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 **June 11, 2021**, 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 11 day of **June**, 2021, I served the within concerning:

Patient's Name:	**Castillo, Regelin P.**
Claim Number:	30217364863-0001
WCAB / EAMS case No:	ADJ14349578; ADJ14349577

- ☒ MPN Notice
- ☒ Designation of Primary Treating Physician & Authorization for Release of Medical Records
- ☐ Financial Disclosure
- ☒ Request for Authorization – **5/28/2021**
- ☒ Itemized – (Billing) / HFCA – **5/28/2021**
- ☐ QME Appointment Notification
- ☐ Primary Treating Physician's Referral
- ☒ Initial Consultation Report – **5/28/2021**
- ☐ Re-Evaluation Report / Progress Report (PR-2) _____
- ☐ 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:

Workers Defenders Law Group
8018 E. Santa Ana Cyn, Ste. 100-215
Anaheim, CA 92808

Sedgwick
P.O. Box 14433
Lexington, KY 40512-4433

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 11 day of **June**, 2021.

ILSE PONCE

ERIC E. GOFNUNG, D.C., QME

SPORTS MEDICINE AND REHABILITATION

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

Employer and/or Workers' Compensation Insurance Carrier:
Adventist Health White Memorial
1720 East Cesar E. Chavez Ave
Los Angeles, CA 90033

Re: Patient - Regelin P. Castillo
Social Security # - 550679707
Date Of Injury -
Employer -
Claim Number -

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

To Whom It May Concern:

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

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

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

Thank you for your assistance with this claim.

With Kind Regards,

Signature: X _____ Printed: Regelin P. Castillo Date: 5/28/27

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

May 28, 2021

Workers Defenders Law Group
8018 E. Santa Ana Cyn, Ste. 100-215
Anaheim, CA 92808

Re:	Patient:	Castillo, Regelin P.
	EMP:	Adventist Health System/West
	INS:	Sedgwick CMS
	Claim #:	30217364863-0001
	WCAB #:	ADJ14349578; ADJ14349577
	DOI:	9/17/2018; CT: 1/1/2009-2/19/2019
	D.O.E./Consultation:	May 28, 2021

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

Time Spent Face to face:	**Exceeded 60 mins**
99354/99355	**0 Unit**

Time spent for prolonged non face-to-face		**Total 99358 Units** (first 31 to 60 minutes per day = 1 unit)	**Total 99359 Units** (61+ minutes, 30 minute increments = 1 unit, not to exceed 60 minutes (total 120 or 2 units) per day)
Records Review	**00 Mins**		
Report Preparation	**Exceeded 30 Mins**		
		1 units	0 units

Dear Gentlepersons:

The above-named patient was seen for a Primary Treating Physician's Initial Evaluation on May 28, 2021, 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 examination was performed with the aid of a chaperone by name, Iris Alvarez.

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

Re: Patient: Castillo, Regelin P.
DOI: 9/17/2018; CT:1/1/2009-2/19/2019
Date of Exam: May 28, 2021

This authorization for treatment is made in compliance with Labor Code 4610 and 8 CCR 9792.6(o) and therefore serves as a written request for authorization for today's evaluation/consultation and treatment recommendations as described in this report. Please comply with Labor Code 4610, 8 CCR 9792.11 – 9792.15, 8 CCR 10112 – 10112.3 (formerly 8 CCR 10225 – 10225.2) and Labor Code 5814.6. Please comply with Sandhagen v. State Compensation Insurance Fund (2008) 44 Cal. 4 ch 230. Please comply with Jesus Cervantes v. El Aguila Food Products, Inc. and Ciga, et al., WCAB en banc, 7-0, November 19, 2009. Be aware that Labor Code 4610(b) requires the defendant to conduct utilization review on any and all requests for treatment. Furthermore, Labor Code 4610 Utilization Review deadlines are mandatory. It is the defendant's duty to forward all consultation and treatment authorization requests to utilization review. Be aware the defendant and insurance company has five working days to authorize, delay, modify or deny a request for all treatment, but 10 days for spinal surgery. Please issue timely payment for medical care and treatment rendered in order to avoid payment of interests and penalties, per labor codes referenced. Failure of the defendant or insurance company to respond in writing within five working days results in an authorization by default. Furthermore, failure to pay for "self-procured" medical care when utilization deadlines are missed triggers penalties for the defendant or the insurance company due to violation of 8 CCR 10225 – 10225.2 and Labor Code 5814/5814.6 and 4603.2b. When there is a dispute with regard to treatment, the right to proceed with the Labor Code 4062 process belongs exclusively to the injured employee. If the treatment recommendations are not authorized by the insurance carrier, this report and bill should be kept together by the Workers' Compensation carrier for the review company. The claims examiner should forward this report to the defense attorney and nurse case manager.

