

SUPERIOR COURT OF CALIFORNIA, COUNTY OF RIVERSIDE

RECEIVED

Southwest Justice Center
30755-D Auld Road, Murrieta, CA 92563
www.riverside.courts.ca.gov

JUL 02 2024

Case Number: CVSW2105539

Case Name: EVANS vs RITA'S FRANCHISE COMPANY, LLC

John Rafael Ramirez
7121 MAGNOLIA AVE STE M
RIVERSIDE, CA 92505

NOTICE OF RELOCATION FOR ALL PURPOSES

You are hereby notified that **effective July 8, 2024**, the above-entitled case will be relocated to **Department M301** at the following location for all purposes:

Menifee Justice Center
27401 Menifee Center Drive
Menifee, CA 92584

The Honorable Angel Bermudez will be presiding in Department **M301**.

If a hearing in this case has been set **on or after July 8, 2024**, and notice of the hearing has already been mailed, published, electronically, or personally served indicating the hearing will be conducted in Department S302, the moving party must give new notice reflecting **M301** and address of the courthouse indicated above. The new notice must be filed with the court **at least four court days** prior to the hearing date.

	Interpreter services are available upon request. If you need an interpreter, please complete and submit the online Interpreter Request Form (https://riverside.courts.ca.gov/Divisions/InterpreterInfo/ri-in007.pdf) or contact the clerk's office and verbally request an interpreter. All requests must be made in advance with as much notice as possible, and prior to the hearing date in order to secure an interpreter.
	Assistive listening systems, computer-assisted real time captioning, or sign language interpreter services are available upon request if at least 5 days notice is provided. Contact the Office of the ADA Coordinator by calling (951) 777-3023 or TDD (951) 777-3769 between 8:00 am and 4:30 pm or by emailing ADA@riverside.courts.ca.gov to request an accommodation. A <i>Request for Accommodations by Persons With Disabilities and Order</i> (form MC-410) must be submitted when requesting an accommodation. (Civil Code section 54.8.)

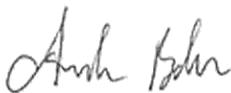
CERTIFICATE OF MAILING

I certify that I am currently employed by the Superior Court of California, County of Riverside, and that I am not a party to this action or proceeding. In my capacity, I am familiar with the practices and procedures used in connection with the mailing of correspondence. Such correspondence is deposited in the outgoing mail of the Superior Court. Outgoing mail is delivered to and mailed by the United States Postal Service, postage prepaid, the same day in the ordinary course of business. I certify that I served a copy of the foregoing notice on this date, by depositing said copy as stated above.

