

ERIC E. GOFNUNG CHIROPRACTIC CORP.
QME OF THE STATE OF CALIFORNIA
SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION
6221 Wilshire Boulevard, Suite 604 • Los Angeles, CA 90048 • Tel: (323) 933-2444 • Fax: (323) 933-2909

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am a resident of the County aforesaid; and I am over the age of eighteen years and not a party to the within action: my business address is 6221 Wilshire Boulevard, Suite 604 Los Angeles, CA 90048.

On 1 day of December 2020, I served the within concerning:

Patient's Name: Chaney, Anisa

Claim Number: 2080381794

On the interested parties in said action, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid in Los Angeles, California, to be hand delivered Via United States Mail.

- | | |
|---|--|
| <input type="checkbox"/> MPN Request | <input type="checkbox"/> QME Appointment Notification |
| <input type="checkbox"/> Notice of Treating Physician | <input type="checkbox"/> Designation Of Primary Treating Physician |
| <input type="checkbox"/> Medical Report _____ | <input type="checkbox"/> Initial Comprehensive Report |
| <input type="checkbox"/> Itemized - (Billing) / HFCA <u>11/16/2020</u> | <input checked="" type="checkbox"/> Re-Evaluation Report / Progress Report (PR-2) |
| <input type="checkbox"/> Doctor's First Report | <input type="checkbox"/> Med Legal Report |
| <input checked="" type="checkbox"/> RFA | <input type="checkbox"/> Permanent & Stationary |
| <input type="checkbox"/> Financial Disclosure | <input type="checkbox"/> Authorization Request for Evaluation/Treatment <u>11/16/2020</u> |

List all parties to whom documents were mailed to:

cc: Workers Defenders Law Group
8018 E Santa Ana Cyn Ste 100-215
Anaheim Hills, CA 92808

Zurich
PO Box 968005
Schaumburg, IL 60196

AIG
PO Box 25977
Shawnee Mission, KS 66225

I declare under penalty and perjury under the laws of the State of California, that the foregoing is true and correct, and that this Declaration was executed at Los Angeles, California on 14 day of December 2020.



Ilse Ponce

Re: Patient: CHANEY, Anisa
DOI: 07/06/2019 – 07/05/2020
Date of Exam: November 16, 2020

The history of injury as related by the patient, the physical examination findings, my conclusions and overall recommendations are as follows.

This authorization for treatment is made in compliance with Labor Code 4610 and 8 CCR 9792.6(o) and therefore serves as a written request for authorization for today's evaluation/consultation and treatment recommendations as described in this report. Please comply with Labor Code 4610, 8 CCR 9792.11 – 9792.15, 8 CCR 10112 – 10112.3 (formerly 8 CCR 10225 – 10225.2) and Labor Code 5814.6. Please comply with Sandhagen v. State Compensation Insurance Fund (2008) 44 Cal. 4 ch 230. Please comply with Jesus Cervantes v. El Aguila Food Products, Inc. and Ciga, et al., WCAB en banc, 7-0, November 19, 2009. Be aware that Labor Code 4610(b) requires the defendant to conduct utilization review on any and all requests for treatment. Furthermore, Labor Code 4610 Utilization Review deadlines are mandatory. It is the defendant's duty to forward all consultation and treatment authorization requests to utilization review. Be aware the defendant and insurance company has five working days to authorize, delay, modify or deny a request for all treatment, but 10 days for spinal surgery. Please issue timely payment for medical care and treatment rendered in order to avoid payment of interests and penalties, per labor codes referenced. Failure of the defendant or insurance company to respond in writing within five working days results in an authorization by default. Furthermore, failure to pay for "self-procured" medical care when utilization deadlines are missed triggers penalties for the defendant or the insurance company due to violation of 8 CCR 10225 – 10225.2 and Labor Code 5814/5814.6 and 4603.2b. When there is a dispute with regard to treatment, the right to proceed with the Labor Code 4062 process belongs exclusively to the injured employee. If the treatment recommendations are not authorized by the insurance carrier, this report and bill should be kept together by the Workers' Compensation carrier for the review company. The claims examiner should forward this report to the defense attorney and nurse case manager.

Interim History:

Ms. Cheney is feeling some improvement with treatment she is undergoing while under our care. She denies any new accidents or injuries. however, she remains symptomatic.

Current Complaints:

1. Neck pain best described as intermittent and slight to moderate, occasionally becoming moderate with prolonged posturing.
2. Bilateral shoulder pain, frequent and slight to moderate, worse on the left. On the right occasional and slight, on the left frequent and moderate.
3. Bilateral wrist and hand pain, worse on the left. On the right intermittent and slight and on the left frequent and moderate, associated with numbness and tingling in both hands.

Re: Patient: CHANEY, Anisa
DOI: 07/06/2019 – 07/05/2020
Date of Exam: November 16, 2020

| <i>Shoulder Ranges Of Motion Testing</i> | | | |
|--|--------|-------------|--------------|
| Movement | Normal | Left Actual | Right Actual |
| Flexion | 180 | 165 | 180 |
| Extension | 50 | 45 | 50 |
| Abduction | 180 | 165 | 180 |
| Adduction | 50 | 45 | 50 |
| Internal Rotation | 90 | 55 | 90 |
| External Rotation | 90 | 45 | 90 |

Elbows & Forearms:

Examination revealed tenderness to palpation at left elbow medial epicondyle and left forearm extensor muscle group.

Valgus Stress Test is positive at the left elbow.

Ranges of motion for the elbows were within normal limits with pain at the left elbow.

Wrists & Hands:

Examination revealed tenderness to palpation at left carpals, distal ulna, distal radius, TFCC. Tenderness at left thenar region.

Tinel's sign is positive at the left. Finkelstein's and Phalen's test were positive at the left.

Ranges of motion for both wrists were within normal limits with pain at the left.

Finger:

Examination of the fingers revealed digital painful ranges of motion of digits one and five on the left hand. Tenderness at the left thumb was noted during palpation.

Ranges of motion for the fingers were within normal limits with pain at the left first and fifth digits.

Grip Strength Testing:

Grip strength testing was performed utilizing the Jamar Dynamometer at the third notch, measured in kilograms, on 3 attempts and produced the following results:

Left: 12/12/12
Right: 30/28/28

Re: Patient: CHANEY, Anisa
 DOI: 07/06/2019 - 07/05/2020
 Date of Exam: November 16, 2020

| <i>Lumbar Spine Range of Motion Testing</i> | | |
|---|--------|--------|
| Movement | Normal | Actual |
| Flexion | 60 | 45 |
| Extension | 25 | 12 |
| Right Lateral Bending | 25 | 15 |
| Left Lateral Bending | 25 | 18 |

Knees & Lower Legs:

Examination revealed tenderness to palpation at left knee medial joint line.

Tenderness to palpation was noted at left lower leg musculature, including gastrocnemius and peroneal musculature.

McMurray's test was positive at the left knee.

Pain and weakness at the left knee during the squat.

Range of motion for the knees decreased with pain on the left, measured as follows.

| <i>Knee Range of Motion Testing</i> | | | |
|-------------------------------------|--------|-------------|--------------|
| Movement | Normal | Left Actual | Right Actual |
| Flexion | 135 | 110 | 125 |
| Extension | 0 | 0 | 0 |

Ankles & Feet:

Examination revealed tenderness to palpation at left talus, calcaneus, talonavicular joint, anterior talofibular ligament, Achilles tendon and tibialis posterior tendons.

Anterior drawer test was positive on the left.

Ranges of motion for the ankles, right normal and left decreased and painful, measured as follows.

| <i>Ankle Range of Motion Testing</i> | | | |
|---|--------|-------------|--------------|
| Movement | Normal | Left Actual | Right Actual |
| Metatarsophalangeal joint (MPJ) Extension | 60 | 60 | 60 |
| MPJ Flexion | 20 | 20 | 20 |
| Ankle Dorsiflexion | 20 | 20 | 15 |
| Ankle Plantar Flexion | 50 | 50 | 30 |
| Inversion (Subtalar joint) | 35 | 35 | 20 |

Re: Patient: CHANEY, Anisa
DOI: 07/06/2019 – 07/05/2020
Date of Exam: November 16, 2020

21. Anxiety and depression, sleeping difficulty, F41.9, F34.1.

Discussion and Recommendations:

The patient is recommended to continue with comprehensive treatment course consisting of chiropractic manipulations and adjunctive multimodality physiotherapy to include myofascial release, hydrocollator, infrared, cryotherapy, electrical stimulation, ultrasound, strengthening, range of motion (active / passive) joint mobilization, home program instruction, therapeutic exercise, intersegmental spine traction and all other appropriate physiotherapeutic modalities **for cervical, thoracic and lumbar spine, left shoulder, left elbow, left wrist and hand, left knee and lower leg, left ankle and foot at once per week for four weeks with a followup in four weeks.**

The patient is **recommended to proceed with x-rays for cervical, thoracic and lumbar spine, left shoulder, left elbow, left wrist, left knee and left ankle.**

Permanent and Stationary Status:

The patient's condition is not permanent and stationary.

