

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

Check the box(es) 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 Form PR-3 or PR-4.

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

**Patient:**

<u>Lugo</u>	<u>Martin</u>			
Patient last name:	Patient first name:	CA.	92627	MI
<u>PO Box 12512</u>	<u>Costa Mesa</u>	<u>State</u>	<u>Zip Code</u>	<u>Male</u>
Patient's street address/PO Box	Patient City	State	Zip Code	Sex
<u>Medical Courier</u>	<u>(949) 609-9888</u>	Date of Birth	<u>7/30/1964</u>	
Occupation	Phone Number			
	<b>Claims Administrator</b>	Date of Injury	<u>1/1/19-4/5/20;3/23/21;</u>	

**PLEASE PROVIDE**

<u>Claims Administrator Name</u>	<u>Claim Number</u>		
<u>Claims Administrator Street Address</u>	<u>Claims Administrator City</u>	<u>State</u>	<u>Zip Code</u>
	<u>Westpac Labs Inc</u>		
<u>Phone Number</u>	<u>Fax Number</u>	<u>Employer Name</u>	<u>Phone Number</u>

The information below must be provided. You may use this form or you may substitute or append a narrative report.

**Subjective Complaints:**

See attached

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

See attached

**Diagnosis:**

- |  |                                  |
|--|----------------------------------|
| 1. <u>Cervical disc protrusion</u>         | ICD-10 <u>M50.20</u>             |
| 2. <u>Cervical radiculopathy</u>           | ICD-10 <u>M54.12</u>             |
| 3. <u>Lumbar musculoligamentous injury</u> | ICD-10 <u>S33.5XXA, S39.012A</u> |
| 4. <u>Lumbar disc protrusion</u>           | ICD-10 <u>M51.26</u>             |
| 5. <u>Lumbar radiculitis</u>               | ICD-10 <u>R54.16</u>             |
| 6. <u>Shoulder sprain / strain</u>         | ICD-10 <u>S43.409A, S46.919A</u> |
| 7. <u>Shoulder sprain / strain</u>         | ICD-10 <u>S43.409A, S46.919A</u> |
| 8. <u>Hip sprain / strain</u>              | ICD-10 <u>S73.109A</u>           |
| 9. <u>Hip sprain / strain</u>              | ICD-10 <u>S73.109A</u>           |
| 10. _____                                  | ICD-10 _____                     |

11. \_\_\_\_\_ ICD-10 \_\_\_\_\_  
 12. \_\_\_\_\_ ICD-10 \_\_\_\_\_

**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?)


Acupuncture treatment, Kinetic Activities 2-3 times a week for 6 weeks.  
 Refer to spinal Ortho & hip ortho.  
 MRIs of cervical spine, left shoulder, and right shoulder, right hip. (third request)  
 Follow up 4-6 weeks

**Work Status:** This patient has been instructed to:

- Remain off-work until 6 weeks
- Return to *modified* work on \_\_\_\_\_ with following limitations or restrictions  
 (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

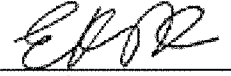
Per FCE, Pending FCE, if able to provide light duty, please contact this office.  
 Work to pain tolerance, working for different employer.

- Return to full duty on \_\_\_\_\_ with no limitations or restrictions.

Physician Signature:  Cal. Lic. # DC 33387  
 Name: Gerald Ferencz DC Specialty: Chiropractic

**Primary Treating Physician:** (original signature, do not stamp) Date of exam: 7-16-2021

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.

Physician Signature:  Cal. Lic. # DC 16128  
 Executed at: La Palma, CA. Date (mm/dd/yyyy) 7-16-2021  
 Physician Name: Edward Komberg, DC Specialty: Chiropractor  
 Physician Address: 7951 Valley View Phone: (714) 994-1131

**PRIVACY NOTICE:** A statement of current data collection and use policies and certain privacy rights of injured workers may be found at the following website: [http://www.dir.ca.gov/od\\_pub/privacy.html](http://www.dir.ca.gov/od_pub/privacy.html)

Lugo, Martin

1/1/19-4/5/20;3/23/21;

**Subjective: (Continued)**

He complains of constant 5-6/10 neck pain. The patient, Mr. Lugo, complains of constant 8/10 low back pain. He presents today with complaint of constant 4-5/10 left shoulder pain. Mr. Lugo presents today complaining of constant 4-5/10 right shoulder pain with numbness and tingling. He presents today complaining of constant 6-7/10 left hip pain. Mr. Lugo presents no pain of right hip pain.

