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 6221 Wilshire Blvd, Suite 605 Los Angeles, CA 90048. I am familiar with a Company's practice where the mail, after being placed in a designated area, is given the appropriate postage and is deposited in a U. S. mailbox in the City of Los Angeles, after the close of the day's business. On **February 8, 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 605 Los Angeles, CA 90048.

On 8 day of **February,** 2021, I served the within concerning:

Patient's Name: **ROQUEMORE, SANDRA**
Claim Number: UW2000031099

☐ MPN Notice

☐ Designation of Primary Treating Physician & Authorization for Release of Medical Records

☐ Financial Disclosure

☐ Request for Authorization –

☒ Itemized – (Billing) / HFCA – 01/11/2021

☐ QME Appointment Notification

☐ Primary Treating Physician's Referral

☐ *Initial Consultation Report –*

☒ Re-Evaluation Report / Progress Report (PR-2) **01/11/2021**

☐ 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 Canyon, Suite 100-215
Anaheim Hills, California 92808

Accident Fund Lansing
P. O. Box 40790
Lansing, Michigan 48901

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 8 day of **February**, 2021.

ILSE PONCE

ERIC E. GOFNUNG CHIROPRACTIC CORP.

SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION

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

January 11, 2021

Workers Defenders Law Group
8018 E. Santa Ana Canyon, Suite 100-215
Anaheim Hills, California 92808

Re: Patient: Roquemore, Sandra Ann
EMP: American Guard Services
INS: NEXT LEVEL ADMINISTRATORS
Claim #: UW2000031099
WCAB #: ADJ13817769 & ADJ13818144
DOI: CT: 04/01/2020-10/26/2020 & 08/01/2020-11/03/2020
D.O.E./Consultation: January 11, 2021

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

Time Spent Face to face:	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	15 Mins		
		0 units	0 units

Dear Gentlepersons:

The above-named patient was seen for a Primary Treating Physician's Followup Evaluation on January 11, 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. **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*.**

Re: Patient: Roquemore, Sandra Ann
DOI: CT: 04/01/2020-10/26/2020 & 08/01/2020-11/03/2020
Date of Exam: January 11, 2021

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

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

Interim History:

Ms. Roquemore is undergoing comprehensive course of treatment under our care consisting of *chiropractic manipulations and adjunctive multimodality physiotherapy*. She is feeling some improvement with treatment, however, remains symptomatic.

Current Complaints (January 11, 2021):

1. Abdominal/stomach issues, intermittent and moderate.

2. Lower back pain frequent and moderate, *occasionally moderate to severe*, radiating to lower extremities.

3. Bilateral feet pain, frequent and moderate, associated with burning sensation.

4. Anxiety and depression.

Re: Patient: Roquemore, Sandra Ann
DOI: CT: 04/01/2020-10/26/2020 & 08/01/2020-11/03/2020
Date of Exam: January 11, 2021

Physical Evaluation (January 11, 2021) – Positive Findings:

Thoracic Spine:

Thoracic spine examination was within normal limits.

Ranges of motion for thoracic spine were restricted secondary to lower back pain, measured as follows.

Thoracic Spine Range of Motion Testing		
Movement	Normal	Actual
Flexion	45	**40**
Extension	0	**0**
Right Rotation	30	**15**
Left Rotation	30	**20**

Lumbosacral Spine:

Examination revealed tenderness to palpation with myospasm of bilateral paralumbar musculature. Tenderness and hypomobility is noted at L1 through L5 vertebral regions.

Milgram's test is positive. Sacroiliac joint compression test is positive on the right.

Straight Leg Raising Test (supine) was positive with increased radiculopathy to right lower extremity:

Right: 40 degrees.
Left: 50 degrees.

Ranges of motion for the lumbar spine were decreased and painful, measured as follows.

Lumbar Spine Range of Motion Testing		
Movement	Normal	Actual
Flexion	60	**45**
Extension	25	**10**
Right Lateral Flexion	25	**15**
Left Lateral Flexion	25	**18**

Hips & Thighs:

Re: Patient: Roquemore, Sandra Ann
DOI: CT: 04/01/2020-10/26/2020 & 08/01/2020-11/03/2020
Date of Exam: January 11, 2021

Examination revealed tenderness to palpation at right greater trochanter, hip abductors.

Patrick Fabere test is positive at the right hip.

Ranges of motion for the hips; left normal, right decreased and painful, measured as follows.

Hip Range of Motion Testing			
Movement	Normal	Left Actual	Right Actual
Flexion	120	120	**80**
Extension	30	30	**20**
Abduction	45	45	**20**
Adduction	30	30	**15**
External rotation	45	45	**25**
Internal rotation	45	45	**20**

Ankles & Feet:

Examination revealed bunions, fungus at great toenails bilaterally.

Tenderness at bilateral plantar fascia.

Ranges of motion of both ankles were within normal limits with pain.

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

Knee extension left 4/5, knee flexion left 4/5, hip abduction right 4/5, all other myotomes 5/5.

Squatting is positive for back pain.

Heel and toe walking is positive for back pain.

Antalgic gait favoring left lower extremity.

Sensory Testing:

Dysesthesia at left L5-S1 dermatomal level.

Diagnostic Impressions:

Re: Patient: Roquemore, Sandra Ann
DOI: CT: 04/01/2020-10/26/2020 & 08/01/2020-11/03/2020
Date of Exam: January 11, 2021

1. Lumbar spine myofasciitis, M79.1.
2. Right sacroiliac joint dysfunction. sprain/strain. M53.3.
3. Lumbar facet-induced versus discogenic pain. M47.816.
4. Lumbar radiculitis, rule out, M54.16.
5. Right hip trochanteric bursitis. M70. 61.
6. Bilateral plantar fasciitis, M72.2.
7. Insomnia, anxiety and depression. G47.00. F41.9. F34.1.
8. Eye irritation, H57.9.

Discussion and Treatment Recommendation:

The patient is recommended comprehensive treatment course consisting of chiropractic manipulations and adjunctive multimodality physiotherapy to include myofascial release, strengthening, range of motion (active / passive) joint mobilization, home program instruction, therapeutic exercise and all other appropriate physiotherapeutic modalities **for lumbar spine and right hip at once per week for four weeks with a followup in four weeks.**

The patient **requires x-rays of lumbar spine.**

The patient **requires MRI or CT scan of the lumbar spine in view of metal in cervical spine post fusion.**

The patient is **recommended psychiatric/psychological consultation for evaluation and treatment of anxiety, stress and depression complaints.**

Permanent and Stationary Status:

The patient's condition is not permanent and stationary.

Work Status/Disability Status:

The patient is temporarily totally disabled until reevaluation in four weeks.

Re: Patient: Roquemore, Sandra Ann
DOI: CT: 04/01/2020-10/26/2020 & 08/01/2020-11/03/2020
Date of Exam: January 11, 2021

Disclosure:

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

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

Re: Patient: Roquemore. Sandra Ann
DOI: CT: 04/01/2020-10/26/2020 & 08/01/2020-11/03/2020
Date of Exam: January 11, 2021

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,

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

Signed this 19th day of January. 2021. in Los Angeles, California.

EEG:svl

Sincerely,

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

Signed this 19th day of January, 2021, in Los Angeles. California.

MK:svl

State of California, Division of Workers' Compensation

REQUEST FOR AUTHORIZATION

DWC Form RFA

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

☑ 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): Roquemore, Sanda A.

Date of Injury (MM/DD/YYYY): 10/26/2020 | Date of Birth (MM/DD/YYYY): 02/11/1955

Claim Number: 564-92-3586 | Employer: American Guard Services, DBA

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: Next Level Administrators | Contact Name: Ruenna Brychta

Address: P.O. Box 1061 | City: Bradenton | State: Fl

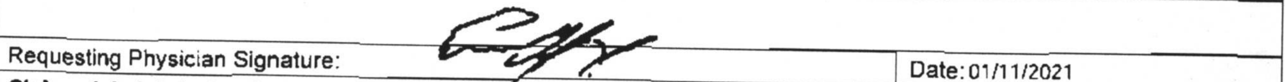
Zip Code: | Phone: (877) 306-6398 | Fax Number: (941) 444-6200

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 4 weeks
Lumbar Facet	M47.816	Therapeutic Exercises	97110	
Hip Trochanteric Bursitis	M70.61	Massage Therapy	97124	
		CMT 3-4 regions	98941	
		Extraspinal Manipulation w/spinal	98943	



