Bell Community Medical Group

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PRIMARY TREATING PHYSICIAN'S INITIAL CONSULTATION REPORT

REQUEST FOR AUTHORIZATION OF TREATMENT/REFERRAL

RE:	**KARIM, AUDRA**
Employer:	**CAL NED**
Insurance Carrier:	**CHUBB**
Claim Number:	**092019015968**
Social Security Number:	**256-53-7045**
WCAB Case Number:	**UNAVAILABLE**
Date of Injury:	**2/6/19**
Applicant Attorney:	**VISIONARY LAW**
Date of Initial Examination:	**FEBRUARY 5, 2020**
Date of Report:	**FEBRUARY 10, 2020**

OPENING STATEMENT:

This report is being prepared under the guidelines of the Division of Workers' Compensation as an initial report for purposes outlining the patient's disability by the primary treating physician. As all interested parties are aware, Ms. Karim elected the undersigned examiner as her free-choice primary treating physician. Approximately 90 minutes were spent in obtaining history and physical, 40 minutes were spent in studies review, and 60 minutes were spent in the preparation of this report.

The patient was evaluated at my office located at 4001 E. Florence Avenue, Bell, California 90201.

WORK HISTORY:

The patient was employed by Cal Ned as a wardrobe dresser. She worked 35-40 hours per week. The movements included simple grasping, power grasping, pushing and pulling, and work at or above shoulder level with both arms. She was required to lift and carry up to 30 pounds frequently. She started working in 2010 to 2/10/19.

HISTORY OF INJURY:

Ms. Karim is a 48-year-old, left-handed, female who was involved in a work-related injury on 2/6/19.

The patient states that she was already having lower back pain from her repetitive work. On 2/6/19, she was carrying a basket weighing about 25-30 pounds and when she finished her shift, she had severe lower back pain. The pain radiated to her hips and legs.

She reported her pain to Cristal Diaz and Joe on 2/6/19, but she was not referred for medical care. She was told to go see her own PCP.

She went to see her PCP at Kaiser on 2/7/19. She was told to go see a doctor at Kaiser on the Job. She was examined and had x-rays. Medications were prescribed and she was started on therapy. She also had an MRI of the lumbar spine. She was sent back to modified work, but was only able to work a few days due to pain.

She hired an attorney but was not sent to a clinic. In 5/2019, she received a call from Kaiser on the Job and told that she could not go back for treatment because her case was denied.

In 6/2019, she asked her union to send her to another work site. She was not able to work due to her pain. She went to County USC and was prescribed medications for pain.

She has also gone to Good Samaritan Hospital and Kaiser, but was denied treatment due to it being a work injury.

She hired a new attorney in 9/2019 and in 10/2019, she saw a panel QME and was recommended to have treatment. She was treated at a clinic in Los Angeles, but on 1/8/2020, she was told that they could no longer treat her. She states that the pain has worsened since she saw the panel QME in 10/2019.

CHIEF COMPLAINT:

The patient presented to the undersigned examiner on 2/5/20, with the following complaints:

1. Upper and mid back pain
2. Low back pain.

3. Bilateral hip numbness.

On examination of the upper, mid back, the pain was noted over the bilateral thoracic regions. The pain was constant in frequency and moderate in intensity. He described the pain as sharp, shooting. The pain was exacerbated to a level of moderate to severe in intensity by walking, standing for 10 minutes, sitting for 10 minutes, and by occasional climbing.

On examination of the lower back pain was noted over the bilateral lumbar regions radiating to the bilateral buttocks. The pain was constant in frequency and moderate in intensity. He described the pain as sharp, shooting. The pain was exacerbated to a level of moderate to severe in intensity by walking, standing for 10 minutes, sitting for 10 minutes, and by occasional climbing.

PAST MEDICAL HISTORY:

Previous Illnesses:

Childhood Illnesses: Denied.

Chronic Illnesses: Denied.

Current Illnesses:

Denied.

