P.O. Box 269120 • Sacramento, CA 95826-9120 • 916.563.1911 • Fax 916.362.3043

12/8/2016

Gary Murata MD
2488 North California Street

Stockton, CA 95204

Fax: (209) 948-3331

Re:	**Tiffany Anderson**
Claim Number:	VE0700184
DOI:	6/19/2008
DOB:	8/22/1970
Date of Receipt (DOK):	12/2/2016
Employer:	Vector JPA
Carrier:	AIMS
Claims Examiner:	Nancy Urton
AMC Event #:	163326

Notice of Utilization Review Determination

Dear Dr. Murata:

Allied Managed Care has performed a utilization review for the claims administrator to determine whether the following treatment is medically reasonable and necessary, and consistent with the Medical Treatment Utilization Schedule adopted pursuant to Labor Code Section 5307.27 and Labor Code Section 4604.5 (c). After a thorough review of the available records, the following determination has been recommended regarding services requested for the claim referenced above.

Certification has been recommended by our physician reviewer for the following services requested:
None

Modification has been recommended by our physician reviewer for the following services requested:

- *Service Modified To: Certify six (6) physical therapy sessions (2x3) for the right knee*

  Date Of Modification: 12/8/2016

  Requested Service: Physical therapy for right knee; two (2) times a week for four (4) weeks

Non-Certification has been recommended by our physician reviewer for the following services requested:
None

Request for Additional Information has been recommended by our physician reviewer for the following services requested:
PR Additional Information Requested For Services: None

Delay has been recommended by our physician reviewer for the following services requested:
None

Withdrawal of the following services was confirmed with the requesting physician:
None

The following physician reviewed this request and made the decision/recommendation:
Dr.

Marvin Pietruszka
P.O. Box 269120, Sacramento, CA 95826-9120
Telephone: (916) 563-1911
Toll Free: (888) 290-1911

Hours of Availability: Monday – Friday 9:00 AM – 5:30 PM Pacific Time

Optional Internal UR Appeals Process for the Requesting Physician

AMC provides a voluntary internal utilization review appeal process. The requesting provider must submit an appeal within ten (10) days after receipt of the utilization decision to modify or deny a proposed treatment. The appeal will be addressed by a different peer review physician than the one providing the initial UR determination. A determination in response to the appeal will be provided in a timely fashion that is appropriate for the nature of the injured worker's condition but shall not exceed thirty (30) days after the date of receipt of the requested appeal.

A request for an internal utilization review appeal must be completed, and a determination issued, by the claims administrator within thirty (30) days after receipt of the request under subdivision (d)(1). An internal utilization review appeal shall be considered complete upon the issuance of a final independent medical review determination under section 9792.10.6(e) that determines the medical necessity of the disputed treatment.

An expedited appeal shall be provided when requested and when there is documentation of:
1) a worker's condition that presents an imminent and serious threat to his or her health (including but not limited to the potential loss of life, limb, or other major bodily function), or
2) when the normal time frame for the appeal process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

In the case of an adverse determination, there shall be availability of the expedited appeals consideration and the further availability of a single standard appeals consideration.

An expedited appeal (as defined by 9792.6) response will be made within seventy-two (72) hours. A standard appeal will be decided within fifteen (15) calendar days from the date of this utilization review determination.

This voluntary internal appeals process neither triggers nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6 (the Independent Medical Review process), but may be pursued on an optional basis.

12-8-16

Appeals and reconsiderations of this determination may be submitted in writing, along with any additional information, to:

Allied Managed Care
Attn: Utilization Review Department
P.O. Box 269120
Sacramento, CA 95826-9120
Toll Free Telephone: (888) 290-1911 Fax: (916) 362-3043

In the event that you would like to discuss this decision with the reviewer, you may contact Allied Managed Care at the number provided above so that an agreed time may be arranged for the call. All reviewers are available for at least four hours per week during normal business days from 9:00 a.m. to 5:30 p.m. Pacific Time, per regulations 9792.9. In the event that the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

A utilization review decision to modify, delay, or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Additionally, you, the injured worker have the right to use the dispute resolution process as per Title 8 of the CCR 9792.10. Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. An objection to this 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-1, within 30 calendar days of receipt of this decision.

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

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.

The injured worker may file an Application for Adjudication of Claim and a Declaration of Readiness to Proceed (expedited trial) and request an expedited hearing.

