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 **February 16, 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 16 day of **February,** 2022, I served the within concerning:

Patient's Name: JOHNSON, MARVETTA
Claim Number: UNASSIGNED

- ☐ MPN Notice
- ☐ Designation of Primary Treating Physician & Authorization for Release of Medical Records
- ☐ Financial Disclosure
- ☒ Request for Authorization - **02/04/22**
- ☒ Itemized - (Billing) / HFCA - **02/04/22**
- ☐ QME Appointment Notification
- ☐ Primary Treating Physician's Referral
- ☐ Initial Consultation Report -
- ☒ Re-Evaluation Report / Progress Report (PR-2) **02/04/22**
- ☐ Permanent & Stationary Evaluation Report _____
- ☐ Post P&S Follow Up - _____
- ☐ Review of Records - _____
- ☐ PQME / Med Legal Report - _____
- ☐ Computerized Dynamic Range of Motion (Rom) And Functional Evaluation Report - _____

List all parties to whom documents were mailed to:

Law offices of Natalia Foley
751 S Weir Canyon, Suite 157-455
Anaheim, CA 92808

Sedgwick
P.O. Box 51350
Ontario, CA 91761

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 **February**, 2022.

ILSE PONCE

ERIC E. GOFNUNG CHIROPRACTIC CORP.

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

February 4, 2022

Law offices of Natalia Foley
751 S Weir Canyon, Suite 157-455
Anaheim, CA 92808

Re:	Patient:	Johnson, Marvetta
	EMP:	Los Angeles County Probation Dept
	INS:	Sedgwick
	Claim #:	Unassigned
	WCAB #:	ADJ14891825
	DOI:	11/06/2020
	D.O.E./Consultation:	February 4, 2022

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

Time Spent Face to face:	**20 Mins**
Time Spent on Report Preparation	**20Mmins**

Dear Gentlepersons:

The above-named patient was seen for a Primary Treating Physician's Follow up Evaluation on February 4, 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. Gofnung.**

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.

Interim History:

The patient report since November until now she has been working for LA County Probation Department where they basically let her go back to work on modified duties; however, her superiors have her sit in the visitors room where she basically does not serve any function, five days a week and 8 hours per day. The patient elaborates that essentially there is COVID, so there are no visitors except once in a while. The patient asks the visitors to sign in. The patient reports that the prolonged sitting is worsening her back pain. The patient reports that she is developing some anxiety and depression as she was in this position during quarantine for essentially like November, December and January with almost no visitors and she felt like confined and once again started developing anxiety and depression. She has not been given any other tasks besides that. MRIs were performed of the lumbar spine, left hip as well as left knee which were reviewed with the patient. Please go to the review of record section for details.

Current Complaints (February 4, 2022):

1. Left shoulder pain is moderate and intermittent to frequent.
2. Left elbow pain, minimal to slight and intermittent.
3. Low back pain with radiation to left lower extremity to the knee, frequent and moderate.
4. Left hip pain, slight and intermittent.

5. Left knee pain, slight and intermittent. The patient denies buckling or walking; however, report clicking during ranges of motion.

6. Left ankle pain, slight and intermittent.

7. Sleeping problems, anxiety and depression with complaints of chest pain which the patient associates with stress.

Physical Evaluation (February 4, 2022) – Positive Findings:

Shoulders & Upper Arms:

Left Shoulder:

On inspection, healed arthroscopic scars were present.

Tenderness was noted over the anterior shoulder over the anterior supraspinatus near insertion, subacromial-subdeltoid bursa, acromioclavicular joint, and periscapular musculature.

Left Hawkins test was positive.

Ranges of motion of the right shoulder and left shoulder were within normal limits.

Elbows & Forearms:

Left Elbow:

Tenderness was not present on today's evaluation.

Ranges of motion of the bilateral elbows were normal.

Grip Strength Testing:

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

Right: 2/4/4
Left: 8/8/8

Thoracic Spine:

Kemp's test elicited increased pain in the left low back area.

Re: Patient: Johnson, Marvetta
DOI: 11/06/2020
Date of Exam: February 4, 2022

Thoracic spine ranges of motion were restricted due to low back pain.

Lumbar Spine:

Examination revealed tenderness over the bilateral paralumbar musculature. Left sacroiliac joint hypomobility present. Tenderness was present at L4-L5 vertebral regions with hypomobility.

Left sacroiliac joint compression test is positive. Milgram's test positive.

Straight Leg Raising Test (seated) was positive for back pain.

Right: 85 degrees
Left: 80 degrees

Range of motion of lumbar spine with decreased and painful, measured as follows: .

Lumbar Spine Range of Motion Testing		
Movement	Normal	Actual
Flexion	60	**40**
Extension	25	**10**
Right Lateral Flexion	25	**15**
Left Lateral Flexion	25	**15**

Hips & Thighs:

Left Hip & Thigh:

Tenderness was noted over the greater trochanteric region and hip bursa.

Left Patrick Fabere test was positive with increased left hip pain predominately over the greater trochanteric region.

Ranges of motion of left hip were normal except flexion and external rotation, but all of them painful.

Hip Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	120	**100**	120
Extension	30	30	30
Abduction	45	45	45
Adduction	30	30	30

External rotation	45	**40**	45
Internal rotation	45	45	45

Knees & Lower Legs:

Left Knee:

Examination revealed slight tenderness at medial joint line.

Left McMurray's test was positive.

Range of motion of the knees, right normal and left was decreased and painful, measured as follows:

Knee Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	135	**130**	135
Extension	0	0	0

Ankles & Feet:

Left Ankle & Foot:

Tenderness to palpation was not present on today's visit.

Ranges of motion were normal at both ankles **with pain upon extreme of inversion, plantar flexion, and dorsiflexion.**

Review of records:

1) I reviewed the entire medical file with all pertinent patient information. I have reviewed my initial history, examination and medical file.

2) Review of lumbar spine interpretation report from study performed on January 6, 2022, as interpreted by Dr. Nicholas Dzebolo, with: Facet hypertrophy at L4-L5 levels causing associated bilateral neuroforaminal narrowing with contact on exiting nerve roots bilaterally with disc herniations of 2 mm.

3) Review of lumbar spine MRI interpretation report from study performed on December 26, 2021, as interpreted by Dr. Amjad Safvi: The study was interpreted as normal.

4) Review of left knee MRI interpretation report from study performed on January 17, 2022 as interpreted by Dr. Amjad Safvi with findings of: Intramuscular hyperintensity in the posterior horn of the medial meniscus suggestive of grade 2 meniscal signal changes as

well as other finding suggestive of chronic partial tear/degeneration. Findings suggestive of myxoid degeneration within posterior cruciate ligament were also noted as well as degenerative narrowing and thinning of articular cartilage at patellofemoral and tibiofemoral joints.

Diagnostic Impressions:

1. Lumbar myofasciitis, M79.1.

2. Left sacroiliac joint dysfunction, sacroiliitis, M53.3.

3. Lumbar facet-induced versus discogenic pain. Facet hypertrophy at L4-L5 levels causing associated bilateral neuroforaminal narrowing with contact on exiting nerve roots bilaterally with disc herniations of 2 mm. M47.816.

4. Left shoulder tenosynovitis/bursitis. Mild supraspinatus and subscapularis tendinosis and acromioclavicular degenerative disease, as per MRI dated 03/03/21, M75.52.

5. Left shoulder impingement syndrome, M75.42.

6. Left shoulder status post arthroscopic surgery around 2011 with aggravation due to November 6, 2020 industrial injury, Z53.33.

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

8. Left trochanteric bursitis, M70.62.

9. Left knee internal derangement, rule out. Intramuscular hyperintensity in the posterior horn of the medial meniscus suggestive of grade 2 meniscal signal changes as well as other finding suggestive of chronic partial tear/degeneration. Findings suggestive of myxoid degeneration within posterior cruciate ligament were also noted as well as degenerative narrowing and thinning of articular cartilage at patellofemoral and tibiofemoral joints as per MRI dated 01/17/22, , M23.92.