Patient states he is having numbness into bilateral legs when standing for 20-30 minutes.

**Objective: (Continued)**

Height: 6'2", Weight: 235 pounds, B.P.: 114/70, Pulse: 70 bpm, right-hand dominant. **Cervical:** The cervical ranges of motion are decreased and painful (Flexion 35/50, Extension 30/60, Left Lateral Flexion 20/45, Right Lateral Flexion 25/45, Left Rotation 50/80, Right Rotation 65/80). There is +3 tenderness to palpation of the cervical paravertebral muscles. There is muscle spasm of the cervical paravertebral muscles and bilateral trapezii. Cervical Compression causes pain. Shoulder Depression causes pain. **Lumbar:** The lumbar ranges of motion are decreased and painful (Flexion 40/60, Extension 5/25, Left Lateral Flexion 15/25, Right Lateral Flexion 10/25). There is +3 tenderness to palpation of the lumbar paravertebral muscles. There is muscle spasm of the lumbar paravertebral muscles and bilateral quadratus lumborum. Kemp's causes pain. Straight Leg Raise causes pain on the left. **Left Shoulder:** The left shoulder ranges of motion are decreased and painful (Flexion 150/180, Extension 50/50, Abduction 140/180, Adduction 40/50, Internal Rotation 90/90, External Rotation 90/90). There is muscle spasm of the trapezius and posterior shoulder. Neer's Impingement causes pain. Speed's causes pain. **Right Shoulder:** The right shoulder ranges of motion are decreased and painful (Flexion 150/180, Extension 50/50, Abduction 140/180, Adduction 40/50, Internal Rotation 80/90, External Rotation 90/90). There is muscle spasm of the trapezius and posterior shoulder. Neer's Impingement causes pain. Supraspinatus Press causes pain. **Left Hip:** The left hip ranges of motion are decreased and painful (Flexion 70/100, Extension 0/0, Internal ROTation 15/20, External Rotattion 25/30, Abduction 20/25, Adduction 10/15). There is muscle spasm of the posterior hip and lateral hip. Ober's causes pain. Patrick's or FABERE causes pain. **Right Hip:** The right hip ranges of motion are decreased and painful (Flexion 80/100, Extension 0/0, Internal ROTation 15/20, External Rotattion 20/30, Abduction 20/25, Adduction 15/15). There is muscle spasm of the posterior hip. Ober's is negative. Patrick's or FABERE is negative.

**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.

<input checked="" type="checkbox"/> New Request <input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health. <input type="checkbox"/> Check box if request is a written confirmation of a prior oral request.	<input type="checkbox"/> Resubmission - Change in Material Facts
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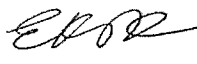
Employee Information	
Name (Last, First, Middle): Lugo, Martin	
Date of Injury (MM/DD/YYYY): 1/1/19-4/5/20; 3/23/21;	Date of Birth (MM/DD/YYYY): 7/30/1964
Claim Number:	Employer: Westpac Labs Inc

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]	Acupuncture 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]	Refer to spinal Ortho and hip Ortho		
Lumbar disc protrusion	[M51.26]	Follow up		4-6 weeks

Requesting Physician Signature: 	Date: 7-16-2021
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Claims Administrator/Utilization Review Organization (URO) Response		
<input type="checkbox"/> Approved <input type="checkbox"/> Denied or Modified (See separate decision letter) <input type="checkbox"/> Delay (See separate notification of delay) <input type="checkbox"/> Requested treatment has been previously denied <input type="checkbox"/> Liability for treatment is disputed (See separate letter)		
Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

**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:	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:	Jul 27, 2021	Number of Pages:	5
Description:	Dr Ferencz Progress Report(PR2) & RFA 7/16/21		

Sent By: Jinna Juarez

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

# Send Result Report



MFP

TASKalfa 5003i

Firmware Version 2VK\_S000.002.232 2021.04.21

RFU9Y03440  
07/27/2021 17:13  
[2VK\_1000.001.402] [2ND\_1100.001.007]

Job No.: 085781

Total Time: 0°01'40"

Page: 005

## Complete

Document: doc08578120210727165422

**Tri-City Health Group  
7951 Valley View  
La Palma, CA 90623**

**Tel: 714 994-1131**

**Fax: 714 994-4415**

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No.	Date/Time	Destination	Times	Type	Result	Resolution/ECM
001	07/27/21 17:10	13106269632	0°01'40"	FAX	OK	200x100 Normal/On