Previous Injuries:

The patient had a motor vehicle accident in 2000. She recovered fully.

Surgeries:

Denied.

Allergies:

Lactose, lentils, strawberry, pineapples.

Current Medications:

Denied.

PHYSICAL EXAMINATION:

The patient was seen in our office on 2/5/20. Her current stated age is 48 . She looked well nourished and well developed and not in acute distress.

Vital signs: HT 5'6 inches; W 196 pounds; P 73; BP 127/87; T: 98.3

Skin:

Examination of the skin demonstrated normal hydration, color, and constituency. There was no rash, induration, or lesions.

Head:

The head was normal cephalic and non-tender. There were no lesions, scars, or deformities.

Eyes:

Pupils were equal, round, and reactive to light and accommodation. There was no nystagmus. The conjunctivae were not injected. The optic disks were unremarkable. There was no papilledema or hemorrhage.

Ears:

The ear canals and tympanic membranes were clear, with no evidence of exudate or bleeding. Hearing was intact.

Nose:

The nasal passages were clear and free of discharge. There was no notable tenderness over the external nose. The septum was in midline.

Throat:

The tongue was well papillated with normal movements of the soft palate with phonation. The oropharynx was not injected. Lips, gums, and internal oral structures were normal. Dentition was good.

Chest:

Normal expansion. No deformity. Lungs: Clear to auscultation and percussion.

Heart:

Regular rate and rhythm. Normal S1, S2. No murmurs, rubs, or gallops. Pulses symmetrical and within normal limits. PMI is not displaced. No thrills.

Abdomen:

Abdomen was soft and non-tender. There was no organomegaly, masses or bruits detected. There were normal bowel sounds present. No hepatosplenomegaly or hernias. No psoas or obturator signs.

Lymphatic:

There is no evidence of neck, axilla, or groin adenopathy.

Neurological Evaluation:

The patient was alert and oriented X 4. Cranial nerves II through XII were intact and symmetrical. Muscle strength was tested and was found to be normal. Deep tendon reflexes were unremarkable. Sensory examination was intact. Romberg and Babinski's signs were negative. There was no clonus. No evidence of muscle atrophy or paralysis was present.

Psychiatric Exam:

The patient's mood and affect were within normal limits. She demonstrated good judgment and awareness. Her recent and remote memory was good and appropriate for age.

Upper Back:

On examination of the upper back, there was tenderness and spasms was noted over the bilateral paravertebral regions.

Ortho Tests:

Kernig/Brudzinski (n.root impo, dural irr):
Negative.

Anterior/Posterior Compression (ribs fx):
Negative.

Lateral Rib Compression (ribs fx):
Negative.

Inspiration/Expiration Breathing (ribs fx):
Negative.

Lower Back:

On examination of the low back, there was tenderness and spasms noted over the bilateral paravertebral regions.

Range of motion:

	Patient (°)	Normal (°)
Forward Flexion	18	Inches from the floor (0)
Extension	05	35
Right Lateral Rotation	20	30
Left Lateral Rotation	20	30
Right Bending	20	30
Left Bending	20	30

Ortho Tests:

Kernig/Brudzinski
While the patient is supine with hands cupped behind the head, each hip is flexed to no more than 90 degrees and then each knee is flexed to no more than 90 degrees. This maneuver tests for meningeal irritation, nerve root impingement, or dural irritation.
Findings: Negative.

Stoop
The patient is asked to walk briskly for a period of 1 minute. This maneuver tests for relationship between the neurogenic intermittent claudication, posture, and walking.
Findings: Negative.

Bowstring (Cram)

While the patient is supine, straight leg raise is performed to the point of pain and the knee is flexed to 20 degrees in attempt to reduce painful symptoms. Popliteal pressure is applied in an attempt to reproduce the radicular pain.
Findings: Negative.

Unilateral SLR (Lasègue)
While the patient is supine with knees extended, the leg is raised until the pain or tightness is noted. This maneuver tests for dural irritation, lumbar spine or sacroiliac involvement.
Findings: Positive.

