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

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 16 day of December, 2019, I served the within concerning:

Patient's Name: Garner, Annette
Claim Number: 1341863

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.

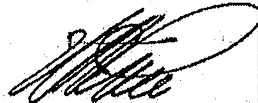
[✓] MPN Request
[ ] Notice of Treating Physician
[ ] Medical Report ___________
[ ] Itemized – (Billing) / HFCA 12/02/2019
[ ] Doctor's First Report
[✓] RFA
[✓] Financial Disclosure
[ ] QME Appointment Notification
[✓] Designation Of Primary Treating Physician
[✓] Initial Comprehensive Report
[ ] Re-Evaluation Report / Progress Report (PR-2)
[ ] Med Legal Report
[ ] Permanent & Stationary
[ ] Authorization Request for Evaluation/Treatment 12/02/2019

List all parties to whom documents were mailed to:

cc: Law Offices of Natalia Foley
8018 E. Santa Ana Cyn Ste 100-215
Anaheim Hills CA 92808

National Interstate
P.O. Box 521
Richfield OH 44288

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 December, 2019.



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December 02, 2019

Law offices Of Natalia Foley
8306 Wilshire Blvd., Suite 115
Beverly Hills, CA 90211

Re:	Patient:	Garner, Annette
	SSN:	561-25-6071
	EMP:	Mission School Transport, Inc.
	INS:	Pending
	Claim #:	Unassigned
	WCAB #:	ADJ12721676
	DOI:	CT: 01/01/2018-10/31/2019
	D.O.E./Consultation:	December 02, 2019

Primary Treating Physician's
Initial Evaluation Report
And Request for Authorization

Dear Gentlepersons:

The above-named patient was seen for a Primary Treating Physician's Initial Evaluation on December 02, 2019, 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.

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.

Job Description:

Ms. Annette Garner was employed by Mission School Transportation as a bus driver at the time of the injury. She began working for this employer on December 1, 1997. She worked full time.

Job activities included driving a bus, and pre-trip requiring lifting the hood requiring forceful pulling.

During the course of work, the patient was required to perform sitting, walking, standing, flexing, twisting, and side-bending and extending the neck, bending and twisting at the waist, squatting, climbing, crawling and kneeling.

The patient would use the bilateral upper extremities repetitively for simple grasping, power grasping, fine manipulation, keyboarding, writing, forceful pulling up to 15 pounds, reaching at shoulder level, reaching above shoulder level, and reaching below shoulder level. The patient was required to lift and carry objects while at work.

The patient worked nine hours per day and five days a week. Her work hours varied. Lunchtimes and rest breaks were to be taken during her four hours downtime. The job involved working 100% outdoors.

The last day the patient worked for Mission School Transportation was October 22, 2019, at which time she was placed on temporary disability by doctor. She was on disability from October 23, 2019, through December 2, 2019.

There was no concurrent employment at the time of the injury.

The patient denies working for any new employer.

Prior Work History:

The patient has worked for the above employer for 22 years.

History of Injury and Treatment as Presented by Patient:

Cumulative Trauma: 01/01/2018-10/31/2019

The patient states that while working at her usual and customary occupation as a bus driver for Mission School Transportation, she sustained a work-related injury to the neck, back, left shoulder/arm, left shoulder blade, left hip, left leg, feet and psyche, which she developed in the course of her employment due to continuous trauma dated from January 1, 2018, to October 31, 2019. She worked in a stressful environment, and as a result she experienced anxiety and difficulty sleeping. She attributes the injuries to the repetitive movements of gripping, grasping, and prolonged sitting while driving a bus doing city driving, as well as freeway driving. She used her hands and arms to turn the steering wheel repetitively. She used her left foot to brace and hold while driving on bumpy streets. She also used forceful pulling when lifting the hood of the bus to make daily inspections. She notes in order to avoid bouncing which increases her back pain while driving the bus she bounced in her seat constantly. In late-2018, the patient developed the onset of pain in her neck, upper back, left shoulder, and shoulder blade with radiating shooting pain into her mid-back. The patient also developed pain in her left hip, leg, and foot. The patient reported her pain to her manager as well as dispatch personnel. She took days off intermittently due to persistent pain and discomfort. The patients' complaints were minimized, and she was not offered medical care.

The patient sought medical care on her own. She presented to Kaiser for evaluation. She was taken off work for a few days and was prescribed medication for pain.

She continued working with pain and discomfort. She recalls she returned to Kaiser on two separate occasions when she had flare-ups.

Due to persistent pain the patient presented to another physician she cannot recall his name at this time. She was evaluated and prescribed medication for anxiety. She was taken off work from 10/25 to 11/25.