Job Description:

Ms. Regelin P. Castillo was employed by Adventist Health System, AKA Adventist Health White Memorial as a medical staff coordinator at the time of the injury. She began working for this employer in or about 1981. She worked full time.

Job activities included attending meetings, reviewing patient files, loading patient charts, and placing them into a cart, and wheeling them outside the office building to the physician's offices, taking handwritten and laptops. The meeting lasted up to 3-4 hours up to 4 times per week, composing reports on computer, meeting, and office work; she spent 95% of her time sitting down at a computer as well as working with physician credential files, including data entry, processing of applications, and filing.

The physical requirements consisted of sitting, walking, standing, flexing, twisting, and side-bending and extending the neck, answering telephones, bending, and twisting at the waist.

The patient is a right-hand dominant female, and she would use the bilateral upper extremities repetitively for simple grasping, power grasping, fine manipulation, keyboarding, writing, pushing, and pulling, reaching at shoulder level, reaching above shoulder level, and reaching below shoulder level.

The patient was required to lift and carry objects while at work. The patient was required to lift and carry objects weighing up to 6 to 8 pounds.

The patient worked 8-10 hours per day and five days a week. Her work hours varied. Lunch break was 30 minutes. Rest break was 10-15 minutes. The job involved working 100% indoors.

The last day the patient worked for Adventist Health System, AKA Adventist Health White Memorial, was in 2019.

There was no concurrent employment at the time of the injury. The patient denies working for any new employer.

Prior Work History:

The patient worked for the above employer for 31 years.

History Of Injury And Treatment As Presented By Patient:

Cumulative Trauma: January 1, 2009-February 19, 2019

The patient states that while working at her usual and customary occupation as a medical staff coordinator for Adventist Health System, AKA Adventist Health White Memorial, she sustained a work-related injury to her left shoulder, both elbows, bilateral wrists, and hands, which she developed in the course of her employment due to continuous trauma dated January 1, 2009, to February 19, 2019. She attributes the pain in her elbows, wrists/hands to the repetitive typing. She attributes the injuries due to prolonged sitting at a computer, repetitive movements, gripping, grasping, filling, lifting files, keyboarding, and answering telephone calls. She worked with persistent pain and discomfort.

In 1993, she experienced progressive pain in her left shoulder due to the repetitive nature of her job. She reported the injury to her employer and was referred to an industrial clinic. Treatment included examination, x-rays, MRI scans, prescribed medication, physical therapy, cortisone injections. The patient notes that she had a flare-up three to four times per year. She relates various doctors have evaluated her over the years. In late 2000, she was rated permanent and stationary and was awarded future. The patient notes that from 2000 through the present, she received medical care for her left shoulder three to four times per year.

She continued working with persistent pain and discomfort until 2019. She notes her left shoulder pain would worsen with lifting, reaching, filing, and typing at work through February 2017.

In or about 2000, the patient presented to an industrial clinic to evaluate the pain in her bilateral elbows, bilateral wrists, and hands. Treatment included examination, physical therapy right

elbow, and occupational therapy for her bilateral hands and wrists. She last received medical care for her right elbow in 2016. She last received medical care for her bilateral hands and wrists in 2017. The patient relates that she has continued to seek medical care on her own alongside treatment from the insurance carrier over the years through the present. Treatment included massage therapy two times per month, 12 times per year.

The patient explains that in 2020, she underwent one cortisone injection to her left shoulder.

In 2021, she underwent a cortisone injection to her left shoulder. The patient reports she did not receive chiropractic treatment. The patient report she developed hypertension while working for Adventist Health System.

SPECIFIC INJURY: September 17, 2018

The patient states that while working at her usual and customary occupation as a medical staff coordinator for Adventist Health System, AKA Adventist Health White Memorial, she sustained a work-related injury to her right knee and right hip. The patient explains that she was walking out of the office building when she slipped on a doormat covering an uneven surface. She lost her balance and landed on both knees. Initially, there was pain and swelling in both knees. In September 2017, the patient presented to an industrial clinic for evaluation. X-rays of both knees were obtained. She was diagnosed with a sprain. She completed several sessions of physical therapy. The pain in her left knee resolved. However, she continued to have pain and swelling in her right knee. She was advised to exercise her right knee, which she relates was worsening the pain. The patient progressively worsened, and she began to have difficulty driving. She continued to see the industrial physician for follow-up. In 2018, more physical therapy sessions were completed. The patient continued to experience stiffness. Her physician advised her to start walking. She experienced clicking and stiffness in her right knee. At the end of 2019, she requested a referral for an orthopedic evaluation.

In December of 2019, the patient was referred for an MRI scan of her right knee.

In January of 2020, the patient was referred for an orthopedic evaluation. Her MRI scan was reviewed, and she was diagnosed with a torn meniscus ligament in her right knee.

In June of 2020, the patient underwent right knee surgery by Dr. Phillip Merritt. The patient notes additional tear to her meniscus cartilage was found during surgery. Several sessions of post-operative physical therapy were completed. Dr. Merritt advised the patient to begin exercising. The patient reports that following her right knee surgery, she developed progressively worsening right hip and back pain due to rotating her hip while working. The patient reports she developed right shoulder pain due to using crutches and favoring left shoulder.

In February of 2021, she hired a fitness trainer to strengthen her muscles and attended a gym where she does assist stretching.

She last saw her PTP—Dr. Nassir on April 8, 2021.

On April 20, 2021, she returned to Dr. Merritt and complained of pain in her right hip. Her MRI scan was reviewed. X-rays of the right hip and right knee were obtained. Dr. Merritt told her that her right knee joint is not tracking and was causing her right hip to rotate while working. She advised continued home-focused exercises, including strengthening the muscles in the right hip, right leg, and right knee. She last saw Dr. Merritt in April of 2021.

The patient initially reported his injury to the employer on September 27, 2018. After reporting the injury to the employer, the patient was provided with an Employee Workers' Compensation Claim Form. She was provided with medical attention. Information regarding Medical Provider Networks and their rights if they are injured was posted in their place of work on the walls in a common area. Upon being hired, they were provided information relating to Medical Provider Networks and their rights if injured at work. Upon reporting their injury, they were provided information relating to Medical Provider Networks and their rights if injured at work.

The patient presents to this office for further evaluation.

Current Complaints:

Bilateral Shoulders:

The pain is slight and moderate, and the symptoms occur intermittent to frequently. The pain radiates to her arm and hand. There are spasms in the left shoulder. She experiences weakness and restricted range of motion for the shoulder as well as numbness and tingling in the shoulder, arm, elbow, and hand. The numbness and tingling in the hands and fingers awaken her at night. She complains of stiffness and experiences increased pain with repetitive motion of the arm/shoulder, the pain is aggravated with backward, lateral, and overhead reaching, pushing, pulling, lifting, and carrying greater and repetitive use of the left extremity. Her pain level varies throughout the day depending on activities. She is not able to sleep on the right/left/either shoulder due to the pain. She has difficulty falling asleep and awakens throughout the night due to the pain and discomfort.

Right Elbow:

The pain is moderate, and the symptoms occur frequently in the right elbow. The pain increases, becoming throbbing and burning in the elbow. The pain radiates into her arm. She has popping and tightness of the elbow. Her pain increases with reaching, pushing, pulling, and lifting.

Left Elbow:

The pain is moderate, and the symptoms occur frequently in the left elbow. The pain in her left elbow originates in her left shoulder. The pain increases, becoming throbbing and burning in the elbow. The pain radiates into her arm. She has popping and tightness of the elbow. Her pain increases with reaching, pushing, pulling, and lifting.

Bilateral Hands/Wrists:

The pain is moderate to severe, and the symptoms occur frequently, in the right and left wrist, hand, and fingers. The pain is aggravated with gripping, grasping, torquing motions, flexion, and extension of the wrist/hand, pinching, fine finger manipulation, driving, repetitive use of the bilateral upper extremities, pushing, pulling, and lifting, and carrying greater than 2-3 pounds. She has cramping, weakness and loss of grip strength in the hand and wrist. There is tingling in the hands and fingers. She has difficulty sleeping and awakens with numbness, tingling and pain, and discomfort. Her pain level varies throughout the day depending on activities.

Lower Back and Right Hip: (Patient points to right sacroiliac joint)

The pain is moderate and the symptoms occur frequently in her right hip, at times becoming sharp, shooting, throbbing, and burning pain. There is no radiating pain. She has a clicking and grinding sensation in the hip. She has difficulty sleeping and awakens with pain and discomfort. Her pain level becomes worse in the evening/morning/varies throughout the day depending on activities.

Right Knee:

The pain is moderate and the symptoms occur frequently in the right knee. The pain increases with prolonged standing and walking, goings, bending, stooping, squatting, and walking on uneven surfaces or slanted surfaces. There is popping and grinding in the right knee, and experiences buckling as well as locking episodes. She has lost her balance as a result of the buckling. She has episodes of swelling in the knee. She is unable to kneel. She has difficulty squatting, ascending, and descending stairs.

Hypertension:

Controlled with medication.

Psyche:

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

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

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

Past Medical History:

Illnesses:

The patient has high blood pressure, which is controlled by medication.

Injuries:

The patient denied any prior work-related injuries.

Approximately ten years ago, the patient was involved in an auto accident and sustained an injury to her lower back. Treatment included examination, prescribed medication, and physical therapy. She relates she made a full recovery.

In or about 2014, the patient was involved in an auto accident and sustained an injury to her lower back. Treatment included examination, prescribed medication, and physical therapy. She relates she made a full recovery.

In February 2017, the patient was working out at a gym and sustained an injury to her thoracic spine. Treatment included examination, prescribed medication, chiropractic treatment, and physical therapy. She relates she made a full recovery.

The patient denied any new injuries.

Allergies:

The patient has allergic rhinitis. She is allergic to sulfa and doxycycline.

Medications:

The patient is taking meloxicam and OTC Advil.

Surgeries:

In June of 2020, the patient underwent right knee surgery.

At four years of age, she underwent a tonsillectomy.

In 1989 and 1992, the patient underwent a C-section.

Hospitalization:

The patient denied any hospitalization.

The patient was asymptomatic and without any disability or impairment prior to the continuous trauma injury from January 1, 2009-February 19, 2019, as related to her left shoulder, both elbows, bilateral wrists, and hands.

The patient was asymptomatic and without any disability or impairment prior to the specific injury on September 27, 2018, as related to the right hip and right knee.

Review of Systems:

Review of systems is remarkable for trouble sleeping, muscle or joint pain, stiffness, anxiety, and stress.

Activities of Daily Living:

Self-Care - Personal Hygiene: As a result of the industrially related injury, the patient states: Difficulty with urination, defecation, and bathing by self, with a rating of 3.5/5.

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

Hand Activities: As a result of the industrially related injury, the patient states: Difficulty with grasping or gripping, lifting, and manipulating small items with a rating of 4/5.

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

Family History:

Mother is deceased and passed away from kidney disease and hypertension.

Father is deceased and passed away from diabetes.

The patient has three siblings. One sibling has environmental uterine cancer.

There is no known history of colon cancer, breast cancer, or heart problems.

Social History:

Ms. Regelin P. Castillo is a 55-year-old married female with two children.

The patient completed college.

The patient consumes no alcohol and does not smoke.

The patient does not exercise.

The patient does not participate in any sports activities.

The patient has no hobbies.

Physical Evaluation (May 28, 2021) – Positive Findings:

General Appearance:

The patient is a 55-year-old female, right-hand dominant who appeared reported age, and was well-developed, well-nourished, and well-proportioned. The patient appears to be alert, cooperative and oriented x3. She is not pregnant.

Vital Signs:

Pulse:	90
Blood Pressure:	139/90
Height:	5'2"
Weight:	165

Cervical Spine:

Gross deformity, edema, swelling, erythema and surgical scars are not present upon visual examination of the cervical spine. Torticollis is not present.

Tenderness and spasm is not present over the paravertebral musculature, upper trapezius musculature, suboccipital musculature, sternocleidomastoid musculature and occiput bilaterally. Tenderness and hypomobility is not present over the vertebral regions from C1 to C7.

Cervical compression, cervical distraction and shoulder depression tests are negative bilaterally. Valsalva orthopedic tests are negative.

Ranges of motion of the cervical spine were performed without pain and spasm.

Cervical Spine Range of Motion Testing		
Movement	Normal	Actual
Flexion	50	50
Extension	60	60
Right Lateral Flexion	45	45
Left Lateral Flexion	45	45
Right Rotation	80	80
Left Rotation	80	80

Shoulders & Upper Arms:

Examination revealed tenderness over the bilateral shoulders at the supraspinatus near insertion as well as over the left subacromial and subdeltoid bursa.

Bilateral Apprehension and Hawkins tests were unremarkable.

Ranges of motion of the bilateral shoulders were normal **with pain at bilateral shoulders upon extremes of flexion and abduction.**

Shoulder Ranges Of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	180	180	180
Extension	50	50	50
Abduction	180	180	180
Adduction	50	50	50
Internal Rotation	90	90	90
External Rotation	90	90	90

Elbows & Forearms:

Examination revealed tenderness over the lateral epicondyles.

Bilateral Cozens' tests were positive.

Ranges of motion of the elbows were normal:

Elbow Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	140	140	140
Extension	0	0	0
Supination	80	80	80

Pronation	80	80	80

Wrists & Hands:

Examination revealed tenderness over the bilateral wrists over the volar and dorsal crease as well as anatomical snuff box and thenar regions.

Bilateral Tinel's sign negative. **Bilateral Finkelstein's test positive.**

Ranges of motion of the bilateral wrists were normal **with pain upon extremes of flexion and extension.**

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

Finger:

Upon inspection, deformity and swelling was noted at the bilateral fifth digits at the distal interphalangeal joints and third digits at the proximal interphalangeal joints.

Tenderness at bilateral hand digits two through five at the proximal interphalangeal and distal interphalangeal joints, predominantly over the distal interphalangeal joints of fifth digits and third digits. Tenderness was also present of bilateral thumbs at the carpometacarpal joints and metacarpophalangeal joints.

Bilateral hands digit ranges of motion were grossly within normal limits with pain upon extremes of range of motion of all digits.

Motor Testing of the Cervical Spine and Upper Extremities:

Deltoid *(C5)*, Biceps *(C5)*, Triceps *(C7)*, Wrist Extensor *(C6)*, Wrist Flexor *(C7)*, Finger Flexor *(C8)* and Finger Abduction *(T1)* motor testing is normal and 5/5 bilaterally.

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

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

Sensory Testing:

C5 *(deltoid)*, C6 *(lateral forearm, thumb & index finger)*, C7 *(middle finger)*, C8 *(little finger & medial forearm)*, and T1 *(medial arm)* dermatomes are intact bilaterally as tested with a Whartenberg's pinwheel.

Upper Extremity Measurements in Centimeters		
Measurements	Left	Right
Biceps	**31**	**30.5**
Forearms	**21**	**20.5**

Thoracic Spine:

Gross edema, swelling, erythema and scars are not present upon visual examination of the thoracic spine. The thoracic spine has a normal kyphotic curvature.

Tenderness and spasm is not present over the paravertebral musculature, trapeziums, rhomboid, latissimus dorsi musculature and interscapular region bilaterally. Tenderness and hypomobility is not present over the vertebral regions from T1 to T12.

Kemp's test is negative.

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

Lumbar Spine:

Examination revealed tenderness over L4-L5 vertebral regions. Right sacroiliac joint tenderness was present.

Milgram's test was positive for low back pain. Right sacroiliac joint compression test was positive.

Straight Leg Raising Test (supine / seated) was positive for discomfort in the bilateral hamstrings:

Right: 75 degrees.
Left: 75 degrees.

Lumbar spine ranges of motion were restricted and painful, with greatest pain upon extension and right lateral flexion, measured as follows:

Lumbar Spine Range of Motion Testing		
Movement	Normal	Actual
Flexion	60	**45**

Extension	25	**15**
Right Lateral Flexion	25	**15**
Left Lateral Flexion	25	**20**

Hips & Thighs:

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

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

Bilateral Patrick Fabere test is unremarkable.

Hip ranges of motion were performed without pain and spasm.

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

Knees & Lower Legs:

Left Knee:

Visual examination of left knee and lower leg does not identify deformity, dislocation, edema, swelling, erythema, scars and lacerations.

Tenderness is not present over the quadriceps tendon, patella, infrapatellar tendon, tibial tuberosity, medial joint line, lateral joint line and popliteal fossa. Palpation of the lower leg muscles/regions was unremarkable for tenderness at the gastrocnemius, tibialis anterior *(dorsiflexion & inversion)* and peroneal musculature *(lateral ankle-eversion)*.

McMurray's test, Varus Stress test, anterior drawer test and posterior drawer test are negative.

Right Knee:

Tenderness was noted over the medial and lateral joint lines. Healed arthroscopic scar was noted over the right knee. Two healed laparoscopic scars were noted at the right knee at the medial and lateral aspects.

Right McMurray's test elicited increased pain at the right knee.

Range of motion of the left knee was normal. **Right knee range of motion was decreased and measured as follow.**

Knee Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	135	135	**115**
Extension	0	0	0

Ankles & Feet:

Bilateral pes planus and bilateral hallux valgus deformity.

Examination of ankles and feet did not demonstrate gross deformity, dislocation, amputation, edema, swelling, erythema, scars, lacerations, hallux valgus and hammertoes. The foot arch height is normal and without pes cavus.

Tenderness is not present of digits 1 through 5, including metatarsals, cuneiforms, navicular, cuboid, talus and calcaneus. Tenderness is not present at the distal tibia, distal fibula, talonavicular joint, anterior talofibular ligament and deltoid ligament. There is no medial ankle instability or lateral ankle instability bilaterally. The Achilles tendon is intact. Tenderness is not present over the tarsal tunnel, sinus tarsi and tibialis posterior tendons *(medial ankle-plantarflexion & inversion*) bilaterally.

Anterior drawer test, posterior drawer test and Tinel's sign are negative bilaterally. The dorsalis pedis pulses are present and equal bilaterally.

Ankle ranges of motion were performed without pain, spasm, weakness, crepitus or instability bilaterally.

Ankle Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Metatarsophalangeal joint (MPJ) Extension	60	60	60
MPJ Flexion	20	20	20
Ankle Dorsiflexion	20	20	20
Ankle Plantar Flexion	50	50	50
Inversion (Subtalar joint)	35	35	35
Eversion (Subtalar joint)	15	15	15

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

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

Squatting was performed to one-third down with pain in the right knee.

Heel and toe walking elicited increased pain in the right knee.

The patient's gait was slightly antalgic favoring right knee.

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

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

Sensory Testing:

L3 *(anterior thigh)*, L4 *(medial leg, inner foot)*, L5 *(lateral leg and midfoot)* and S1 *(posterior leg and outer foot)* dermatomes are intact bilaterally upon testing with a pinwheel.

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

Lower Extremity Measurements Circumferentially & Leg Length in Centimeters		
Measurements (in cm)	Left	Right
Thigh - 10 cm above patella with knee extended	**51**	**51.5**
Calf - at the thickest point	**35**	**35.5**
Leg Length - Anterior Superior Iliac Spine To Medial Malleolus	**95**	**95**

Diagnostic Impressions:

1. Lumbar myofasciitis, M79.1.
2. Right sacroiliac joint dysfunction, sacroiliitis, M53.3.
3. Lumbar facet-induced versus discogenic pain, M47.816.
4. Bilateral shoulder tenosynovitis/bursitis, M75.51.
5. Bilateral elbow lateral epicondylitis, M77.10.