Bilateral SLR
While the patient is supine with knees extended, both legs are raised simultaneously until the pain or tightness is noted. This maneuver differentiates lumbar spine versus sacroiliac joint involvement.
Findings: Positive at greater than 70%.

Hoover
While the patient is supine with heels in examiner hands, unilateral SLR is performed. This maneuver tests for neuromuscular weakness.
Findings: Negative.

90-90 SLR
While the patient is supine with both hips at 90 degrees and knees bent in relaxed position, one knee at a time is extended maximally. This maneuver tests for tight hamstrings.
Findings: Positive

Well SLR
While the patient is supine with knees extended, SLR test performed on uninvolved leg. This maneuver tests for vertebral disk damage.
Findings: Positive.

Spring
While patient is prone, springing force is applied to the vertebrae. This maneuver tests for hypermobility or hypomobility of vertebrae.
Findings: Negative.

Gaenslen's
While patient is lying on uninvolved side with the involved leg slightly hyperextended, uninvolved knee is flexed towards the chest and involved hip further extended. This maneuver tests for sacroiliac joint involvement.

Findings: Negative.

Patrick/Faber
While the patient is supine, the leg is flexed, abducted, and externally rotated until the foot rests on top of the opposite knee. Then, the leg is slowly abducted towards the table. This maneuver tests for sacroiliac, iliopsoas, and hip joint involvement
Findings: Negative.

Bragard's
While the patient is supine, SLR test is performed to the point of pain. The leg is lowered below the level of the painful symptoms and the foot is dorsiflexed. This maneuver confirms radiculopathy.
Findings: Negative.

Waddell
The patient is tested for appropriateness of response to tenderness, axial loading, rotation, straight leg raising in the seated position, regional disturbances and overreaction.
Findings: Negative.

Heel/Toe walk
The patient is instructed to walk few steps on the heels, turn around and walk on the toes. This maneuver tests for L5 and S1 radiculopathy.
Findings: Negative.

HIP EXAM

There is tenderness and spasms noted over the bilateral lateral hips.

Range of Motion:

	Patient (°)		
	Normal (°)	Right	Left
Flexion	115	100	100
Extension	30	20	20
Abduction	50	40	40
Adduction	30	30	30
External Rotation	65	65	65
Internal Rotation	35	35	35

Ortho Tests:
Hip Scouring
While the patient is supine and his involved hip flexed and adducted and knee fully flexed, the hip is adducted and internally/externally rotated and downward pressure applied. This maneuver tests for hip pathology.
Findings: Positive

Nelaton's Line
The position of greater trochanter is related to the line from the anterior superior iliac spine to the ischial tuberosity. This test assesses the possibility of Coxa Vara.
Findings: Negative.

Craig's
While the patient is prone, the femur is rotated until the greater trochanter is parallel to the table. The angle between the long axis of the lower leg and the perpendicular axis to the table is measured. This test assesses hip pathology.
Findings: Positive.

90-90 SLR
While the patient is supine stabilizing both hips at 90 degrees, knees are actively extended. This maneuver assesses hamstrings tightness.
Findings: Positive

Faber/Patrick
While the patient is supine, the leg is flexed, abducted, and externally rotated until the foot rests on top of the opposite knee. Then, the leg is slowly abducted towards the table. This maneuver tests for sacroiliac, iliopsoas, and hip joint involvement
Findings: Positive

Ely's
While the patient is prone, the knee is passively flexed. This maneuver assesses rectus femoris tightness.
Findings: Negative.

Tripod
While the patient sitting with both knees flexed at 90 degrees over the edge of the table, the knees are passively extended. This maneuver assesses the extensibility of the hamstrings.
Findings: Negative.

Femoral Nerve Traction
While the patient lies on uninvolved side with the neck flexed, the hip is flexed about 15 degrees and the knee moved from complete extension into flexion. This maneuver assesses mobilization of the femoral nerve.
Findings: Negative.

