ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

12626 Riverside Drive, Suite 510 • North Hollywood, California 91607 • Tel. (818)623-9633 • Fax (818) 623-9533

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am a citizen of the United States. I am over the age of 18 years and not a party of the above-entitled action; my business address is 6221 Wilshire Blvd, Suite 605 Los Angeles, CA 90048. I am familiar with a Company's practice where the mail, after being placed in a designated area, is given the appropriate postage and is deposited in a U. S. mailbox in the City of Los Angeles, after the close of the day's business. On **April 6, 2021**, I served the within following letter / forms on all parties in this action by placing a true copy thereof enclosed in a sealed envelope in the designated area for out-going mail addressed as set forth above or electronically on the specified parties with email addresses as identified. I declare under the penalty of perjury that the foregoing is true and correct under the laws of the State of California and that this declaration was executed at 6221 Wilshire Blvd, Suite 605 Los Angeles, CA 90048.

On 6 day of **April,** 2021, I served the within concerning:

Patient's Name: **CHANEY, ANISA**
Claim Number: 2080381794

- ☐ MPN Notice
- ☐ Designation of Primary Treating Physician & Authorization for Release of Medical Records
- ☐ Financial Disclosure
- ☐ Request for Authorization –
- ☒ Itemized – (Billing) / HFCA – 3/12/2021
- ☐ QME Appointment Notification
- ☐ Primary Treating Physician's Referral
- ☐ Initial Consultation Report –
- ☒ Re-Evaluation Report / Progress Report (PR-2) 3/12/2021
- ☐ Permanent & Stationary Evaluation Report – _____
- ☐ Post P&S Follow Up - _____
- ☐ Review of Records - _____
- ☐ PQME / Med Legal Report - _____
- ☐ Computerized Dynamic Range of Motion (Rom) And Functional Evaluation Report - _____

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

AIG
PO Box 25977
Shawnee Mission, KS 66225

Zurich
PO Box 968005
Schaumburg, IL 60196

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 6 day of April, 2021.

ILSE PONCE

ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

6221 Wilshire Boulevard, Suite 604/Los Angeles, California90048/ Tel. (323) 933-2444 / Fax (323) 933-2909

March 12, 2021

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

Re:	Patient:	Chaney, Anisa
	SSN:	561-39-6450
	EMP:	Sunbridge Hallmark Health Serv. DBA: Playa Del Rey Ctr
	INS:	American Zurich Insurance Company
	Claim #:	2080381794
	WCAB #:	ADJ13521436
	DOI:	CT: 07/06/2019 – 07/05/2020
	D.O.E./Consultation:	March 12, 2021

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	**Exceeded 30 Mins**		
		1 units	0 units

Dear Gentlepersons:

The above-named patient was seen for a Primary Treating Physician's Followup Evaluation on March 12, 2021, 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. **Dr. Gofnung is the PTP and the patient was examined by Dr. Gofnung.** The patient was examined with the aid of a chaperone by name Antonietta Schultz.

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

Re: Patient: CHANEY, Anisa
DOI: CT: 07/06/2019 – 07/05/2020
Date of Exam: March 12, 2021

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:

The patient report she is not working. She denies any new accidents or injuries. She reports she is under the care of internal medicine doctor, Dr. Daldalyan. She did not attend acupuncture evaluation and that has been rescheduled. She has not undergone any x-ray or MRI studies as recommended by the undersigned until present. She reports she is claustrophobic and requests an open MRI. The patient was last seen in my office on February 15, 2021. The patient reports she has been exercising at home as instructed to tolerance. Please note, essentially the patient has not had any formal treatment for her orthopedic injuries for close to four weeks. Please note, the patient reports she developed right knee pain due to favoring the left knee. She complained of difficulty standing up from a seated position with spasming occurring of her lower leg musculature.