10. Left ankle sinus tarsi syndrome, resolving, G57.50.

11. Anxiety and depression, F41.9, F34.1.

12. 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 lumbar spine, left shoulder, left hip, and left knee at once every other week for six weeks with a followup in six weeks.**

Diagnostic studies recommended:

1) The patient is recommended x-rays of the left elbow, left shoulder, and left ankle.
2) The patient is recommended NCV/EMG studies of the lower extremities for further workup of lumbar radicular complaints.

Specialty evaluations recommended:

1) Acupuncture treatment.
2) Interventional pain management evaluation for further workup for spine-related complaints and pharmacological management to explore interventional pain management options.
3) Orthopedic evaluation for further workup of left upper extremity in view of history of prior left shoulder surgery.
4) Internal medicine consultation for further workup of chest pain and rule out organic causes.

The patient is **recommended left knee stabilizer brace and left hip trochanteric brace to use based on pain levels.**

The patient is **recommended home exercise to tolerance of core strengthening utilizing a gym ball, wall squats, McKenzie exercise, and resistance band training for the extremities. The patient is recommended aqua therapy and authorization is hereby requested. The patient also encouraged to swim if she has access to pool to tolerance. The patient is encouraged light resistance training that could be done in gym-like setting with machines and free weights to tolerance to maximize functional restoration and expedite recovery. The patient was instructed to avoid high-impact type of activities.**

Permanent and Stationary Status:

The patient's condition is not permanent and stationary.

Work Status/Disability Status:

In view of the patient's reported worsening of her back and in view of MRI findings, the patient at this time will be placed on temporary total disability for six weeks.

Re: Patient: Johnson, Marvetta
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Date of Exam: February 4, 2022

Disclosure:

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

I performed the physical examination, reviewed the document and reached a conclusion, of this report which was transcribed by Acu Trans Solution LLC and I proofread and edited the final draft prior to signing the report in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (J) of Section 139.2.

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628(J)): "I declare under penalty of perjury that the information contained in this report and it's attachments, if any, is true and correct to the best of my knowledge and belief, except as to information I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true."

In compliance with recent Workers' Compensation legislation (Labor Code Section 5703 under AB 1300): "I have not violated Labor Code Section 139.3 and the contents of this report are true and correct to the best of my knowledge. This statement is made under penalty of perjury and is consistent with WCAB Rule 10978."

The undersigned further declares that the charges for this patient are in excess of the RVS and the OMFS codes due to high office and staff costs incurred to treat this patient, that the charges are the same for all patients of this office, and that they are reasonable and necessary in the circumstances. Additionally, a medical practice providing treatment to injured workers experiences extraordinary expenses in the form of mandated paperwork and collection expenses, including the necessity of appearances before the Workers' Compensation Appeals Board. This office does not accept the Official Medical Fee Schedule as prima facie evidence to support the reasonableness of charges. I am a board-certified Doctor of Chiropractic, a state-appointed Qualified Medical Evaluator, a Certified Industrial Injury Evaluator and certified in manipulation under anesthesia. Based on the level of services provided and overhead expenses for services contained within my geographical area, I bill in accordance with the provisions set forth in Labor Code Section 5307.1.

NOTE: The carrier/employer is requested to immediately comply with 8 CCR Section 9784 by overnight delivery service to minimize duplication of testing/treatment. This office considers "all medical information relating to the claim" to include all information that either has, will, or could reasonably be provided to a medical practitioner for elicitation of medical or medical-legal opinion as to the extent and compensability of injury, including any issues regarding AOE/COE - to include, but not be limited to, all treating, evaluation, and testing reports, notes, documents, all sub rosa films, tapes, videos, reports; employer-level investigation documentation including statements of individuals; prior injury documentation; etc. This is a continuing and ongoing request to immediately comply with 8 CCR Section 9784 by overnight delivery service should such information become available at any time in the future. Obviously, time is of the essence in providing evaluation and treatment. Delay in providing information can only result in an unnecessary increase of treatment and testing costs to the employer.

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

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

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

Re: Patient: Johnson, Marvetta
DOI: 11/06/2020
Date of Exam: February 4, 2022

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 14th day of February, 2022, in Los Angeles, California.