KNEES:

There is no tenderness noted on palpation.

ROM:

	Patient (°)		Normal (°)
	Right	Left	
Extension	180	180	180
Flexion	135	135	135

Orthopedic Tests

Patella Tend/Ligament Length
While the patient is supine, the distances between the superior pole of the patella to the inferior pole of the patella and between the inferior pole of the patella and the tibial tubercle are compared. A ratio of greater than 1 indicates patella baja and a ratio of less than 1 indicates patella alta.
Findings: Negative.

Patellar Apprehension
While the patient is supine, the patella is pushed laterally. This maneuver tests patellar subluxation or dislocation.
Findings: Negative.

Q-Angle
While the patient is supine, the angle between anterior superior iliac spine to midpoint of patella to tibial tubercle is measured. Angle greater than normal is indicative of patellofemoral pathology.
Findings: Negative.

Medial-Lateral Grind
While the patient is supine and the hip and knee maximally flexed, rotating motion is applied to the tibia. This maneuver tests for meniscal tear.
Findings: Negative.

Bounce Home
While the patient is supine, the knee is flexed and let passively fall into extension. This maneuver tests for meniscal tear.
Findings: Negative.

Patellar Grind
While the patient is supine with both knees extended. He is asked to contract quadriceps muscle and inferior pressure is applied to the patella. This maneuver tests for chondromalacia patella.
Findings: Negative.

Anterior Lachman's
While the patient is supine with the knee flexed to 20-30 degrees, anterior force is applies to the tibia. Increased anterior translation is indicative of the anterior cruciate ligament injury.
Findings: Negative.

Anterior Drawer
While the patient is supine with the hip flexed to 45 degrees and the knee flexed to 90 degrees, anterior force is applied to tibia. Increased anterior translation is indicative of the anterior cruciate ligament injury.
Findings: Negative.

Posterior Lachman's
While the patient is supine with the knee flexed to 20-30 degrees, posterior force is applies to the tibia. Increased posterior translation is indicative of the posterior cruciate ligament injury.
Findings: Negative.

Posterior Drawer
While the patient is supine with the hip flexed to 45 degrees and the knee flexed to 90 degrees, posterior force is applied to tibia. Increased posterior translation is indicative of the posterior cruciate ligament injury.
Findings: Negative.

Valgus Stress
While the patient is supine with the knee fully extended, a valgus force is applied to the knee. Medial knee pain or increased valgus translation is indicative of medial cruciate ligament, posterior cruciate ligament, or posteromedial capsule injury.
Findings: Negative.

Varus Stress
While the patient is supine with the knee fully extended, a varus force is applied to the knee. Lateral knee pain or increased varus translation is indicative of lateral cruciate ligament, posterior cruciate ligament, or arcuate complex injury.
Findings: Negative.

McMurray
While the patient is supine with the knee fully flexed, the tibia is externally rotated with valgus force applied and then internally rotated with varus force applied. The knee is then extended. This maneuver tests medial and lateral menisci.
Findings: Negative.

Apley Compression
While the patient is prone with the knee flexed to 90 degrees, the tibia is rotated as downward force is applied through the heel. This maneuver tests medial and lateral menisci.
Findings: Negative.

Strength:

	Right		Left	
	Patient	Normal	Patient	Normal
Hip Flexion	5	5	5	5
Hip Extension	5	5	5	5
Knee Flexion	5	5	5	5
Knee Extension	5	5	5	5
Foot Dorsiflexion	5	5	5	5
Foot Plantar Flexion	5	5	5	5

Key: 0 – no contraction, 1 – feeble contraction, 2 – move with assistance, 3 – hold against gravity, 4 – resists against pressure, 5 – normal

Deep tendon reflexes:

	Right		Left	
	Patient	Normal	Patient	Normal
Knee	2+	2+	2+	2+
Achilles	2+	2+	2+	2+

Key: 0 – absent, 1 – hypo, 2 – normal, 3 – increased, 4 – hyperactive.

