DAVID FEDER, L.AC., Q.M.E.

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 29 day of January, 2021, I served the within concerning:

Patient's Name: **Jermakow, Szymon**
Claim Number: 00080887

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 1/28/2021
- ☐ QME Findings & Summary
- ☐ Doctor's First Report
- ☐ QME Appointment Notification
- ☐ Radiological Report
- ☐ Initial Comprehensive Report
- ☒ Re-Evaluation Report / Progress Report (PR-2)
- ☐ Chart Notes
- ☐ Authorization Request For Evaluation/Treatment 1/28/2021
- ☒ RFA

List all parties to whom documents were mailed to:

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

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

Pacific Compensation
PO Box 5042
Thousand Oaks, CA 91359

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 28 day of January, 2021.

Ilse Ponce

E. DAVID FEDER, L.AC.
SPORTS-MEDICINE & ORTHOPEDIC-INJURIES
6221 Wilshire Blvd., Suite 604 | Los Angeles, California 90048
Tel: (323) 993-2444 | Fax (323) 933-2909

JANUARY 28, 2021

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

RE:		
	PATIENT:	JERMAKOV, SZYMON
	EMP:	PACIFIC PLASTICS
	INS:	PACIFIC COMP.
	CLAIM NO.:	00080887
	WCAB NO.:	ADJ13487196
	D.O.I.:	CT: 01/01/2010-03/15/2020
	D.O.E./CONSULTATION:	JANUARY 28, 2021

TREATING PHYSICIAN'S RE-EVALUATION REPORT AND REQUEST FOR AUTHORIZATION

INTERIM HISTORY: The above referenced patient has been undergoing acupuncture treatments with the undersigned with treatments including electro-acupuncture and adjunctive physiotherapies in below referenced area since 10/27/2020. The patient reports the acupuncture treatments have been providing the patient with relief of symptoms and the below referenced condition has functionally improved since beginning treatments due to improved range of motion and decreased severity of symptoms. The patient reports a better ability to perform activities of daily living.

CHIEF CURRENT COMPLAINTS:
(as related to acupuncture therapy)

1) Current Body part: L/S
Pain: 0 – 10 3-5 Describe
Stiffness: Min____ Slight____ Mod X Sev____ Describe
Numbness: Min____ Slight____ ~~Mod~~ Sev____ Describe
Tingling: Min____ Slight____ ~~Mod~~ Sev____ Describe
Pain med usage: Less Y / N Describe
Sleep Improved: Y / N Describe
Functional Improvement: (R) Side 50% improvement

2) Current / Additional / New / Body part:
Pain: 0 – 10____ Describe
Stiffness: Min____ Slight____ Mod____ Sev____ Describe
Numbness: Min____ Slight____ Mod____ Sev____ Describe
Tingling: Min____ Slight____ Mod____ Sev____ Describe
Pain med usage: Less Y / N Describe
Sleep Improved: Y / N Describe
Functional Improvement:

PATIENT NAME: JERMAKOV, SZYMON

EXAMINATION:

1) Current Body part: ~~(X)~~ 4L5

Myofascial Restrictions: Min____ Slight____ Mod X Sev____ Describe_____

Guarding/ Hypertonicity: Min____ Slight____ Mod X Sev____ Describe_____

Myofascial TP's: Min____ Slight____ Mod X Sev____ Describe_____

Tenderness: Min____ Slight____ Mod L Sev____ Describe_____

AROM: Flx 30 Ext 10 Lat Flx R 12 L 12 Rot R 15 L 15 Abd R____ L____ Add R____ L____

Ext Rot R____ L____ Int Rot R____ L____ Pronat R____ L____ Sup R____ L____

Rad Dev R____ L____ Uln Dev R____ L____

Dorseflex R____ L____ Plantarflex R____ L____ Inv R____ L____ Ev R____ L____

Additional notes: _____

2) Current / Additional / New / Body part: _____

Myofascial Restrictions: Min____ Slight____ Mod____ Sev____ Describe_____

Guarding/ Hypertonicity: Min____ Slight____ Mod____ Sev____ Describe_____

Myofascial TP's: Min____ Slight____ Mod____ Sev____ Describe_____

Tenderness: Min____ Slight____ Mod____ Sev____ Describe_____

AROM: Flx____ Ext____ Lat Flx R____ L____ Rot R____ L____ Abd R____ L____ Add R____ L____

