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

Proof of Service

Date 7/17/2017

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 7/17/2017 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 - 2856 Applewood Drive
, LODI, CA 95242

Stockwell Harris - Defense Attorney

Patti Triska - Claims Examiner

Guy Medford - Applicant Attorney

Mitchell Swanson - Requesting Provider

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

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

7/17/2017

Mitchell Swanson DC
900 S. Fairmont Ave. #B

LODI, CA 95240

Fax: (209) 368-2084

Re:	**Tiffany Anderson**
Claim Number:	VE0700184
DOI:	6/19/2008
DOB:	8/22/1970
Date of Receipt (DOK):	7/14/2017
Employer:	Vector JPA
Carrier:	AIMS
Claims Examiner:	Patti Triska
AMC Event #:	185061

Notice of Utilization Review Determination

Dear Dr. Swanson:

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 four (4) chiropractic treatments over six weeks*

  Date Of Modification: 7/14/2017

  Requested Service: Chiropractic spinal manipulation, extra spinal manipulation, soft tissue mobilization; eight (8) visits over six (6) 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.
Mark Landes

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.

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 Patti Triska 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,

Ericka Sutton
Utilization Review Nurse
(888) 290-1911

185061

Date of Report: 07/14/17

Mitchell Swanson, DC
900 S. Fairmont Avenue
Suite B
Lodi, CA 95240

RE:	**Tiffany Anderson**
Claim Number:	VE0700184
DOI:	06/19/08
DOB:	08/22/70
DOK:	07/14/17
Employer:	Vector JPA
Claims Examiner:	Patti Triska
Carrier:	AIMS
AMC Case #:	185061

Utilization Review / Peer Review Report

Dear Dr. Swanson,

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

Requested Service/Procedure(s):	Determination(s):
Chiropractic spinal manipulation, extra spinal manipulation, soft tissue mobilization; eight (8) visits over six (6) weeks	**Modified: Certify four (4) chiropractic treatments over six weeks**

Teleconference(s): On 07/11/17 at 14:07PT, a telephone call was placed to speak with Dr. Swanson at 209-368-5535 and Cary took a detailed message including case details, case due time and a call back number. Cary said that she ameded the cpt code as the treatment was requested and approved only for the knee. The knee treatment evaluation and treatment was approved on 06/21/17 and the evaluation took place on 07/06/17 and now they are waiting for approval of 8 visits. Dr. Swanson was with a patient and may call back to clarify what treatment he provides for the knee.

The case was discussed with Dr. Swanson at 10:48PT on 07/14/17. Dr. Swanson said that the patient has had three surgeries with Dr. Morada and Dr. Morada wants the patient to undergo treatment with Dr. Swanson to address the imbalances and weakness about the knee region that are resulting in mechanical difficulties. According to the patient, she did get benefit with the prior physical therapy activities. Dr. Swanson said that the treatment will be active and will address the quad weakness, pelvic tilt, and externally rotated right leg to restore some balance to the patient who will do a home program and be monitored, and updated weekly after an initial 2-3 visits.

Clinical History:

PT progress note dated 01/23/17 notes that the patient has completed 6 sessions of physical therapy and pain is currently reported at 2/10. Pain at its worst is rated 6/10. The patient was treated with therapeutic exercise and therapeutic activities as well as e-stim. The patient has improved loading and gait tolerance but continues to have medial knee pain. The patient has a functional level that allows for 1.5 hours of training in the facility.

Doctor's first report of occupational injury or illness dated 07/06/17 indicates that the patient has a history of 3 surgical procedures to the right knee. The patient complains of constant right knee and right hip pain rated 3/10 at best and rated 8/10 at worst. On examination, there is diffuse right knee tenderness especially at the medial joint line and fibular head. There are noted trigger points at right popliteal muscle. There is noted tenderness to palpation at the sacroiliac joint. There is noted left paralumbar hypertonicity. Treatment plan is for spinal manipulation to the right hip and right knee and soft tissue mobilization to the right knee.

Review of claim notes that the patient was approved for 6 sessions of physical therapy for the right knee on 12/08/16 and chiropractic evaluation and treatment on 06/21/17.

Documents submitted for review:

- 07/10/17 UR referral form
- 07/07/17 Fax cover sheet
- 07/07/17 Request for authorization
- 07/06/17 Doctor's first report of occupational injury or illness submitted by Mitchell Swanson, DC
- 06/21/17 Approval of medical authorization request
- 06/06/17 Primary treating physician's progress report submitted by Gary Murata, MD
- 01/23/17 PT daily note
- 01/23/17 PT progress note submitted by Monty Merrill, PT
- 01/20/17 PT daily note
- 01/11/17 PT daily note
- 12/08/16 Peer review report submitted by Marvin Pietruszka, MD
- 11/29/16 Visit note submitted by Gary Murata, MD
- 04/02/15 Primary treating physician's progress report submitted by Gary Murata, MD

Rationale/UR Determination(s):

The records submitted for review indicate that this 46-year-old patient reported an injury on 06/19/08. The submitted medical reports for review indicate that the patient complains of constant right knee and right hip pain rated 3/10 at best and rated 8/10 at worst. On examination, there is diffuse right knee tenderness especially at the medial joint line and fibular head. There is noted trigger points at right popliteal muscle. The provider is requesting chiropractic spinal manipulation and soft tissue mobilization; however, it was noted that the patient was previously approved for chiropractic evaluation and treatment on 06/21/17. In the case discussion it was noted that the evaluation took place on 07/06/17 and this evaluation noted pain in the right hip and knee with diffuse tenderness. It was further noted that treatment will only be to the knee. In this case the patient has received prior physical therapy services for the knee. Guidelines do not recommend the use of manipulation for treatment of knee conditions. Guidelines also do not recommend the sole use of passive modalities for knee conditions. The patient has completed physical therapy services for the knee that did include an exercise component and there is limited evidence that a

significant change in status has occurred since those services were rendered. A return to care for passive treatment including manipulation and soft tissue mobilization is not supported at this chronic stage.

Upon discussion, it is noted that the patient has had three surgeries and chiropractic treatment is requested to address the imbalances and weakness about the knee region that are resulting in mechanical difficulties. According to the patient, she did get benefit with the prior physical therapy activities. Dr. Swanson said that the treatment will be active and will address the quad weakness, pelvic tilt, and externally rotated right leg to restore some balance to the patient who will do a home program and be monitored, and updated weekly after an initial 2-3 visits. With evidence of prior improvement with active care in physical therapy and a clear plan for ongoing active chiropractic care to address specific deficits that are impacting the patient's ongoing pain and functional difficulties, medical necessity of an initial trial of four chiropractic treatments is supported and recommended for modified certification. Medical necessity of ongoing care will require documented evidence of objective progress and continued need for skilled intervention as opposed to use of a home exercise program.

Guidelines/Criteria Used:

Evidence citations for chiropractic spinal manipulation, extra spinal manipulation, soft tissue mobilization

Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. Section 9792.24.2 (July 28, 2016) Pages 110-111. Manual therapy & manipulation: Manual therapy and manipulation, performed by a variety of practitioners, including physical therapists and chiropractors, are passive interventions that are typically combined with recommended treatment, especially active interventions (e.g., exercise). Recommended for chronic pain if caused by musculoskeletal conditions, and only when manipulation is specifically recommended by the provider in the plan of care. Manual Therapy is widely used in the treatment of musculoskeletal pain with the intended goal of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Manipulation under anesthesia is not recommended. See also specific body-part chapters in the MTUS.
Recommended treatment parameters:
a. Time to produce effect: 4 to 6 treatments.
b. Frequency: 1 to 2 times per week for the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks.
c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached MMI and maintenance treatments have been determined. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. (Colorado, 2006) Injured workers with complicating factors may need more treatment, if documented by the treating physician.

California MTUS. ACOEM's Knee Complaints (2nd edition, 2004). Summary of Recommendations and Evidence. Page(s) 346-347.

Table 13-6. Summary of Recommendations for Evaluating and Managing Knee Complaints
Physical treatment methods:
Recommended: Nonoperative rehabilitation for medial collateral ligament injuries (C,D); Short postoperative rehabilitation for ACL repair prior to home exercise program (D); Conservative treatment for selected ruptures of the ACL (D); Exercise for cases of anterior knee pain or ligament strain (D)
Not recommended: Passive modalities without exercise program (D); Manipulation (D)

ODG-TWC Knee and Leg Procedure Summary Online Version last updated 05/12/2017 states that manual therapy is recommended.

ODG-TWC Knee and Leg Procedure Summary Online Version last updated 05/12/2017 states that manipulation is not recommended. There are no studies showing that manipulation is proven effective for patients with knee and leg complaints. If a decision is made to use this treatment despite the lack of convincing evidence, 12 visits over 8 weeks is considered best practice. (The treatment may be chiropractic physical therapy versus manipulation.)

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

Mark Landes, D.C.
Doctor of Chiropractic
CA License 18133
Physician Reviewer – Allied Managed Care
Utilization Review Services

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: 2856 Applewood Drive, 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): 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): Mitchell Swanson

Practice Name: Mitchell Swanson | Specialty: DC

Address: 900 S. Fairmont Ave. #B, LODI, 95240, CA

Phone Number: (209) 368-5535 | Fax Number: (209) 368-2084

Claims Administrator Name: AIMS

Adjuster/Contact Name: Patti Triska

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): Chrondromalacia patellae right knee, complex tear lateral meniscus right kı

Date of Utilization Review Determination Letter: 07/17/2017

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 informaton 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: Modified Request - Physical Medicine - Other Original Service Requested - Chiropractic spinal manipulation, extra spinal manipulation, soft tissue mobilization; eight (8) visits over six (6) weeks; Certify four (4) chiropractic treatments over six weeks; Determination Date: 07/14/2017

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 916.362.3043

Proof of Service

Date 7/13/2017

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 7/13/2017 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 - 2856 Applewood Drive
, LODI, CA 95242

Stockwell Harris - Defense Attorney

Patti Triska - Claims Examiner

Guy Medford - Applicant Attorney

Mitchell Swanson - Requesting Provider

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

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

7/13/2017

Mitchell Swanson DC
900 S. Fairmont Ave. #B

LODI, CA 95240

Fax: (209) 368-2084

Re:	**Tiffany Anderson**
Claim Number:	VE0700184
DOI:	6/19/2008
DOB:	8/22/1970
Date of Receipt (DOK):	7/7/2017
Employer:	Vector JPA
Carrier:	AIMS
Claims Examiner:	Patti Triska
AMC Event #:	184422

Notice of Utilization Review Determination

Dear Dr. Swanson:

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:

- *Chiropractic spinal manipulation, extra spinal manipulation, soft tissue mobilization; eight (8) visits over six (6) weeks*

  Date of Non Certification: 7/13/2017

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.
Mark Landes
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.

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 Patti Triska at (916) 563-1911. 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,

Ericka Sutton
Utilization Review Nurse
(888) 290-1911

184422

Date of Report: 07/13/17

Mitchell Swanson, DC
900 S. Fairmont Avenue
Suite B
Lodi, CA 95240

RE:	**Tiffany Anderson**
Claim Number:	VE0700184
DOI:	06/19/08
DOB:	08/22/70
DOK:	07/07/17
Employer:	Vector JPA
Claims Examiner:	Patti Triska
Carrier:	AIMS
AMC Case #:	184422

Utilization Review / Peer Review Report

Dear Dr. Swanson,

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

Requested Service/Procedure(s):	**Determination(s):**
Chiropractic spinal manipulation, extra spinal manipulation, soft tissue mobilization; eight (8) visits over six (6) weeks	**Non-certify**

Teleconference(s): On 07/11/17 at 14:07PT, a telephone call was placed to speak with Dr. Swanson at 209-368-5535 and Cary took a detailed message including case details, case due time and a call back number. Cary said that she amended the CPT code as the treatment was requested and approved only for the knee. The knee treatment evaluation and treatment was approved on 06/21/17 and the evaluation took place on 07/06/17 and now they are waiting for approval of 8 visits. Dr. Swanson was with a patient and may call back to clarify what treatment he provides for the knee.

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:

PT progress note dated 01/23/17 notes that the claimant has completed 6 sessions of physical therapy and pain is currently reported at 2/10. Pain at its worst is rated 6/10. The claimant was treated with therapeutic exercise and therapeutic activities as well as e-stim. The claimant has

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improved loading and gait tolerance but continues to have medial knee pain. The claimant has a functional level that allows for 1.5 hours of training in the facility.
Doctor's first report of occupational injury or illness dated 07/06/17 indicates that the claimant has a history of 3 surgical procedures to the right knee. The claimant complains of constant right knee and right hip pain rated 3/10 at best and rated 8/10 at worst. On examination, there is diffuse right knee tenderness especially at the medial joint line and fibular head. There is noted trigger points at right popliteal muscle. There is noted tenderness to palpation at the sacroiliac joint. There is noted left paralumbar hypertonicity. Treatment plan is for spinal manipulation to the right hip and right knee and soft tissue mobilization to the right knee.

Review of claim notes that the claimant was approved for 6 sessions of physical therapy for the right knee on 12/08/16 and chiropractic evaluation and treatment on 06/21/17.

