

ERIC E. GOFNUNG CHIROPRACTIC CORP.

QME OF THE STATE OF CALIFORNIA

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

**6221 Wilshire Boulevard, Suite 604 • Los Angeles, CA 90048 • Tel: (323) 933-2444 • Fax:
(323) 933-2909**

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

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

On 5 day of December 2019, I served the within concerning:

Patient's Name: Young, Benetia

Claim Number: 19006760

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

11/25/2019

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

11/25/2019

List all parties to whom documents were mailed to:

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

Athens Administrators
P.O. Box 696
Concord, CA 94522

Bethe C. Barley, Esq.
Stander Reubens Thomas Kinsey
200 N Pacific Coast Highway, Suite 1550
El Segundo, CA 90245

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 5 day of December 2019.



Ilse Ponce

ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

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

November 25, 2019

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

Re: Patient: Young, Benetia
SSN: 547-08-0936
EMP: Star View Adolescent Center
INS: Athens Administrators
Claim #: 19006760
WCAB #: ADJ12213522
DOI: 04/18/2019
D.O.E./Consultation: November 25, 2019

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

Dear Gentlepersons:

The above-named patient was seen for a Primary Treating Physician's Followup Evaluation on November 25, 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

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Date of Exam: November 25, 2019

review. Be aware the defendant and insurance company has five working days to authorize, delay, modify or deny a request for all treatment, but 10 days for spinal surgery. Please issue timely payment for medical care and treatment rendered in order to avoid payment of interests and penalties, per labor codes referenced. Failure of the defendant or insurance company to respond in writing within five working days results in an authorization by default. Furthermore, failure to pay for "self-procured" medical care when utilization deadlines are missed triggers penalties for the defendant or the insurance company due to violation of 8 CCR 10225 – 10225.2 and Labor Code 5814/5814.6 and 4603.2b. When there is a dispute with regard to treatment, the right to proceed with the Labor Code 4062 process belongs exclusively to the injured employee. If the treatment recommendations are not authorized by the insurance carrier, this report and bill should be kept together by the Workers' Compensation carrier for the review company. The claims examiner should forward this report to the defense attorney and nurse case manager.

Interim History:

Ms. Young has been undergoing comprehensive course of treatment under our care consisting of chiropractic manipulations and adjunctive multimodality physiotherapy. She is feeling improvement with treatment, however, she remains symptomatic. The patient denies any new accidents or injuries. She has not returned to work until present.

Current Complaints (November 25, 2019):

1. Neck pain, best described as frequent and moderate.
2. Left shoulder pain, frequent and moderate.
3. Mid back pain, frequent and moderate.
4. Lower back pain, frequent and moderate-to-severe.
5. Nausea, difficulty concentrating, dizziness, headaches, numbness in the left side of the face, anxiety and depression and sleep difficulty.

Physical Evaluation (November 25, 2019) – Positive Findings:

Head & Face, Eyes, Ears, Nose and Mouth:

Reveals tenderness at left occipital region.

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Cervical Spine:

Examination of the cervical spine revealed tenderness to palpation with myospasm of 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 cervical spine were decreased and painful with spasm, measured as follows:

<i>Cervical Spine Ranges of Motion Testing</i>		
Movement	Normal	Actual
Flexion	50	35
Extension	60	25
Right Lateral Flexion	45	25
Left Lateral Flexion	45	30
Right Rotation	80	45
Left Rotation	80	65

Shoulders & Upper Arms:

Exam revealed antalgic position of left shoulder, tenderness and myospasm noted at the left supraspinatus, infraspinatus and periscapular musculature as well as left deltoid musculature.

Hawkins test was positive at the left shoulder.

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

<i>Shoulder Ranges of Motion Testing</i>			
Movement	Normal	Left Actual	Right Actual
Flexion	180	160	180
Extension	50	25	50
Abduction	180	150	180
Adduction	50	45	50
Internal Rotation	90	50	90
Extension Rotation	90	45	90

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Motor Testing of The Cervical Spine and Upper Extremities:

Left deltoid 4/5, left wrist extensor 4/5, left wrist flexor 4/5, all other myotomes 5/5.

Sensory Testing:

Dysesthesia at left C6-C7 dermatomal levels.

<i>Upper Extremity Measurements in Centimeters</i>		
Measurements	Left	Right
Biceps	25	25.5
Forearms	20	19.5

Thoracic Spine:

Examination of thoracic spine revealed tenderness to palpation at left trapezium and rhomboid musculature with myospasm noted.

Ranges of motion of thoracic spine were decreased due to pain at the lumbar spine, measured as follows:

<i>Thoracic Spine Ranges of Motion Testing</i>		
Movement	Normal	Actual
Flexion	60	45
Extension	0	0
Right Rotation	30	15
Left Rotation	30	18

Lumbar Spine:

Examination of the lumbar spine revealed tenderness to palpation at bilateral paralumbar musculature with myospasm noted.

Tenderness and hypomobility were noted at L1 through L5 vertebral regions.

Milgram's test was positive.

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

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Right: 55 degrees
Left: 45 degrees

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

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

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

Squatting is positive for back pain. Heel and toe walking difficulty and positive for back pain.

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

<i>Lower Extremity Measurements Circumferentially & Leg Length in Centimeters</i>		
Measurements (in cm)	Left	Right
Thigh - 10 cm above patella with knee extended	66	66.5
Calf - at the thickest point	35	35.5

Diagnostic Impressions:

1. Cephalgia, closed head trauma, tinnitus left, trauma brain injury, rule out, G44.099, S09.90XA, H93.12, S06.2X9D.
2. Cervical spine sprain/strain, cervical facet-induced versus discogenic pain, cervical radiculitis left, S13.4XXA, M53.82, M54.12.
3. Lumbar spine sprain/strain, lumbar facet-induced versus discogenic pain, lumbar radiculitis left, S39.012A, M46.1, M54.16.
4. Left shoulder sprain/strain, S43.401A.
5. Left rotator cuff tear, rule out, M75.102.
6. Left shoulder tenosynovitis and bursitis, M65.811.

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

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 **cervical, and lumbar spine and left shoulder at two times per week for four weeks with a followup in four weeks.**

The patient requires **x-rays of left shoulder.**

The patient requires **MRI of cervical and lumbar spine and left shoulder.**

The patient requires **NCV/EMG of upper extremities** in order to fully evaluate her condition.

The patient is recommended **psychiatric consultation with Dr. Musher.**

The patient is recommended **neurology consultation with regards to traumatic brain injury, close head trauma evaluation and treatment.**

Work Status:

The patient is to return to modified with the following restrictions. No repeated flexing, extending or rotating of the neck. No repeated work with left arm above shoulder height. No lifting in excess of 15 pounds. No repeated bending or stooping. If modified duty as indicated is not provided, the patient is then considered temporarily totally disabled until reevaluation in four weeks.

Disclosure:

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

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628)(b): "I declare that Dr. Kravchenko examined the patient and may have assisted with initial

Re: Patient: Young, Benetia
DOI: 04/18/2019
Date of Exam: November 25, 2019

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

Re: Patient: Young, Benetia
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statements of individuals; prior injury documentation; etc. This is a continuing and ongoing request to immediately comply with 8 CCR Section 9784 by overnight delivery service should such information become available at any time in the future. Obviously, time is of the essence in providing evaluation and treatment. Delay in providing information can only result in an unnecessary increase of treatment and testing costs to the employer.

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

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

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

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

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

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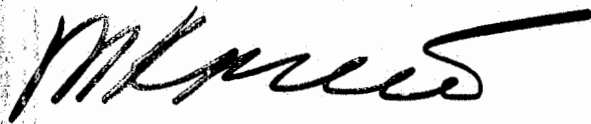
Sincerely,



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

Signed this 27th day of November, 2019, in Los Angeles, California.

EEG:




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

Signed this 27th day of November, 2019, in Los Angeles, California.

MK:svl


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

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

<input checked="" type="checkbox"/> New Request					<input type="checkbox"/> Resubmission – Change in Material Facts				
<input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health									
<input type="checkbox"/> Check box if request is a written confirmation of a prior oral request.									
Employee Information									
Name (Last, First, Middle): Young, Benetia									
Date of Injury (MM/DD/YYYY): 04/18/2019					Date of Birth (MM/DD/YYYY): 01/08/1965				
Claim Number: 19006760					Employer: Star View Adolescent Center				
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: Athens Administrators					Contact Name: Timothy Chapin				
Address: P.O. Box 696					City: Concord			State: CA	
Zip Code: 94522-0696		Phone: (925) 826-1226			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 Sprain	S13.4XXD	Electrical Stimulation	G0283	2 x a week for 4 weeks					
Lumbar Sprain	S33.5XXD	Therapeutic Exercises	97110						
Shoulder Tenosynovitis	M65.812	Massage Therapy	97124						
		CMT 5 regions	98942						
		Extraspinal Manipulation w/spinal	98943						
Requesting Physician Signature: 							Date: 11/25/2019		
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**

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<input checked="" type="checkbox"/> New Request		<input type="checkbox"/> Resubmission – Change in Material Facts		
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Employee Information				
Name (Last, First, Middle): Young, Benetia				
Date of Injury (MM/DD/YYYY): 04/18/2019		Date of Birth (MM/DD/YYYY): 01/08/1965		
Claim Number: 19006760		Employer: Star View Adolescent Center		
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: Athens Administrators		Contact Name: Timothy Chapin		
Address: P.O. Box 696		City: Concord	State: CA	
Zip Code: 94522-0696	Phone: (925) 826-1226	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 Sprain	S13.4XXD	X-Rays of		
Lumbar Sprain	S33.5XXD	Left Shoulder		
Shoulder Tenosynovitis	M65.812			
Requesting Physician Signature: 		Date: 11/25/2019		
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**

