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: P.O.Box 477, LODI, CA, 95241

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): 2008063013030534077925 — EAMS Case Number (if applicable): N/A

Employee Attorney (if known): Guy Medford

Address: 306 E. Main St., Ste 304, , CA, 95202

Phone Number: (209) 992-0702 — Fax Number: (209) 227-8062

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) 946-7161 — Fax Number: (209) 948-3331

Claims Administrator Name: AIMS

Adjuster/Contact Name: Dana Simondi

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): Status post arthroscopy

Date of Utilization Review Determination Letter: 06/05/2018

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:

Addendum 1

PR: Non-Certification of Service - Physical Medicine - One year gym membership, right knee stregthining; Determination Date: 06/05/2018

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:

P.O. Box 269120 • Sacramento, CA 95826-9120 • 916.563.1911 • Fax 916.362.304

Proof of Service

Date 6/5/2018

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 95826-9120

On 6/5/2018 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 - P.O.Box 477 , LODI, CA 95241

Stockwell Harris - Defense Attorney

Gary Murata - Requesting Provider

Guy Medford - Applicant Attorney

Dana Simondi - 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 3:43 PM Pacific on 6/5/2018 in Sacramento, CA.

Electronically Signed by:
Olga Buts
Allied Managed Care, Inc.

P.O. Box 269120 • Sacramento, CA 95826-9120 • 916.563.1911 • Fax 916.362.304

6/5/2018

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 RFA 1st Received:	5/30/2018
Employer:	Vector JPA
Carrier:	AIMS
Claims Examiner:	Dana Simondi
AMC Event #:	215938

Notice of Utilization Review Determination

Dear Dr. Murata:

3

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:
None

Non-Certification has been recommended by our physician reviewer for the following services requested:

- *One year gym membership, right knee stregthining*

  Date of Non Certification: 6/5/2018

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

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 review 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 ten (10) days after the date of receipt of the requested appeal.

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.

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,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.

Patient Legal Appeal Rights For Independent Medical Review

The injured worker has the right to use the dispute resolution process as per Title 8 of the CCR.

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 Dana Simondi at (916) 563-1900. 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

Respectfully,

Wendy Powell
Utilization Review Nurse
(888) 290-1911

06/05/18

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:	05/30/18
Employer:	Vector JPA
Claims Examiner:	Dana Simondi
Carrier:	AIMS
AMC Case #:	215938

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):**
One year gym membership, right knee strengthening	**Non-certify**

Teleconference(s): On 06/4/18 at 09:32PT a call was placed to Dr. Murata at 209-946-7161 to discuss the case. The office voicemail was reached and a detailed message was left with a call back number for the provider.

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:

This is a 47-year-old female patient with a date of injury on 06/19/08. Dr. Murata evaluates the patient and recommends a one-year gym membership for knee strengthening exercises. The patient is permanent and stationary. Work status is standing and walking occasionally with no kneeling or squatting. The patient continues to have pain and weakness as well as catching about the knee. The patient is interested in another course of physical therapy. Physical examination reveals right knee range of motion 0-120° with quadriceps strength 4+/5. There was mild diffuse joint tenderness and the patient's gait pattern is normal. If the patient fails conservative treatment,

she is a possible candidate for arthroscopy of the right knee. Medications are also refilled to include Norco 7.5/325 mg.

Documents submitted for review:

- 05/31/18 UR Referral
- 05/29/18 Fax Cover Page
- 05/24/18 Request for Authorization
- 05/22/18 Therapy Order submitted by Gary Murata, MD
- 05/22/18 Primary Treating Physician's Progress Report submitted by Gary Murata, MD
- 07/14/17 Peer Review submitted by Mark Landes, DC
- 07/13/17 Peer Review submitted by Mark Landes, DC
- 07/06/17 Doctor's First Report of Occupational Injury or Illness
- 06/08/17 Primary Treating Physician's Progress Report submitted by Gary Murata, MD
- 12/08/16 Peer Review submitted by Marvin Pietruszka, MD
- 11/29/16 Visit Note submitted by Gary Murata, MD

Rationale/UR Determination(s):

The MTUS guidelines do not specifically address this. ODG Knee and Leg Chapter regarding gym memberships states, not recommended as a medical prescription unless a home exercise program has not been effective and there is a need for equipment. Plus, treatment needs to be monitored and administered by medical professionals. While an individual exercise program is of course recommended, more elaborate personal care where outcomes are not monitored by a health professional, such as gym memberships or advanced home exercise equipment, may not be covered under this guideline, although temporary transitional exercise programs may be appropriate for patients who need more supervision. Although the treating provider recommends the patient for a gym membership to address ongoing right knee complaints and strengthening, Dr. Murata does not provide a rationale as to why the patient would need a gym membership and utilization of specialty equipment over that of home exercises as provided in previous physical therapy sessions. There is no indication that the patient's home exercises are ineffective or require more aggressive treatment and specialty equipment at this time. Given the above, the requested gym membership is not recommended for certification.

Guidelines/Criteria Used:

The MTUS guidelines do not specifically address this.

ODG Knee and Leg Chapter (updated 05/15/18)
Gym memberships
Not recommended as a medical prescription unless a home exercise program has not been effective and there is a need for equipment. Plus, treatment needs to be monitored and administered by medical professionals. While an individual exercise program is of course recommended, more elaborate personal care where outcomes are not monitored by a health professional, such as gym memberships or advanced home exercise equipment, may not be covered under this guideline, although temporary transitional exercise programs may be appropriate for patients who need more supervision. For more information on recommended

treatments, see Physical therapy (PT) & Exercise. See also the Low Back Chapter.

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.*

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

Avrom Simon, M.D.
American Board of Preventive Medicine
Subcertification in Occupational Medicine
CA License G87171
Physician Reviewer – Allied Managed Care
Utilization Review Services