She returned to work, but due to increased pain and anxiety, she returned to the physician, who took her off work through November 25, 2019. She last treated with the private practice physician in October of 2019.

The patient returned to Kaiser Urgent Care due to severe upper back and left shoulder pain. The patient was evaluated by the physician on duty. A prescription for Tylenol was dispensed. She was taken off work through December 2, 2019.

The patient initially reported her injury to the employer in late 2018. After reporting the injury to the employer, the patient was not provided with an Employee Workers' Compensation Claim Form. She was not provided with medical attention. She is unaware if information regarding Medical Provider Networks and their rights were posted in her place of work. Upon being hired, they were not provided information relating to Medical Provider Networks and their rights if injured at work. Upon reporting their injury, they were not provided information relating to Medical Provider Networks and their rights if injured at work.

The patient presents to this office for further evaluation and treatment of her industrial injuries.

Current Complaints:

Neck:

The pain is moderate to severe, and the symptoms occur frequently. The pain is aggravated with flexing or extending the head and neck, turning her head from side to side, prolonged positioning of the head and neck, forward bending, pushing, pulling, lifting and carrying greater than 5-10 pounds, and working or reaching at or above shoulder level. There is radiating pain from the neck into her shoulders and her head, and she has been experiencing frequent headaches. She is experiencing burning sensations. The patent has difficulty falling asleep and is often awakened during the night by the neck pain. There is stiffness and restricted range of motion in the head and neck. Her pain level varies throughout the day. Pain medication provides her pain improvement, but she remains symptomatic.

Left Shoulder:

The pain is moderate to severe, and the symptoms occur frequently. The pain radiates to her arm and bicep. She experiences weakness and restricted range of motion for the shoulder as well as numbness and burning sensation in the shoulder and arm. She complains of stiffness and experiences increased pain with repetitive movement of the arm/shoulder, the pain is aggravated with backward, lateral, and overhead reaching, pushing, pulling, lifting and carrying greater than 3-5 pounds, and repetitive use of the left upper extremities. Her pain level varies throughout the day depending on activities. She is not able to sleep on the left shoulder due to the pain. She has difficulty falling asleep and awakens throughout the night due to the pain and discomfort.

Thoracic Spine:

The pain is moderate to severe, and the symptoms occur frequently in the upper and mid-back. The pain increases with twisting and turning at the waist, forward bending, pushing, pulling, and lifting and carrying. The pain radiates into her left shoulder blade and upper back and into her left shoulder and arm. She complains of tightness, in the mid back area.

Left Hip:

The pain is moderate to severe, and the symptoms occur frequently, in her left hip, at times becoming sharp, shooting, and burning pain. Her pain travels to her left leg into her left calf. She has a locking sensation in the hip. She has difficulty sleeping and awakens with pain and discomfort. Her pain level varies throughout the day depending on activities.

Feet:

The pain is moderate to severe, and the symptoms occur intermittently, in her feet, at times becoming pins and needle-like pain. The pain is dominant in the left foot. She has episodes of swelling, numbness and tingling in her feet. She has difficulty standing and walking for a prolonged period. Her pain worsens when she flexes/extends or rotates her feet. The patient walks with an uneven gait. Her pain level varies throughout the day depending on activities. She has difficulty sleeping and awakens with pain and discomfort. Pain medication provides her temporary relief.

Psyche:

The patient has continuous episodes of anxiety, stress, and depression due to chronic pain and disability status. She denies suicidal ideation.

The patient has difficulty sleeping, often obtaining a few hours of sleep at a time. She worries about her medical condition and the future.

The patient's condition has worsened due to continued work, lack of medical treatment, and activities of daily living.

PAST MEDICAL HISTORY:

Illnesses:

The patient denies any major medical illnesses.

Injuries:

Approximately seven years ago, while working for the same employer, the patient sustained an injury to her left upper back when she was punched by a co-worker. Medical care was rendered in the prescribed medication and physical therapy. The patient relates she made a full recovery.

The patient denied any non-work-related injuries.

The patient denied any new injuries.

Allergies:

The patient denied any known allergies.

Medications:

The patient is taking over-the-counter extra strength-Tylenol as needed for pain.

Surgeries:

Approximately 30 years ago, the patient underwent a gastric bypass.

Approximately 38 years ago, the patient underwent removal of bunion surgery to both feet.

Hospitalization:

The patient denied any hospitalization.

The patient was asymptomatic and without any disability or impairment prior to the continuous trauma injury from January 1, 2018, to October 13, 2019, as related to the neck, back, left shoulder/arm, left shoulder blade, left hip, left leg, feet, and psyche.

Review of Systems:

The review of systems is remarkable for trouble sleeping, muscle pain, stiffness, anxiety, depressed mood, social withdrawal, emotional problems, and stress.