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<input checked="" type="checkbox"/> New Request	<input type="checkbox"/> Resubmission – Change in Material Facts
<input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health	
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Employee Information

Name (Last, First, Middle): Young, Benetia	
Date of Injury (MM/DD/YYYY): 04/18/2019	Date of Birth (MM/DD/YYYY): 01/08/1965
Claim Number: 19006760	Employer: Star View Adolescent Center

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
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Specialty: Chiropractor		NPI Number: 1821137134
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Claims Administrator Information

Company Name: Athens Administrators		Contact Name: Timothy Chapin
Address: P.O. Box 696		City: Concord State: CA
Zip Code: 94522-0696	Phone: (925) 826-1226	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 Sprain	S13.4XXD	MRI of		
Lumbar Sprain	S33.5XXD	Cervical Spine		
Shoulder Tenosynovitis	M65.812	Lumbar Spine		
		Left Shoulder		


Requesting Physician Signature: 	Date: 11/25/2019
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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:	

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

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Date of Injury (MM/DD/YYYY): 04/18/2019		Date of Birth (MM/DD/YYYY): 01/08/1965		
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Cervical Sprain	S13.4XXD	NCV/EMG Studies		
Lumbar Sprain	S33.5XXD	Upper Extremities		
Shoulder Tenosynovitis	M65.812			
Requesting Physician Signature: 		Date: 11/25/2019		
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**

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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
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Employee Information

Name (Last, First, Middle): Young, Benetia
 Date of Injury (MM/DD/YYYY): 04/18/2019 Date of Birth (MM/DD/YYYY): 01/08/1965
 Claim Number: 19006760 Employer: Star View Adolescent Center

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

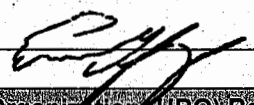
Claims Administrator Information

Company Name: Athens Administrators Contact Name: Timothy Chapin
 Address: P.O. Box 696 City: Concord State: CA
 Zip Code: 94522-0696 Phone: (925) 826-1226 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 Sprain	S13.4XXD	Psychiatric Consultation		
Lumbar Sprain	S33.5XXD	With Dr. Gennady Musher		
Shoulder Tenosynovitis	M65.812			

Requesting Physician Signature:  Date: 11/25/2019

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:

2 providers that meet your search criteria have been selected.

[Refine Search Results](#)

[Change Location/Name](#)

[Start New Search](#)

[1 Create Directory](#)

Search Criteria:

Your Search Criteria (from previous steps)

Plan Name: Anthem Premier MPN; Lookup State: CA; Provider Types: Other Physicians and Health Professionals; Specialties: Psychiatry;
Last Name Like: Musher; First Name Like: Gennady

Sort Results by:

Legend
^c Board Certified

<input checked="" type="checkbox"/> Musher, Gennady, MD 6221 Wilshire Blvd Ste 401 Los Angeles, CA 90048 Phone: (323) 655-3747 County: Los Angeles Gender: Male	Report Provider Data <input type="button" value="Map"/> Specialty: Psychiatry ^c
<input type="checkbox"/> Musher, Gennady, MD 6221 Wilshire Blvd Ste 401B Los Angeles, CA 90048 Phone: (323) 655-3747 County: Los Angeles Gender: Male	Report Provider Data <input type="button" value="Map"/> Specialty: Psychiatry ^c

[Change Location/Name](#)

[Start New Search](#)

1

To report inaccuracies in the provider information listed, please contact us at (877) 307-1245. You may also email us at wcpdo@anthemwc.com

Medical Access Assistant(s) can be reached at (844) 752-1144 or by email at anthempremiermaa@anthemwc.com

This directory was last updated on: 11/27/2019


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

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

<input checked="" type="checkbox"/> New Request					<input type="checkbox"/> Resubmission – Change in Material Facts				
<input type="checkbox"/> Expedited Review: Check box if employee faces an imminent and serious threat to his or her health									
<input type="checkbox"/> Check box if request is a written confirmation of a prior oral request.									
Employee Information									
Name (Last, First, Middle): Young, Benetia									
Date of Injury (MM/DD/YYYY): 04/18/2019					Date of Birth (MM/DD/YYYY): 01/08/1965				
Claim Number: 19006760					Employer: Star View Adolescent Center				
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: Athens Administrators					Contact Name: Timothy Chapin				
Address: P.O. Box 696					City: Concord			State: CA	
Zip Code: 94522-0696		Phone: (925) 826-1226			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 Sprain	S13.4XXD	Neurology Consultation							
Lumbar Sprain	S33.5XXD								
Shoulder Tenosynovitis	M65.812								
Requesting Physician Signature: 							Date: 11/25/2019		
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:									