Current Complaints (March 12, 2021):

1. Neck pain, slight to moderate.
2. Left shoulder pain, slight.

3. Left elbow pain, slight to moderate.

4. Left wrist, hand and thumb pain, moderate.

5. Low back pain, moderate.

6. Left knee pain, minimal to slight.

7. Right knee pain with spasming.

8. Left ankle and foot pain, resolved.

9. Sleeping problems, anxiety, stress, headaches, and abdominal pain.

Physical Evaluation (March 12, 2021) – Positive Findings:

Cervical Spine:

Examination revealed tenderness to palpation 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.

Cervical Spine Range of Motion Testing		
Movement	Normal	Actual
Flexion	50	**45**
Extension	60	**50**
Right Lateral Bending	45	**45**
Left Lateral Bending	45	**40**
Right Rotation	80	**75**
Left Rotation	80	**70**

Shoulders & Upper Arms:

Left Shoulder:

Examination revealed tenderness to left supraspinatus.

Hawkins test was positive at the left shoulder.

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

Shoulder Ranges Of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	180	180	180
Extension	50	50	50
Abduction	180	**170**	180
Adduction	50	50	50
Internal Rotation	90	**85**	90
External Rotation	90	**80**	90

Elbows & Forearms:

Left Elbow:

Examination revealed tenderness over the left lateral epicondyle and left forearm extensor muscle group.

Left Cozen's test is positive today.

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

Wrists & Hands:

Left Wrist & Hand:

Tenderness was present over the left thumb over the first carpometacarpal joint and metacarpophalangeal joint.

Finkelstein's test was positive. Phalen's test on the left wrist is positive.

Ranges of motion of the left hand digits were within normal limits with tenderness at the left thumb at extremes of range of motion.

Grip Strength Testing:

Grip strength testing was not performed on today's visit; however, prior grip strength testing performed utilizing the Jamar Dynamometer at the third notch, measured in kilograms, on 3 attempts produced the following results:

Left: 30/32/32
Right: 24/30/28

Motor Testing of the Cervical Spine and Upper Extremities:

Left deltoid 4/5; all other myotomes appear to be within normal limits at 5/5.

Sensory Testing:

Sensory testing was not performed on today's visit; however, prior testing showed dysesthesia at left C6-C7 dermatomal levels, dysesthesia in left hand medial nerve distribution.

Thoracic Spine:

Examination revealed tenderness to palpation of left parathoracic and left trapezius musculature. Tenderness and hypomobility were noted at T4 through T7 vertebral regions.

Kemp's test is positive on the left.

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

Thoracic Spine Range of Motion Testing		
Movement	Normal	Actual
Flexion	60	**50**
Extension	0	**0**
Right Rotation	30	**30**
Left Rotation	30	**25**

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) was performed on today's visit and was positive for increased back discomfort.

Right: 70 degrees.
Left: 70 degrees.

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

Lumbar Spine Range of Motion Testing		
Movement	Normal	Actual
Flexion	60	**50**
Extension	25	**20**
Right Lateral Bending	25	**25**
Left Lateral Bending	25	**20**

Knees & Lower Legs:

Left Knee:

Tenderness to palpation was not present on today's visit of the left knee.

Tenderness was not present at left lower leg musculature today.

Murray's test was unremarkable.

Patient left knee did not hurt during the squatting.

Right Knee:

Examination revealed tenderness to palpation was noted at the medial joint line with pain and difficulty rising from squatting position.

Right knee McMurray's test elicited increased pain at the right knee.

Ranges of motion for the knees were within normal limits.

Ankles & Feet:

Left Ankle and Foot:

Examination did not reveal any tenderness to palpation at left ankle or foot on today's evaluation.

Anterior drawer test was unremarkable and did not elicit any increased pain.

Ranges of motion for the left ankle and foot were normal and pain-free.

