Matthew Longacre, M.D.
FELLOW, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Law Offices of Workers Defenders Law Group
751 S. Weir Canyon Rd., Suite 157-455
Anaheim, CA 92808
Attn: Natalia Foley, Attorney at Law

Law Offices of Fellman & Associates
5777 W. Century Blvd., Suite 1195
Los Angeles, CA 90045
Attn: Jill E'Lynn M. Roderick, Attorney at Law

Sedgwick
P.O. Box 14450
Lexington, KY 40512
Attn: Marsha Matthews, Claims Examiner

RE:	KHAMENIA, ALENA
DOI:	CT: March 6, 2022- January 15, 2023; CT: July 16, 2022- January 2, 2023
SSN:	XXX-XX-9857
DOB:	February 18, 1981
Claim #:	4A2302G36RJ-0001; 4A2302G37SS-0001
WCAB#:	ADJ17287529, ADJ17287564
Panel #:	7569160
Employer:	Macy's Inc. dba Bloomingdale's, Inc.
Occupation:	Sales Associate

PANEL QUALIFIED MEDICAL-LEGAL SUPPLEMENTAL REPORT:
REVIEW OF ADDITIONAL RECORDS
SEPTEMBER 1, 2023

EVALUATION HISTORY:

Panel Qualified Medical Evaluation	June 2, 2023
Supplemental to Panel Qualified Medical Evaluation	**September 1, 2023**

This supplemental report meets the ML203-95 criteria.

SCHEDULING: (818) 855-2470
P.O. Box 261548, Encino, CA 91426
FAX: (818) 855-2471

REVIEW OF RECENTLY SUBMITTED DIAGNOSTICS AS FOLLOWS:

I have received 4 pages of medical records from ProHealth Imaging. I have reviewed all of the pages actually received and my opinion is based upon all such received records.

The following is a summary of records.

7/10/23 RAMIN AKHAVAN, M.D. PROHEALTH IMAGING. MRI OF LUMBAR W/O CONTRAST. Impression: L4-5: Disc dessication 4-5 mm disc bulge with mild to moderate ligamentum flavum hypertrophy contribute to moderate spinal canal stenosis and mild bilateral neural foraminal stenosis. L5-S1: disc dessication 3-4 mm disc bulge contributes to minimal bilateral foraminal stenosis.

7/10/23 RAMIN AKHAVAN, M.D. PROHEALTH IMAGING. MRI OF LEFT SHOULDER W/O CONTRAST. Impression: no significant internal derangement.

DIAGNOSES

1. LUMBAR STRAIN WITH POSSIBLE LEFT S1 RADICULOPATHY.
2. LEFT SHOULDER IMPINGEMENT SYNDROME WITH BURSITIS.
3. LEFT WRIST STRAIN.
4. STRESS AND ANXIETY.
5. RASH.
6. MRI OF LUMBAR W/O CONTRAST DATED 7/10/23 REVEALED: L4-5: DISC DESSICATION 4-5 MM DISC BULGE WITH MILD TO MODERATE LIGAMENTUM FLAVUM HYPERTROPHY CONTRIBUTE TO MODERATE SPINAL CANAL STENOSIS AND MILD BILATERAL NEURAL FORAMINAL STENOSIS. L5-S1: DISC DESSICATION 3-4 MM DISC BULGE CONTRIBUTES TO MINIMAL BILATERAL FORAMINAL STENOSIS.
7. MRI OF LEFT SHOULDER W/O CONTRAST DATED 7/10/23 REVEALED: NO SIGNIFICANT INTERNAL DERANGEMENT.

DISCUSSION

The patient was previously evaluated on 6/2/23 for a panel QME. After my examination, it was felt that the patient had not reached MMI and further treatment was recommended. MRI scans were ordered for further evaluation.

I have now reviewed the MRI and have incorporated the findings into my diagnoses. After review of the MRI, my opinions and recommendations outlined in my 6/2/23 report remains unchanged.

SUMMARY OF CONCLUSIONS

CAUSATION:

Body Part	CT 3/6/22-1/15/23
Lumbar	Defer to trier of fact.
Left shoulder	Defer to trier of fact.
Left wrist	Defer to trier of fact.

TEMPORARY DISABILITY PERIOD:

TEMPORARY DISABILITY PERIOD	
TTD	NONE

PERMANENT & STATIONARY STATUS:

MAXIMUM MEDICAL IMPROVEMENT	
Body part	MMI date
ALL	DEFERRED

DISCLOSURE:

This report is for Medical-Legal Assessment only and is not to be construed as a complete physical examination for general health purposes. Only those symptoms which I believe to have been involved in the injury, or might relate to the injury, have been assessed in detail.

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 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.

I further declare that I have not violated any of the provisions of California Labor Code Sections 139.3 or 139.2 with regard to the evaluation of this applicant or the preparation of this report.

I further declare under penalty of perjury that there has been no violation of California Labor Code Section 139.32(d)(2), in that I have not offered, delivered, received or accepted any rebate, refunds, commission, preference, patronage, dividend, discount or other consideration whether in the form of money, or otherwise as compensation or inducement for any referred examination or evaluation.

