DAVID FEDER, L.AC.
Tel. (323) 933-2444 / Fax (323) 933-2909

6221 Wilshire Boulevard, Suite 604
Los Angeles, California 90048

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

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am a resident of the County aforesaid: and I am over the age of eighteen years and not a party to the within action: my business address is 6221 Wilshire Blvd., Suite 604, Los Angeles, CA 90048.

On 22 day of April, 2021, I served the within concerning:

Patient's Name: Roquemore, Sandra
Claim Number: UW2000031099

On the interested parties in said action, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid in Los Angeles, California, to be hand delivered Via United States Mail.

- ☐ MPN Request
- ☐ Notice of Treating Physician
- ☐ Medical Report ____________
- ☐ Itemized – (Billing) / HFCA 4/15/2021
- ☐ QME Findings & Summary
- ☐ Doctor's First Report
- ☑ RFA
- ☐ QME Appointment Notification
- ☒ Referral Notice
- ☒ Initial Comprehensive Report
- ☐ Re-Evaluation Report / Progress Report (PR-2)
- ☐ Chart Notes
- ☐ Authorization Request For Evaluation/Treatment 4/15/2021

List all parties to whom documents were mailed to:

Workers Defenders Law Group
Natalia Foley, Esq.
8018 E. Santa Ana Canyon, Suite 100-215
Anaheim Hills, CA 92808

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

Next Level Administrators
P.O. Box 1061
Bradenton, FL 34205

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 22 day of April, 2021.

Ilse Ponce

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

April 15, 2021

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

Re: Patient:	Roquemore, Sandra Ann
EMP:	American Guard Services
INS:	Next Level Administrators
Claim #:	UW2000031099
WCAB #:	ADJ13817769; ADJ13188144
DOI:	CT:4/1/2020 – 10/26/2020; 8/1/2020 – 11/3/2020
D.O.E./Consultation:	April 15, 2021

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

Dear Dr. Gofnung:

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

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

Re: Patient: Roquemore, Sandra Ann
D/I: CT:4/1/2020 – 10/26/2020; 8/1/2020 – 11/3/2020

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

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

My history and physical examination are as follows:

HISTORY OF INJURY AS PRESENTED BY THE PATIENT:

The above referenced patient reported sustaining an injury to the below-referenced body parts on the above-referenced date of injury during their course of employment as a security guard. The patient reported the injury resulted while performing their usual and customary work duties which included hours of standing and walking. The patient reports that they are not currently working.

WORK HISTORY:

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

CHIEF CURRENT COMPLAINTS:

1. Pain and stiffness in the lumbar spine which occasionally radiates into the bilateral lower extremities, best described as constant and moderate (7/10) becoming severe (9/10) with activities that include prolonged walking and standing.

Re: Patient: Roquemore, Sandra Ann
D/I: CT:4/1/2020 – 10/26/2020; 8/1/2020 – 11/3/2020

PAST MEDICAL HISTORY

Previous illness:	None.
Previous injuries:	None.
Previous surgeries:	None.
Allergies:	None.
Medications:	None.
Past general health	Good.

REVIEW OF SYSTEMS

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

FAMILY HISTORY

Family history is non-contributory.

SOCIAL HISTORY

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

PHYSICAL EVALUATION – POSITIVE OBJECTIVE FINDINGS:

Initial Observation:

The patient is a 66-year-old right-hand dominant female who appeared to be their reported age, and was well developed, well nourished, well proportioned and of average build. They appeared to be alert, cooperative, responsive and oriented times three. The patient was previously released from therapy having been determined to have reached maximum medical improvement. The patient has experienced a flare-up in their lumbar spine and was referred to

the undersigned for a trial course of acupuncture to address the current flare-up. Their movements were guarded and they presented with an antalgic position to their lumbar spine due to pain.

PHYSICAL EVALUATION – POSITIVE OBJECTIVE FINDINGS:

Lumbar Spine:

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

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

Flexion	60 / 90
Extension	15 / 25
Left Lateral Flexion	15 / 25
Right Lateral Flexion	15 / 25
Left Rotation	30 / 45
Right Rotation	30 / 45

INITIAL DIAGNOSTIC IMPRESSIONS:

1. Lumbar spine sprain/strain.
2. Lumbar spine Myofascitis.

DISCUSSION AND RECOMMENDATIONS:

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

Re: Patient: Roquemore, Sandra Ann
D/I: CT:4/1/2020 – 10/26/2020; 8/1/2020 – 11/3/2020

TREATMENT PLAN:

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

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

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

DISCLOSURE:

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

In compliance with recent Workers' Compensation legislation (Labor Code Section 4628) (b): "I declare that I personally took the history, performed the physical examination, prepared and reviewed the document and reached a conclusion, and I proofread and edited the final draft prior to signing the report in compliance with the guidelines established by the Industrial Medical Council or the Administrative Director pursuant to paragraph 5 of the subdivision (J) of Section 139.2. " In compliance with recent Workers' Compensation legislation (Labor Code Section 4628 (J)): " I declare under penalty of perjury that the information contained in this report and it's attachments, if any, is true and correct to the best of my knowledge and belief, except as to information I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true." In compliance with recent Workers' Compensation legislation (Labor Code Section 5703 under AB 1300): "I have not violated Labor Code Section 139.3 and the contents of this report are true and correct to the best of my knowledge. This statement is made under penalty of perjury and is consistent with WCAB Rule 10978."

Time spent on Review of Records and preparation of this report, including dictation and editing, exceeded 45 minutes.

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

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

Sincerely,

Re: Patient: Roquemore, Sandra Ann
D/I: CT:4/1/2020 – 10/26/2020; 8/1/2020 – 11/3/2020

Edmond David Feder, L.Ac.

Signed this 15th day of April, 2021, in Los Angeles, California.

