DAVID FEDER, L.AC.

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

6221 Wilshire Boulevard, Suite 604
Los Angeles, California 90048

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

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 Blvd., Suite 604, Los Angeles, CA 90048.

On 13 day of June 2022, I served the within concerning:

Patient's Name: Johnson, Marvetta
Claim Number: 2100578D

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 6/2/2022
- ☐ QME Findings & Summary
- ☐ Doctor's First Report
- ☐ RFA
- ☐ QME Appointment Notification
- ☒ Referral Letter From Primary Treating Physician
- ☒ Initial Comprehensive Report 6/2/2022
- ☐ Re-Evaluation Report / Progress Report (PR-2)
- ☐ Secondary Treating Physician's Maximum Medical Improvement Report
- ☒ Authorization Request For Evaluation/Treatment 6/2/2022

List all parties to whom documents were mailed to:

CC: Workers Defenders Law Group
751 S Weir Canyon, Suite 157-455
Anaheim, CA 92808

CC: Eric E. Gofnung Chiropractic Corp.
6221 Wilshire Blvd., Suite 604
Los Angeles, CA 90048

CC: 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 **13** day of June, 2022.

Ilse Ponce

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: 2100578D		Employer: Los Angeles County Probation Dept.	

Requesting Physician Information

Name: Edmond Feder			
Practice Name: Edmond Feder LAC		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) 933-1564	
Specialty: Acupuncture		NPI Number: 1104958313	
E-mail Address: ilse.ponce@att.net			

Claims Administrator Information

Company Name: Sedgwick CMS, Inc.		Contact Name:	
Address: P.O. Box 51350		City: Ontario	State: CA
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.)
Lumbar sprain	S33.5XXA	Initial Acupuncture Consultation	99203	1 Time
Lumbar Spine Myofascitis	M79.1	Report	WC002	
		Transcriptions	99199	

Requesting Physician Signature: Date: 06/02/2022

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

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Zip Code: 90048	Phone: (323) 933-2444	Fax Number: (323) 933-1564	
Specialty: Acupuncture		NPI Number: 1104958313	
E-mail Address: ilse.ponce@att.net			

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Address: P.O. Box 51350		City: Ontario	State: CA
Zip Code:	Phone:	Fax Number:	
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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.)
Lumbar sprain	S33.5XXD	Follow-Up/Re-Evaluation	99213	1 Time
Lumbar Spine Myofascitis	M79.1	Report	WC002	
		Transcriptions	99199	

Requesting Physician Signature:	Date: 06/02/2022

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

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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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.)
Lumbar sprain	S33.5XXD	Neuromuscular Re-education	97112	2 x per week for 4 weeks
Lumbar Spine Myofascitis	M79.1	Massage Therapy	97124	
		Acupuncture, 1 or more needles	97813	
		Acupuncture, 1 or more needles	97814	

Requesting Physician Signature: [signature] Date: 06/02/2022

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:		

E. DAVID FEDER, L.AC.
SPORTS MEDICINE & ORTHOPEDIC INJURIES
6221 Wilshire Blvd., Suite 604 | Los Angeles, California 90048
Tel: (323) 993-2444 | Fax (323) 933-2909

June 2, 2022

Eric E. Gofnung Chiropractic Corp.
6221 Wilshire Blvd., Ste 604
Los Angeles, CA 90048

Re: Patient:	Johnson, Marvetta
EMP:	Los Angeles County Probation Dept.
INS:	Sedgwick
Claim #:	Unassigned
WCAB #:	ADJ14891825
DOI:	11/6/2020
D.O.E./Consultation:	June 2, 2022

Treating Physician's Initial Comprehensive Consultation Report and Request for Authorization

Dear Dr. Gofnung:

The above-captioned patient was seen at your request on the above date of service for examination and evaluation by the undersigned physician, a Licensed Acupuncturist qualified and licensed by the California Acupuncture Board of the State of California 6221 Wilshire Boulevard, Los Angeles, California 90048 on the date of service listed above. The time spent performing the examination and evaluation by the undersigned physician was in compliance with the guidelines established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) or subdivision (j) of Section 139.2 or Section 5307.6.

This report and bill should be kept together by the Workers' Compensation carrier for the review company. The claims examiner should forward this report to the defense attorney and nurse case manager. This report serves as a written request for written authorization for today's evaluation/consultation and all additional appropriate treatment. This request is in compliance per AB 775 and with the mandates contained in Reg. 9792.6. Please pay within 60 days to avoid interest and penalties per labor code 4603.2 and 5814.

