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 **December 07, 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 **07** day of **December,** 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 – **10/29/2021**
- ☐ QME Appointment Notification
- ☐ Primary Treating Physician's Referral
- ☐ Initial Consultation Report –
- ☐ Re-Evaluation Report / Progress Report (PR-2) _____
- ☒ Permanent & Stationary Evaluation Report – **10/29/2021**
- ☐ 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
751 S Weir Canyon, Suite 157-455
Anaheim, CA 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 **07** day of **December**, 2021.

ILSE PONCE

ERIC E. GOFNUNG CHIROPRACTIC CORP.

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6221 Wilshire Boulevard, Suite 604/Los Angeles, California90048/ Tel. (323) 933-2444 / Fax (323) 933-2909

October 29, 2021

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

Re:	Patient:	Roquemore, Sandra Ann
	EMP:	American Guard Services
	INS:	Accident Fund Lansing
	Claim #:	UW2000031099
	WCAB #:	ADJ13817769 & ADJ13818144
	DOI:	CT: 04/01/2020-10/26/2020 & 08/01/2020-11/03/2020
	D.O.E./Consultation:	October 29, 2021

Post Permanent and Stationary Followup Report

Time Spent Face to face:	**10 mins**
Time Spent on Report Preparation	**10 mins**

Dear Gentlepersons:

The above-named patient was seen for a Post Permanent and Stationary Followup Evaluation on October 29, 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.**

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
DOI: CT: 04/01/2020-10/26/2020 & 08/01/2020-11/03/2020
Date of Exam: October 29, 2021

My history and physical examination are as follows.

Interim History:

Please note this patient was declared permanent and stationary on June 7, 2021 and was subsequently seen for followup in my office on August 16, 2021. The patient reports her condition is predominantly unchanged since she was declared permanent and stationary. The patient reports she has not undergone the CT scan of the lumbar spine nor the ophthalmology nor psychiatric consultation as recommended by the undersigned. The patient continues to experience same issues and continues to rely on the one-point walking cane. The patient reports that she saw a Worker's Compensation doctor who she believed to be an AME or QME sometime about three months ago. Please note, that report is not yet available for my review.

Current Complaints (October 29, 2021):

1. Abdominal/stomach issues, intermittent and moderate.
2. Lower back pain frequent and moderate, radiating to lower extremities, associated with weakness of lower extremities.
3. Right hip pain occasional and slight.
4. Bilateral feet pain, frequent and moderate, associated with burning sensation at the soles.
5. Anxiety and depression.
6. Sleep difficulty.
7. Eye irritation.

Physical Evaluation (October 29, 2021) – Positive Findings:

Thoracic Spine:

Thoracic spine examination is normal.

Ranges of motion for thoracic spine were restricted secondary to lower back pain.

Lumbosacral Spine:

Examination revealed tenderness to palpation with muscle guarding of bilateral paralumbar musculature. Tenderness and hypomobility were noted at L2 through L5 vertebral regions.

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

Straight Leg Raising Test (seated) elicited increased lower back pain with increased radiculopathy to right lower extremity:

Right: 45 degrees
Left: 55 degrees

Ranges of motion for the lumbar spine were restricted and painful and predominantly unchanged since last evaluation.

Hips & Thighs:

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

Patrick Fabere test increased lower back pain and right hip pain.

Ranges of motion for right hip were unchanged from prior exam.

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.

Re: Patient: Roquemore, Sandra Ann
DOI: CT: 04/01/2020-10/26/2020 & 08/01/2020-11/03/2020
Date of Exam: October 29, 2021

Diagnostic Impressions:

1. Lumbar spine myofasciitis, M79.1.
2. Lumbar facet-induced versus discogenic pain, M47.816.
3. Lumbar radiculitis, rule out, M54.16.
4. Right sacroiliac joint dysfunction, sprain/strain, M53.3.
5. Right hip trochanteric bursitis rule out, 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 Recommendations:

Please note, the patient reports she underwent cervical spine fusion surgery years ago and for this reason it seems that she was recommended CT scan of the lumbar; however, I believe the patient can undergo an MRI study of the lumbar spine, which is a superior study to evaluate the nature and extent of injuries, and I recommend the patent undergo MRI study of the lumbar spine for the reasons I explained, as well as ophthalmology as well as psychiatric consultation.

The patient is **recommended home exercise to tolerance of ranges of motion and stretching as taught in my office. The patient is encouraged to swim and do aqua therapy if she has access to pool as well as light resistance training with light weights and machines to maximize her function and for conditioning purposes.**

Permanent and Stationary Status:

The patient's condition is permanent and stationary as of 06/07/21.

I formally request **the AME/QME reports from about three months ago to be forwarded to my attention as soon as possible.**

Work Restriction:

The patient was declared permanent and stationary on 06/07/2021 with the following work restrictions, which remain unchanged.

No lifting in excess of 10 pounds. No repeated bending or twisting. Must be able to change positions as needed. If modified duty as indicated is not provided, then the patient is temporarily totally disabled until reevaluation at next visit.

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."

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: October 29, 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 02 day of December, 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): Roquemore, Sanda A.			
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: 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 Time
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: 10/29/2021

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:		