Activities of Daily Living:

Physical Activities: As a result of the industrially-related injury, the patient states: Difficulty with standing, sitting, reclining, walking, and going up and downstairs, with a rating of 4/5.

Travel: As a result of the industrially-related injury, the patient states: Difficulty with riding in a car or bus, driving a car, and restful night sleep pattern, with a rating of 4/5.

Family History:

Mother is deceased and passed away from diabetes and pneumonia.

Father is deceased and passed away from a heart attack.

The patient has four brothers and two sisters. They are well and in good health.

There is no known history of colon cancer, prostate cancer, and breast cancer.

Social History:

Ms. Garner is married and has five adult children.

The patient completed high school.

The patient consumes no alcohol and does not smoke.

The patient does not exercise.

Physical Evaluation (December 02, 2019) – Positive Findings:

General Appearance:

The patient is a 60-year-old right-handed female who appeared to be reported age, and was well-developed, well-nourished, and well-proportioned. The patient appears to be alert, cooperative and oriented x3.

Vital Signs:

Pulse:	79
Blood Pressure:	125/75
Height:	218
Weight:	5'5"

Cervical Spine:

Examination of the cervical spine revealed tenderness to palpation with myospasm of the left paracervical and left upper trapezium musculature.

Tenderness and hypomobility were noted at C1 through C7 vertebral regions.

Shoulder depression test was positive on the left.

Ranges of motion for the cervical spine were decreased and painful with spasm, measured as follows:

Re: Patient: Garner, Annette
DOI: CT: 01/01/2018-10/31/2019
Date of Exam: December 02, 2019

Cervical Spine Ranges of Motion Testing		
Movement	Normal	Actual
Flexion	50	**30**
Extension	60	**20**
Right Lateral Flexion	45	**30**
Left Lateral Flexion	45	**35**
Right Rotation	80	**40**
Left Rotation	80	**45**

Shoulders & Upper Arms:

Exam revealed antalgic position of left shoulder, tenderness to palpation and myospasm at left supraspinatus and infraspinatus musculature, left subscapularis and periscapular musculature Tenderness at left subacromial bursa. Tenderness at left acromioclavicular joint.

Hawkins test was positive at the left shoulder.

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

Shoulder Ranges of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	180	**160**	180
Extension	50	**40**	50
Abduction	180	**150**	180
Adduction	50	**40**	50
Internal Rotation	90	**45**	90
Extension Rotation	90	**45**	90

Elbows & Forearms:

Deformity, dislocation, edema, swelling, erythema, scars and lacerations are not present upon visual examination of the elbow bilaterally.

Tenderness is not present over the lateral epicondyle, medial epicondyle and cubital tunnel bilaterally. Tenderness is not present over the flexor muscle group and extensor muscle group of the forearm bilaterally.

Ranges of motion of the elbows were within normal limits.

Elbow Ranges of Motion Testing

Re: Patient: Garner, Annette
DOI: CT: 01/01/2018-10/31/2019
Date of Exam: December 02, 2019

Movement	Normal	Left Actual	Right Actual
Flexion	140	140	140
Extension	0	0	0
Supination	80	80	80
Pronation	80	80	80

Wrists & Hands:

Examination revealed tenderness to palpation at left carpals and left thenar region.

Phalen's test was positive at the left wrist.

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

Wrist Ranges of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	60	60	60
Extension	60	60	60
Ulnar Deviation	30	30	30
Radial Deviation	20	20	20

Digital painful ranges of motion of the digits two through five on the left hand. Decreased ranges of motion of all digits on the left hand by 10% with pain.

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:

Right: 0/0/0.
Left: 0/0/0.

Motor Testing of The Cervical Spine and Upper Extremities:

Deltoid *(C5)*, Biceps *(C5)*, Triceps *(C7)*, Wrist Extensor *(C6)*, Wrist Flexor *(C7)*, Finger Flexor *(C8)* and Finger Abduction *(T1)* motor testing is normal and 5/5 bilaterally, **with the exception of deltoid left 4/5, wrist extensor left 4/5, finger flexor left 4/5, all other myotomes 5/5.**

Re: Patient: Garner, Annette
DOI: CT: 01/01/2018-10/31/2019
Date of Exam: December 02, 2019

Deep Tendon Reflex Testing of the Cervical Spine and Upper Extremities:

Biceps *(C5, C6)*, Brachioradial *(C5, C6)* and Triceps *(C6, C7)* deep tendon reflexes are normal and 2/2 bilaterally.