Requesting Physician Signature: | Date: 01/11/2021

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

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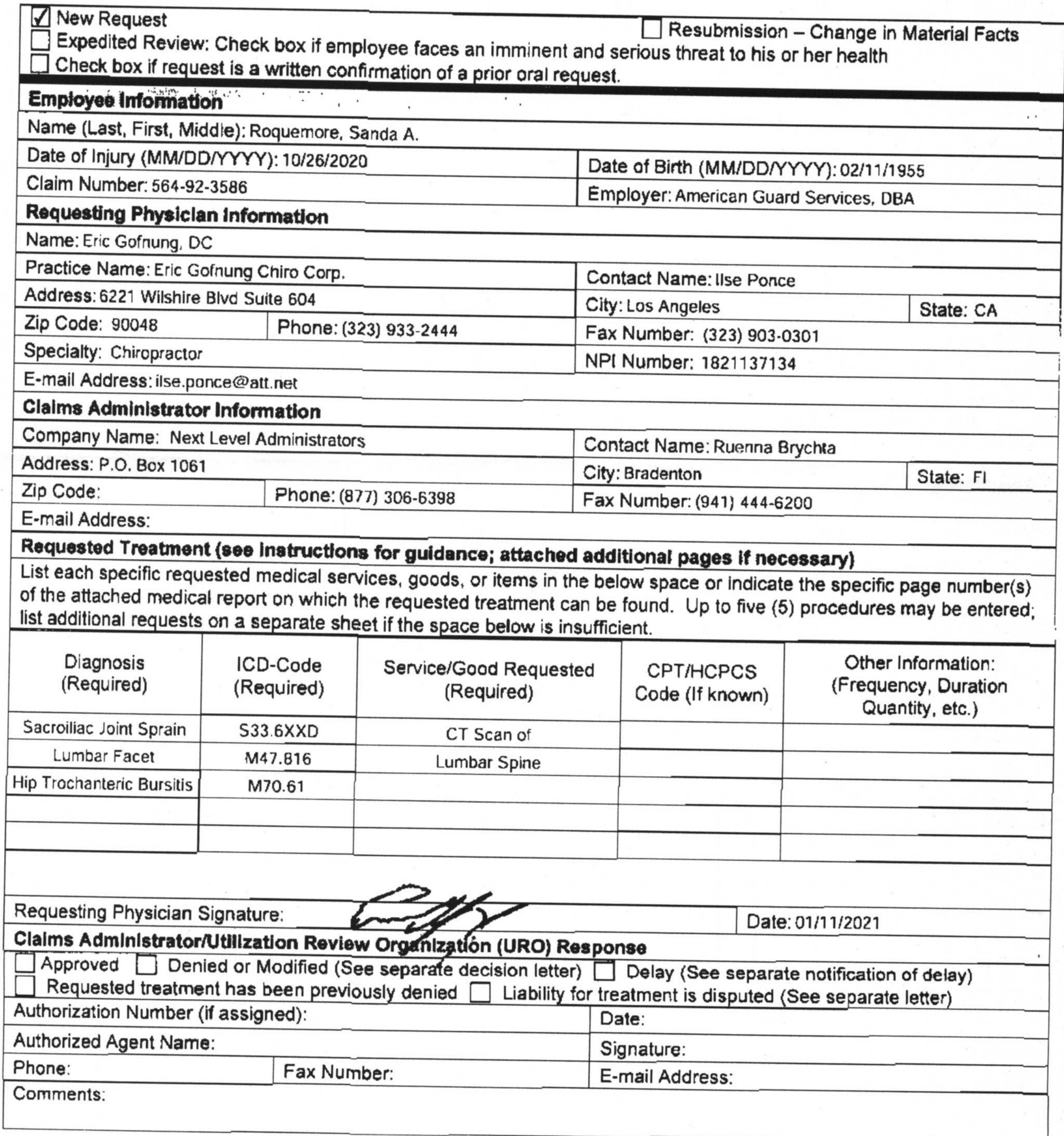

☑ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
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Name (Last, First, Middle): Roquemore, Sanda A.

Date of Injury (MM/DD/YYYY): 10/26/2020 | Date of Birth (MM/DD/YYYY): 02/11/1955

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Sacroiliac Joint Sprain	S33.6XXD	CT Scan of		
Lumbar Facet	M47.816	Lumbar Spine		
Hip Trochanteric Bursitis	M70.61			

Requesting Physician Signature: [signature] | Date: 01/11/2021

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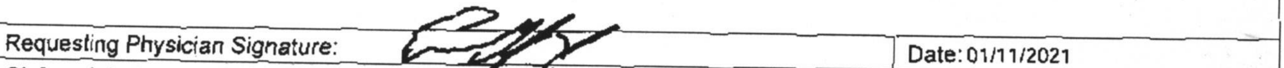
Sacroiliac Joint Sprain	S33.6XXD	Psychiatric/ Psychological		
Lumbar Facet	M47.816	Consultation		
Hip Trochanteric Bursitis	M70.61			



Requesting Physician Signature: Date: 01/11/2021

Claims Administrator/Utilization Review Organization (URO) Response

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☐ Requested treatment has been previously denied ☐ *Liability for treatment is disputed (See separate letter)*

Authorization Number (if assigned):		Date:
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Comments:		

State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
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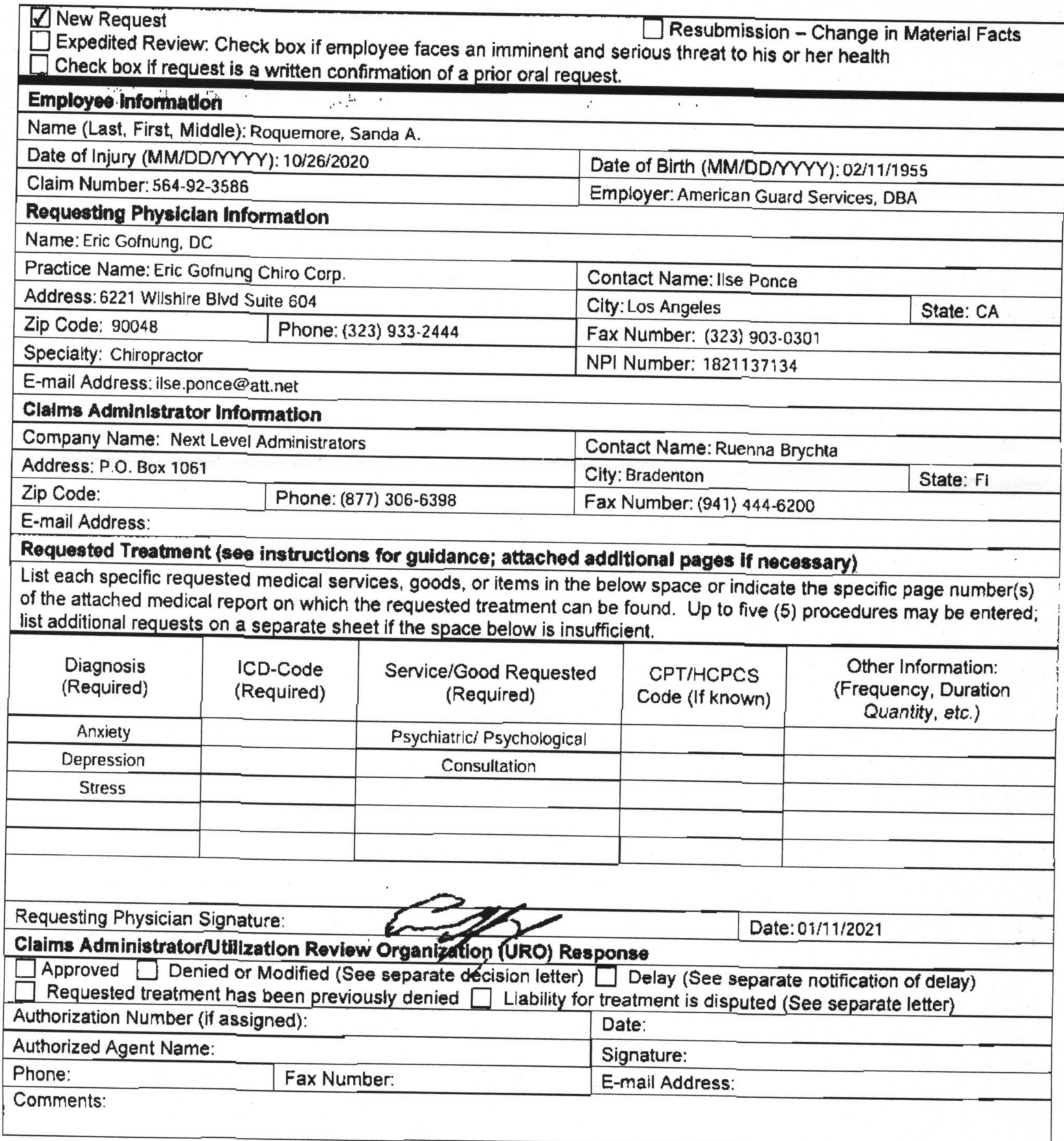

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Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration *Quantity, etc.*)
Anxiety		Psychiatric/ Psychological		
Depression		Consultation		
Stress				

Requesting Physician Signature: | Date: 01/11/2021

Claims Administrator/Utilization Review Organization (URO) Response

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