Ext Rot R____ L____ Int Rot R____ L____ Pronat R____ L____ Sup R____ L____

Rad Dev R____ L____ Uln Dev R____ L____

Dorseflex R____ L____ Plantarflex R____ L____ Inv R____ L____ Ev R____ L____

Additional Comments: _____

DIAGNOSIS:

☐ Cervical Spine - Sprain/Strain (S13.4XX) / Radiculopathy (M54.12) ☐ Thoracic Spine - Sprain/Strain (S23.3XX) ☒ Lumbar Spine - Sprain/Strain (S33.8XX2) / Radiculopathy (M54.16) ☐ Myofascitis / Myalgia (M79.1) ☐ Shoulder / Upper Arm - Sprain/Strain (S43.409)
☐ Elbow - Sprain/Strain(S53.409) ☐ Forearm - Sprain/Strain(S56.919) / ☐ Wrist - Sprain/Strain (S63.509) ☐ Hand - Sprain/Strain (S63.90X)
☐ Carpal Tunnel Syndrome (G56.00) ☐ Knee - Sprain/Strain (S83.90X) ☐ Leg - Sprain/Strain (S86.919)
☐ Ankle - Sprain/Strain (S93.409) ☐ Foot - Sprain/Strain (S93.609)
☐ Other _____ ☐ Other _____

TREATMENT PLAN:

☒ Continue treatment with current body part 2 times per week for 4 weeks.

☐ Modify treatment plan: Discontinue treatment with current body part as it has reached maximum medical improvement from an acupuncture standpoint. Begin: _____ (new body part) _____ times per week for _____ weeks.

☐ Discontinue treatment. Patient has reached maximum medical improvement. ☐ Follow-up in _____ weeks.

☐ Discontinue treatment per pre-authorization through medical provider network. ☐ Patient has reached maximum medical improvement / ☐ Patient has NOT reached maximum medical improvement from an acupuncture standpoint.

INTERPRETER PRESENT ☒ No ☐ Yes Name: _____

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.

David Feder, L.Ac. #AC 7946

1/28/2021
Date of evaluation

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): Jermakow, Szymon			
Date of Injury (MM/DD/YYYY): 03/15/2020		Date of Birth (MM/DD/YYYY): 05/04/1940	
Claim Number: 00080887		Employer: Pacific Plastics	

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: Pacific Compensation		Contact Name: Milagros Palacios	
Address: PO Box 5042		City: Thousand Oaks	State: CA
Zip Code:	Phone: (818) 575-8505	Fax Number: (818) 575-8575	
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	S33.5XXD	Neuromuscular Re-education	97112	2 x per week for 4 weeks
Lumbar Spine Myofascitis	M79.1	Massage Therapy	97124	
Lumbar Radiculopathy	M54.16	Acupuncture, 1 or more needles	97813	
		Acupuncture, 1 or more needles	97814	

Requesting Physician Signature:	Date: 01/28/2021

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
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Employee Information

Name (Last, First, Middle): Jermakow, Szymon			
Date of Injury (MM/DD/YYYY): 03/15/2020		Date of Birth (MM/DD/YYYY): 05/04/1940	
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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: Pacific Compensation		Contact Name: Milagros Palacios	
Address: PO Box 5042		City: Thousand Oaks	State: CA
Zip Code:	Phone: (818) 575-8505	Fax Number: (818) 575-8575	
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*	*Follow-Up/Re-Evaluation*	99213	1 Time
Lumbar Spine Myofascitis	M79.1	Report	WC002	
Lumbar Radiculopathy	M54.16	Transcriptions	99199	

Requesting Physician Signature: Date: 01/28/2021

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:		