Sensory Testing:

C5 *(deltoid)*, C6 *(lateral forearm, thumb & index finger)*, C7 *(middle finger)*, C8 *(little finger & medial forearm)*, and T1 *(medial arm)* dermatomes are intact bilaterally as tested with a Whartenberg's pinwheel **with the exception of dysesthesia at left C6 dermatomal level, dysesthesia at left hand median nerve distribution.**

Upper Extremity Measurements in Centimeters		
Measurements	Left	Right
Biceps	**35**	**35.5**
Forearms	**25**	**25.5**

Thoracic Spine:

Examination revealed tenderness to palpation at bilateral parathoracic and trapezium musculature. Tenderness at left rhomboid musculature with myospasm noted.

Tenderness and hypomobility were noted at T1 through T6 vertebral regions.

Kemp's test was positive on the left.

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

Thoracic Spine Ranges of Motion Testing		
Movement	Normal	Actual
Flexion	60	**40**
Extension	0	**0**
Right Rotation	30	**12**
Left Rotation	30	**14**

Lumbar Spine:

Examination of the lumbar spine revealed tenderness to palpation at left paralumbar musculature.

Tenderness at L3 through L5 vertebral regions.

Re: Patient: Garner, Annette
DOI: CT: 01/01/2018-10/31/2019
Date of Exam: December 02, 2019

Sacroiliac joint compression test was positive on the left.

Straight Leg Raising Test (supine) elicited increased lower back pain.

Right: 45 degrees
Left: 40 degrees

Ranges of motion for the lumbar spine were decreased and painful with spasm, measured as follows:

Lumbar Spine Ranges of Motion Testing		
Movement	Normal	Actual
Flexion	60	**40**
Extension	25	**10**
Right Lateral Flexion	25	**18**
Left Lateral Flexion	25	**22**

Hips & Thighs:

Deformity, dislocation, edema, swelling, erythema, scars and lacerations are not present upon visual examination of the hips and thighs.

Tenderness and spasm is not present over the greater trochanteric region, hip bursa, hip abductor, hip adductor, quadriceps, biceps femoris musculature and femoroacetabular joint bilaterally.

Ranges of motion of the hips were within normal limits.

Hip Ranges Of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	120	120	120
Extension	30	30	30
Abduction	45	45	45
Adduction	30	30	30
External rotation	45	45	45
Internal rotation	45	45	45

Knees & Lower Legs:

Re: Patient: Garner, Annette
DOI: CT: 01/01/2018-10/31/2019
Date of Exam: December 02, 2019

Examination revealed tenderness to palpation at left infrapatellar tendon, left lateral joint line and left popliteal fossa. Tenderness and myospasm noted at left lower leg musculature.

McMurray's test was positive at the left knee. Valgus stress test was positive at left knee.

Ranges of motion of the knees, right normal, left decreased and painful. Pain and weakness at the left knee during the squat.

Knee Ranges Of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	135	**110**	135
Extension	0	0	0

Ankles & Feet:

Examination of ankles and feet revealed bilateral pes planus. Tenderness at left talonavicular joint and anterior talofibular ligament. Tenderness at left tibialis posterior tendons. Tenderness at left plantar fascia.

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

Ankle Ranges Of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Metatarsophalangeal joint (MPJ) Extension	60	60	60
MPJ Flexion	20	20	20
Ankle Dorsiflexion	20	**18**	20
Ankle Plantar Flexion	40	**30**	40
Inversion (Subtalar joint)	30	**20**	30
Eversion (Subtalar joint)	20	**18**	20

Motor, Gait& Coordination Testing of the Lumbar Spine and Lower Extremities:

Ankle Dorsiflexion *(L4)*, Great Toe Extension *(L5)*, Ankle Plantar Flexion *(L5/S1)*, Knee Extension *(L3, L4)*, Knee Flexion, Hip Abductor and Hip Adductor motor testing was normal and 5/5 **with the exception of knee extension left 4/5, all other myotomes 5/5.**

Squatting is positive for back pain and left knee pain. Heel and toe walking unable to perform due to left knee pain.

Re: Patient: Garner, Annette
DOI: CT: 01/01/2018-10/31/2019
Date of Exam: December 02, 2019

Antalgic gait favoring left lower extremity.

Deep Tendon Reflex Testing of the Lumbar Spine and Lower Extremities:

Ankle *(Achilles-S1)* and Knee *(Patellar Reflex-L4)* deep tendon reflexes are normal and 2/2.