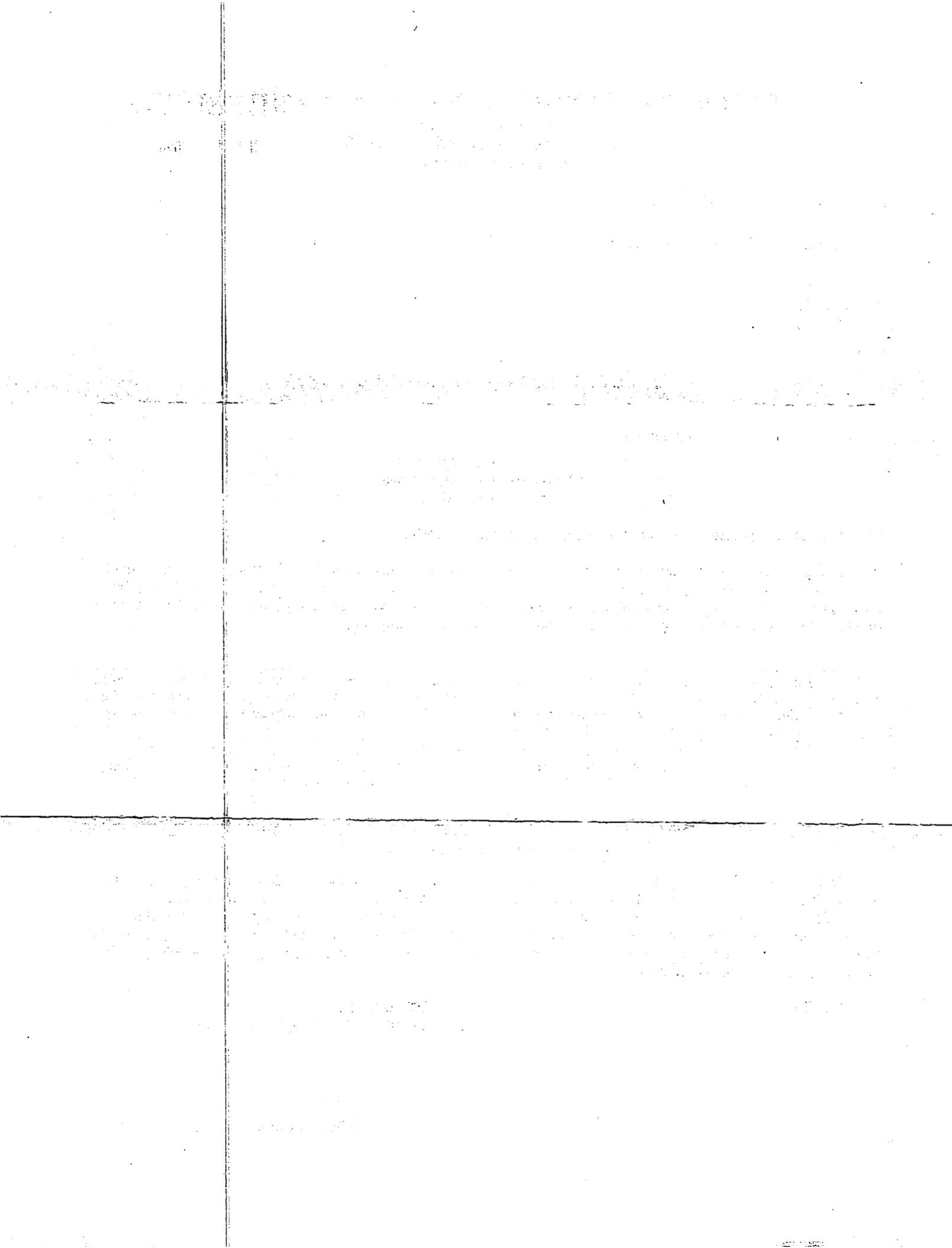
Dated: 06/27/2024

JASON B. GALKIN,
Court Executive Officer/Clerk of the Court

by:



A. Behrman, Deputy Clerk



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You said you've got other resources
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got from [redacted]
sent to [redacted]

John R Ramirez, Esq.
The Ramirez Firm
7121 Magnolia Ave Ste M
Riverside CA 92504-3805





June 25, 2024

Gilbert Sarabia
9414 Kauffman Ave
South Gate, CA 90280-5155

NOTICE REGARDING DENIAL OF WORKERS' COMPENSATION BENEFIT

Claim Number:

2080416431

Date of Loss:

06-11-2024

Insured:

Schmitt Contracting Inc

Claimant:

Gilbert Sarabia

American Zurich Ins. Co.

08 - WC Southwest
PO Box 968005
Schaumburg, IL
60196-8005

Telephone: (800) 338-3160

Fax: (818) 227-1740

<http://www.zurichna.com>

Dear Gilbert Sarabia:

American Zurich Ins. Co. is handling your workers' compensation claim on behalf of Schmitt Contracting Inc. This notice is to advise you of the status of disability benefits for your workers' compensation injury on the date shown above.

After careful consideration of all available information, we are denying liability for your claim of injury. Workers' compensation benefits are being denied because no active policy is in effect for alleged date of injury of 6/11/2024. Your employer last year of coverage ended on 10/31/2018.

For claims reported on or after April 19, 2004, regardless of the date of injury, if you submitted a claim form to your employer or claims administrator, Labor Code section 5402(c) provides that within one working day after you file the claim form, the employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for the alleged injury and shall continue to provide such medical treatment until the claims administrator accepts or denies liability for the claim. Until the date the claim is accepted or rejected, liability for medical treatment under this Labor Code section shall be limited to a maximum of ten thousand dollars (\$10,000).

Unless you have done so already, you should immediately send for consideration of payment, all bills for medical services provided between the date the completed claim form was given to the employer and the date that liability for the claim is rejected.

If you are represented, you may contact your attorney with any questions.

Additional information may be found in the publication Workers' Compensation in California: A Guidebook for Injured Workers. A complete copy of the Guidebook may be obtained at the website of the Division of Workers' Compensation (see URL below) or by contacting an Information and Assistance (I&A) Officer of the Division of Workers' Compensation. Chapters 2, 4 and 9 of the Guidebook contain information addressing the determination of liability for a workers' compensation claim and the QME process.



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June 25, 2024

Guidebook for Injured Workers:

<http://www.dir.ca.gov/InjuredWorkerGuidebook/InjuredWorkerGuidebook.html>

Chapter 2: After You Get Hurt on the Job

<http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter2.pdf>

Chapter 4: Resolving Problems with Medical Care and Medical Reports: <http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter4.pdf>

Chapter 9: For More Information and Help

<http://www.dir.ca.gov/InjuredWorkerGuidebook/Chapter9.pdf>

The State of California requires that you be given the following information:

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, Stephen Landowski (818) 227-1305. You also have the right to be represented by an attorney of your choice. However, if you are represented by an attorney, you should call your attorney, not me, Stephen Landowski.

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 (800)736-7401.

Keep this notice. It contains important information about your workers' compensation benefits.

Sincerely,
American Zurich Ins. Co.

Stephen Landowski
Claim Specialist
(818) 227-1305
stephen.landowski@zurichna.com

CC:
scott@schmittcontracting.com

The Ramirez Firm
7121 Magnolia Ave Ste M
Riverside, CA 92504-3805

Attn: Office Manager
Acoba Chiropractic Group, APC
902 N Grand Ave Ste 100A



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June 25, 2024

Santa Ana, CA 92701-4218



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2618 San Miguel Dr, #477
Newport Beach CA 92660

appeal per ad pastiel
denied.

John Ramirez
7121 Magnolia Ave. Ste. M
Riverside, CA 92504

June 28, 2024

Dear John Ramirez,

You are being copied on the following letter from Medex Managed Care regarding a Workers Compensation Claim for: Sonja Leigh

If you have any questions please contact your Claims Adjuster/Carrier.

Regards,

Medex Managed Care.

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NOTICE OF UTILIZATION REVIEW DETERMINATION

Date: 6/27/2024

Yury Furman, MD
3602 Inland Empire Blvd., Ste B-120
Ontario CA 91764
Inland Metro Medical Group Inc.
Fax #: (909) 265-9600

Regarding Employee:

Sonja Leigh
1320 Shadow Circle
Upland CA 91784
Phone: (951) 422-5140
DOB: 10/04/1969

Claim Number: 144792

DOI: 06/14/2023

Client: San Bernardino County
Claims Examiner: Linda Bobiles
Phone: (909) 386-8997
Review Type: Prospective

Reference #: RF-00018973

Dear Yury Furman, MD,

The 06/14/2024 request for medical treatment was first received by the Claims Examiner on 06/20/2024 and reviewed in accordance with title 8, California Code of Regulations Sec. 9792.6.1(d). On 6/27/2024 a decision was made in regard to the requested medical treatment.

The determination(s) are listed below.