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.

In an effort to expedite the delivery of medical services and treatment to the patient, all Utilization Review phone calls must be scheduled with our office at least 24 hours in advance of the requested phone call date and time. As my office treatment schedule is filled months in advance, the aforementioned is necessary in order to allocate a date and time for the Utilization Review phone call and thus, expediting the process by ensuring all parties are available for the discussion to address all needed issues. Per Labor Code 9792.9(h), "Every claims administrator shall maintain telephone access from 9:00 am to 5:30 pm Pacific Time, on normal business days, for health care providers to request authorization for medical services."

My history and physical examination are as follows:

HISTORY OF INJURY AS PRESENTED BY THE PATIENT:

The above referenced patient reported sustaining an injury to the below-referenced body parts on the above-referenced date of injury during their course of employment as a Senior Detention Services Officer. The patient reported the injury resulted she was restraining a youth . The patient reports that they are not currently working.

WORK HISTORY:

The patient denied and concurrent employment at the time of injury. They denied any other employment or activity that could contribute to, or further worsen, their condition.

CHIEF CURRENT COMPLAINTS:

1. The patient presented with pain and stiffness in the left lumbar spine which radiates into left hip and lower extremity, best described as constant and 8-9/10 becoming 10/10 with activities that include prolonged sitting, laying down and when standing.

PAST MEDICAL HISTORY

Previous illness:	Diabetes; High blood pressure.
Previous injuries:	None.
Previous surgeries:	None.
Allergies:	None.

Re: Patient: Johnson, Marvetta
D/I: 11/6/2020

Medications:	Diabetes; High blood pressure.
Past general health	Good.

REVIEW OF SYSTEMS

Ears/Nose/Throat:	Denied.
Eyes:	Denied.
Lungs:	Denied.
Liver:	Denied.
G-I tract:	Denied.
Kidney/bladder:	Denied.
Reproductive:	Denied.
Neurological:	Denied.
Heart/Circulatory:	High blood pressure.
Psychological:	Denied.

FAMILY HISTORY

Family history is non-contributory.

SOCIAL HISTORY

The patient does not smoke tobacco.
The patient does not drink alcohol.
The patient does not exercise, and does not participate in any sports activities.
The patient explains they are only able to perform their activities of daily living with pain and limitations. They are not able to perform their customary and usual work duties due to pain and impairment.
The patient has not returned to work.

PHYSICAL EVALUATION – POSITIVE OBJECTIVE FINDINGS:

Initial Observation:

The patient is a 54-year-old right-hand dominant female who appeared to be their reported age, and was well developed, well nourished, well proportioned and of average build. They appeared to be alert, cooperative, responsive and oriented times three. The patient was released from therapy, having been determined to have reached maximum medical improvement. The patient subsequently experienced a flare-up and was referred for a trial course of acupuncture to address their current flare-up. The patient presents today to the undersigned with a flare-up in their lumbar spine. Their movements were guarded and they presented with an antalgic position to their lumbar due to pain.

Re: Patient: Johnson, Marvetta
D/I: 11/6/2020

PHYSICAL EVALUATION – POSITIVE OBJECTIVE FINDINGS:

Lumbar Spine:

Examination of the lumbar spine revealed tenderness to palpation which is moderate with moderate myospasm and guarding in the left lumbar paravertebral musculature.

The ranges of motion testing for the lumbar spine were as follows:

Flexion	85 / 90
Extension	05 / 25
Left Lateral Flexion	15 / 25
Right Lateral Flexion	15 / 25
Left Rotation	25 / 45
Right Rotation	35 / 45

INITIAL DIAGNOSTIC IMPRESSIONS:

1. Lumbar spine sprain/strain.
2. Lumbar spine Myofasciitis.
3. Lumbar spine facet-induced pain.
4. Sciatic joint dysfunction - left.