163326

Date of Report: 12/08/16

Gary Murata, MD
2488 North California Street
Stockton, CA 95204

Re:	**Tiffany Anderson**
Claim Number:	VE0700184
DOI:	06/19/08
DOB:	08/22/70
DOK:	12/02/16
Employer:	Vector JPA
Claims Examiner:	Nancy Urton
Carrier:	AIMS
AMC Case #:	163326

Utilization Review / Peer Review Report

Dear Dr. Murata,

After reviewing the available information, my recommendation to the carrier is as follows:

Requested Service/Procedure(s):	**Determination(s):**
Physical therapy; eight (8) sessions (2x4), right knee	**Modified: Certify six (6) physical therapy sessions (2x3) for the right knee**

Teleconference(s): On 12/05/16 at 15:40PT a telephone call was placed to (209)948-3333 and a detailed message was left for Dr. Murata on Madison's voicemail including a return callback number.

Contact Not Achieved. Absent the opportunity to speak with the requesting physician, the submitted medical records were reviewed and the following is determined:

Clinical History:

Visit note dated 11/29/16 indicates that the claimant complains of right knee pain. The claimant continues to have pain and weakness as well as catching about the right knee. In the past, the claimant had improvement with these symptoms with physical therapy. The claimant is interested in another course of physical therapy. The claimant is feeling better since last visit. The claimant still feels more pain in the right knee. The claimant did not attend physical therapy, which was ordered on last visit due to family issues. Upon examination of the right knee, the range of motion is 0-120 degrees. Quadriceps strength is graded 4+/5. There is mild diffuse joint tenderness. The

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Respectfully,

Ericka Sutton
Utilization Review Nurse
(888) 290-1911

claimant had multiple chemical exposures. Treatment plan is for 6 sessions of physical therapy for the right knee and medications. The claimant has work restrictions to standing and walking occasionally and no kneeling or squatting.

Review of claim notes that the claimant was approved for 8 sessions of physical therapy for the right knee on 01/28/15 and another 8 sessions on 04/10/15.

Documents submitted for review:

- 12/05/16 UR referral form
- 12/02/16 Request for authorization
- 11/29/16 PT order
- 11/29/16 Visit note submitted by Gary Murata, MD
- 04/10/15 UR certification
- 04/02/15 PR-2 submitted by Gary Murata, MD
- 01/28/15 UR certification
- 01/21/15 PR-2 submitted by Gary Murata, MD
- 04/21/14 Peer review report submitted by Richard Kaplan, MD

Rationale/UR Determination(s):

The records submitted for review indicate that this 46-year-old claimant reported an injury on 06/19/08. The submitted medical reports for review indicate that the claimant was previously treated with physical therapy in the right knee with noted improvement in symptoms. Recently, the claimant has complaints of right knee pain and weakness as well as catching about the right knee. There is noted weakness of quadriceps and the range of motion is 0-120 degrees. Given these findings, the medical necessity for an initial six sessions of physical therapy is established to address the flare-up of symptoms and to improve functionality. Response to care and progress towards goals should be evaluated following this timeframe to determine if adequate progress is being achieved. Recommend partial certification of physical therapy 2 times a week for 3 weeks.

Guidelines/Criteria Used:

Evidence citations for physical therapy

Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. Section 9792.24.2 (July 28, 2016) Pages 143-144. Physical medicine: Recommended as indicated below. Physical medicine encompasses interventions that are within the scope of various practitioners (including Physical Therapy, Occupational Therapy, Chiropractic, and MD/DO). Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) is not indicated for addressing chronic pain in most instances; refer to the specific modality within these guidelines (e.g., massage, ultrasound) Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Refer to the specific intervention within these guidelines (e.g., exercise.) This form of therapy may require supervision from a therapist or medical provider such as verbal, visual, and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance

or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006). Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)
ODG Physical Therapy Guidelines –
Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.
Myalgia and myositis, unspecified (ICD9 729.1):
9-10 visits over 8 weeks
Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2)
8-10 visits over 4 weeks
Reflex sympathetic dystrophy (CRPS) (ICD9 337.2):
26 visits over 16 weeks
Arthritis (ICD9 715):
9 visits over 8 weeks
Post-injection treatment: 1-2 visits over 1 week
Post-surgical treatment: Refer to the MTUS Postsurgical Treatment Guidelines
Patients should be formally assessed after a "six-visit clinical trial" to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy.