I further declare under penalty of perjury that the total number of pages of records reviewed by me as part of the medical legal evaluation and preparation of the report was 4 pages.

This declaration is being signed on 09/01/2023, in the county of Los Angeles.

Sincerely Yours,

Matthew Longacre, M.D.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
LONGACRE MED-LEGAL, APC

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☑ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.
PO BOX 261548

Requester's name and address (optional)

6 City, state, and ZIP code
ENCINO, CA. 91426

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

8	2	–	3	2	9	0	5	4	9

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here Signature of U.S. person ▶ _____ Date ▶ 7-25-22

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

State of California

DIVISION OF WORKERS' COMPENSATION - MEDICAL UNIT

AME or OME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

Case Name : ALENA KHAMENIA v MACY'S INC. DBA BLOOMINGDALES, INC.
(Employee name) *(Claims administrator name, or if none employer)*

Claim No. : 4A2302G36RJ-0001 EAMS or WCAB Case No. *(if any)*: ADJ17287529

I, **PATSY ZUNIGA**, declare:
(Print Name)

1. I am over the age of 18 and not a party to this action.

2. My business address is: **P.O. Box 261548 Encino, CA 91426**

3. On the date shown below, I served the attached original, or a true and correct copy of the original, comprehensive medical-legal report, HCFA 1500 and W-9 Form on each person or firm named below, by placing them in a sealed envelope, addressed to the person or firm named below, and by:

A	Depositing the sealed envelope with the U. S. Postal Service with the postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the U. S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: *(For each addressee, enter A - E as appropriate)*	Date Served:	Addressee and Address Shown on Envelope:
A	**09/05/23**	**Please See Attached Service List**

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: **09/05/23**

(signature of declarant)

PATSY ZUNIGA
(print name)

Service List

Case Name: ALENA KHAMENIA v MACY'S INC. DBA BLOOMINGDALES, INC.
(Employee name) *(Claims administrator name, or if none employer)*

Claim No.: 4A2302G36RJ-0001 **EAMS or WCAB Case No. (*If any*):** ADJ17287529

SEDGWICK\4
P.O. BOX 14450
LEXINGTON, KY 40512

NATALIA FOLEY
751 S. WEIR CANYON RD., SUITE 157-455
ANAHEIM, CA 92808

JILL E'LYNN M. RODERICK
5777 W. CENTURY BLVD., SUITE 1195
LOS ANGELES, CA 90045

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

SEDGWICK
MARSHA MATTTHEWS
P.O. BOX 14450
LEXINGTON KY 40512

PICA W P01

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK (ID#)	OTHER X (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 592959857

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): KHAMENIA, ALENA	3. PATIENT'S BIRTH DATE: MM 02 DD 18 YY 1981 SEX: M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): MACY'S INC DBA BLOOMINGDALES,
5. PATIENT'S ADDRESS (No., Street): 18444 COLLINS ST 3	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street):
CITY: TARZANA STATE: CA	8. RESERVED FOR NUCC USE	CITY: STATE:
ZIP CODE: 91356 TELEPHONE (Include Area Code): (562) 8416455		ZIP CODE: TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: 4A2302G36RJ0001
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) YES [X] NO [ ]	a. INSURED'S DATE OF BIRTH MM 02 DD 18 YY 1981 SEX M [ ] F [X]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):	b. OTHER CLAIM ID (Designated by NUCC): Y4|4A2302G36RJ-0001
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME:
d. INSURANCE PLAN NAME OR PROGRAM NAME:	10d. CLAIM CODES (Designated by NUCC):	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 9a, and

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE 09/05/23

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below
SIGNED Signature on File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM 01 DD 15 YY 2023 QUAL	15. OTHER DATE MM DD YY QUAL	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN MATTHEW LONGACRE MD	17a. [ ] 17b. NPI: 1750608303	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY
19. ADDITIONAL CLAIM INFORMATION(Designated by NUCC)		20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line: A S33.5XXA B M75.42 C S63.502A D [ ] E [ ] F [ ] G [ ] H [ ] I [ ] J [ ] K [ ] L [ ]	ICD Ind. 0	22. RESUBMISSION CODE: ORIGINAL REF. NO.: 23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
QME SUPPLEMENTAL REPORT											
1 09 01 23	09 01 23	11		ML203	95	ABC	650 00	1		ZZ	207X00000X
										NPI	1750608303
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 650 00	29. AMOUNT PAID $ 0 00	30. Rsvd for NUCC Use
823290549 [ ] [X]	A48276				

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH. # (818) 8552470
MATTHEW LONGACRE MD	LONGACRE MEDLEGAL, APC 16530 VENTURA BLVD, SUITE 100 ENCINO CA 91436	LONGACRE MEDLEGAL APC PO BOX 261548 ENCINO CA 914261548
SIGNED DATE 09/05/23	a. 1750608303 b.	a. 1750608303 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR

APPROVED OMB 0938-1197 FORM 1500 (02-12)