EEG:svl

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

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

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

Employee Information

Name (Last, First, Middle): Johnson, Marvetta

Date of Injury (MM/DD/YYYY): 11/06/2020
Claim Number:

Date of Birth (MM/DD/YYYY): 12/11/1967
Employer: Los Angeles County Probation Dept.

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: Sedgwick
Contact Name:

Address: P.O. Box 51350
City: Ontario
State: CA

Zip Code:
Phone: (909) 942-8918
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.)
Sacroiliac Joint Sprain	S33.6XXD	Electrical Stimulation	G0283	1xevery 2 weeks for 6 weeks
Lumbar Facet	M47.816	Therapeutic Exercises	97110	
Shoulder Tenosynovitis	M65.812	Massage Therapy	97124	
Hip Trochanteric Bursitis	M70.62	CMT 3-4 regions	98941	
Knee Internal Derangemc	M23.92	Extraspinal Manipulation w/spinal	98943	

Requesting Physician Signature:
Date: 02/04/2022

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:

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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: Sedgwick		Contact Name:	
Address: P.O. Box 51350		City: Ontario	State: CA
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Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Hypertension	I10	Internal Medical Consultation		

Requesting Physician Signature: Date: 02/04/2022

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Authorized Agent Name:		Signature:
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Comments:

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Sacroiliac Joint Sprain	S33.6XXD	X-rays		
Lumbar Facet	M47.816	left elbow		
Shoulder Tenosynovitis	M65.812	left shoulder		
Hip Trochanteric Bursitis	M70.62	left ankle		
Knee Internal Derangemc	M23.92			

Requesting Physician Signature: Date: 02/04/2022

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Sacroiliac Joint Sprain	S33.6XXD	NCV / EMG		
Lumbar Facet	M47.816	Lower Extremities		
Shoulder Tenosynovitis	M65.812			
Hip Trochanteric Bursitis	M70.62			
Knee Internal Derangemc	M23.92			

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Name (Last, First, Middle): Johnson, Marvetta

Date of Injury (MM/DD/YYYY): 11/06/2020	Date of Birth (MM/DD/YYYY): 12/11/1967
Claim Number:	Employer: Los Angeles County Probation Dept.

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: Sedgwick		Contact Name:	
Address: P.O. Box 51350		City: Ontario	State: CA
Zip Code:	Phone: (909) 942-8918	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.)
Sacroiliac Joint Sprain	S33.6XXD	Acupuncture Consultation		
Lumbar Facet	M47.816	and Treatment		
Shoulder Tenosynovitis	M65.812			
Hip Trochanteric Bursitis	M70.62			
Knee Internal Derangeme	M23.92			

Requesting Physician Signature: Date: 02/04/2022

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

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

Comments:

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

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

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

Employee Information

Name (Last, First, Middle): Johnson, Marvetta

Date of Injury (MM/DD/YYYY): 11/06/2020	Date of Birth (MM/DD/YYYY): 12/11/1967
Claim Number:	Employer: Los Angeles County Probation Dept.

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Specialty: Chiropractor		NPI Number: 1821137134	

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Claims Administrator Information

Company Name: Sedgwick		Contact Name:	
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Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Sacroiliac Joint Sprain	S33.6XXD	Interventional Pain Management		
Lumbar Facet	M47.816	Consultation		
Shoulder Tenosynovitis	M65.812			
Hip Trochanteric Bursitis	M70.62			
Knee Internal Derangemd	M23.92			

Requesting Physician Signature: Date: 02/04/2022

Claims Administrator/Utilization Review Organization (URO) Response

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Authorized Agent Name:	Signature:
Phone: Fax Number:	E-mail Address:

Comments:

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.)
Sacroiliac Joint Sprain	S33.6XXD	Orthopedic Consultation		
Lumbar Facet	M47.816			
Shoulder Tenosynovitis	M65.812			
Hip Trochanteric Bursitis	M70.62			
Knee Internal Derangemd	M23.92			

Requesting Physician Signature: Date: 02/04/2022

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Authorization Number (if assigned):	Date:
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Comments: