Meraki RCM

From	Priyanka	To	AmTrust North America
Telephone		Clearinghouse	Jopari
Fax	----------	Payer ID	16535
Email	Admin@gmail.com		

Original Bill

Patient Name	Chris Milana
Claim Number	32145689-1
Patient Control No	

Medical Treatment

Billing Provider	WorkMed California, APC
DOS	11-01-2023
Charge Amount	1055.3
Rendering Provider	Kevin Calhoun

Payment Compliance Dates

	15 WORKING DAYS
11/28/2023	12/06/2023
Original Bill 837 (e-Bill) Sent	EOR and Payment

e-Bill Transmission

45 CALENDAR DAYS	60 CALENDAR DAYS
01/05/2024	01/20/2024
Private Entity Employer Penalty and interest due for unpaid portion of bill	Government Entity Employer Penalty and interest due for unpaid portion of bill

AMTRUST NORTH AMERICA
-

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

CMS1500 PAGE 1 OF 8 PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLACKLUNG ☐ (ID#) OTHER ☒ (ID#)	1.a INSURED'S I.D. NUMBER (For Program in item 1): 000-00-0000
2. PATIENT'S NAME(Last Name, First Name, Middle Initial): MILANA, CHRIS 3. PATIENT'S BIRTH DATE MM DD YY SEX M ☒ F ☐	4. INSURED'S NAME(Last Name, First Name, Middle Initial): MERAKI RCM SOLUTIONS, LLC
5. PATIENT'S ADDRESS (NO.,Street): , ST. #208 8020 DE PALMA 6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☒	7. INSURED'S ADDRESS (NO.,Street): 1055 W. 7TH ST ,33RD FLOOR
CITY: LAKEWOOD STATE: CA 8. RESERVED FOR NUCC USE	CITY: LOS ANGELES STATE: CA
ZIPCODE: 90713 TELEPHONE(Include Area Code): , (909) 612-3145	ZIPCODE: 90017 TELEPHONE(Include Area Code):
9. OTHER INSURED'S NAME(Last Name, First Name, Middle Initial)	11. INSURED'S POLICY GROUP OR FECA NUMBER: Unknown
a. OTHER INSURED'S POLICY OR GROUP NUMBER 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT?(Current or Previous) ☒ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC): 32145689-1 Value
c. RESERVED FOR NUCC USE c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME: Value
d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENIFIT PLAN? ☒ Yes ☐ No **If yes,** complete items 9,9a, and 9d.
READ BACK OF FORM BEFORE COMPLETEING & SIGNING THIS FORM 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benifits either to myself or to government benifits either to myself or to the party who accepts assignment below. SIGNED SIGNATURE ON FILE DATE 10/10/2023	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benifits to the undersigned physician or supplier for service described below. SIGNED
14.DATE OF CURRENT ILLNESS, INJURY,or PREGNANCY (LMP) MM Value DD Value YY Value QUAL. 15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17.a 17.b NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19.ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? ☐ Yes ☐ No $CHARGES 22. RESUBMISSION CODE ORIGINAL REF. NO.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 10 A. A009 B. Value C. Value D. Value E. Value F. Value G. Value H. Value I. Value J. Value K. Value L. Value	23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. AMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID.#
1	11	01	23				11		99214		A	392 58	1	004	ZZ NPI	1215628623 1144239401
2	11	01	23				11		WC002			0 0	1	004	ZZ NPI	1215628623 1144239401
3	11	01	23				11		97750		A ,B ,C ,D	106 62	1	004	ZZ NPI	1215628623 1144239401
4	11	01	23				11		97124		A ,B ,C ,D	95 62	1	004	ZZ NPI	1215628623 1144239401
5	11	01	23				11		97810		A ,B ,C ,D	117 86	1	004	ZZ NPI	1215628623 1144239401
6	11	01	23				11		97811		A ,B ,C ,D	87 86	1	004	ZZ NPI	1215628623 1144239401

25. FEDERAL TAX I.D NUMBER: 330184132 SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.: 477DB9122800-1	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ 1055 .3	29. AMOUNT PAID $ 0 .00	30. Rsvd for NUCC Use - 0 .00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGRESS OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Kevin Calhoun SIGNATURE ON FILE 10/10/2023 - DATE	32. SERVICE FACILITY LOCATION INFORMATION Fresno-New 2440 W Shaw Ave #106 2440 W Shaw Ave #106 Fresno California a. NPI 1487029278 b.	33. BILLING PROVIDER INFO & PH #( ) WorkMed California, APC PO BOX 3327 Seal Beach California 90740 a. NPI 1487029278 b.			

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 form 1500 (02-12)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

AMTRUST NORTH AMERICA
-

CARRIER

CMS1500 PAGE 2 OF 8 PICA

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3. PATIENT'S BIRTH DATE MM DD YY SEX M ☒ F ☐

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6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☒

7. INSURED'S ADDRESS (NO.,Street): 1055 W. 7TH ST ,33RD FLOOR

CITY: LAKEWOOD | STATE: CA

8. RESERVED FOR NUCC USE

CITY: LOS ANGELES | STATE: CA

ZIPCODE: 90713 | TELEPHONE(Include Area Code): , (909) 612-3145

ZIPCODE: 90017 | TELEPHONE(Include Area Code):

9. OTHER INSURED'S NAME(Last Name, First Name, Middle Initial):

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

b. RESERVED FOR NUCC USE:

c. RESERVED FOR NUCC USE:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT?(Current or Previous) ☒ YES ☐ NO

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

c. OTHER ACCIDENT? ☐ YES ☐ NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER: Unknown

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER CLAIM ID (Designated by NUCC): 32145689-1 Value

c. INSURANCE PLAN NAME OR PROGRAM NAME: Value

d. IS THERE ANOTHER HEALTH BENIFIT PLAN? ☒ Yes ☐ No **If yes,** complete items 9,9a, and 9d.

READ BACK OF FORM BEFORE COMPLETEING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benifits either to myself or to government benifits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 10/10/2023

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benifits to the undersigned physician or supplier for service described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY,or PREGNANCY (LMP) MM Value DD Value YY Value QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17.a

17.b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ Yes ☐ No $CHARGES

22. RESUBMISSION CODE ORIGINAL REF. NO.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below(24E) ICD Ind. 10

A. A009 B. A009 C. Value D. Value
E. Value F. Value G. Value H. Value
I. Value J. Value K. Value L. Value

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2	11	01	23			11		97814		A ,B ,C ,D	114 06	1	004	ZZ NPI	1215628623 1144239401
3															
4															
5															
6															

25. FEDERAL TAX I.D NUMBER: 330184132 SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 477DB9122800-1

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $ 1055 .3

29. AMOUNT PAID $ 0 .00

30. Rsvd for NUCC Use - 0 .00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGRESS OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Kevin Calhoun
SIGNATURE ON FILE 10/10/2023
- DATE

32. SERVICE FACILITY LOCATION INFORMATION
Fresno-New
2440 W Shaw Ave #106
2440 W Shaw Ave #106
Fresno California
a. NPI 1487029278 b.

33. BILLING PROVIDER INFO & PH #( )
WorkMed California, APC
PO BOX 3327
Seal Beach California 90740
a. NPI 1487029278 b.

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): Pan, Lijuan (Hannah),			
Date of Injury (MM/DD/YYYY): 05/09/2013 05/09/2013		Date of Birth (MM/DD/YYYY):05/25/1963	
Claim Number: 975986-1		Employer: Value Windows and Doors Duarte	

Requesting Physician Information

Name: Andrew Shen, M.D.			
Practice Name: Andrew Shen, M.D.		Contact Name: Leely Lin	
Address:2095 S. Atlantic Blvd., 2nd Floor		City: Monterey Park	State: CA
Zip Code: 91754	Phone: 626-965-9078	Fax Number:626-965-9076	
Specialty: Urgent Care/Occupational Medicine		NPI Number:1851469209	
E-mail Address: optimalhealthmedcenter@gmail.com			

Claims Administrator Information

Company Name: AMTRUST North America		Contact Name: Ms. Jannell Dulaney	
Address: P.O. Box 89404		City: Cleveland	State: OH
Zip Code: 44101	Phone:	Fax Number:216-643-5500,	
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.)
(S33.5XXA) Sprain of ligaments of lumbar spine, initial encounter		Acupuncture treatment		2x3 lumbar spine
		Follow up with psychiatrist		
		Purchase of home IF unit with electrotherapy supplies		Rehab Solutions
		Referral to pain management		
		Follow up in one month		

☐ ☐ ☐

Requesting Physician Signature: Date: 03/08/2018

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:

SUPPLEMENTAL
INTERSPEC IF SEQUENTIAL STIMULATOR FOLLOW-UP

REH Chart #: 27006 Dispense Date: 08/18/2017

PATIENT

Name: Lijuan Pan
Street Address: 1221 Oakbum Dr.
City/State/Zip: Walnut, CA 91789
Date of Birth: 05/25/1963 Social Security #: 616310782

PHYSICIAN

Name: Andrew Shen, M.D.
Street Address: 2095 S. Atlantic Blvd, 2nd floor
City/State/Zip: Monterrey Park, CA 91754

The patient has completed the recommended trial period using the Interspec IF Sequential Stimulator home unit.

RESULTS / FINDINGS

Based on the results of the trial period, I recommend the following:

X Patient has found the device to be effective in relieving the following:

- ■ Managing chronic pain
- □ Managing acute or post-op pain
- □ Increase/maintain range of motion
- □ Promote healing for faster recovery
- □ Osteoarthritis
- ■ Increase circulation
- □ Reduce swelling
- ■ Relieve muscle spasms
- □ Re-educate muscles
- □ Rheumatoid arthritis

_____ Patient has not had any noticeable benefit from using the device during the trial period.

TREATMENT PLAN

X Recommend the purchase of the Interspec IF Sequential Stimulator, and supplies as needed, for further long-term use of the device based on positive treatment outcomes.

TX: 3x DAY / 20-40 MINUTES

_____ Discontinue usage of the unit, effective immediately.

Physician's Signature: _____ Date: 3/8/18

NPI / DEA: 1851469209

ORIGINAL COPY: Rehab Solutions **DUPLICATE COPY:** Patient Chart

Rev 2.1
9/27/17

Optimal
Health Institute
2095 S. Atlantic Blvd., 2nd floor, Monterey Park, CA 91754
18725 E. Gale Ave. #130, City of Industry, CA 91748
Tel: 626-965-9078 Fax: 626-965-9076

WORKER'S COMPENSATION PROGRESS EVALUATION REPORT
(with urgent request for authorization)

3/8/2018

AmTrust North America
P.O. Box 89404
Cleveland, OH 44101

Employee:	Lijuan Pan
Social Security #:	616-31-0782
Date of Injury:	5/9/2013
Date of Exam:	3/8/2018
Employer:	Value Windows and Doors Duarte
Claim Number:	975986-1

Attention: Ms. Jannell Dulaney

To Whom It May Concern:

Ms. Lijuan Pan entered my office for evaluation and treatment of injuries she sustained while at work. At the time of the injury she was employed by Value Windows and Doors Duarte. Following is the patient's description of her injury as well as a brief listing of the results of my examination findings.

Interim History:
Patient is complaining of pain in her lower back which radiates down her legs. The pain is a 7/10 and is present 100% of the time. Patient states the pain is the same as last visit. The pain is worse with prolonged sitting such as driving a car.
She gets numbness and weakness in her legs LT>RT.

She is doing acupuncture which is helping with pain relief and increasing her ADL.
She is taking oral medications which also provide relief.

She gets an increase in pain when she misses therapy sessions.

The medications are helping her sleep better.
She is using the home IF unit and lumbar brace which gives her relief.

She's had an epidural in her lumbar spine in the past. She claims she had dizziness, increased blood sugar, and an increase in her weight. She was told not to have any more epidural injections.

She is complaining of continued anxiety and depression over her pain and situation. She follows up with the psychiatrist. She is taking sertraline 100mg daily.
She denies thoughts to hurt herself or others.

Subjective:
Lijuan Pan presented to the office for consultation and examination due to a work injury that occurred on 5/9/2013. The injury occurred while she was pushing, pulling and lifting while at her job.

Occupational History:
She has been working as a worker in a window company for the past 1 years.

Patient's position requires the patient to be pushing, pulling and lifting. The patient is in seated position 1-2 hours per day. The patient is walking and standing for 6-8 hours per day. The patient is required to lift up to 100 pounds.

Patient was injured on 5/9/2013. On that day she was lifting a roll of aluminum material with a coworker, but she was lifting most of the weight since her coworker was already injured. As she was putting the roll on the cart, the cart moved and caused her to injur her back. She felt a tearing pain immediately in her lower back. The incident happened at the end of her shift. She returned the next day to report the injury and to go to the company doctor.
She claims she gets numbness radiating down her left leg.

Patient reported the injury to her supervisor.
Patient provided with medical treatment.

Ms. Pan described that she has discomfort in her lumbar, left sacroiliac, left buttock and left posterior leg area. She rates the discomfort right now as a 8 on a scale of 10 with 10 being the worst and is noticeable approximately 100% of the time. The discomfort at its worst is rated as a 9 and at its best it is a 6.

The onset of the pain was gradual and was first noticed 5/9/2013. Since the complaint began the symptoms have generally been worse. She reports that the pain is aggravated by prolonged sitting, prolonged walking, lying down and is 25 % worse when it is aggravated and it will stay that way for 30 minutes. She states that the discomfort is relieved by: resting and is reportedly diminished by 25%. The quality of the discomfort is described as numbness, sharp and aching and is at its worst in the evening.

Patient has HTN, but denies any other medical conditions.
Patient denies alcohol or tobacco use.

Objective:

Her blood pressure was taken in the sitting and the observed measurement was 124/77.
Her pulse measured 75 bpm.
Her skin temperature was measure to be 98.4 degrees Fahrenheit.
She is 64" tall. She weighs 155 pounds.

Patient has palpable tenderness at lumbar and left sacroiliac.
Abnormal gait.
Skin inspection wnl
DTR wnl.
Patient is moving slowly from pain.

She is wearing the lumbar brace.

Lumbar Ranges of Motion

Lumbar Flexion 20 /60
Lumbar Extension 0 /30
Lumbar L Lateral Flexion 5/30
Lumbar R Lateral Flexion 5/30
Lumbar L Rotation5 /30
Lumbar R Rotation5 /30

Positive SLR on her right side at 45.

EMG/NCV of the bilateral lower extremities done on 7/25/2017 shows:
There is electrodiagnostic evidence on NCS consistent with a bilateral peroneal motor nerve and left tibial motor nerve neuropathy. This finding can also be seen in a bilateral L5-S1 lumbar sacral radiculopathy.

Assessment:
The patient received a letter to transfer care to MPN. Per labor code 9767.10, "persists without full cure or worsens over a period of at least 90 days or requires ongoing treatment to maintain remission or prevent deterioration", the patient may stay with the current provider. Therefore, per patient's request, we will continue to treat this patient under labor code.

The following is a list of diagnostic impressions for Ms. Pan's current condition:(S33.5XXS) Sprain of ligaments of lumbar spine, M54.16

Discussion:
We have a 53 year old, Female, who sustained an injury while at work and is experiencing continuing trauma. The patient's condition is not permanent and stationary at this time.

Patient wishes to exercise her right to select a treating doctor of Her choice. We have accepted this request and would appreciate receiving copies of all prior medical records you may have relating to this injury, which will assist us in the determination of the patient's future treatment. Please forward the same information to this office upon receipt of this evaluation and on future dates, if additional medical records or consultations are received by you.

Plan:

Acupuncture 2x3 to the lumbar spine with decompression due to successful prior sessions

Continue medication as prescribed:
Tramadol 50mg 1 tab po bid #60 for severe pain
Gabapentin 300mg 1 tab po bid #60 for radiating pain

Follow up with psychiatrist.

She will be scheduled with a spine specialist to discuss her treatment options for her lumbar spine.

Patient is benefiting from using the Interspec IF-II unit and I am recommending the purchase with electrotherapy supplies.

I am requesting for a referral to pain management for Norco.

Continue home exercises and therapy.

Follow up appointment in one month.

(Opinion As To The Extent Of Disability And Working Ability)

Disability: TTD for 45 days or restrictions as per FCE 11/21/2017

Functional Capacity Assessment:

Dynamic Rating is based on the Highest Mean static lifting test score and indicates the theoretical load a subject may be able to lift dynamically on an occasional basis (Blankenship, 1990). Frequent and constant values are derived from the occasional lift value using percentages from the Dictionary of Occupational Titles, 1991.

NIOSH Test Dynamic Rating	Occasional	Frequent	Constant
Lifting and carrying in standing position	5 lbs	2 lbs	1 lbs
Lifting at shoulder level close to torso	3 lbs	2 lbs	1 lbs
Lifting at shoulder level away from torso	1 lbs	1 lbs	0 lbs
Kneeling lift	–	–	–
Torso bending lift	–	–	–
Ground level lift	–	–	–

Patient is to be restricted from any lifting below the waist level at this time.

STAND and/or WALK a total of:
Less than >2 HOURS per 8 hour day

SIT a total of:

Less than 8 HOURS per 8 hour day
Patient should also be allowed to alternate activities as needed.

PUSH and/or PULL (including hand or foot controls):
LIMITED (Describe degree of limitation)

Pushing of 0 lbs, with lumbar and hip flexion combined at less than 10 degree flexion

Pulling of 0 lbs, with lumbar at 5 degree extension only.

ACTIVITIES ALLOWED:

	Frequently	Occasionally	Never
Climbing		X	
Balancing		X	
Stooping		X	
Kneeling		X	
Crouching		X	
Crawling		X	
Twisting		X	
Reaching	X		
Handling	X		
Fingering	X		
Feeling	X		
Seeing	X		
Hearing	X		

Speaking X

Additional Restrictions:

Patient should be restricted from repetitive flexion and extension of the lumbar spine, cervical spine, bending stooping, kneeling or squatting.