Work Status/Disability Status:

No lifting in excess of 15 pounds. No repeated work with left arm above shoulder height. No repeated bending or twisting. No repeated or forceful grasping, torquing, pulling, and pushing with left hands. No repeated squatting, kneeling, or climbing. If modified duty as indicated is not provided, then the patient is considered temporarily totally disabled until reevaluation in four weeks.

Disclosure:

I derived the above opinions from the oral history as related by the patient, revealed by the available medical records, diagnostic testing, credibility of the patient, examination findings and my clinical experience. This evaluation was carried out at 6221 Wilshire Boulevard, Suite 604, Los Angeles, California 90048. I prepared this report, including any and all impressions and conclusions described in the discussion.

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628)(b): "I declare that Dr. Kravchenko examined the patient and may have assisted with initial preparation and assembly of components of this report, and I, Dr. Gofnung, the primary treating physician, have reviewed the report, edited the document, reviewed the final draft and I am in agreement with the findings, including any and all impressions and conclusions as described in the this report."

I performed the physical examination, reviewed the document and reached a conclusion, of this report which was transcribed by Acu Trans Solution I.L.C and I proofread and edited the final draft prior to signing the report in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (J) of Section 139.2.

Re: Patient: CHANEY, Anisa
DOI: 07/06/2019 – 07/05/2020
Date of Exam: November 16, 2020

Sincerely,

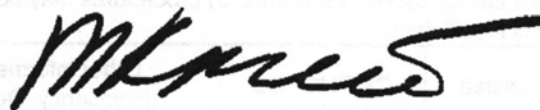


Eric E. Gofnung, D.C.
Manipulation Under Anesthesia Certified
State Appointed Qualified Medical Evaluator
Certified Industrial Injury Evaluator

Signed this 17 day of November, 2020, in Los Angeles, California.

EEG:svl

Sincerely,



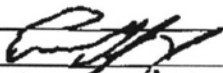
Mayya Kravchenko, D.C., QME
State Appointed Qualified Medical Evaluator
Certified Industrial Injury Evaluator

Signed this 24 day of November, 2020, in Los Angeles, California.

MK:svl

**State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA**

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

| <input checked="" type="checkbox"/> New Request | | <input type="checkbox"/> Resubmission – Change in Material Facts | | |
|--|-----------------------|--|---------------------------|---|
| <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. | | | | |
| Employee Information | | | | |
| Name (Last, First, Middle): Chaney, Anisa | | | | |
| Date of Injury (MM/DD/YYYY): 07/05/2020 | | Date of Birth (MM/DD/YYYY): 09/06/1973 | | |
| Claim Number: 2080381794 | | Employer: Sunbridge Hallmark Health Services DBA Playa De | | |
| Requesting Physician Information | | | | |
| Name: Eric Gofnung, DC | | | | |
| Practice Name: Eric Gofnung Chiro Corp. | | Contact Name: Ilse Ponce | | |
| Address: 6221 Wilshire Blvd Suite 604 | | City: Los Angeles | State: CA | |
| Zip Code: 90048 | Phone: (323) 933-2444 | Fax Number: (323) 903-0301 | | |
| Specialty: Chiropractor | | NPI Number: 1821137134 | | |
| E-mail Address: ilse.ponce@att.net | | | | |
| Claims Administrator Information | | | | |
| Company Name: Zurich | | Contact Name: | | |
| Address: PO Box 968005 | | City: Schaumburg | State: IL | |
| Zip Code: | Phone: (800) 338-3160 | Fax Number: (818) 227-1740 | | |
| 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 Code (If known) | Other Information: (Frequency, Duration Quantity, etc.) |
| Carpal Tunnel | G56.02 | Electrical Stimulation | G0283 | 1 x a week for 4 weeks |
| Internal Derangement | M23.92 | Therapeutic Exercises | 97110 | |
| Tenosynovitis Lt Ankle | M65.872 | Massage Therapy | 97124 | |
| | | CMT 5 regions | 98942 | |
| | | Extraspinal Manipulation w/spinal | 98943 | |
| Requesting Physician Signature:  | | Date: 11/16/2020 | | |
| 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: | | | | |

STATE OF ALABAMA
DEPARTMENT OF REVENUE
OFFICE OF THE COMMISSIONER

Notice is hereby given that the following information was received from the Department of Revenue of the State of Alabama for the year ending December 31, 1964.