Sensory Testing:

L3 *(anterior thigh)*, L4 *(medial leg, inner foot)*, L5 *(lateral leg and midfoot)* and S1 *(posterior leg and outer foot)* dermatomes are intact bilaterally upon testing with a pinwheel **with the exception of dysesthesia at left L4 and L5 dermatomal levels.**

Girth & Leg Length (Anterior Superior Iliac Spine to Medial Malleoli) measurements were taken of the lower extremities, as follows in centimeters:

Lower Extremity Measurements Circumferentially & Leg Length in Centimeters		
Measurements (in cm)	**Left**	**Right**
Thigh - *10 cm above patella with knee extended*	**60**	**60.5**
Calf - *at the thickest point*	**35.5**	**36**

Diagnostic Impressions:

1. Cervical spine myofasciitis, cervical facet-induced versus discogenic pain, cervical radiculitis, left, M79.1, M53.82, M54.12.
2. Thoracic spine myofasciitis, thoracic facet-induced versus discogenic pain, M79.1, S29.012A.
3. Lumbar myofasciitis, M79.1.
4. Left shoulder tenosynovitis/bursitis, M65.811
5. Left shoulder impingement syndrome, rule out, M75.42.
6. Left Carpal Tunnel Syndrome.
7. Patellar tendinitis, left, M76.52.

8. Internal derangement of the left knee, rule out M23.92.

9. Bilateral pes planus, M21.40.

10. Left plantar fasciitis, M72.2

11. Insomnia, anxiety and depression, G47.00, F41.8.

Discussion and Treatment Recommendations:

The patient is recommended a 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 hand and left knee at two times per week for four weeks with a follow up in four weeks**.

Treatment for the left ankle and foot is deferred to podiatrist.

The patient requires **x-rays of cervical and thoracic spine and left foot, MRI of cervical spine and left shoulder, NCV/EMG of upper extremities.**

The patient requires **psychiatric consultation with Dr. Musher**.

The patient requires **pain management consultation**.

Medical Causation Regarding AOE/COE:

In my opinion, it is within a reasonable degree of medical probability that the causation of this patient's neck, back, left upper extremity and left lower extremity injuries and resultant conditions, as well as need for treatment are industrially related and secondary to continuous trauma injuries from 01/01/2018 through 10/31/2019 while working for Mission School Transportation as a bus driver.

I concluded my opinion based on this patient's job description, history of injury as reported, medical records (if any provided), as well as the patient's complaints, my physical examination findings and diagnostic impressions, and absent evidence to the contrary.

Permanent and Stationary Status:

The patient's condition is not permanent and stationary at this time. She is in need of further treatment.

Work Status:

The patient is 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 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.

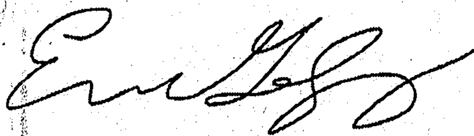
Time spent face-to-face 50 minutes and non face-to-face 20 minutes.

Re: Patient: Garner, Annette
DOI: CT: 01/01/2018-10/31/2019
Date of Exam: December 02, 2019

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 __11__ day of December, 2019, in Los Angeles, California.

EEG:

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

Signed this __11__ day of December, 2019, in Los Angeles, California.