ODG-TWC Knee and Leg Procedure Summary Online Version last updated 11/22/2016 provides best practice physical medicine treatment guidelines for pain in joint and effusion in joint as that which allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT, in 9 visits over 8 weeks. To justify ongoing treatment, even within these guidelines, patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy). In addition to a "six-visit clinical trial", every six visits thereafter the treating therapist should validate improvement in function in order for treatment to continue.

Dictated. Subject to transcription variance.

CONFLICT OF INTEREST ATTESTATION:

I have reviewed the above case and attest that I ***do not*** *have a material professional, familial, or financial conflict of interest regarding any of the following: the referring entity; the insurance issuer or group health plan that is the subject of the review; the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator, plan fiduciary, or plan employee; the health care provider, the health provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of any principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of this review. I* ***do not*** *accept compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I* ***was not*** *involved with the specific episode of care prior to referral of the case for review.*

163326

I attest that I have the scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review as well as current, relevant experience and/or knowledge to render a determination for the case under review. I am currently providing direct patient care in this field of expertise and have done so for a minimum of five years.

Respectfully,
Allied Managed Care

Marvin Pietruszka, MD, FCAP
American Board of Preventive Medicine
Board Certified in Occupational Medicine
American Board of Pathology
Board Certified in Anatomic & Clinical Pathology
CA License A30858
Physician Reviewer – Allied Managed Care
Utilization Review Services

12-8-16

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: [X] Regular [ ] Expedited	Modification after Appeal [ ]
Employee Name (First, MI, Last): Tiffany Anderson	
Address: 1900 Lake Shore Dr., LODI, CA, 95242	
Phone Number: (209) 263-7132	Employer Name: Vector JPA
Claim Number: VE0700184	Date of Injury (MM/DD/YYYY): 06/19/2008
WCIS Jurisdictional Claim Number (if assigned): N/A	EAMS Case Number (if applicable): N/A
Employee Attorney (if known):	
Address:	
Phone Number:	Fax Number:
Requesting Physician Name (First, MI, Last): Gary Murata	
Practice Name: Gary Murata	Specialty: Orthopedics
Address: 2488 North California Street, Stockton, 95204, CA	
Phone Number: (209) 948-3333	Fax Number: (209) 948-3331
Claims Administrator Name: AIMS	
Adjuster/Contact Name: Nancy Urton	
Address: P.O. Box 269120, Sacramento, CA, 95826-9120	
Phone Number: 800-559-9891	Fax Number: 916-563-1919
Disputed Medical Treatment (complete below section)	
Primary Diagnosis (Use ICD Code where practical): right condromalacia patellae; right complex tear of meniscus; pain right kn	
Date of Utilization Review Determination Letter: 12/08/2016	
Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? [ ] Yes [X] 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.	
1.	
2. **See attached Addendum 1**	
3.	
4.	
Request for Review and Consent to Obtain Medical Records	
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.	
Employee Signature:	Date:

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Addendum 1

PR: Modified Request - Physical Medicine - Other Original Service Requested - Physical therapy for right knee; two (2) times a week for four (4) weeks; Certify six (6) physical therapy sessions (2x3) for the right knee; Determination Date: 12/08/2016

12-8-16

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.

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):	

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:

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P.O. Box 269120 • Sacramento, CA 95826-9120 • 916.563.1911 • Fax 916.362.3043

Proof of Service

Date 12/8/2016

I am a citizen of the United States and work in the County of Sacramento, CA. I am over the age of eighteen years and not a party to the within matter.

My business address is:

Allied Managed care
PO Box 269120
Sacramento, CA 95826

On 12/8/2016 I served:
- Peer Review Determination
- IMR Form
- Self-Addressed envelope

On the parties listed below by sending a true copy thereof by postal mail, fax or email.

Regarding : Tiffany Anderson - Claimant

Copy of the above letter sent To:

Tiffany Anderson - Claimant - 1900 Lake Shore Dr. ,
LODI, CA 95242

Stockwell Harris - Defense Attorney

Gary Murata - Requesting Provider

Nancy Urton - Claims Examiner

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

Executed on at 2:59 PM Pacific on 12/8/2016 in Sacramento, CA.

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