

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:	MI	
<u>PO Box 12512</u>	<u>Costa Mesa</u>	<u>CA.</u>	<u>92627</u>
Patient's street address/PO Box	Patient City	State	Zip Code
<u>Medical Courier</u>	<u>(949) 609-9888</u>	Date of Birth	<u>7/30/1964</u>
Occupation	Phone Number		

Claims Administrator Date of Injury 1/1/19-4/5/20;3/23/21;

PLEASE PROVIDE

<u>Claims Administrator Name</u>	<u>Claim Number</u>
<u>Claims Administrator Street Address</u>	<u>Claims Administrator City</u>
<u>Phone Number</u>	<u>State</u>
<u>Fax Number</u>	<u>Zip Code</u>
<u>Westpac Labs Inc</u>	<u>Employer Name</u>
<u>Phone Number</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 2-3 times a week for 6 weeks.
 Follow up with Dr. Mays.
 Pending MRI studies.
 Follow up 4-6 weeks.

Work Status: This patient has been instructed to:


Remain off-work until 10/1/21

Return to *modified* work on _____ with 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.

Physician Signature:  _____ Cal. Lic. # DC 28971
 Name: Patrick Kim DC Specialty: Chiropractic

Primary Treating Physician: (original signature, do not stamp) Date of exam: 8/17/2021
 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) 8/17/2021
 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.htm

Lugo, Martin

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

Subjective: (Continued)

The patient, Mr. Lugo, presents today with complaint of constant 5-6/10 neck pain, stiffness, and tingling. Mr. Lugo has complaint of constant severe 7/10 dull, achy low back pain and stiffness. Numbness of the leg with prolonged standing. Difficulty with prolonged sitting. He is complaining of intermittent 4-5/10 achy left shoulder pain. He complains of constant 5-6/10 achy, burning right shoulder pain, numbness, tingling, and weakness radiating to hand. He goes with numbness and tingling. He presents today with complaint of constant 5-6/10 dull, achy, sharp, stabbing left hip pain. Wake patient up at night. The patient, Mr. Lugo, presents today complaining of occasional 2-3/10 achy right hip pain.

Objective: (Continued)

Height: 6'2", Weight: 340 pounds, Temp.: 97.4° F, B.P.: 139/98, Pulse: 77 bpm, right-hand dominant. Limping noted. The patient is using a cane for hip and low back support. **Cervical:** The cervical ranges of motion are painful. There is no bruising, swelling, atrophy, or lesion present at the cervical spine. There is +3 tenderness to palpation of the cervical paravertebral muscles bilaterally. There is muscle spasm of the cervical paravertebral muscles and bilateral trapezius. Shoulder Depression causes pain right, radiating pain when bend to left. **Lumbar:** The lumbar ranges of motion are painful. There is no bruising, swelling, atrophy, or lesion present at the lumbar spine. There is +3 tenderness to palpation of the lumbar paravertebral muscles and bilateral SI joints. There is muscle spasm of the lumbar paravertebral muscles. Kemp's causes pain. **Left Shoulder:** The left shoulder ranges of motion are painful. There is no bruising, swelling, atrophy, or lesion present at the left shoulder. There is +3 tenderness to palpation of the trapezius, anterior shoulder, and posterior shoulder. There is muscle spasm of the trapezius. Yergason causes pain. Neer's Impingement causes pain. **Right Shoulder:** The right shoulder ranges of motion are painful. There is no bruising, swelling, atrophy, or lesion present at the right shoulder. There is +3 tenderness to palpation of the trapezius, anterior shoulder, and posterior shoulder. There is muscle spasm of the trapezius. Yergason causes pain. Neer's Impingement causes pain and mild tingling. **Left Hip:** The left hip ranges of motion are within normal limits. There is no bruising, swelling, atrophy, or lesion present at the left hip. There is +3 tenderness to palpation of the posterior hip and lateral hip. **Right Hip:** The right hip ranges of motion are within normal limits. There is no bruising, swelling, atrophy, or lesion present at the right hip. There is +3 tenderness to palpation of the lateral hip.

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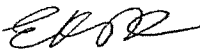
Employee Information	
Name (Last, First, Middle): Lugo, Martin	
Date of Injury (MM/DD/YYYY): 1/1/19-4/5/20;3/23/21;	Date of Birth (MM/DD/YYYY): 7/30/1964
Claim Number:	Employer: Westpac Labs Inc

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: 1629278935
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: 8-17-2021
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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:	

Send Result Report



MFP

TASKalfa 5003i

Firmware Version 2VK_S000.001.322 2019.09.24

RFU9Y03466
08/25/2021 09:08
[2VK_1000.001.201] [2ND_1100.001.007]

Job No.: 134137

Total Time: 0°02'45"

Page: 005

Complete

Document: doc13413720210825085221

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:	Aug 25, 2021	Number of Pages:	5
Description:	Dr. Komberg Progress Report (PR-2) & RFA 8/17/2021		

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	08/25/21 09:05	13106269632	0°02'45"	FAX	OK	200x100 Normal/Off

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

Tel: 714 994-1131

Fax: 714 994-4415

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