MK:svl

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

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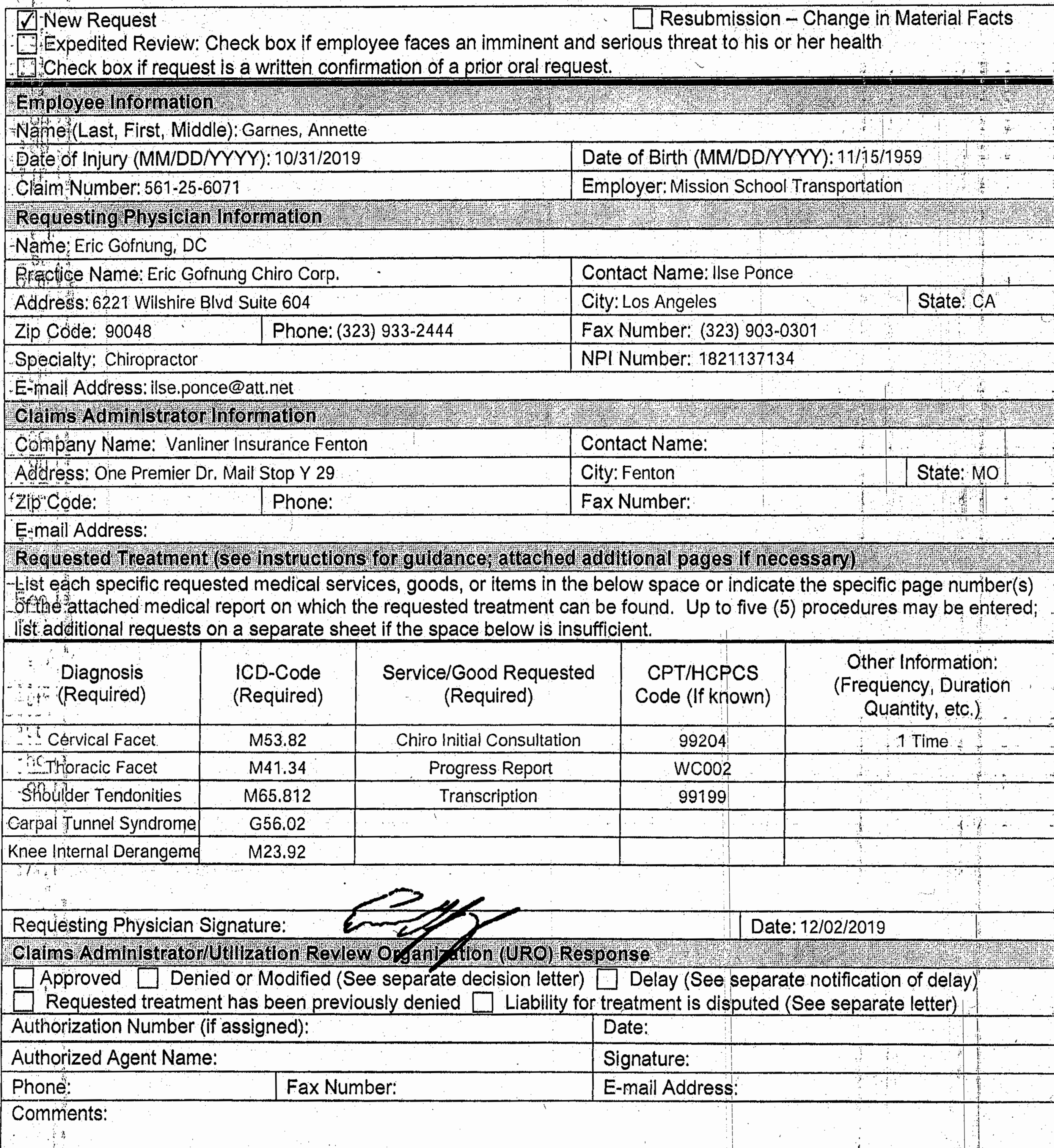

☑ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information

Name (Last, First, Middle): Garnes, Annette

Date of Injury (MM/DD/YYYY): 10/31/2019	Date of Birth (MM/DD/YYYY): 11/15/1959
Claim Number: 561-25-6071	Employer: Mission School Transportation

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: Vanliner Insurance Fenton		Contact Name:	
Address: One Premier Dr. Mail Stop Y 29		City: Fenton	State: MO
Zip Code:	Phone:	Fax Number:	

E-mail Address:

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Cervical Facet	M53.82	Chiro Initial Consultation	99204	1 Time
Thoracic Facet	M41.34	Progress Report	WC002	
Shoulder Tendonities	M65.812	Transcription	99199	
Carpal Tunnel Syndrome	G56.02			
Knee Internal Derangeme	M23.92			

Requesting Physician Signature: [signature] Date: 12/02/2019

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

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Claim Number: 561-25-6071	Employer: Mission School Transportation

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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: Vanliner Insurance Fenton		Contact Name:	
Address: One Premier Dr. Mail Stop Y 29		City: Fenton	State: MO
Zip Code:	Phone:	Fax Number:	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

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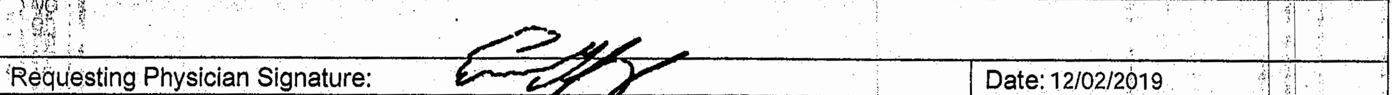
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Cervical Facet	M53.82	Electrical Stimulation	G0283	2 x a week for 4 weeks
Thoracic Facet	M41.34	Therapeutic Exercises	97110	
Shoulder Tendonities	M65.812	Massage Therapy	97124	
Carpal Tunnel Syndrome	G56.02	CMT 1-2 regions	98940	
Knee Internal Derangeme	M23.92	Extraspinal Manipulation w/spinal	98943	



Requesting Physician Signature: Date: 12/02/2019

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)

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Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:

Comments:

State of California, Division of Workers' Compensation

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Claim Number: 561-25-6071	Employer: Mission School Transportation

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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: Vanliner Insurance Fenton		Contact Name:	
Address: One Premier Dr. Mail Stop Y 29		City: Fenton	State: MO
Zip Code:	Phone:	Fax Number:	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