Treatment(s):

Req. #	Requested Treatment	Determined Treatment	Decision
TR-00018973-001	Initial chiropractic therapy 2x4 weeks for the cervical spine	Initial chiropractic therapy 2x4 weeks for the cervical spine	Approve
TR-00018973-002	Celebrex 200mg #90	Celebrex 200mg #90	Approve
TR-00018973-003	Esomeprazole 20mg #45	Esomeprazole 20mg #45	Deny

Rationale:

This is a 54-year-old female patient, date of injury: 06/14/2023. Mechanism of injury: not specified. The patient most recently presented on 6/14/24 with complaints of pain in the head accompanied by tightness, frequent cervical spine pain with associated stiffness, frequent lumbar spine pain radiating down the bilateral lower extremities, frequent right shoulder pain with pinching sensation and occasional burning, frequent left shoulder pain with intermittent burning and limited ROM, and symptoms of anxiety and stress. Objective findings included difficulty focusing and sleeping due to headaches; decreased cervical ROM, tenderness upon palpation of the bilateral trapezius and cervical paravertebral muscles, pain with cervical compression and shoulder decompression; lower back stiffness exacerbated by prolonged weightbearing activities, decreased lumbar ROM, tenderness upon palpation of the bilateral S1 joints and lumbar paravertebral muscles, spasms of the lumbar paravertebral muscles, pain with sitting SLR and Kemp's test; decreased ROM in bilateral shoulders, tenderness upon palpation of the AC joint, anterior, lateral, and posterior aspects of bilateral shoulders, and pain with Neer's and Yergason's tests. Diagnoses include headache, cervical displacement in an unspecified cervical region, cervicalgia, lumbosacral intervertebral disc displacement, lumbar radiculopathy, low back pain, impingement syndrome of bilateral shoulders, anxiety disorder, and strain of unspecified muscle, fascia and tendon at the shoulder and upper arm level of bilateral arms. Treatment to date has included medications as well as, LINT and TPII therapy between 4/30/24 and 6/14/24.

A call was placed to Yury Furman, MD at the number provided (909) 265-9500 on 2024-06-26 at 12:21 PM. A message was left on the office's general voicemail.

A call was placed to Yury Furman, MD at the number provided (909) 265-9500 on 2024-06-27 at 09:56 AM. A message was left on office's general voicemail.

Regarding Initial chiropractic therapy 2x4 weeks for the cervical spine, the current MTUS guidelines state that Manipulation/mobilization of the cervical and/or thoracic spine is recommended for short-term relief of cervical pain or as a component of an active treatment program focusing on active exercises for acute cervicothoracic pain. However, high amplitude, high velocity manipulation is not recommended. Frequency/Dose/Duration: Dependent on severity. Most patients with more severe spine conditions may receive up to 12 visits over 6 to 8 weeks, typically one to 3 times a week;(958-960) total treatments dependent on response to therapy. Substantial progression (e.g., return to work or activities, increasing ability to tolerate exercise, reduced medication use) should be documented at each follow-up visit. In this case, the patient with presents complaints of pain in the head accompanied by tightness, frequent cervical spine pain with associated stiffness, frequent lumbar spine pain radiating down the bilateral lower extremities, frequent right shoulder pain with pinching sensation and occasional burning, frequent left shoulder pain with intermittent burning and limited ROM, and symptoms of anxiety and stress. Objective findings included difficulty focusing and sleeping due to headaches; decreased cervical ROM, tenderness upon palpation of the bilateral trapezii and cervical paravertebral muscles, pain with cervical compression and shoulder decompression; lower back stiffness exacerbated by prolonged weightbearing activities, decreased lumbar ROM, tenderness upon palpation of the bilateral S1 joints and lumbar paravertebral muscles, spasms of the lumbar paravertebral muscles, pain with sitting SLR and Kemp's test; decreased ROM in bilateral shoulders, tenderness upon palpation of the AC joint, anterior, lateral, and posterior aspects of bilateral shoulders, and pain with Neer's and Yergason's tests. In addition, there is documentation of a treatment plan to trial chiropractic. Therefore, the request is approved.

CA MTUS - Cervical and Thoracic Spine (MTUS Effective Date April 18, 2019) - Manipulation/Mobilization for Acute, Subacute, or Chronic Cervicothoracic Pain

Regarding Celebrex 200mg #90, the current MTUS guidelines state Oral NSAIDs are recommended for treatment of chronic persistent pain. Indications: Chronic persistent pain sufficiently severe to require medication. Generally, generic ibuprofen, naproxen or other older generation NSAIDs are recommended as first-line medications. Acetaminophen is a reasonable alternative, or can be used as an adjunct, although evidence suggests it is modestly less efficacious. Over-the-counter (OTC) agents may suffice and may be tried first. Generally, generic ibuprofen, naproxen or other older generation NSAIDs are recommended as first-line medications. Second-line medications should include one of the other generic medications. COX-2 selective agents are recommended as a third- or fourth-line medications when there are contraindications for other NSAIDs and/or there are risks of GI complications; however, concomitant treatment with misoprostol, sucralfate, and proton pump inhibitors are also options for gastro-protection. Due to the potential adverse effects from chronic use (more than 2 months) of NSAIDs, patients should be periodically monitored for adverse effects such as hypertension, blood loss, renal insufficiency (as manifested by an increased creatinine), and hepatic enzyme elevations. Older patients and those with co-morbidities may require more frequent monitoring. In this case, the patient with presents complaints of pain in the head accompanied by tightness, frequent cervical spine pain with associated stiffness, frequent lumbar spine pain radiating down the bilateral lower extremities, frequent right shoulder pain with pinching sensation and occasional burning, frequent left shoulder pain with intermittent burning and limited ROM, and symptoms of anxiety and stress. Objective findings included difficulty focusing and sleeping due to headaches; decreased cervical ROM, tenderness upon palpation of the bilateral trapezii and cervical paravertebral muscles, pain with cervical compression and shoulder decompression; lower back stiffness exacerbated by prolonged weightbearing activities, decreased lumbar ROM, tenderness upon palpation of the bilateral S1 joints and lumbar paravertebral muscles, spasms of the lumbar paravertebral muscles, pain with sitting SLR and Kemp's test; decreased ROM in bilateral shoulders, tenderness upon palpation of the AC joint, anterior, lateral, and posterior aspects of bilateral shoulders, and pain with Neer's and Yergason's tests. In addition, there is documentation of a treatment plan to initiate Celebrex with the understanding that symptomatic improvement and functional benefit will be assessed for a subsequent request. Therefore, the request is approved.

CA MTUS – Chronic Pain (MTUS effective date: December 1, 2017): Oral NSAIDs for Chronic Persistent Pain

Regarding Esomeprazole 20mg #45, the current MTUS guidelines state that concomitant prescriptions of cytoprotective medications are recommended for patients treated with non-selective NSAIDs at substantially increased risk for gastrointestinal bleeding. There are four commonly used cytoprotective classes of drugs: misoprostol, sucralfate, double-dose histamine Type 2 receptor blockers (famotidine, ranitidine, cimetidine, etc.), and proton pump inhibitors (esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole). In this case, the patient presents complaints of pain in the head accompanied by tightness, frequent cervical spine pain with associated stiffness, frequent lumbar spine pain radiating down the bilateral lower extremities, frequent right shoulder pain with pinching sensation and occasional burning, frequent left shoulder pain with intermittent burning and limited ROM, and symptoms of anxiety and stress. Objective findings included difficulty focusing and sleeping due to headaches; decreased cervical ROM, tenderness upon palpation of the bilateral trapezius and cervical paravertebral muscles, pain with cervical compression and shoulder decompression; lower back stiffness exacerbated by prolonged weightbearing activities, decreased lumbar ROM, tenderness upon palpation of the bilateral S1 joints and lumbar paravertebral muscles, spasms of the lumbar paravertebral muscles, pain with sitting SLR and Kemp's test; decreased ROM in bilateral shoulders, tenderness upon palpation of the AC joint, anterior, lateral, and posterior aspects of bilateral shoulders, and pain with Neer's and Yergason's tests. In addition, there is documentation of a treatment plan to initiate Celebrex and Esomeprazole. However, most recent medical report does not clearly identify any evidence of increased risk for gastrointestinal bleeding. Therefore, the request is denied.

CA MTUS - Low Back Disorders (MTUS Effective Date November 23, 2021) - NSAIDs for Patients at Risk for GI Adverse Effects

Documents Provided for Review:

1. DWC RFA Form dated 06/14/2024
2. Progress Report dated 06/14/2024

DETERMINATION IS VALID FOR ONE (1) YEAR.

This utilization review determination was made in response to a specific review request. Further requests for authorization should be made through the Claims Administrator. Determination of payment for this service is based on eligibility and any questions should be addressed to the claims administrator.

This review determination does not guarantee compensability or claim acceptance. These are determined by your workers compensation insurance carrier.

MODIFIED or NON-CERTIFIED DECISIONS - DISPUTE INFORMATION

To the Physician:

If you disagree with this decision and/or have additional information that was not available at the time of this review and desire to initiate a reconsideration, contact MEDEX HCO at 2618 San Miguel Dr., #477 Newport Beach, CA 92660, Fax- 949-612-9207. Any additional information will be reviewed, and if necessary, sent to a Physician Reviewer for reconsideration according to the Utilization Review process. This reconsideration process is optional and must be initiated within ten (10) days of the determination. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

To the Employee (and their Attorney if represented):

The above-mentioned internal reconsideration process is optional. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

Any dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6, which state that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30 calendar days of receipt of the decision, or TEN (10) DAYS for disputes related to the formulary.

The State of California requires this notice to include the following language:

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your claims examiner, Linda Bobiles at (909) 386-8997. However, if you are represented by an attorney, please contact your attorney.

For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.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 toll-free 1-800-736-7401.

If you have questions, please call 949-221-1700, Opt. 4.

Si usted tiene preguntas referente a esta carta, favor de llamar al número (949) 236-8915.

Sincerely,



Jonathan Marezbian, MD
Neurology
Medical License CA A151052, OH #35.133574, MS #25841, TN #56920, CT #05
UR@medexhco.com
Phone: (949) 221-1700 Fax: (949) 612-9207

Copies to: See Proof of Service

State of California, Division of Workers' Compensation
APPLICATION FOR INDEPENDENT MEDICAL
REVIEW DWC Form IMR

TO REQUEST INDEPENDENT MEDICAL REVIEW:

1. Sign and date this application and consent to obtain medical records.
2. Mail or fax the application and a copy of the written decision you received that denied or modified the medical treatment requested by your physician to:
DWC-IMR, c/o Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009 FAX Number: (916) 605-4270
3. Mail or fax a copy of the signed application to your Claims Administrator.

Type of Utilization Review:	<input checked="" type="checkbox"/> Regular <input type="checkbox"/> Expedited	Modification after Appeal
Employee Name (First, MI, Last): Sonja Leigh		
Address: 1320 Shadow Circle Upland CA 91784		
Phone Number: (951) 422-5140	Employer Name: San Bernardino County	
Claim Number: 144792	Date of Injury (MM/DD/YYYY): 06/14/2023	
WCIS Jurisdictional Claim Number (if assigned): 2023061611543515783564	EAMS Case Number (if applicable):	
Employee Attorney (if known): John Ramirez		
Address: 7121 Magnolia Ave. Ste. M Riverside CA 92504		
Phone Number: (877) 372-2250	Fax Number: (877) 471-6985	
Requesting Physician Name (First, MI, Last): Yury Furman, MD		
Practice Name: Inland Metro Medical Group Inc.	Specialty: Neurology	
Address: 3602 Inland Empire Blvd., Ste B-120 Ontario CA 91764		
Phone Number: (909) 265-9500	Fax Number: (909) 265-9600	
Claims Administrator Name: San Bernardino County		
Adjuster/Contact Name: Linda Bobiles		
Address: ELECTRONICALLY NOTIFIED FAX/EMAIL 222 W. Hospitality Lane, Third Floor San Bernardino County CA 92415		
Phone Number: (909) 386-8997.	Fax Number: (909) 386-8711.	
Disputed Medical Treatment (complete below section)		
Primary Diagnosis (Use ICD Code where practical): Z56,S46912A,S161XXA,Z0000,M542		
Date of Utilization Review Determination Letter: 6/27/2024		
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Reason:		
List each specific requested medical services, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient.		
TR-00018973-003 - Esomeprazole 20mg #45		
Request for Review and Consent to Obtain Medical Records		

