State of California
Division of Workers' Compensation

Additional pages attached ☒

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:

Lugo	Martin		
Patient last name:	Patient first name:		MI
PO Box 12512	Costa Mesa	CA. 92627	Male
Patient's street address/PO Box	Patient City	State Zip Code	Sex
Medical Courier	(949) 609-9888	Date of Birth 7/30/1964	
Occupation	Phone Number		

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

PLEASE PROVIDE

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

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.	Cervical disc protrusion	ICD-10	M50.20
2.	Cervical radiculopathy	ICD-10	M54.12
3.	Lumbar musculoligamentous injury	ICD-10	S33.5XXA, S39.012A
4.	Lumbar disc protrusion	ICD-10	M51.26
5.	Lumbar radiculitis	ICD-10	R54.16
6.	Shoulder sprain / strain	ICD-10	S43.409A, S46.919A
7.	AC Joint sprain / strain	ICD-10	S43.50XA
8.	Shoulder sprain / strain	ICD-10	S43.409A, S46.919A
9.	Hip sprain / strain	ICD-10	S73.109A
10.	Hip sprain / strain	ICD-10	S73.109A

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?

Follow up 4-6 weeks
Pending MRI left hip.

Work Status: This patient has been instructed to:

☒ Remain off-work until 10/29/21

☐ 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 32616
Name: Sepideh Tarameshloopoor, DC Specialty: Chiropractic

Primary Treating Physician: (original signature, do not stamp) Date of exam: 9/15/2021

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*) 9/15/2021
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

Subjective: (Continued)
He presents today complaining of constant moderate 5-6/10 achy neck pain, stiffness, tingling, and cramping pain when moving to the left side. He presents today with complaint of constant moderate 7/10 dull, achy low back pain, stiffness, and tingling. He is complaining of frequent mild 3/10 left shoulder pain. The patient, Mr. Lugo, has complaint of frequent moderate 4/10 right shoulder pain, numbness, and tingling. He is complaining of constant moderate 6/10 left hip pain. He is complaining of intermittent mild 2/10 right hip pain.

Objective: (Continued)
Height: 6'2", Weight: 340 pounds, Temp.: 97.4° F, B.P.: 159/94, Pulse: 70 bpm, right-hand dominant. Dermatome sensation is intact and equal bilaterally in both the upper and lower extremities. **Cervical:** The cervical ranges of motion are decreased. There is no bruising, swelling, atrophy, or lesion present at the cervical spine. There is +3 tenderness to palpation of the cervical paravertebral musclesbilateral trapezii. There is muscle spasm of the cervical paravertebral muscles and bilateral trapezii. Cervical Compression causes pain. Cervical Distraction causes pain. **Lumbar:** The lumbar ranges of motion are decreased. 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 and bilateral gluteus. Kemp's causes pain on the left radiation. Seated Straight Leg Raise causes pain on the left radiation. **Left Shoulder:** The left shoulder ranges of motion are decreased. 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, anterior shoulder, and posterior shoulder. Speed's causes pain. Apley's Scratch causes pain. **Right Shoulder:** The right shoulder ranges of motion are decreased. 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, anterior shoulder, and posterior shoulder. Speed's causes pain. Apley's Scratch causes pain. **Left Hip:** The left hip ranges of motion are decreased. There is no bruising, swelling, atrophy, or lesion present at the left hip. There is +3 tenderness to palpation of the anterior hip, posterior hip, and lateral hip. There is muscle spasm of the anterior hip, posterior hip, and lateral hip. Patrick's or FABERE causes pain. **Right Hip:** The right hip ranges of motion are decreased. There is +3 tenderness to palpation of the anterior hip, posterior hip, and lateral hip. There is muscle spasm of the anterior hip, posterior hip, and lateral hip. Patrick's or FABERE causes pain.

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: 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]			
Rule out cervical disc	[M50.20]			
Lumbar musculoligamentous injury	[S33.5XXA, S39.012A]	Follow up		4-6 weeks
Lumbar disc protrusion	[M51.26]			

Requesting Physician Signature: Ed Komberg Date: 9-15-2021

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:		

Send Result Report

MFP

TASKalfa 5003i

Firmware Version 2VK_S000.002.314 2021.07.19

RFU9Y03466
09/27/2021 15:50
[2VK_1000.002.001] [2ND_1100.001.007]

Job No.: 139381 Total Time: 0°02'39" Page: 005

Complete

Document: doc13938120210927153303

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

Tel: 714 994-1131 Fax: 714 994-4415

MEDICAL FACSIMILE COVER SHEET

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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:	Sep 27, 2021	Number of Pages:	5
Description:	Dr. Komberg Progress Report (PR-2) & RFA 9/15/2021		

Sent By: Angela D.

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	09/27/21 15:43	13106269632	0°02'39"	FAX	OK	200x100 Normal/On

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

Tel: 714 994-1131 **Fax: 714 994-4415**

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