6. Bilateral wrists tenosynovitis, M65.849.

7. Bilateral de Quervain's stenosing tenosynovitis of the thumbs, M65.4.

8. DJD of hands and wrists, rule out, M19.049, M19.032.

9. Right knee status post surgery, June 2020, Z53.33.

10. Right knee internal derangement, rule out, M23.91.

11. Hypertension, I10

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

Treatment Plan:

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, bilateral elbows, bilateral wrists, hands and thumbs, right knee at once a week for six weeks with a followup in six weeks.**

The patient is **recommended x-rays of the bilateral shoulders, elbows, wrists, and hands and MRI of the right knee.**

The patient is **recommended stabilized right knee brace as well as bilateral wrist braces, bilateral epicondylitis braces and bilateral thumb Spica to use as necessary based on pain levels.**

The patient is **recommended orthopedic evaluation in regards to extremity issues.**

The patient was **recommended internal medicine evaluation for further workup of causation, nature and extent of hypertension.**

Treatment recommendations for the bilateral shoulders will be readdressed on the patient's followup after she has been able to undergo x-rays.

Medical Causation Regarding AOE/COE:

In my opinion, it is within a reasonable degree of medical probability that the causation of this patient's injuries, resultant conditions, as well as need for treatment with regards to left

shoulder, both elbows, both wrists and hands are industrially related and secondary to continuous trauma from 1/1/2009 to 2/19/2019; with regards to right knee, low back, and right sacroiliac joint are industrially related and secondary to the 09/17/18 injury, and with regards to right shoulder is industrially related and secondary to continuous trauma from 1/1/2009 to 2/19/2019 as well as the right knee injury of 9/17/18 while working for Adventist Health System, AKA Adventist Health White Memorial as a medical staff coordinator.

This patient reports developing right shoulder pain due to use of crutches and walker following the right knee surgery of June 2020.

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

Permanent and Stationary Status:

The patient's condition is not permanent and stationary.

Work Status/Disability Status:

The patient was returned to modified duty on 5/28/21, precluding work with shoulders at or above shoulder height, precluding lifting in excess of 5 pounds with furthermore restricted to occasional basis. No repeated bending or stooping. No repetitive or forceful gripping, grasping, torqueing, pulling, and pushing. The patient is precluded from squatting, kneeling, or climbing and prolonged standing and walking. The patient must be able to change position from standing to sitting as needed based on pain levels. The patient should use bilateral epicondylitis brace, bilateral wrist and thumb Spica as well as lumbar orthosis and right knee brace while working. The patient was also limited to work no more than four hours per day.

If modified duty as indicated is not provided, then the patient is considered temporarily totally disabled 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.

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."

Re: Patient: Castillo, Regelin P.
DOI: 9/17/2018; CT:1/1/2009-2/19/2019
Date of Exam: May 28, 2021

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.

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.

Re: Patient: Castillo, Regelin P.
DOI: 9/17/2018; CT:1/1/2009-2/19/2019
Date of Exam: May 28, 2021

Sincerely,

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

Signed this 9 day of June, 2021, 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): Castillo, Regelin			
Date of Injury (MM/DD/YYYY): 02/19/2021		Date of Birth (MM/DD/YYYY): 07/23/1965	
Claim Number: 30217364863-0001		Employer: Adventist Health White Memorial	

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			

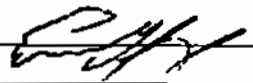
Claims Administrator Information

Company Name: Sedgwick		Contact Name: Karlina Swaim	
Address: P.O. Box 14433		City: Lexington	State: KY
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.)
Sacroiliac Joint Sprain	S33.6XXA	Chiro Initial Consultation	99204	1 Time
Lumbar Facet	M47.816	Progress Report	WC002	
		Transcription	99199	

Requesting Physician Signature:  Date: 05/28/2021

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): Castillo, Regelin			
Date of Injury (MM/DD/YYYY): 02/19/2021		Date of Birth (MM/DD/YYYY): 07/23/1965	
Claim Number: 30217364863-0001		Employer: Adventist Health White Memorial	

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: Karlina Swaim	
Address: P.O. Box 14433		City: Lexington	State: KY
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.)
Sacroiliac Joint Sprain	S33.6XXD	Electrical Stimulation	G0283	1 x a week for 6 weeks
Lumbar Facet	M47.816	Therapeutic Exercises	97110	
		Massage Therapy	97124	
		CMT 3-4 regions	98941	

Requesting Physician Signature: Date: 05/28/2021

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): Castillo, Regelin			
Date of Injury (MM/DD/YYYY): 02/19/2021		Date of Birth (MM/DD/YYYY): 07/23/1965	
Claim Number: 30217364863-0001		Employer: Adventist Health White Memorial	

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: Karlina Swaim	
Address: P.O. Box 14433		City: Lexington	State: KY
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.)
Hypertension	I10	Internal Medicine Evaluation		

Requesting Physician Signature: Date: 05/28/2021

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): Castillo, Regelin			
Date of Injury (MM/DD/YYYY): 02/19/2021		Date of Birth (MM/DD/YYYY): 07/23/1965	
Claim Number: 30217364863-0001		Employer: Adventist Health White Memorial	

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: Karlina Swaim	
Address: P.O. Box 14433		City: Lexington	State: KY
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.)
Shoulder Tenosynovitis	M65.811/M65.812	X-rays of		
		bilateral shoulders		

Requesting Physician Signature: [signature] Date: 05/28/2021

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): Castillo, Regelin			
Date of Injury (MM/DD/YYYY): 09/17/2018		Date of Birth (MM/DD/YYYY): 07/23/1965	
Claim Number:		Employer: Adventist Health White Memorial	

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: Karlina Swaim	
Address: P.O. Box 14433		City: Lexington	State: KY
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.)
Elbow Lateral Epicondylit	M77.10	Electrical Stimulation	G0283	1 x a week for 6 weeks
Wrist Tenosynovitis	M65.849	Therapeutic Exercises	97110	
De Quervain	M65.4	Massage Therapy	97124	
Knee Internal Derangmer	M23.91	Extraspinal Manipulation w/spinal	98943	

Requesting Physician Signature: Date: 05/28/2021

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): Castillo, Regelin			
Date of Injury (MM/DD/YYYY): 09/17/2018		Date of Birth (MM/DD/YYYY): 07/23/1965	
Claim Number:		Employer: Adventist Health White Memorial	

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: Karlina Swaim	
Address: P.O. Box 14433		City: Lexington	State: KY
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.)
Elbow Lateral Epicondylit	M77.10	X-rays of		
Wrist Tenosynovitis	M65.849	bilateral elbows		
De Quervain	M65.4	bilateral wrists		
Knee Internal Derangmer	M23.91	bilateral hands		

Requesting Physician Signature: Date: 05/28/2021

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): Castillo, Regelin			
Date of Injury (MM/DD/YYYY): 09/17/2018		Date of Birth (MM/DD/YYYY): 07/23/1965	
Claim Number:		Employer: Adventist Health White Memorial	

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: Karlina Swaim	
Address: P.O. Box 14433		City: Lexington	State: KY
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.)
Elbow Lateral Epicondylit	M77.10	MRI of		
Wrist Tenosynovitis	M65.849	right knee		
De Quervain	M65.4			
Knee Internal Derangmer	M23.91			

Requesting Physician Signature: Date: 05/28/2021

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): Castillo, Regelin			
Date of Injury (MM/DD/YYYY): 09/17/2018		Date of Birth (MM/DD/YYYY): 07/23/1965	
Claim Number:		Employer: Adventist Health White Memorial	

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: Karlina Swaim	
Address: P.O. Box 14433		City: Lexington	State: KY
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.)
Elbow Lateral Epicondylit	M77.10	Orthopedic Evaluation		
Wrist Tenosynovitis	M65.849			
De Quervain	M65.4			
Knee Internal Derangmer	M23.91			

Requesting Physician Signature: Date: 05/28/2021

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): Castillo, Regelin			
Date of Injury (MM/DD/YYYY): 09/17/2018		Date of Birth (MM/DD/YYYY): 07/23/1965	
Claim Number:		Employer: Adventist Health White Memorial	

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: Karlina Swaim	
Address: P.O. Box 14433		City: Lexington	State: KY
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.)
Elbow Lateral Epicondylit	M77.10	Stabilized right knee brace		
Wrist Tenosynovitis	M65.849	bilateral wrists braces		
De Quervain	M65.4	bilateral epicondylitis braces		
Knee Internal Derangmer	M23.91	bilateral thumb spica		

Requesting Physician Signature: Date: 05/28/2021

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:		