<p>I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the claims administrator named above. I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.</p>	
Employee Signature:	Date:

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation claims administrator sent you a written determination letter that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review (IMR) of the medical treatment request by a physician who is not connected to your claims administrator. If the IMR is decided in your favor, your claims administrator must give you the service or treatment your physician requested.

IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL, DELAY, OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO ON PAGE ONE OF THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this form with a copy of the written determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your claims administrator.

- The information on the form was filled in by your claims administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.
- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. This person may sign the application for you and submit documents on your behalf.
- If the recommended medical treatment that was denied or modified must be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.
- Mail or fax the application and a copy of the utilization review decision to:

**DWC-IMR, c/o Maximus Federal Services, Inc.
P.O. Box 138009, Sacramento, CA 95813-
8009 FAX Number: (916) 605-4270**

- Your IMR application, along with a copy of the written determination letter, must be received by Maximus Federal Services, Inc. within thirty-five (35) days from the mailing date of the written determination letter informing you that the medical treatment requested by your treating physician was denied or modified.
- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written determination letter.

Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.

- Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.

Page Break

**Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC
Form IMR)**

Section I. To be completed by the Employee:

Employee Name (Print):	
------------------------	--

I wish to designate

Name of Individual (Print):	
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to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature:	Date:
---------------------	-------

**Section II. To be completed by the Authorized Representative designated above. Law firms,
organizations, and groups may represent the Employee, but an individual must be
designated to act on the Employee's behalf.**

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

Name:		
I am a/an:		
(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)		
Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	
State Bar Number (if applicable):		
Representative Signature:		Date:



Joseph C. Campo

PROOF OF SERVICE

Lewis Brisbois Bisgaard & Smith LLP

[1] I am at least 18 years old, not a party to this action, and not a protected person listed in any of the orders.

[2] I have served the copy of the following document(s): RF-00018973

[3] I am regularly familiar with the ordinary practice of the business of collecting, processing, and depositing correspondence in the United States Postal Service and that the correspondence will be deposited the same day with postage thereon fully paid, and have prepared a true copy thereof (as described above) for collection and mailing following ordinary business practices to the person(s) indicated below (or by facsimile, as indicated).

Sonja Leigh
1320 Shadow Circle
Upland, CA 91786
Curtis A. Gole

Linda Bobiles
ZELMS ERLICH & MACK
ELECTRONICALLY NOTIFIED FAX/EMAIL, 222 W. Hospitality Lane, Third Floor
San Bernardino County, CA 92415
20920 Warner Center Ln Ste B
Notified via email to: Linda.Bobiles@rm.sbcounty.gov

Yury Furman, MD
3602 Inland Empire Blvd., Ste B-120
Ontario, CA 91762
Attorneys for Anne Hulegard, Gary Stager and Beachside Ventures
Notified via fax to: 9092659600

John Ramirez
7121 Magnolia Ave, Ste. M
Jessey Thaler
Riverside, CA 92504
Notified via fax to: 8774716985
THALER LAW

Charles Fuertsch
17011 Beach Blvd Fl 9
385 N Alameda Street
San Bernardino, CA 92415
Notified via fax to: 9092659600
Huntington Beach, CA 92647

[4] My Name, Address and Telephone Number:
Dan Smith
Attorneys for RS Real Estate Plus, Inc., RS Prime Properties, Inc., and Raafat
Salama
MEDEX Health Care, Inc.
2618 San Miguel Dr., #477
Newport Beach, CA 92660

[5] I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

John R. Ramirez

Date: 6/27/2024

THE RAMIREZ FIRM

CONFIDENTIALITY NOTICE:

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