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

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 604 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 **July 16, 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 604 Los Angeles, CA 90048.

On **16** day of **July,** 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 – **6/23/2021**
- ☐ QME Appointment Notification
- ☐ Primary Treating Physician's Referral
- ☐ Initial Consultation Report –
- ☒ Re-Evaluation Report / Progress Report (PR-2) **6/23/2021**
- ☐ 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
5753 E. Santa Ana Canyon Rd Ste G No.616
Anaheim, CA 92807

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 **16** day of **July**, 2021.

ILSE PONCE

ERIC E. GOFNUNG CHIROPRACTIC CORP.
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June 23, 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:	June 23, 2021

Primary Treating Physician's Post Permanent and Stationary Followup Report

Time Spent Face to face:	**15 mins**
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	**10 Mins**		
		0 units	0 units

Dear Gentlepersons:

The above-named patient was seen for a Primary Treating Physician's Post Permanent and Stationary Followup on June 23, 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 Jossue Lucas.

Re: Patient: Chaney, Anisa
DOI: CT: 07/06/2019 – 07/05/2020
Date of Exam: June 23, 2021

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. This report serves as a written request for written authorization for today's evaluation/consultation and all additional appropriate treatment. This request is in compliance per AB 775 and with the mandates contained in Reg. 9792.6. Please pay within 60 days to avoid interest and penalties per Labor Code §§4603.2 and 5814.

My history and physical examination are as follows.

Interim History:

This patient was declared permanent and stationary by the undersigned on April 30, 2021. The patient reports she was seen by a neutral doctor, an AME or QME, in late April of 2021 as well. The patient explains that a little over two weeks ago her right knee condition worsened with no mechanism of injury and she on own went out and got a right knee brace as well as one-point walking cane which she uses and she has significant pain and difficulty at this time. The patient reports all other issues remain unchanged from when she was declared permanent and stationary by the undersigned.

Current Complaints (June 23, 2021):

1. Neck pain, slight to moderate.

2. Left shoulder pain, slight to moderate.

3. Left elbow pain, minimal.

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

5. Low back pain, moderate.

6. Left knee pain, minimal.

7. Right knee pain, frequent and moderate to severe.

8. Left ankle and foot pain, resolved.

9. Sleeping problems, anxiety, stress.

10. At this time the patient does not have abdominal pain.

Re: Patient: Chaney, Anisa
DOI: CT: 07/06/2019 – 07/05/2020
Date of Exam: June 23, 2021

Physical Evaluation (June 23, 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 restricted and painful.

Shoulders & Upper Arms:

Left Shoulder:

Examination revealed tenderness over the left supraspinatus near insertion as well as over the subacromial and subdeltoid bursa.

Hawkins test was positive at the left shoulder.

Bilateral shoulder ranges of motion were normal with pain in the left at extremes of ranges of motion.

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.

Ranges of motion of the bilateral wrists were within normal limits without pain.

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

Left: 20/20/20
Right: 25/20/20

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.

Thoracic Spine:

Examination revealed tenderness to palpation of left parathoracic and left trapezius musculature. Tenderness and hypomobility were noted at T4 through T6 vertebral regions.

Kemp's test is positive on the left.

Thoracic spine ranges of motion were decreased and painful.

Lumbosacral Spine:

Examination revealed tenderness to palpation 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.

Lumbar spine ranges of motion were decreased and painful.

Knees & Lower Legs:

Right Knee:

The patient presented today with a one-point walking cane as well as right knee brace with metal stays, which was pulled down during the exam revealing generalized swelling of the knee anteriorly. The patient had generalized tenderness with greatest amount of tenderness over the patella. The patient could not stand without the knee brace.

Orthopedic testing was not performed on today's visit.

Diagnostic Impressions:

1. Cervical spine myofasciitis, M79.1.

2. Cervical spine facet-induced versus discogenic pain, M53.82.

3. Thoracic spine myofasciitis, M79.1

4. Thoracic facet-induced versus discogenic pain, M54.6.

5. Lumbar spine myofasciitis, M79.1.

6. Left sacroiliac joint dysfunction, sprain/strain, M53.3.

7. Lumbar facet-induced versus discogenic pain, M46.1.

8. Lumbar radiculitis left, rule out M54.16

9. Left shoulder tenosynovitis/bursitis, M75.52.

10. Left shoulder impingement syndrome, rule out, M75.42.

11. Left elbow medial epicondylitis, resolving, M77.02.

12. Left brachioradialis tendinitis, resolving, M75.22.

13. Left wrist tenosynovitis, resolving, M65.849.

14. Left carpal tunnel syndrome, rule out, G56. 02.

15. Triangular fibrocartilage complex tear, left, rule out S63.592A.

16. Left knee pain, resolving.

17. Right knee sprain, rule out internal derangement, S83.8X1A.

18. Flare-up of right knee condition.

19. Tenosynovitis of left lower leg, resolved, M65.869.

20. Tenosynovitis of left ankle and foot, resolved, M65. 872.

21. Left Achilles tendinitis, resolved, M76.62.

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

23. Abdominal pain, resolved, R10.9.

Re: Patient: Chaney, Anisa
DOI: CT: 07/06/2019 – 07/05/2020
Date of Exam: June 23, 2021

Discussion and Treatment Recommendations:

The patient was declared permanent and stationary.

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 left shoulder.**

At this time, **the patient was recommended orthopedic consultation as soon as possible and the patient was recommended to seek help through outside Workers' Compensation system through an orthopedic surgeon for further workup of her right knee issues at this time while she is awaiting scheduling through the undersigned.**

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. The patient is encouraged to go to gym and perform strength training with light weight to tolerance to include free weights as well as machines as well as swimming and walking to tolerance to maintain her current level of condition in an effort to further improve.**

Permanent and Stationary Status:

The patient's condition is now permanent and stationary.

Work Status:

The patient was declared permanent and stationary on 04/30/2021 with the following work restrictions, which remain unchanged.

No lifting in excess of over 20 pounds and furthermore restricted to occasional basis. The patient should be able to sit and stand as needed based on pain levels. If the patient's abdominal pain returns, she should be seen by an internist for further work.

If modified duty as indicated is not provided, then the patient is considered temporarily totally disabled until reevaluation at next visit.

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.

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: CT: 07/06/2019 – 07/05/2020
Date of Exam: June 23, 2021

Sincerely,

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

Signed this 9 day of July, 2021, in Los Angeles, California.

EEG:

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; 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.)
Left shoulder tenosynoviti	M75.52	Left shoulder MRI		

Requesting Physician Signature: X | Date: 06/23/2021

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: