ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

12626 Riverside Drive, Suite 510 • North Hollywood, California 91607 • Tel. (818) 623-9633 • Fax (818) 623-9533

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 12626 Riverside Drive, Suite 510 North Hollywood, Ca 91607. 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 **14th** day of **January**, 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.

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

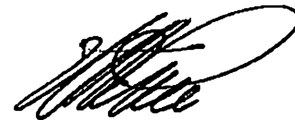
- ☐ MPN Notice
- ☐ Designation of Primary Treating Physician & Authorization for Release of Medical Records
- ☒ Request for Authorization – **12/16/2021**
- ☒ Itemized – (Billing) / HFCA – **12/16/2021**
- ☐ QME Appointment Notification
- ☐ Primary Treating Physician's Referral
- ☐ Other: _____ - _____
- ☐ Initial Consultation Report – _____
- ☒ Re-Evaluation Report / Progress Report (PR-2) – **12/16/2021**
- ☐ 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 of perjury that the foregoing is true and correct under the laws of the State of California and that this Declaration was executed at 12626 Riverside Drive, Suite 510 North Hollywood, Ca 91607 on **14th** day of **January**, 2022.



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December 16, 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
D.O.E./Consultation: December 16, 2021

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

Time Spent Face to face:	15 minutes
Time Spent on Report Preparation	15 minutes

Dear Gentlepersons:

The above-named patient was seen for a Primary Treating Physician's Follow up Evaluation on December 16, 2021, in my office located at 12626 Riverside Drive, Suite 510, North Hollywood, California 91607. The following information contained in this report is derived from a review of the available medical records, as well as the oral history as presented by the patient. **My associate, Dr. Kravchenko, examined the patient and I, Dr. Gofnung, the primary treating physician, agree with Dr. Kravchenko's physical examination findings and conclusions.**

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

This authorization for treatment is made in compliance with Labor Code 4610 and 8 CCR 9792.6(o) and therefore serves as a written request for authorization for today's evaluation/consultation and treatment recommendations as described in this report. Please comply with Labor Code 4610, 8 CCR 9792.11 – 9792.15, 8 CCR 10112 – 10112.3 (formerly 8

CCR 10225 – 10225.2) and Labor Code 5814.6. Please comply with Sandhagen v. State Compensation Insurance Fund (2008) 44 Cal. 4 ch 230. Please comply with Jesus Cervantes v. El Aguila Food Products, Inc. and Ciga, et al., WCAB en banc, 7-0, November 19, 2009. Be aware that Labor Code 4610(b) requires the defendant to conduct utilization review on any and all requests for treatment. Furthermore, Labor Code 4610 Utilization Review deadlines are mandatory. It is the defendant's duty to forward all consultation and treatment authorization requests to utilization 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.

Note: This patient is being treated in our office for multiple claims/body parts; the current report is related to the Right Knee, Lumbar Spine, and Right Shoulder and Right Hip with DOI: 09/17/2018.

Interim History:

Ms. Castillo has been performing home exercise program. She has not returned to work. The patient was seen by QME on December 7, 2021. She is scheduled to begin acupuncture treatment later this month. The patient remains symptomatic. She denies any new accidents or injuries.

Current Complaints (December 16, 2021):

1. Low back pain, intermittent and slight to moderate, worse with prolonged sitting, prolonged weight bearing.

2. Right knee pain associated with feeling of instability and clicking as well as locking, best described as frequent and slight to moderate, worse with prolonged weight bearing, squatting, walking over uneven surface, and going up and down the stairs.

3. Hypertension, controlled on medication.

4. Stress and anxiety.

Physical Evaluation (December 16, 2021) – Positive Findings:

Lumbar Spine:

Examination revealed tenderness to palpation with muscle guarding over bilateral paralumbar musculoskeletal. Tenderness and hypomobility at L4-L5 vertebral regions.

Milgram's test was positive. Right sacroiliac joint compression test was positive.

Straight Leg Raising Test (supine) was positive bilaterally.

Right: 60 degrees
Left: 65 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	**50**
Extension	25	**15**
Right Lateral Flexion	25	**18**
Left Lateral Flexion	25	**20**

Right Knee:

Examination revealed tenderness to palpation at right knee medial and lateral joint lines. Healed arthroscopic scar over the right knee.