Pulses:

	Right		Left	
	Patient	Normal	Patient	Normal
Femoral	2+	2+	2+	2+
Popliteal	2+	2+	2+	2+

Posterior Tibial	2+	2+	2+	2+
Dorsalis Pedis	2+	2+	2+	2+

Key: 0 – absent, 1 – with Doppler only, 2 – normal

Circumference:

	Right	Left
Thigh	48	48 cm
Knee	41	41 cm
Calf	40	40 cm
Ankle	22	22 cm

Sensation:

1-2 ICS (T1)	Normal
Nipples (T4)	Normal
Lower ribs (T7)	Normal
Umbilicus (T10)	Normal
Symph.Pubis (L1)	Normal
Medial Thigh (L2-3)	Abnormal
Knee (L4)	Abnormal
Lateral Calf (L5)	Abnormal
Lateral Foot (S1)	Abnormal
Perianal (S2-S4)	Normal

DIAGNOSTIC STUDIES:

X-RAYS:

X-rays of the lumbar spine, bilateral hips, and thoracic spine were performed by George Santos, x-ray technician, and results are pending. A drug screen was done.

DIAGNOSES:

1. Bilateral hip bursitis vs. internal derangement.
2. Thoracic radiculopathy M54.14.
3. Lumbar radiculopathy M54.16.

Toxic/chemical compound is not involved. Symptoms are consistent with the account of injury. There were no complicating conditions.

CAUSATION:

The patient is a 48-year-old female who, while performing her normal and customary duties and during the course of her employment, sustained injuries as described above while employed at Cal Ned.

Based on the history as provided by the patient and the results of examination, it is fair to say with reasonable medical probability that the injuries sustained by the patient, which resulted in disability and the need for medical treatment, arose out of and occurred during the course of the employment, and were the direct result and sole contributing factor of the industrial injury referenced above.

WORK STATUS:

The patient is placed on modified duty work.

WORK RESTRICTIONS:

The patient is placed on modified duty work. lifting limited to 10lbs., no bending and no prolong walking/standing/sitting)

FACTORS OF DISABILITY:

Subjective and objective factors of disability to be addressed when the patient's condition has reached a permanent and stationary status.

APPORTIONMENT:

The issue of apportionment will be addressed when the patient's condition has reached a permanent and stationary status.

VOCATIONAL REHABILITATION:

The issue of vocational rehabilitation will be addressed when the patient's condition has reached a permanent and stationary status.

RECOMMENDED TREATMENT:

On an industrial basis, the patient should continue with physical therapy to the upper back, lower back, bilateral hips, consisting of hot packs, myofascial

manipulation, ultrasound, EMS, ortho-bed, exercise, and Diathermy, start with 6 sessions (2x/wk for 3wks) and continue if helpful for functional restoration.

The patient was prescribed lumbar support, Nexium, Anaprox and Norflex.

The patient needs to obtain consultation with chiropractor.

The patient needs to obtain MRI scan of the lumbar spine and bilateral hips.

The patient needs to obtain SPF NCS of the thoracic spine, lumbar spine.

The patient needs to obtain NCS/EMG of the lower extremities.

Medical Necessity: Neurological findings on exam. Pain not improved after 1 month of conservative treatment.

As the pain progresses, A-delta fibers diminish in conductivity. The result is that the patient looses the ability to localize the lesion, and becomes dependent on the C-Type fibers of the paleospinalthalamic pathway[1]. The Neural-Scan takes advantage of this mechanism by testing A-delta fiber function in all the major nerves in a region, so the subject is her own control independent of age, gender and population data comparisons. The nerve requiring the highest amplitude to cause impulse conduction is the nerve associated with the nerve-root lesions with 95% sensitivity, as shown in a published peer-reviewed three-year study[2].