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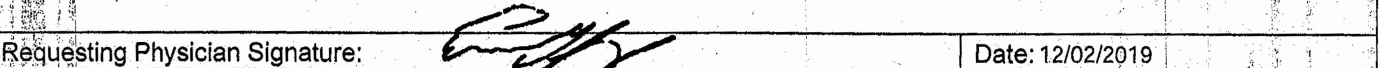
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Cervical Facet	M53.82	Pain Management		
Thoracic Facet	M41.34	consultation		
Shoulder Tendonities	M65.812			
Carpal Tunnel Syndrome	G56.02			
Knee Internal Derangeme	M23.92			

Requesting Physician Signature:  Date: 12/02/2019

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Specialty: Chiropractor		NPI Number: 1821137134	

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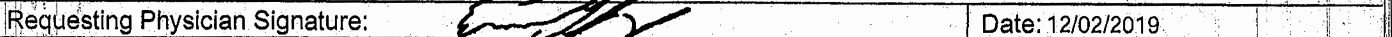
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Cervical Facet	M53.82	X-rays of		
Thoracic Facet	M41.34	cervical spine		
Shoulder Tendonities	M65.812	thoracic spine		
Carpal Tunnel Syndrome	G56.02	left foot		
Knee Internal Derangeme	M23.92			



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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: Vanliner Insurance Fenton	Contact Name:
Address: One Premier Dr. Mail Stop Y 29	City: Fenton State: MO
Zip Code: Phone:	Fax Number:
E-mail Address:	

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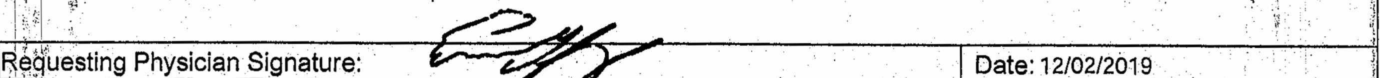
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Cervical Facet	M53.82	MRI of		
Thoracic Facet	M41.34	cervical spine		
Shoulder Tendonities	M65.812	left shoulder		
Carpal Tunnel Syndrome	G56.02			
Knee Internal Derangeme	M23.92			



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Employee Information

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Date of Injury (MM/DD/YYYY): 10/31/2019 | Date of Birth (MM/DD/YYYY): 11/15/1959

Claim Number: 561-25-6071 | Employer: Mission School Transportation

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Name: Eric Gofnung, DC

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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: Vanliner Insurance Fenton | Contact Name:

Address: One Premier Dr. Mail Stop Y 29 | City: Fenton | State: MO

Zip Code: | Phone: | Fax Number:

E-mail Address:

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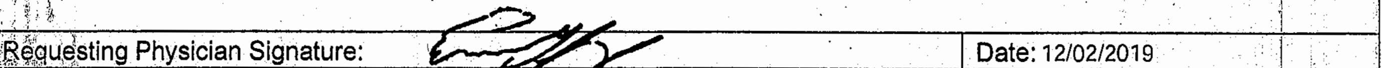
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Cervical Facet	M53.82	NCV/EMG of		
Thoracic Facet	M41.34	upper extremities		
Shoulder Tendonities	M65.812			
Carpal Tunnel Syndrome	G56.02			
Knee Internal Derangeme	M23.92			



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State of California, Division of Workers' Compensation

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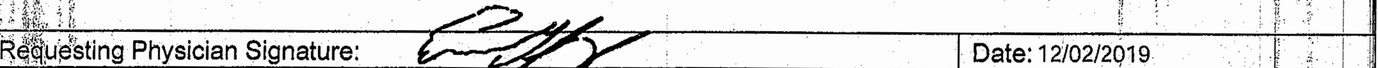
Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Anxiety	F41.9	Psychiatric Consultation		
		with Dr. Gennady Musher		



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Phone:	Fax Number:	E-mail Address:
Comments:		

ERIC E. GOFNUNG, D.C., QME

SPORTS MEDICINE AND REHABILITATION

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

Date: 12 / 2 / 2019

To Employer: Mission School Transportation Inc.

RE: Employee/ Injured worker: Annette Garner
SS# and/or Date of birth 561-25-6071 ; 11/15/1959
Date of Injury: CT: 01/01/2018 - 10/31/2019
Claim #:
WCAB #: ADJ 12721676
EAMS Case #:

The patient named above has designated: ☑ **Eric Gofnung, D.C.** ☐ **Mayya Kravchenko, D.C.** ☐ **Jyrki Suutari, D.C.** as their Primary Treating Physician. The patient is being scheduled to be seen in our office for evaluation and treatment of their industrially related injuries.

Please inform us if you have an established Medical Provider Network (MPN)? Please provide us with the following information so that we can inform and provide the injured worker with the proper information on how to select a treating physician from the employer's MPN.

Per Title 8 CCR 9767.5 an employer's MPN must have at least three (3) physicians in my area of specialty, of Chiropractic, to treat the injured worker. These three chiropractors must be within 30 minutes or 15 miles of a covered employee's residence or workplace.