Orthopedic testing not performed due to post-surgical status.

Range of motion of the left knee was normal. **Range of motion for right knee was decreased and painful.**

Knee Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	135	135	**120**
Extension	0	0	0

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

Right knee extension 4/5, all other myotomes 5/5.

Squatting was performed parallel with right knee pain.

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

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 MRI of right knee performed 7/15/21 interpreted by Amjad Safvi, MD, radiologist revealed the following: Joint effusion. Tear of medial meniscus. Partial tear of anterior cruciate ligament. Degenerative narrowing of articular cartilages at patellofemoral and tibiofemoral joints.

3) Review of MRI of lumbar spine performed on 8/10/21 interpreted by Nicholas Dzebolo, MD, radiologist revealed the following: At L4-L5, and L5-S1, 2 to 2.3 mm disc bulges.

Diagnostic Impressions:

1. Lumbar spine myofasciitis, M79.1.

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

3. Lumbar facet-induced versus discogenic pain, M47.816.

4. Lumbar disc herniations, per MRI, M51.26

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

6. Right knee internal derangement confirmed by MRI, M23.91.

7. Hypertension, I10

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

Re: Patient: Castillo, Regelin P.
DOI: 9/17/2018
Date of Exam: December 16, 2021

Discussion and Treatment Recommendations:

The patient is recommended to continue with 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 right knee and lower leg at once per month with a followup in four weeks.**

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

The patient is **recommended to proceed with acupuncture treatment.**

She is **recommended to continue with the home exercise program.**

Permanent and Stationary Status:

The patient's condition is not permanent and stationary.

Work Status/Disability Status:

No lifting over 20 pounds. No repeated squatting, kneeling, climbing, prolonged standing and prolonged walking. No driving over 1 hour without a break. Must be able to change positons as needed. If modified duty as indicated is not provided, then the patient is considered temporarily totally disabled until reevaluation in four weeks.

Disclosure:

I derived the above opinions from the oral history as related by the patient, revealed by the available medical records, diagnostic testing, credibility of the patient, examination findings and my clinical experience. This evaluation was carried out at 12626 Riverside Drive, Suite 510, North Hollywood, California 91607. I prepared this report, including any and all impressions and conclusions described in the discussion.

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628)(b): " I declare that Dr. Kravchenko examined the patient and may have assisted with initial preparation and assembly of components of this report, and I, Dr. Gofnung, the primary treating physician, have reviewed the report, edited the document, reviewed the final draft and I am in agreement with the findings, including any and all impressions and conclusions as described in the this report."

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

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

under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true."

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

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

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

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

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

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

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

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

Sincerely,

Re: Patient: Castillo, Regelin P.
DOI: 9/17/2018
Date of Exam: December 16, 2021

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

Signed this 14th day of January, 2022, in North Hollywood, California.

EEG:svl

Sincerely,

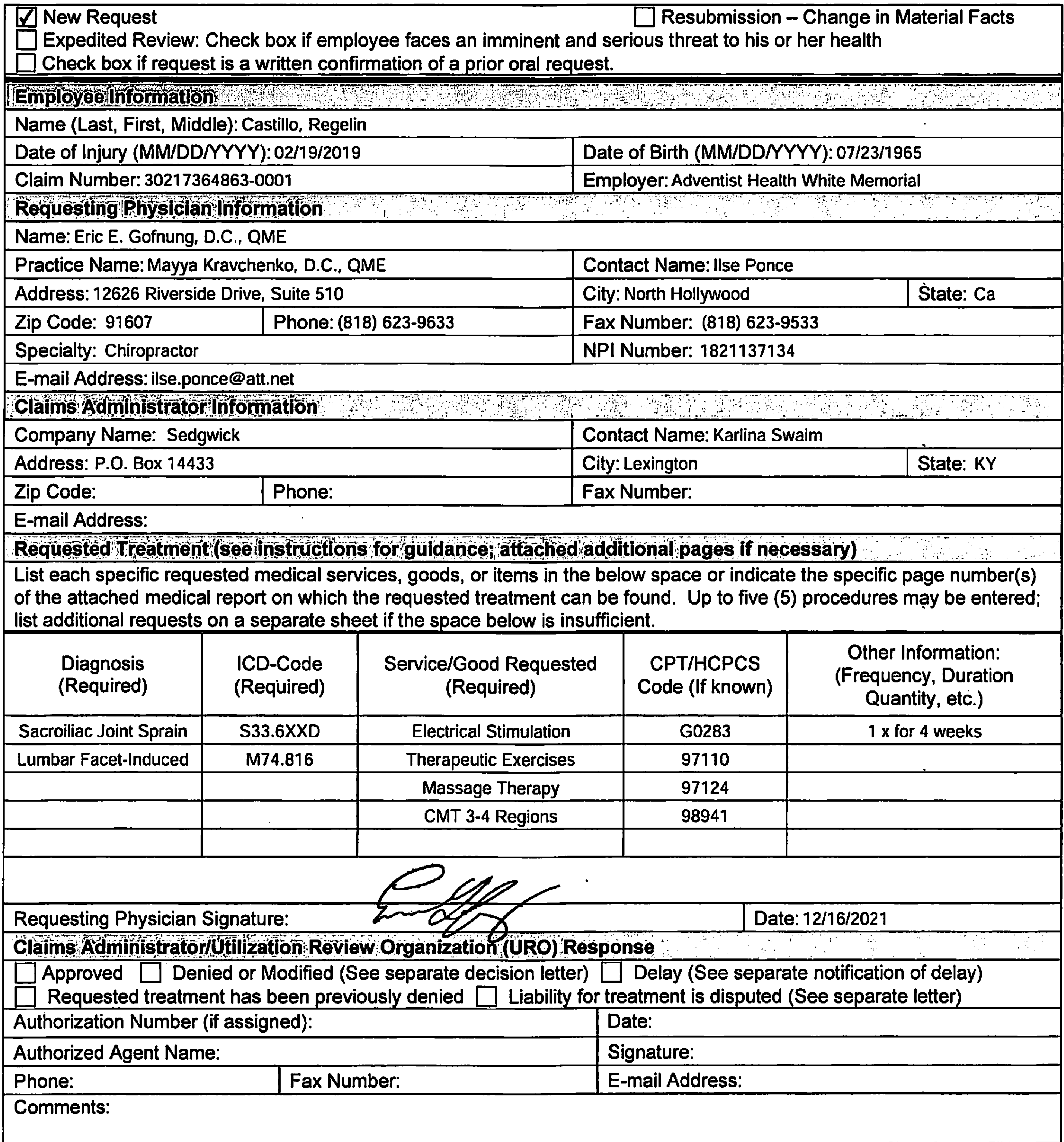
Mayya Kravchenko, D.C., QME
State Appointed Qualified Medical Evaluator
Certified Industrial Injury Evaluator

Signed this 14th day of January, 2022, in North Hollywood, California.

MK:svl

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

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



☑ 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): 02/19/2019	Date of Birth (MM/DD/YYYY): 07/23/1965
Claim Number: 30217364863-0001	Employer: Adventist Health White Memorial

Requesting Physician Information

Name: Eric E. Gofnung, D.C., QME			
Practice Name: Mayya Kravchenko, D.C., QME		Contact Name: Ilse Ponce	
Address: 12626 Riverside Drive, Suite 510		City: North Hollywood	State: Ca
Zip Code: 91607	Phone: (818) 623-9633	Fax Number: (818) 623-9533	
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 for 4 weeks
Lumbar Facet-Induced	M74.816	Therapeutic Exercises	97110	
		Massage Therapy	97124	
		CMT 3-4 Regions	98941	

Requesting Physician Signature: [signature] Date: 12/16/2021

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)

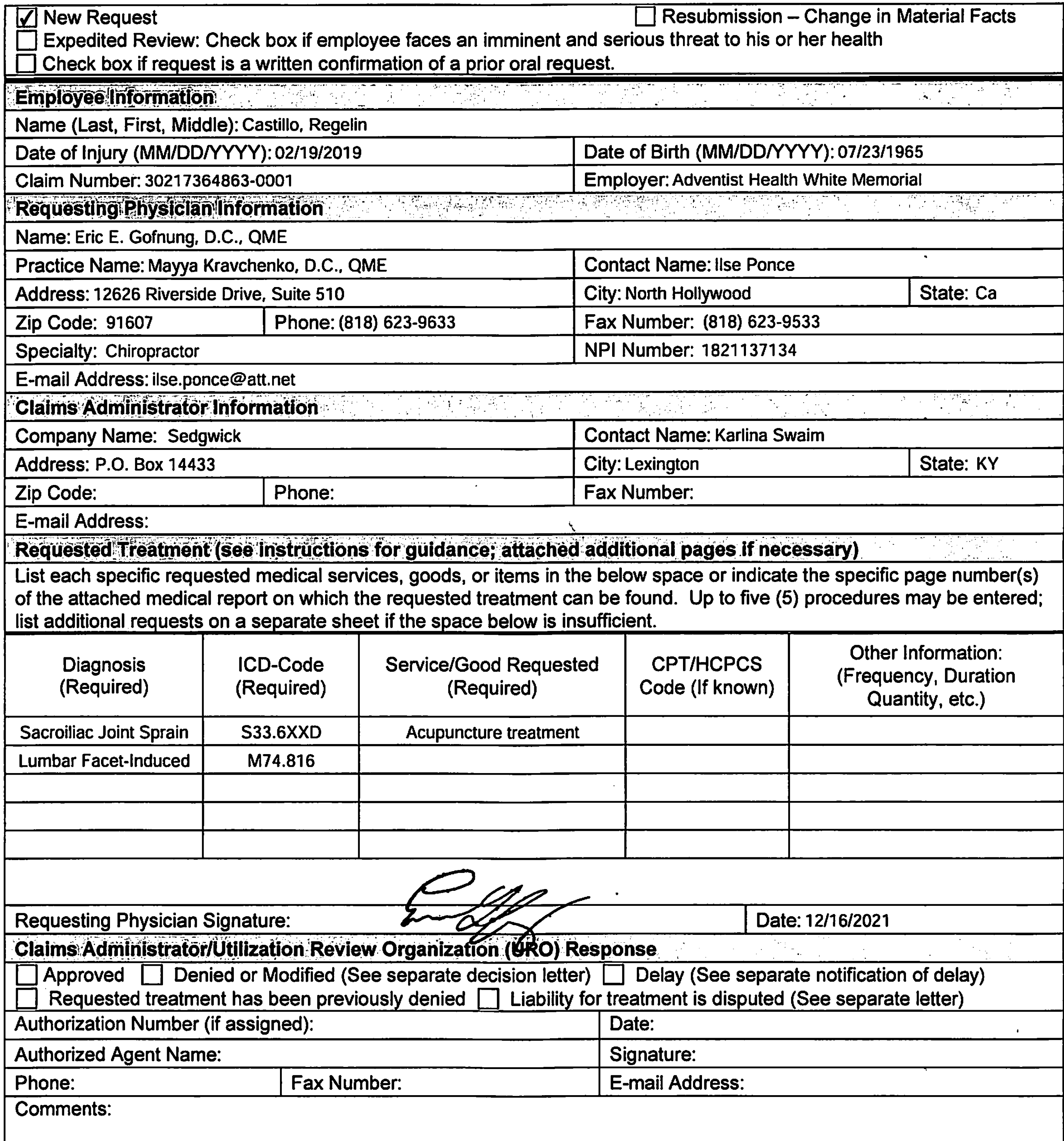
Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

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): 02/19/2019	Date of Birth (MM/DD/YYYY): 07/23/1965
Claim Number: 30217364863-0001	Employer: Adventist Health White Memorial

Requesting Physician Information			
Name: Eric E. Gofnung, D.C., QME			
Practice Name: Mayya Kravchenko, D.C., QME		Contact Name: Ilse Ponce	
Address: 12626 Riverside Drive, Suite 510		City: North Hollywood	State: Ca
Zip Code: 91607	Phone: (818) 623-9633	Fax Number: (818) 623-9533	
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	Acupuncture treatment		
Lumbar Facet-Induced	M74.816			

Requesting Physician Signature: [signature] Date: 12/16/2021

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:		