He has complaint of frequent 8/10 left hip pain.

6) The patient, Mr. Lugo has no right hip pain.

OBJECTIVE FINDINGS:

Height: 6'2"

Weight: 235 pounds

B.P.: 147/79

Pulse: 76 bpm

Right-hand dominant

Cervical Spine:

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	35º	50º
Extension	30º	60º
Left Lateral Bending	20º	45º
Right Lateral Bending	30º	45º
Left Rotation	50º	80º
Right Rotation	65º	80º

Orthopedic Tests:

Cervical Compression is positive.

Shoulder Depression is positive.

Lumbar Spine:

Range of Motion:

The lumbar ranges of motion are decreased.

	Range	Normal
Flexion	40º	60º
Extension	5º	25º
Left Lateral Bending	15º	25º

Right Lateral Bending	10º	25º

Orthopedic Tests:

Kemp's causes pain.

Sitting Straight Leg Raise causes pain on the left.

Left Shoulder:

There is muscle spasm of the posterior shoulder and trapezius.

Range of Motion:

The left shoulder ranges of motion are decreased and painful.

	Range	Normal
Flexion	150º	180º
Extension	50º	50º
Abduction	140º	180º
Adduction	40º	40º
Internal Rotation	80º	80º
External Rotation	90º	90º

Orthopedic Tests:

Neer's causes pain.

Supraspinatus Press causes pain.

Right Shoulder:

There is muscle spasm of the posterior shoulder and lateral shoulder.

Range of Motion:

The right shoulder ranges of motion are decreased and painful.

	Range	Normal
Flexion	150º	180º
Extension	50º	50º
Abduction	140º	180º
Adduction	40º	40º
Internal Rotation	80º	80º
External Rotation	90º	90º

Orthopedic Tests:

Neer's causes pain.

Supraspinatus Press causes pain.

<u>Left Hip:</u>

There is muscle spasm of the posterior hip and lateral hip.

Range of Motion:

The left hip ranges of motion are decreased and painful.

	Range	Normal
Flexion	70º	100º
Extension	10º	30º
Abduction	15º	40º
Adduction	10º	20º
Internal Rotation	25º	40º
External Rotation	35º	50º

Orthopedic Tests:

Ober's causes pain.

Patrick's FABERE causes pain.

Right Hip:

There is muscle spasm of the posterior hip.

Range of Motion:

The right hip ranges of motion are decreased and painful.

	Range	Normal
Flexion	80º	100º
Extension	25º	30º
Abduction	30º	40º
Adduction	10º	20º
Internal Rotation	30º	40º
External Rotation	40º	50º

Orthopedic Tests:

Ober's causes pain.

Patrick's FABERE causes pain.

DIAGNOSES:

Cervical musculoligamentous injury [S13.8XXA]

Rule out cervical disc [M50.20]

Lumbar musculoligamentous injury [S33.5XXA, S39.012A]

Lumbar disc protrusion [M51.26]

Lumbar radiculitis [R54.16]

Shoulder sprain / strain, left [S43.402A, S46.912A]

Shoulder sprain / strain, right [S43.401A, S46.911A]

Hip sprain / strain, left [S73.102A]

Hip internal derangement [M24.9]

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

PLAN:

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

MRIs of cervical spine, left shoulder, and right shoulder, right hip. EMG/NCV of bilateral upper and lower extremities.

Referral: Pain Management.

WORK STATUS:

Mr. Martin Lugo is on temporary total disability through May 31, 2021.

CAUSATION:

Based upon the provided history and medical evidence as available, Mr. Lugo's injuries are believed to be attributable to, and the direct result of, the work-related trauma that occurred on 1/1/19-4/5/20;3/23/21;.

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.

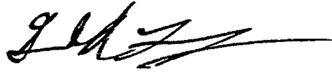
AUTHORIZATION REQUEST:
Authorization for above referenced treatment is requested based upon proposed treatment plan and medically reasonable treatment requirements. This is per Labor Code 4600 and Title 8, Section 9792.6, C.C.R. and Rule 9785(b); therefore, we are requesting written authorization to 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.

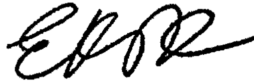
I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

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

Sincerely,



Gerald Ferencz 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.

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): Lugo, Martin
Date of Injury (MM/DD/YYYY):1/1/19-4/5/20;3/23/21; | Date of Birth (MM/DD/YYYY): 7/30/1964
Claim Number: | Employer: Westpac Labs Inc

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: 1184078859
E-mail Address:

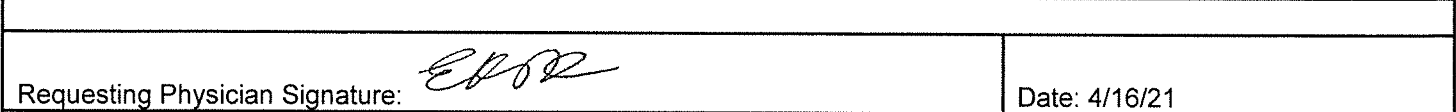
Claims Administrator Information

Company Name: | Contact Name:
Address: | City: | State:
Zip Code: | Phone: | Fax Number:
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 therapy		2-3 x week for 6 weeks
Rule out cervical disc	[M50.20]	MRIs of cervical spine, left shoulder, and right shoulder, right hip.		
Lumbar musculoligamentous injury	[S33.5XXA, S39.012A]	EMG/NCV of bilateral upper and lower extremities.		
Lumbar disc protrusion	[M51.26]	Refer to Pain Management		
		Follow up		4-6 weeks



Requesting Physician Signature: | Date: 4/16/21

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:

Send Result Report

MFP

TASKalfa 5003i

Firmware Version 2VK_S000.001.322 2019.09.24

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[2VK_1000.001.201] [2ND_1100.001.007]

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Document: doc10709920210426152500

Tri-City Health Group
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MEDICAL FACSIMILE COVER SHEET

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Confidentiality Notice

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The following fax contains information pertaining to:

Patient Name:	Martin Lugo
Employer:	Westpac Labs Inc
Insurance:	Per CCR §9780.1 & §9781 please provide carrier information
Claim Number:	Unavailable
Facsimile:	Unknown
Applicant Attorney:	Workers Defenders Law Group
Facsimile:	(310) 626-9632

Date Sent:	Apr 26, 2021	Number of Pages:	11
Description:	Dr. Komberg Doctor's First Report (Form 5021) & RFA 4/16/2021		

Sent By: Angela Del Real

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

No.	Date/Time	Destination	Times	Type	Result	Resolution/ECM
001	04/26/21 15:27	13106269632	0°03'05"	FAX	OK	200x100 Normal/On

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La Palma, CA 90623

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Date Sent:	Apr 26, 2021	Number of Pages:	11
Description:	Dr. Komberg Doctor's First Report (Form 5021) & RFA 4/16/2021		

Sent By: Angela Del Real

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