DISCUSSION AND RECOMMENDATIONS:

In view of the patient's chief current complaints and the examination of findings with reference to the patient's current evaluation with regard to the above-referenced area of complaint pursuant to Title 8. Industrial Relations Division 1. Department of Industrial Relations, Chapter 4.5. Division of Workers' Compensation, Subchapter 1. Administrative Director -- Administrative Rules, Article 5.5.2 Medical Treatment Utilization Schedule, section § 9792.21 which govern acupuncture treatment which states: (A) The indications for acupuncture include the following presenting complaints in reference to the following the MTUS Practice Guidelines (i) Neck and Upper Back Complaints; (ii) Elbow Complaints; (iii) Forearm, Wrist, and Hand Complaints: (iv) Low Back Complaints; (v) Knee Complaints; (vi) Ankle and Foot Complaints & (vii) Pain, Suffering, and the Restoration of Function. (B) Frequency and duration of acupuncture treatment may be performed as follows: (i) Time to produce functional improvement: 3 to 6 treatments. (ii) Frequency: 1 to 3 times per week; (iii) Optimum duration of acupuncture treatment as related to a body part is 1 to 2 months. (D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(f) of the Medical Treatment Utilization Schedule which states: "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment. Shoulder complaints are referenced to and deemed treatable on page 204 in the ACOEM Practice Guidelines, Second Edition (2004), **I recommend this patient undergo a comprehensive treatment course of acupuncture and all other appropriate physiotherapeutic modalities for the above-referenced area of complaint for a course of treatments 2 times per week for 4 weeks after which time the patient will be re-evaluated to determine what course should be followed at that time, which may include additional accepted body parts as indicated in subsequent evaluations. The patient was explained their condition and recommended treatment in detail and agrees to proceed.**

Re: Patient: Johnson, Marvetta
D/I: 11/6/2020

TREATMENT PLAN:

1. Electro-acupuncture to increase local circulation; Decrease myofascial hypertonicity; Relieve or decrease myospasm and guarding; Deactivate or decrease active and/or latent trigger points; Relieve or decrease myofascial pain in the affected areas of complaint and injury; Down-regulate the central nervous system decreasing myofascial hypertonicity and overall stress levels in the patient.

2. Neuro-Muscular Re-education to increase R.O.M. and decrease pain and stiffness resulting from habitual restrictive neuromuscular patterns through the kinesthetic re-training of proprioceptive mechanisms.

1. Myofascial massage to deactivate myofascial trigger points, release myofascial adhesions and contractures and lengthen shortened myofascial structures.

DISCLOSURE:

I derived the above opinions from the oral history as related by the patient, revealed by the available medical records, credibility of the patient, examination findings and my clinical experience. This evaluation was carried out at 6221 Wilshire Boulevard, 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 I personally took the history, performed the physical examination, prepared and reviewed the document and reached a conclusion, 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."

Time spent on face to face with patient: 15 minutes
Time spent on review of records and preparation of this report: 15 minutes

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3.

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

Sincerely,

Re: Patient: Johnson, Marvetta
D/I: 11/6/2020

Edmond David Feder, L.Ac.

Signed this 2nd day of June, 2022, in Los Angeles, California.

EDF

ERIC E. GOFNUNG CHIROPRACTIC CORP.

QME of the State of California

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

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

June 2, 2022

David Feder, L.Ac.
6221 Wilshire Blvd., Suite 604
Los Angeles, CA 90048

Re:	Patient:	Johnson, Marvetta
	EMP:	Los Angeles County Probation Dept
	INS:	Sedgwick
	Claim #:	Unassigned
	WCAB #:	ADJ14891825
	DOI:	11/06/2020

Primary Treating Physicians Referral Notice

Dear David Feder, L.Ac.:

The above-named patient is being referred to you for the following secondary to their work related accident (s):

☒ Acupuncture consultation and treatment, if necessary, of:
☐ Cervical spine ☐ Thoracic spine ☐ Lumbar spine ☐ Shoulder - Upper Arm L / R
☐ Elbow – Forearm L / R ☐ Wrist – Hand L / R
☐ Hip – Thigh L / R ☐ Knee – Lower Leg L / R ☐ Foot – Ankle L / R
☐ Other_____

Please note, if you do not believe the patient to have reached maximum medical improvement for the organ system, then initiate appropriate treatment and issue your impairment upon the patient reaching maximal medical improvement.

David Feder, L.Ac., please provide a narrative report with a detailed history/physical examination, diagnoses and treatment recommendations as related to your initial consultation. Please provided supplemental narrative reports as related to follow ups in order to provide information of patient status to assist with patient management.

The patient's diagnostic impressions include the following:

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.

Please evaluate and advise.

Please find enclosed all necessary medical records. Please forward a complete report to my office once the patient has been seen.

If you should have any further questions, please do not hesitate to contact my office.

Sincerely,

Eric Gofnung, DC

E.G./cc

Cc: Served on all parties with proof of service.