Of note is the main difference between SPF NCS and standard NCV/EMG testing. The latter only test for sensory and motor function but not the pain directly. It is well established that NCV/EMG, CT and MRI scans are not primary diagnostic method but adjunctive to the H&P exam[3]. Unfortunately, H&P exam is not very sensitive. Cork reports in her three-year study of severe back pain patients, in which of the 49 patients studied 25 were failed back surgery cases, the patients that should be the easiest to diagnose, the physical-neurological exam only had 62% sensitivity in locating the specific nerve-root involved[4].
1

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[1]References:

1.Guyton & Hall, **Textbook of Medical Physiology**: Ninth Edition, W B Saunders Co. 1996:610-611
2. Randall Cork, MD, PhD et al: *Predicting Nerve-Root Pathology with V-sNCT*, **Internet Journal of Anesthesiology**, Vol 6 No 1 (2002)
3. Weiner, Goetz: **Neurology for the Non-Neurologist**: Second Edition, J B Lippincott; 1989:23
4. Randall Cork, MD, PhD et al: *Predicting Nerve-Root Pathology with V-sNCT*, **Internet Journal of Anesthesiology**, Vol 6 No 1 (2002)

The patient will be re-evaluated on February 10, 2020, at which time, her condition will be reassessed and further treatment recommendations will be given. The patient's prognosis at this time is considered guarded.

I am requesting a baseline Functional Capacity Evaluation (FCE) to objectively determine patient's ability to perform his job and/or the need for specific modification in attempt to allow the patient to participate in productive employment, as recommended by CA MTUS. Chronic pain, page 8:

A comprehensive battery of performance-based tests used to assess an individual's ability for work and ADL. An FCE may be done to identify and individual's ability to perform specific job tasks associated with a job (job-specific FCE), or his/her ability to perform physical activities associated with any job (general FCE).

FCE will be performed at the beginning of treatment and repeated on as needed basis to access functional improvement and ability to perform more strenuous job duties.

Please note: if the case is accepted, only accepted body parts will be treated, but all the claimed body parts will have to be addressed as required by CCR §9785 (d).

Consider this report a formal authorization request for the above procedures/referrals. Also, please forward all available medical records to us.

PLEASE FORWARD ALL MEDICAL RECORDS WITHIN SIX (6) DAYS FROM THE DATE OF THIS REQUEST OR FROM THE DATE OF RECEIPT OF ANY SUBSEQUENTLY-RECEIVED PHYSICIAN'S REPORT, AS REQUIRED BY REGULATION SECTION 10608

BASIS OF OPINION:

I have reviewed the patient's objective findings. After review of such, it is clear to the undersigned examiner that the opinions expressed in this report are supported by a preponderance of medical evidence. In completing my evaluation, I also considered the duties of Ms. Karim's occupation at the time of injury, the duration of time since the injury, and her physical limitations.

AFFIDAVIT OF COMPLIANCE:

In compliance with Section 10606 and Labor Code 4628 Rules of Practice and Procedures Manual of the Workers' Compensation Appeals Board, this disclosure is made:

The patient's history, as related to this work-related injury, was obtained by this examiner. I personally reviewed her medical history and the background information with the patient and performed all necessary changes and additions for clarification. I also personally performed a complete medical examination on this patient and completed this report.

In addition, 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 made under penalty of perjury.

I, Michael Bazel, M.D., 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 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.

STATEMENT REFERABLE TO REASONABLE COST OF CLERICAL EXPENSE NECESSARY TO PRODUCE THIS REPORT AS PER CALIFORNIA STATUTE 4628.

The state of California Labor Code Statute 4628 entitled "Responsibilities of physician signing medical legal report" paragraph (D) authorizes "Reasonable costs of clerical expense necessary to produce the report."