The following information was received from the Department of Revenue of the State of Alabama for the year ending December 31, 1964:

The following information was received from the Department of Revenue of the State of Alabama for the year ending December 31, 1964:

| NAME | ADDRESS | CITY | STATE | ZIP |
|------|---------|------|-------|-----|
| ... | ... | ... | ... | ... |


The following information was received from the Department of Revenue of the State of Alabama for the year ending December 31, 1964:

| NAME | ADDRESS | CITY | STATE | ZIP |
|------|---------|------|-------|-----|
| ... | ... | ... | ... | ... |

The following information was received from the Department of Revenue of the State of Alabama for the year ending December 31, 1964:

State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

| <input checked="" type="checkbox"/> New Request | | <input type="checkbox"/> Resubmission – Change in Material Facts | | |
|--|-----------------------|--|---------------------------|---|
| <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. | | | | |
| Employee Information | | | | |
| Name (Last, First, Middle): Chancy, Anisa | | | | |
| Date of Injury (MM/DD/YYYY): 07/05/2020 | | Date of Birth (MM/DD/YYYY): 09/06/1973 | | |
| Claim Number: 2080381794 | | Employer: Sunbridge Hallmark Health Services DBA Playa De | | |
| Requesting Physician Information | | | | |
| Name: Eric Gofnung, DC | | | | |
| Practice Name: Eric Gofnung Chiro Corp. | | Contact Name: Ilse Ponce | | |
| Address: 6221 Wilshire Blvd Suite 604 | | City: Los Angeles | State: CA | |
| Zip Code: 90048 | Phone: (323) 933-2444 | Fax Number: (323) 903-0301 | | |
| Specialty: Chiropractor | | NPI Number: 1821137134 | | |
| E-mail Address: ilse.ponce@att.net | | | | |
| Claims Administrator Information | | | | |
| Company Name: Zurich | | Contact Name: | | |
| Address: PO Box 968005 | | City: Schaumburg | State: IL | |
| Zip Code: | Phone: (800) 338-3160 | Fax Number: (818) 227-1740 | | |
| 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 Code (If known) | Other Information: (Frequency, Duration Quantity, etc.) |
| Sacroiliac Joint Sprain | S33.6XXD | Electrical Stimulation | G0283 | 1 x a week for 4 weeks |
| Cervical Facet | M53.82 | Therapeutic Exercises | 97110 | |
| Thoracic Facet | M41.34 | Massage Therapy | 97124 | |
| Shoulder Tenosynovitis | M65.812 | CMT 5 regions | 98942 | |
| Elbow Medial Epicondylitis | M77.02 | Extraspinal Manipulation w/spinal | 98943 | |
| Requesting Physician Signature:  | | Date: 11/16/2020 | | |
| 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: | | | | |

Re: Patient: CHANEY, Anisa
DOI: 07/06/2019 – 07/05/2020
Date of Exam: November 16, 2020

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628(J)): "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 I have indicated I have 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."

In compliance with recent Workers' Compensation legislation (Labor Code Section 5703 under AB 1300): "I have not violated Labor Code Section 139.3 and the contents of this report are true and correct to the best of my knowledge. This statement is made under penalty of perjury and is consistent with WCAB Rule 10978."

The undersigned further declares that the charges for this patient are in excess of the RVS and the OMF'S codes due to high office and staff costs incurred to treat this patient, that the charges are the same for all patients of this office, and that they are reasonable and necessary in the circumstances. Additionally, a medical practice providing treatment to injured workers experiences extraordinary expenses in the form of mandated paperwork and collection expenses, including the necessity of appearances before the Workers' Compensation Appeals Board. This office does not accept the Official Medical Fee Schedule as prima facie evidence to support the reasonableness of charges. I am a board-certified Doctor of Chiropractic, a state-appointed Qualified Medical Evaluator, a Certified Industrial Injury Evaluator and certified in manipulation under anesthesia. Based on the level of services provided and overhead expenses for services contained within my geographical area, I bill in accordance with the provisions set forth in Labor Code Section 5307.1.