Re: Patient: CHANEY, Anisa
DOI: CT: 07/06/2019 – 07/05/2020
Date of Exam: March 12, 2021

Diagnostic Impressions:

1. Thoracic spine myofasciitis, M79.1
2. Thoracic facet-induced versus discogenic pain, M54.6.
3. Lumbar spine myofasciitis, M79.1.
4. Left sacroiliac joint dysfunction, sprain/strain, M53.3.
5. Lumbar facet-induced versus discogenic pain, M46.1.
6. Lumbar radiculitis left, rule out M54.16
7. Left shoulder tenosynovitis/bursitis, M75.52.
8. Left shoulder impingement syndrome, rule out, M75.42.
9. Left elbow medial epicondylitis, M77.02.
10. Left brachioradialis tendinitis, M75.22.
11. Left wrist tenosynovitis, M65.849.
12. Left carpal tunnel syndrome, rule out, G56. 02.
13. Triangular fibrocartilage complex tear, left, rule out S63.592A.
14. Knee internal derangement, left, rule out, M23.92.
15. Right knee sprain, rule out internal derangement, S83.8X1A.
16. Tenosynovitis of left lower leg, M65.869.
17. Tenosynovitis of left ankle and foot, M65. 872.
18. Left Achilles tendinitis, M76.62.
19. Anxiety and depression, sleeping difficulty, F41.9, F34.1.
20. Abdominal pain, R10.9.

21. Flare-up secondary to no treatment for the last month as well as performance of activities of daily living as evidenced by physical examination.

Treatment Plan:

Please note that the patient's right knee appears to be the compensable consequence of left knee injury and therefore industrial in causation.

The patient is recommended treatment 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 wrist and thumb once a week for four weeks with a followup in four weeks.**

The patient is **recommended to proceed with acupuncture evaluation and treatment.**

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

The patient is **recommended MRI of the cervical spine, lumbar spine, and right knee.**

The patient is **recommended home exercises to include range of motion and stretching, McKenzie exercises, wall squats, core strengthening utilizing a gym ball as well as resistance band training to improve function and strength.**

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, torqueing, 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.

Re: Patient: CHANEY, Anisa
DOI: CT: 07/06/2019 – 07/05/2020
Date of Exam: March 12, 2021

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.

I performed the physical examination, reviewed the document and reached a conclusion, of this report which was transcribed by Acu Trans Solution LLC 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.

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 it's 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 OMFS 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/COE - 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 Manuel 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.

Re: Patient: CHANEY, Anisa
DOI: CT: 07/06/2019 – 07/05/2020
Date of Exam: March 12, 2021

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.

Sincerely,

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

Signed this 24 day of March, 2021, in Los Angeles, California.

EEG: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.

☐ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent 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): 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 E Gofnung			
Practice Name: Eric E. Gofnung Chiropractic Corp.		Contact Name:	
Address: 6221 Wilshire Blvd Suite 604		City: Los Angeles	State: CA
Zip Code: 90048	Phone: (323) 933-2444	Fax Number: (323) 933-2909	
Specialty: Chiropractor		NPI Number: 1821137134	
E-mail Address:			

Claims Administrator Information

Company Name: Zurich		Contact Name:	
Address: P.O.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, attach 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	M47.816	Massage Therapy	97124	
Shoulder Tenosynovitis	M65.812	CMT 5 regions	98942	
Elbow Medial Epicondylitl	M77.02	Extraspinal Manipulation w/spinal	98943	

Requesting Physician Signature: X Date: 03/12/2021

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:		

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.

☐ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent 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): Chaney, Anlsa	
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 E Gofnung			
Practice Name: Eric E. Gofnung Chiropractic Corp.		Contact Name:	
Address: 6221 Wilshire Blvd Suite 604		City: Los Angeles	State: CA
Zip Code: 90048	Phone: (323) 933-2444	Fax Number: (323) 933-2909	
Specialty: Chiropractor		NPI Number: 1821137134	
E-mail Address:			

Claims Administrator Information

Company Name: Zurich		Contact Name:	
Address: P.O.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.)
Wrist Tenosynovitis	M65.849	Electrical Stimulation	G0283	1 x a week for 4 weeks
Knee Internal Derangeme	M23.92	Therapeutic Exercises	97110	
Ankle/foot tenosynovitis	M65.872	Massage Therapy	97124	
Lumbar Facet	M46.1	CMT 5 regions	98942	
		Extraspinal Manipulation w/spinal	98943	

Requesting Physician Signature: X	Date: 03/12/2021

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:		