Please be advised, that the fees charged by this office exceed the official medical fee schedule in this matter. Such fees above the schedule are in accordance with Labor code #5307.1. The explanation for the increased fees would be as follows:

1. Michael Bazel, M.D., and staff have been providing Workers' Compensation evaluation and treatment for seven years and have treated thousand of patients.
2. The fees charged do not exceed AOC/DA's usual and customary charges.
3. The fees are within the range of those charged by medical doctors within and around the local community.
4. The economic aspects of a medical practice within a Workers' Compensation practice involves overhead expenses which include but are not limited to the need for qualified persons to conduct collection and

make appearances before the board. There is also the overhead involved in the average amount of time between incurring costs and receipt of payment. The fees must be above the official medical fee schedule in order to maintain the medical practice.

We request to be added to the Address List of Service of all Notices of Conference, Mandatory Settlement Conferences and Hearings before the Workers' Compensation Appeals Board. We are advising the Worker's Compensation Appeals Board that we 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 Manual Index No. 6.610, effective February 1, 1995, we request that defendants, with full authority to resolve our lien, telephone our office and ask to speak with our workers' Compensation lien negotiator.

The foregoing declaration was signed in the County of Los Angeles, on February 10, 2020.

Sincerely,

Michael Bazel, M.D., Q.M.E.
Diplomate of American Board of Emergency Medicine
Medical Director
Bell Community Medical Group

MB: dw

PROOF OF SERVICE BY MAIL:

STATE OF CALIFORNIA – COUNTY OF LOS ANGELES

I, the undersigned, am employed in the County of Los Angeles, and the State of California. I am over eighteen years of age and not a party to the within action. My business address is:

4001 E. FLORENCE AVE.
BELL, CALIFORNIA 90201

On _____ I served the following document(s).
PRIMARY TREATING PHYSICIAN'S INITIAL CONSULTATION REPORT AND RFA
By placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Los Angeles, CA Addressed as follows:

INSURANCE CARRIER: CHUBB
P.O. BOX 42065
PHOENIX, AZ. 85080

EMPLOYER:

APPLICANT ATTORNEY: VISIONARY LAW
8605 SANTA MONICA BLVD. #86277
W. HOLLYWOOD, CA 90069

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 made under penalty of perjury.

DATE OF REPORT: FEBRUARY 10, 2020

Dated this 24 day of February 2020, at Los Angeles, California.

SIGNED: Rosie J Santos
ROSIE SANTOS

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): KARIM, AUDRA			
Date of Injury (MM/DD/YYYY): 2/6/19		Date of Birth (MM/DD/YYYY): 1/18/72	
Claim Number: 092019015968		Employer: CAL NED	

Requesting Physician Information

Name: Michael Bazel, MD			
Practice Name: Bell Community Medical Group		Contact Name:	
Address: 4001 E. Florence Ave.		City: Bell	State: CA
Zip Code: 90201	Phone: 323-562-0595	Fax Number: 323-562-2047	
Specialty: Emergency Medicine		NPI Number: 1598712978	
E-mail Address: BazMD@aol.com			

Claims Administrator Information

Company Name: CHUBB		Contact Name:	
Address: P.O. BOX 42065		City: PHOENIX	State: AZ
Zip Code: 85080	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.)
Thoracic radiculopathy	M54.14.			
Lumbar radiculopathy	M54.16.			
SEE ATTACHED				

For specific treatment plan and requested procedures and consultations refer to report on Page # 14

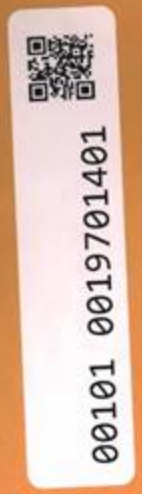
Requesting Physician Signature: Date: 2/10/20

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:



VISIONARY LAW
8605 SANTA MONICA BLVD #86277
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Mail Item Details

Item ID:	0000000101 0019701401
Received:	6/15/2020 7:55 PM BST
Delivered:	6/15/2020 8:43 PM BST
Arrived in Mailbox:	6/15/2020 8:43 PM BST
Carrier:	USPS
Mail Class:	First Class
Pages:	20
Dimensions:	12.29 x 9.10 x 0.20 in
Weight:	4.00 oz
Sender Text:	