Documents submitted for review:

- 07/10/17 UR referral form
- 07/07/17 Fax cover sheet
- 07/07/17 Request for authorization
- 07/06/17 Doctor's first report of occupational injury or illness submitted by Mitchell Swanson, DC
- 06/21/17 Approval of medical authorization request
- 06/06/17 Primary treating physician's progress report submitted by Gary Murata, MD
- 01/23/17 PT daily note
- 01/23/17 PT progress note submitted by Monty Merrill, PT
- 01/20/17 PT daily note
- 01/11/17 PT daily note
- 12/08/16 Peer review report submitted by Marvin Pietruszka, MD
- 11/29/16 Visit note submitted by Gary Murata, MD
- 04/02/15 Primary treating physician's progress report submitted by Gary Murata, 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 complains of constant right knee and right hip pain rated 3/10 at best and rated 8/10 at worst. On examination, there is diffuse right knee tenderness especially at the medial joint line and fibular head. There is noted trigger points at right popliteal muscle. The provider is requesting chiropractic spinal manipulation and soft tissue mobilization; however, it was noted that the claimant was previously approved for chiropractic evaluation and treatment on 06/21/17. In the case discussion it was noted that the evaluation took place on 07/06/17 and this evaluation noted pain in the right hip and knee with diffuse tenderness. It was further noted that treatment will only be to the knee. In this case the claimant has received prior physical therapy services for the knee. Guidelines do not recommend the use of manipulation for treatment of knee conditions. Guidelines also do not recommend the sole use of passive modalities for knee conditions. The claimant has completed physical therapy services for the knee that did include an exercise component and there is limited evidence that a significant change in status has occurred since those services were rendered. A return to care for passive treatment including manipulation and soft tissue mobilization is not supported at this chronic stage. Recommend non-certification.

Guidelines/Criteria Used:

Evidence citations for chiropractic spinal manipulation, extra spinal manipulation, soft tissue mobilization

Chronic Pain Medical Treatment Guidelines MTUS – 8 C.C.R. Section 9792.24.2 (July 28, 2016) Pages 110-111. Manual therapy & manipulation: Manual therapy and manipulation, performed by a variety of practitioners, including physical therapists and chiropractors, are passive interventions that are typically combined with recommended treatment, especially active interventions (e.g., exercise). Recommended for chronic pain if caused by musculoskeletal conditions, and only when manipulation is specifically recommended by the provider in the plan of care. Manual Therapy is widely used in the treatment of musculoskeletal pain with the intended goal of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Manipulation under anesthesia is not recommended. See also specific body-part chapters in the MTUS.
Recommended treatment parameters:
a. Time to produce effect: 4 to 6 treatments.
b. Frequency: 1 to 2 times per week for the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks.
c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached MMI and maintenance treatments have been determined. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. (Colorado, 2006) Injured workers with complicating factors may need more treatment, if documented by the treating physician.

California MTUS. ACOEM's Knee Complaints (2nd edition, 2004). Summary of Recommendations and Evidence. Page(s) 346-347.
Table 13-6. Summary of Recommendations for Evaluating and Managing Knee Complaints
Physical treatment methods:
Recommended: Nonoperative rehabilitation for medial collateral ligament injuries (C,D); Short postoperative rehabilitation for ACL repair prior to home exercise program (D); Conservative treatment for selected ruptures of the ACL (D); Exercise for cases of anterior knee pain or ligament strain (D)
Not recommended: Passive modalities without exercise program (D); Manipulation (D)

ODG-TWC Knee and Leg Procedure Summary Online Version last updated 06/27/2017 states that manual therapy is recommended.

ODG-TWC Knee and Leg Procedure Summary Online Version last updated 06/27/2017 states that manipulation is not recommended. There are no studies showing that manipulation is proven effective for patients with knee and leg complaints. If a decision is made to use this treatment despite the lack of convincing evidence, 12 visits over 8 weeks is considered best practice. (The treatment may be chiropractic physical therapy versus manipulation.)

184422

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

Mark Landes

Mark Landes, D.C.
Doctor of Chiropractic
CA License 18133
Physician Reviewer – Allied Managed Care
Utilization Review Services

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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: 2856 Applewood Drive, 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): 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): Mitchell Swanson

Practice Name: Mitchell Swanson | Specialty: DC

Address: 900 S. Fairmont Ave. #B, LODI, 95240, CA

Phone Number: (209) 368-5535 | Fax Number: (209) 368-2084

Claims Administrator Name: AIMS

Adjuster/Contact Name: Patti Triska

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): Chrondromalacia patellae right knee, complex tear lateral meniscus right kr

Date of Utilization Review Determination Letter: 07/13/2017

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 - Chiropractic spinal manipulation, extra spinal manipulation, soft tissue mobilization; eight (8) visits over six (6) weeks; Determination Date: 07/13/2017

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: