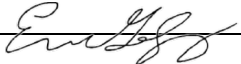


State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

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

<input type="checkbox"/> New Request		<input type="checkbox"/> Resubmission – Change in Material Facts		
<input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health				
<input type="checkbox"/> Check box if request is a written confirmation of a prior oral request.				
Employee Information				
Name (Last, First, Middle):				
Date of Injury (MM/DD/YYYY):			Date of Birth (MM/DD/YYYY):	
Claim Number:			Employer:	
Requesting Physician Information				
Name:				
Practice Name:			Contact Name:	
Address:			City:	State:
Zip Code:	Phone:		Fax Number:	
Specialty:			NPI Number:	
E-mail Address:				
Claims Administrator Information				
Company Name:			Contact Name:	
Address:			City:	State:
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.)
Requesting Physician Signature: 			Date:	
Claims Administrator/Utilization Review Organization (URO) Response				
<input type="checkbox"/> Approved <input type="checkbox"/> Denied or Modified (See separate decision letter) <input type="checkbox"/> Delay (See separate notification of delay)				
<input type="checkbox"/> Requested treatment has been previously denied <input type="checkbox"/> Liability for treatment is disputed (See separate letter)				
Authorization Number (if assigned):			Date:	
Authorized Agent Name:			Signature:	
Phone:	Fax Number:		E-mail Address:	
Comments:				

State of 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.

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Employee Information

Name (Last, First, Middle):	
Date of Injury (MM/DD/YYYY):	Date of Birth (MM/DD/YYYY):
Claim Number:	Employer:

Requesting Physician Information

Name:	
Practice Name:	Contact Name:
Address:	City: State:
Zip Code: Phone:	Fax Number:
Specialty:	NPI Number:
E-mail Address:	


Claims Administrator Information

Company Name:		Contact Name:
Address:		City: State:
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.)

Requesting Physician Signature: 	Date:
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Claims Administrator/Utilization Review Organization (URO) Response

<input type="checkbox"/> Approved		<input type="checkbox"/> Denied or Modified (See separate decision letter)		<input type="checkbox"/> Delay (See separate notification of delay)	
<input type="checkbox"/> Requested treatment has been previously denied		<input type="checkbox"/> Liability for treatment is disputed (See separate letter)			
Authorization Number (if assigned):			Date:		
Authorized Agent Name:			Signature:		
Phone:	Fax Number:	E-mail Address:			
Comments:					

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

September 23, 2022

Workers Defenders Law Group
8018 E. Santa Ana Cyn., Ste. 100-215
Anaheim Hills, CA 92808
Attn: Natalia Foley, Esq.

Re: Patient: Shah, Bhargav K.
SSN: Unavailable
EMP: Disneyland Resort
INS: Disney Anaheim
Claim #: DLRW2022095173
WCAB #: ADJ16483391
DOI: July 20, 2022
D.O.E./Consultation: September 23, 2022

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

Time Spent Face to face:	10 minutes
Time Spent on Report Preparation	10 minutes

Dear Gentlepersons:

The above-named patient was seen for a Primary Treating Physician's Follow up Evaluation on September 23, 2022, 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. Kravchenko.**

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

Re: Patient: Shah, Bhargav K.
DOI: July 20, 2022
Date of Exam: September 23, 2022

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:

Please note, the patient was initially seen in my office on August 8, 2022, and returns today following that visit. The patient did not return prior to today for the treatment recommended as the patient reports he was out of the country in India due to a recent death in the family as well as for dental procedures which the patient underwent in India. The patient reports his pains are unchanged from when he was here last time. He reports significant pain in his left knee. He utilizes a one-point cane during ambulation, which the patient presents with today, and he reports his back pain persists with radiation to lower extremities.

Current Complaints (September 23, 2022):

1. Low back pain with radiation to lower extremities, more so to the left, frequent and moderate.
2. Left knee pain, moderate to severe and frequent, with episodes of buckling. The patient utilizes a one-point walking cane for ambulation.
3. Anxiety and depression, sleeping problems.

Re: Patient: Shah, Bhargav K.
DOI: July 20, 2022
Date of Exam: September 23, 2022

Physical Evaluation (September 23, 2022) – Positive Findings:

Lumbar Spine:

Examination revealed tenderness to palpation with muscle guarding of bilateral paralumbar musculature. Tenderness at left sacroiliac joint. Tenderness and hypomobility is noted at L4 to L5 vertebral regions.

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

Straight Leg Raising Test performed seated was positive bilaterally.

Right: 70 degrees

Left: 45 degrees

Lumbar spine ranges of motion were decreased and painful, measured as follows:

<i>Lumbar Spine Range of Motion Testing</i>		
Movement	Normal	Actual
Flexion	60	30
Extension	25	10
Right Lateral Flexion	25	10
Left Lateral Flexion	25	15

Knees & Lower Legs:

Examination revealed tenderness to palpation at left knee infrapatellar tendon, medial and lateral joint lines. Tenderness at left lower leg musculature including gastrocnemius, tibialis anterior and peroneal musculature.

McMurray's test is positive at the left knee. Anterior drawer test is positive at the left knee.

Range of motion for the knees, right normal, left decreased and painful.

Weakness and pain at the left knee during the squat. The patient is putting left leg in the antalgic position during squatting.

<i>Knee Range of Motion Testing</i>			
Movement	Normal	Left Actual	Right Actual
Flexion	135	60	135
Extension	0	0	0

Re: Patient: Shah, Bhargav K.
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Motor, Gait & Coordination Testing of The Lumbar Spine and Lower Extremities:

Left knee extension and flexion 4/5, all other myotomes 5/5.

Squatting is performed one-fourth down with left knee pain.

Heel and toe walking was unable to be performed due to left knee pain.

Antalgic gait favoring left lower extremity. The patient ambulates with a one-point cane and a soft knee brace.

Sensory Testing:

Hypoesthesia at left L5-S1 dermatomal levels.

Diagnostic Impressions:

1. Lumbar spine myofasciitis secondary to antalgic gait, M79.1.
2. Lumbar spine facet-induced versus discogenic pain, M47.816.
3. Lumbar radiculitis, M54.16.
4. Left knee and lower leg sprain/strain, S83.92XA. S86.112A.
5. Left knee meniscus tear, rule out, S83.282A.
6. Left cruciate ligament tear, rule out, S83. 512A.
7. Insomnia, G47.00.

Discussion and Treatment Recommendations:

The patient is recommended 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 left knee and lower leg at once per week for six weeks with a followup in six weeks.**

I recommend for the lumbar spine to be added to the claim form and the patient will then be recommended chiropractic manipulations and physiotherapy for lumbar spine

Re: Patient: Shah, Bhargav K.
DOI: July 20, 2022
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once a week for six weeks. Lumbar spine is a compensable consequence of the left knee injury.

I respectfully request MRI results for the left knee that were performed.

Specialty evaluation recommended:

1. The patient is recommended **orthopedic surgical consultation.**

Permanent and Stationary Status:

The patient's condition is not permanent and stationary.

Work Status/Disability Status:

TTD until reevaluation in six 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

Re: Patient: Shah, Bhargav K.
DOI: July 20, 2022
Date of Exam: September 23, 2022

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.

Sincerely,



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

Signed this 23rd day of September, 2022, in Los Angeles, California.

EEG:svl

ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

6221 Wilshire Blvd., 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 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 October 07, 2022, 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 07th day of October, 2022, I served the within concerning:

Patient's Name: **SHAH, BHARGAV K.**
Claim Number: **DLRW2022095173**
WCAB / EAMS case No: **ADJ16483391**


- | | |
|---|--|
| <input type="checkbox"/> MPN Notice | <input type="checkbox"/> Initial Consultation Report – |
| <input type="checkbox"/> Designation of Primary Treating Physician & Authorization for Release of Medical Records | <input checked="" type="checkbox"/> Re-Evaluation Report / Progress Report (PR-2) <u>09/23/2022</u> |
| <input type="checkbox"/> Financial Disclosure | <input type="checkbox"/> Permanent & Stationary Evaluation Report – _____ |
| <input checked="" type="checkbox"/> Request for Authorization – <u>09/23/2022</u> | <input type="checkbox"/> Post P&S Follow Up - _____ |
| <input checked="" type="checkbox"/> Itemized – (Billing) / HFCA – <u>09/23/2022</u> | <input type="checkbox"/> Review of Records - _____ |
| <input type="checkbox"/> QME Appointment Notification | <input type="checkbox"/> PQME / Med Legal Report - _____ |
| <input type="checkbox"/> Primary Treating Physician's Referral | <input type="checkbox"/> Computerized Dynamic Range of Motion (Rom) And Functional Evaluation Report - _____ |

List all parties to whom documents were mailed to:

Workers Defenders Law Group
8018 E. Santa Ana Cyn., Ste. 100-215
Anaheim Hills, CA 92808
Attn: Natalia Foley, Esq

Disneyland Resort
P.O. Box 3909
Anaheim, CA 92803

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 07th day of October, 2022.



ILSE PONCE