NOTE: The carrier/employer is requested to immediately comply with 8 CCR Section 9784 by overnight delivery service to minimize duplication of testing/treatment. This office considers "all medical information relating to the claim" to include all information that either has, will, or could reasonably be provided to a medical practitioner for elicitation of medical or medical-legal opinion as to the extent and compensability of injury, including any issues regarding AOE/COI - to include, but not be limited to, all treating, evaluation, and testing reports, notes, documents, all sub rosa films, tapes, videos, reports; employer-level investigation documentation including statements of individuals; prior injury documentation; etc. This is a continuing and ongoing request to immediately comply with 8 CCR Section 9784 by overnight delivery service should such information become available at any time in the future. Obviously, time is of the essence in providing evaluation and treatment. Delay in providing information can only result in an unnecessary increase of treatment and testing costs to the employer.

I will assume the accuracy of any self-report of the examinee's employment activities, until and unless a formal Job Analysis or Description is provided. Should there be any concern as to the accuracy of the said employment information, please provide a Job Analysis/Description as soon as possible.

I request to be added to the Address List for Service of all Notices of Conferences, Mandatory Settlement Conferences and Hearings before the Workers' Compensation Appeals Board. I am advising the Workers' Compensation Appeals Board that I may not appear at hearings or Mandatory settlement Conferences for the case in chief. Therefore, in accordance with Procedures set forth in Policy and Procedural Manual Index No. 6.610, effective February 1, 1995, I request that defendants, with full authority to resolve my lien, telephone my office and ask to speak with me.

~~The above report is for medicolegal assessment and is not to be construed as a report on a complete physical examination for general health purposes. Only those symptoms which I believe have been involved in the injury, or might relate to the injury, have been assessed. Regarding the general health of the patient, the patient has been advised to continue under the care of and/or to get a physical examination for general purposes with a personal physician.~~

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Should you have any questions with regard to this consultation please contact me at my office.

Re: Patient: CHANEY, Anisa
 DOI: 07/06/2019 – 07/05/2020
 Date of Exam: November 16, 2020

| | | | |
|---------------------------|----|----|----|
| Eversion (Subtalar joint) | 15 | 15 | 15 |
|---------------------------|----|----|----|

Diagnostic Impressions:

1. Cervical spine myofasciitis, M79.1.
2. Cervical facet-induced versus discogenic pain, M53.82.
3. Cervical radiculitis left, rule out, M54.12.
4. Thoracic spine myofasciitis, M79.1
5. Thoracic facet-induced versus discogenic pain, M54.6.
6. Lumbar spine myofasciitis, M79.1.
7. Left sacroiliac joint dysfunction, sprain/strain, M53.3.
8. Lumbar facet-induced versus discogenic pain, M46.1.
9. Lumbar radiculitis left, rule out M54.16
10. Left shoulder tenosynovitis/bursitis, M75.52.
11. Left shoulder impingement syndrome, rule out, M75.42.
12. Left elbow medial epicondylitis, M77.02.
13. Left brachioradialis tendinitis, M75.22.
14. Left wrist tenosynovitis, M65.849.
15. Left carpal tunnel syndrome, rule out, G56.02.
16. Triangular fibrocartilage complex tear, left, rule out S63.592A.
17. Knee internal derangement, left, rule out, M23.92.
18. Tenosynovitis of left lower leg, M65.869.
19. Tenosynovitis of left ankle and foot, M65.872.
20. Left Achilles tendinitis, M76.62.

Re: Patient: CHANEY, Anisa
DOI: 07/06/2019 – 07/05/2020
Date of Exam: November 16, 2020

Motor Testing of the Cervical Spine and Upper Extremities:

Deltoid left 4/5; wrist extensor left 4/5; finger flexor, finger abduction and wrist flexor 4/5 on the left; triceps left 4/5. All other myotomes 5/5.

Sensory Testing:

Dysesthesia at left C6-C7 dermatomal levels, dysesthesia in left hand medial nerve distribution.