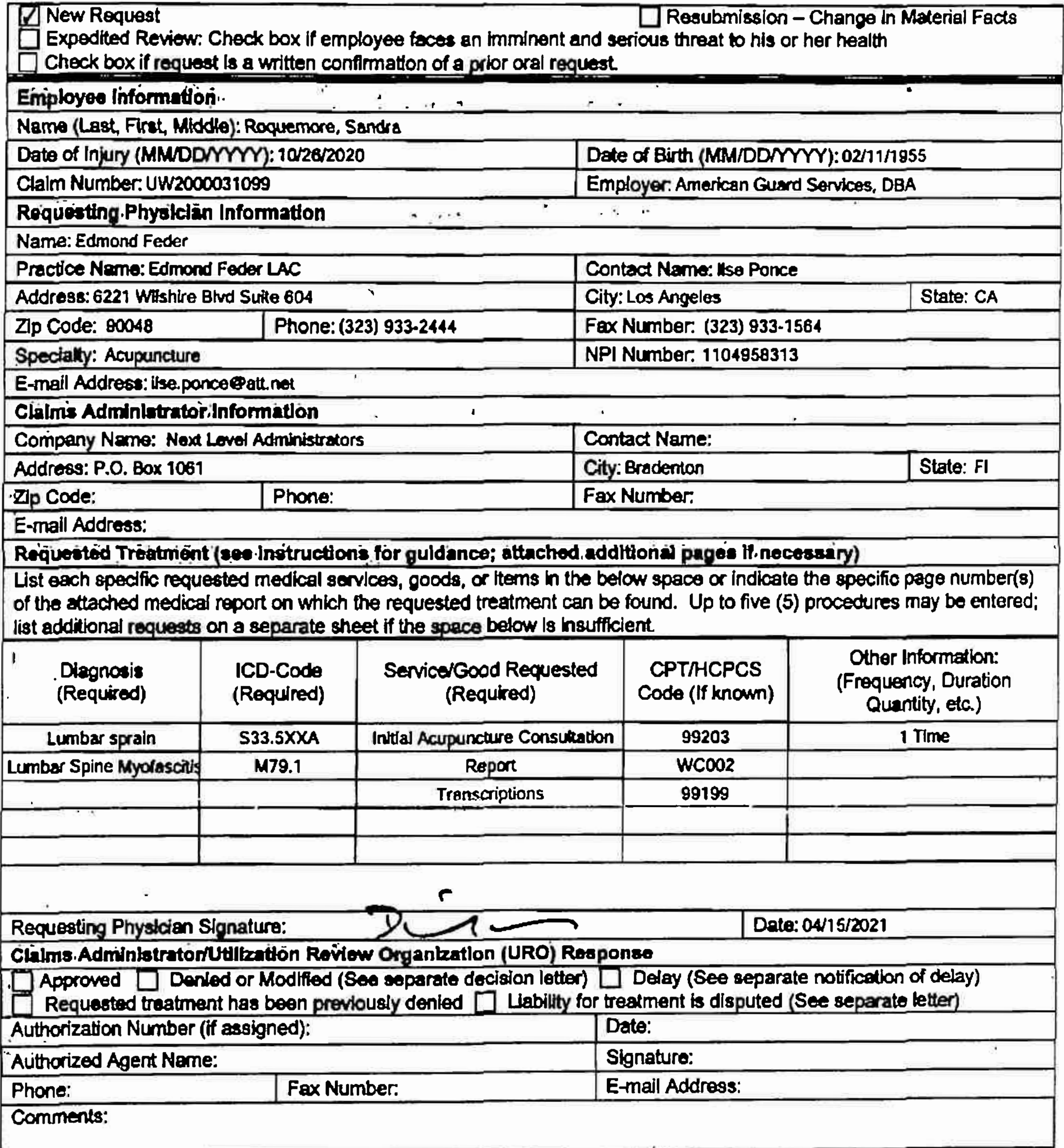
EDF

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, Sandra	
Date of Injury (MM/DD/YYYY): 10/26/2020	Date of Birth (MM/DD/YYYY): 02/11/1955
Claim Number: UW2000031099	Employer: American Guard Services, DBA

Requesting Physician Information

Name: Edmond Feder			
Practice Name: Edmond Feder LAC		Contact Name: Ilse Ponce	
Address: 6221 Wilshire Blvd Suite 604		City: Los Angeles	State: CA
Zip Code: 90048	Phone: (323) 933-2444	Fax Number: (323) 933-1564	
Specialty: Acupuncture		NPI Number: 1104958313	
E-mail Address: ilse.ponce@att.net			

Claims Administrator Information

Company Name: Next Level Administrators		Contact Name:	
Address: P.O. Box 1061		City: Bradenton	State: Fl
Zip Code:	Phone:	Fax Number:	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

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

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Lumbar sprain	S33.5XXA	Initial Acupuncture Consultation	99203	1 Time
Lumbar Spine Myofascitis	M79.1	Report	WC002	
		Transcriptions	99199	

Requesting Physician Signature: [signature] Date: 04/15/2021

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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E-mail Address:			

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Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Lumbar sprain	S33.5XXD	Neuromuscular Re-education	97112	2 x per week for 4 weeks
Lumbar Spine Myofasciti	M79.1	Massage Therapy	97124	
		Acupuncture, 1 or more needles	97813	
		Acupuncture, 1 or more needles	97814	

Requesting Physician Signature: Date: 04/15/2021

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)