Please list the names and phone numbers of these three (3) Chiropractors on the following lines:

________________________________, D.C.; (_______) _______-__________

________________________________, D.C.; (_______) _______-__________

________________________________, D.C.; (_______) _______-__________

If this list of three Chiropractors in the employer's MPN is not forwarded to our office within five (5) days, we will take this to mean that you do not have three chiropractors on your MPN list within 30 minutes or 15 miles of the covered employee's residence or workplace.

If so, then the patient has requested this office to evaluate and to treat his/her industrially related medical needs and we will proceed to evaluate and treat the injured worker as needed on an industrial basis.

If you, the insurance company/employer, fail or refuse to furnish treatment to the injured worker, then the expense incurred for medical services furnished will be due as per Section 5402, subdivision (b) and (c). Labor Code 5402 (b)(c), requires the employer to authorize all appropriate medical care up to $10,000 until the liability for the claimed injury is accepted or rejected. If payment of this bill is denied; we will pursue provisions under L.C. 4603.2

As of 06/01/04, Labor code 5814 mandates a 25% penalty on the amount of payment unreasonably delayed (10% if self-imposed). Accordingly, it would be requested that the employer please provide immediate payment.

Patient's name: Annette Garner Signature: X Annette Garner

ERIC E. GOFNUNG CHIROPRACTIC CORP.

QME OF THE STATE OF CALIFORNIA

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

Tel. (323) 933-2444 λ Fax (323) 933-2909

6221 Wilshire Boulevard, Suite 604
Los Angeles, California 90048

12626 Riverside Dr., Suite 510
North Hollywood, California 91607

Disclosure. You may be referred to one or more of the physicians or other health care practitioners listed below. They or their family members may provide services to or have another financial interest directly or indirectly with each other.

Eric Gofnung, DC, Allen Massihi, DPM, Mayya Kravchenko, DC, Javier Torres, MD

If you would like to know of alternatives to any of them or to any other health care practitioner or facility you are referred to, please let your examining or treating doctor or his or her office staff know.

Complaints. If you have any questions, concerns, or complaints regarding any referral or any other service, please contact your doctor or his or her office manager. Your confidential communications will be protected. You have the right to file a complaint with the doctor's state licensing agency: for a chiropractor, it would be the Board of Chiropractic Examiners, 2525 Natomas Park Drive, Suite 260, Sacramento, CA 95833; for a podiatrist, the Board of Podiatric Medicine, 2005 Evergreen Street, Ste. 1300, Sacramento, CA 95815-3831; for an allopathic physician (M.D.), the Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815; for an acupuncturist, the California Acupuncture Board, 1747 N. Market Blvd, Suite 180, Sacramento, CA 95834, and for an osteopath (D.O.), the Osteopathic Medical Board of California, 1300 National Drive, Suite #150, Sacramento, CA 95834-1991.

I have received this disclosure:

Annette Garner
Signature of patient

Date signed by patient: 12/2/19

Annette Garner
Type or print name of patient

Date received by patient: 12/2/19

AV
Office staff initials

ERIC E. GOFNUNG, D.C., QME

SPORTS MEDICINE AND REHABILITATION

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

Employer and/or Workers' Compensation Insurance Carrier:

Employer	Insurance Carrier
Mission School Transp	Vanliner Insurance Fenton
201 W. Sotello St	One Premier Dr. Mail Stop Y 29
Los Angeles CA 90012	Fenton, MO 63026

Re:
- Patient - Annette Garner
- Social Security # - 561-25-6071
- Date Of Injury - CT: 01/01/18 - 10/31/2019
- Employer - Mission School Transportation
- Claim Number -

Designation of Primary Treating Physician and/or Request of Change of Physician & Authorization For Release Of Medical Records

To Whom It May Concern:

I, Annette Garner, request a change of primary treating physician and/or request to be treated by a doctor of chiropractic and designate Dr. Eric E. Gofnung as my primary treating physician pursuant to Article 2 (commencing with section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code. Please accept my signature below as confirmation of my designation of Dr. Eric E. Gofnung as my primary treating physician. Pursuant to California Labor Code 4601, a request for change of physician may be made at any time.

I request all available present and future medical records to be forwarded to Dr. Eric E. Gofnung for review and comment. Please accept my signature below as my full authorization for release of my medical records and my authorization to release all necessary medical information regarding my condition to all parties involved, which include, but are not limited to my employer and/or their worker's compensation insurance company, to process the claim.

Please refer to the letterhead for Dr. Eric Gofnung's information.

Thank you for your assistance with this claim.

With Kind Regards,

Signature: X Annette Garner Printed: Annette Garner Date: 12/2/19