The patient should also reframe from working on slippery surfaces, and avoid prolong stair climbing.

Patient should be allowed to unlimited feeling, seeing, hearing, and speaking.

Pursuant to Labor Code #4628, the following declaration is made:

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to the 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.

1. State and Federal Laws require that you spend a sufficient amount of time reviewing the attached documentation prior to rendering any adverse determination on medical necessity.
2. We request that you immediately forward our claims and all of the patient's documentation which you have received to a licensed health provider of the same profession who has a sufficient level of training and experience in the form of are in question so that a proper review can be performed (LC 4610, sec. e)
3. Furthermore, you are required to be consistent with State and Federal Law. The reviewer must base his or her decision on the cure or relieve medical necessity standard. (LC 4600 sec. a- "services that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer", Vorster v. Bowen- A federal case which prohibits carriers from denying care based solely on utilization review criteria when documentation is provided along with the claims.)
4. In the unlikely event that this claim should be denied, you are required by State and Federal Law to provide specific and clinical reasons and the criteria utilized as the basis for decisions in a timely fashion. Additionally you must also provide recommendation for what are is determined to be appropriate and why. Failure to do so may result in a proceeding to issue and order for penalties for each failure. (LC 4610, sec. g4 states, Communications regarding decisions to modify, delay, or deny medical treatment services requested by professionals shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity LC 4610, sec. g(1)- " … decisions shall be made in a timely fashion…not to exceed five working days from the receipt of the information…", LC 4610, sec. I- "IF the administrative director determines that the employer…has failed to meet any of the timeframes…may asses penalties for each failure.")
5. Please be advised all patient care rendered will be in accordance with current California Worker's Compensation Laws and Regulations, specifically the ACOEM guidelines in situations where applicable. In situations where a ACOEM guidelines do not apply, i.e., certain chronic cases, the care rendered will be based upon scientifically peer reviewed evidence based considerations with supportive documentation provided per LC 4604.5, "For all injuries not covered by the ACOEM Practice guidelines… treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the medical community."

6. Please be advised if claim to paid within 45 days as required LC 4603.2 (b)(1), we will accept the Official Medical Fee Schedule and not pursue Usual and Customary Fees and/or penalties, interest and fines as prescribed by law. (LC 4603.2, sec. b1- "Payment shall be made by the employer within 45 working days after receipt of each separate, itemization medical services provided. Any properly documented list of services provided not paid at the rates the in effect under Section 5307.1 within the 45-working-day period shall be increased by 15 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the itemization...", Lerick Case: (Ramierz v Fresh Express) Usual and Customary Fees- "Case law has determined that you may be paid you usual and customary fees, not the WC Official Medical Fee Schedule in a case that is denied or not paid with the required time frame.")

We look forward to working with you in a cooperative nature as is recommended between the insurance companies and health care providers by the authors of ACOEM guidelines. If there is any further information we may provide that will help us in the endeavor of the recovery for the injured worker, please notify us.

DISCLOSURE:

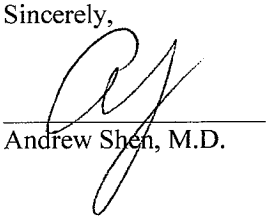
This medical report was hand-drafted and/or dictated by me and typed as noted below. This report expresses my professional findings, opinions and conclusions on matters discussed.

I declare under penalty of perjury that the information contained in this report and its attachments, if any is true and correct to the best of my knowledge and belief, except as to the information that I have indicated I receive from others. As to that information, I declare under penalty of perjury that the information provided to me and, except as noted herein, than I believe it to be true.

I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is under penalty of perjury.

Executed on 3/8/2018, at Monterey Park, CA 91754.

Sincerely,



Andrew Shen, M.D.

PROOF OF SERVICE BY MAIL

I am a resident of the State of California, Country of Los Angeles. I am over the age of eighteen years and not a party of the above-entitled action. My business address is 2095 S Atlantic Blvd, Monterey Park, CA 91754.

On 3/8/2018 I served the attached documents on said action, by placing a true copy thereof enclosed in a sealed envelope with postage fully prepaid in the United States Mail at Monterey Park, California addressed as follows:

To:
AmTrust North America
P.O. Box 89404
Cleveland, OH 44101

Law Offices of Williams O. Owour
735 W. Duarte Road, Suite 206
Arcadia, CA 91007

Documents:
REQUIRED PROGRESS REPORT 3/8/2018

Jenny Y., Leely Lin, Eric T.