Next Level Administrators
www.nextleveladmin.com

P.O. Box 1061
Bradenton, FL 34206
T: 941.306.2393
F: 941.444.6200

Proof of Service By Mail

(STATE OF CALIFORNIA)

I am a citizen of the United States and a resident of the County of Sacramento; I am over the age of eighteen years and not a party to the within entitled action; and my business address is in Folsom, CA 95630.

Claimant: Sandra Roquemore
Claim #: UW2000031101

On this date, I served the within:

RFA Response Letter: 4/19/2021

RFA: 3/8/2021

On the following persons:

Eric Gofnung, DC
6221 Wilshire Blvd., Ste. 604
Los Angeles, CA 90048

Workers Defender Law Firm
8018 E Santa Ana Canyon Rd., Suite 100
Anaheim, CA 92808

DJG Law Group
David Gonzales
8181 East Kaiser Blvd., Ste. 100
Anaheim, CA 92808

Sandra Roquemore
1763 Exposition Blvd
Los Angeles, CA 90018

By placing a true copy thereon fully prepaid, in the United States mail in Folsom, CA.

I certify under penalty of perjury, that the foregoing is true and correct.

Executed on this April 19, 2021 in Folsom, CA.

Signed Michael Mangels

Next Level Administrators
nextleveladmin.com

P.O. Box 1061
Bradenton, FL 34206
T: 941.306.2393
F: 941.444.6200

April 19, 2021

Eric Gofnung, DC
6221 Wilshire Blvd., Ste. 604
Los Angeles, CA 90048

RE: Employee: Sandra Roquemore
Carrier: United Wisconsin Insurance Company
Policyholder: Cornerstone Capital Group Inc LCF Vets Securing America Inc American Guard Services (dba)
Employer: Vets Securing America Inc American Guard Services (dba)
Claim#: UW2000031101
D/A: 11/03/2020

Dear Eric Gofnung, DC,

I received your Request for Authorization for medical Treatment (RFA) on 4/16/2021 for Interventional Pain Management Consultation, Acupuncture Consultation with Dr. Edmond Feder, Electrical Stimulation, Therapeutic Exercises, Massage Therapy, CMT 3-4 regions and Extraspinal Manipulation w/spinal.

Per CCR 6460.9(1) your RFA cannot be processed because this claim has been denied.

Please be advised that any and all future RFA's will not be submitted to Utilization Review pursuant to CCR 9792.9(1). Any dispute under this subdivision shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

You have a right to disagree with decisions affecting your claim. If you have any questions about the information provided to you in this notice, please call, Patricia Carruthers at (941) 900-4764 . You also have the right to be represented by an attorney of your choice. However, if you are represented, please contact your attorney with any questions you have.

For information about the workers' compensation claims process and your rights and obligations, go to www.dir.ca.gov or contact an Information and Assistance (I&A) Officer of the State Division of Workers' Compensation. For recorded information and a list of offices, call 1-800-736-7401.

Sincerely,

Patricia Carruthers
Claim Adjuster

CC:

Next Level Administrators
nextleveladmin.com

P.O. Box 1061
Bradenton, FL 34206
T: 941.306.2393
F: 941.444.6200

Workers Defender Law Firm
8018 E Santa Ana Canyon Rd., Suite 100
Anaheim, CA 92808

DJG Law Group
David Gonzales
8181 East Kaiser Blvd., Ste. 100
Anaheim, CA 92808

Sandra Roquemore
1763 Exposition Blvd
Los Angeles, CA 90018

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 6021, 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.

[redacted]

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

[redacted]

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			

[redacted]

Company Name: Med 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:			

[redacted]

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	Interventional Pain Management		RECEIVED
Lumber Facet	M47.816	Consultation		
Hip Trochanteric Bursitis	M70.61			APR 16 2021
				NLA

Requesting Physician Signature: [signature] Date: 03/03/2021

[redacted]

☐ 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: 04/16/2021
Authorized Agent Name:		Signature: Patricia Carruthers
Phone:	Fax Number:	E-mail Address:

Comments: Claim has been denied AOE/COE 01/28/2021

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.

[redacted]

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

[redacted]

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			

[redacted]

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:			

[redacted]

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Sacroiliac Joint Sprain	S33.6XXD	Acupuncture Consultation		
Lumbar Facet	M47.816	with Dr. Edmond Feder		
Hip Trochanteric Bursitis	M70.61			

Requesting Physician Signature: [redacted] Date: 03/08/2021

[redacted]

☐ 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.

[redacted]

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	
[redacted]			
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			
[redacted]			
Company Name: Next Level Administration		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:			

[redacted]

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 in 6 weeks
Lumber 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: [signature] Date: 03/08/2021

[redacted]

☐ 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:		