Thoracic Spine:

Examination revealed tenderness to palpation with myospasm of left parathoracic and left trapezius musculature. Tenderness and hypomobility were noted at T1 through T8 vertebral regions.

Kemp's test is positive on the left.

Ranges of motion for thoracic spine were decreased and painful, measured as follows.

| <i>Thoracic Spine Range of Motion Testing</i> | | |
|---|--------|--------|
| Movement | Normal | Actual |
| Flexion | 45 | 40 |
| Extension | 0 | 0 |
| Right Rotation | 30 | 15 |
| Left Rotation | 30 | 20 |

Lumbosacral Spine:

Examination revealed tenderness to palpation with muscle guarding of bilateral paralumbar musculature. Tenderness at left sacroiliac joint. Tenderness and hypomobility at L3 through L5 vertebral regions.

Milgram's test is positive. Sacroiliac joint compression test is positive on the left.

Straight Leg Raising Test (supine) elicited increased low back pain with increased radiculopathy to left lower extremity:

Right: 50 degrees.

Left: 40 degrees.

Ranges of motion for the lumbar spine were decreased and painful, measured as follows.

Re: Patient: CHANEY, Anisa
DOI: 07/06/2019 – 07/05/2020
Date of Exam: November 16, 2020

4. Lower back pain frequent and moderate, worse with prolonged weight bearing, forward bending, lifting, pushing or pulling.
5. Left knee pain, intermittent to frequent and moderate, associated with occasional swelling and giving way.
6. Bilateral ankle and foot pain, intermittent and slight to moderate.

Physical Evaluation (November 16, 2020) – Positive Findings:

Cervical Spine:

Examination revealed tenderness to palpation with muscle guarding of bilateral paracervical and left upper trapezius musculature. Tenderness and hypomobility were noted at C3 through C7 vertebral regions.

Shoulder depression test is positive on the left.

Ranges of motion for the cervical spine were decreased and painful, measured as follows.

| <i>Cervical Spine Range of Motion Testing</i> | | |
|---|--------|--------|
| Movement | Normal | Actual |
| Flexion | 50 | 40 |
| Extension | 60 | 25 |
| Right Lateral Flexion | 45 | 30 |
| Left Lateral Flexion | 45 | 35 |
| Right Rotation | 80 | 50 |
| Left Rotation | 80 | 60 |

Shoulders & Upper Arms:

Examination revealed antalgic position of the left shoulder.

Tenderness to palpation with myospasm of left supraspinatus, infraspinatus, and periscapular musculature.

Hawkins test was positive at the left shoulder.

Ranges of motion for the shoulders, right normal, left decreased and painful, measured as follows.

ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

6221 Wilshire Boulevard, Suite 604, Los Angeles, California 90048 | Tel. (323) 933-2444 | Fax (323) 933-2909

November 16, 2020

Workers Defenders Law Group
8018 E. Santa Ana Canyon, Suite 100-215
Anaheim Hills, California 92808

Re: Patient: Chaney, Anisa
SSN: 000-00-0000
EMP: Sunbridge Hallmark Health Serv. DBA: Playa Del Rey Ctr
INS: American Zurich Insurance Company
Claim #: 2080381794
WCAB #: ADJ13521436
DOI: 07/06/2019 - 07/05/2020
D.O.E./Consultation: November 16, 2020

**Primary Treating Physician's
Followup Evaluation Report
And Request for Authorization**

| | |
|--------------------------|--------|
| Time Spent Face to face: | |
| 99354/99355 | 0 Unit |

| Time spent for prolonged non face-to-face | | Total 99358 Units (first 31 to 60 minutes per day = 1 unit) | Total 99359 Units (61+ minutes, 30 minute increments = 1 unit, not to exceed 60 minutes (total 120 or 2 units) per day) |
|---|---------|---|---|
| Records Review | 00 Mins | | |
| Report Preparation | 15 Mins | | |
| | | 1 units | 0 units |

Dear Gentlepersons:

The above-named patient was seen for a Primary Treating Physician's Followup Evaluation on November 16, 2020, in my office located at 6221 Wilshire Boulevard, Suite 604, Los Angeles, California 90048. The following information contained in this report is derived from a review of the available medical records, as well as the oral history as presented by the patient. **My associate, Dr. Kravchenko, examined the patient and I, Dr. Gofnung, the primary treating physician, agree with Dr. Kravchenko's physical examination findings and conclusions.**