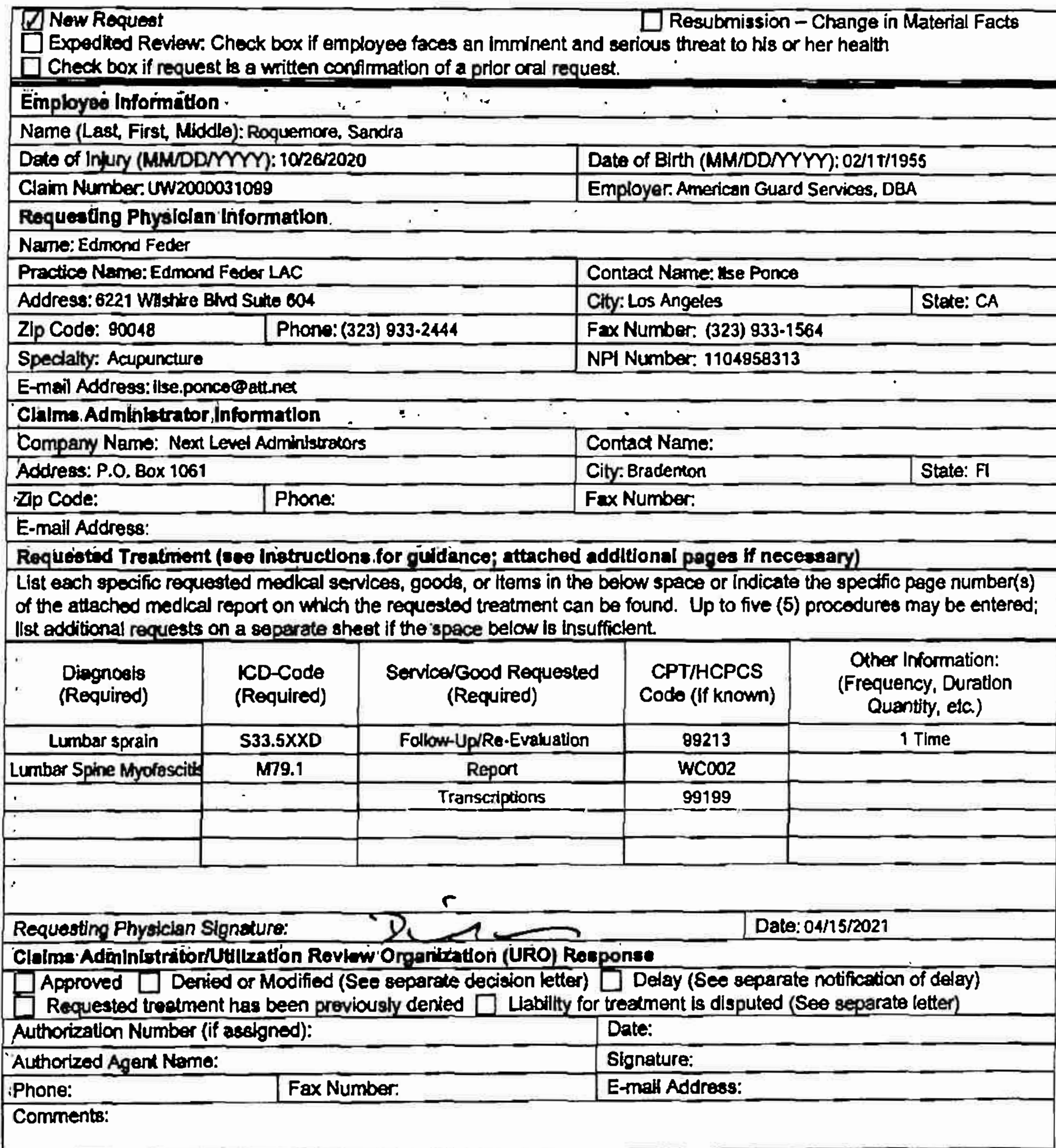
Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

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.



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☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
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List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Lumbar sprain	S33.5XXD	Follow-Up/Re-Evaluation	99213	1 Time
Lumbar Spine Myofascitis	M79.1	Report	WC002	
		Transcriptions	99199	

Requesting Physician Signature: [signature] Date: 04/15/2021

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:		

ERIC E. GOFNUNG CHIROPRACTIC CORP.
QME of the State of California
SPORTS MEDICINE & ORTHOPEDIC - NEUROLOGICAL REHABILITATION
6221 Wilshire Boulevard, Suite 604 / Los Angeles, California 90048 / Tel. (323) 933-2444 / Fax (323) 933-2909 -2909

March 8, 2021

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

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

Primary Treating Physicians Referral Notice

Dear David Feder, L.Ac.:

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

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

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

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

The patient's diagnostic impressions include the following:

1. Lumbar 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 fascitis, M72.2.

Appointment Scheduled Date and Time:

Please evaluate and advise.

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

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

Sincerely,

Eric Gofnung, DC

E.G./cc

Cc: Served on all parties with proof of service.