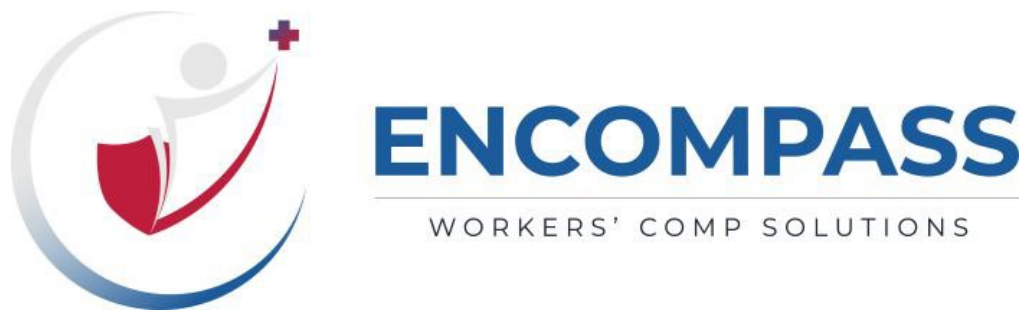


UTILIZATION REVIEW (UR) PLAN

(California DWC Compliant – Effective April 1, 2026)

URO #127



Submitted 5/13/2026, 8/26/2026

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IV. PURPOSE AND SCOPE

The purpose of this Utilization Review (UR) Plan is to ensure that all medical treatment provided to injured workers is medically necessary, evidence-based, and consistent with applicable California workers' compensation laws and regulations. This plan is designed to promote timely access to appropriate care while supporting optimal clinical outcomes and cost-effective treatment.

This UR Plan is established in accordance with California Labor Code §4610 and implementing regulations set forth in Title 8 of the California Code of Regulations. It incorporates all applicable statutory and regulatory requirements governing utilization review, including those adopted and revised with an effective date of April 1, 2026.

If a member of the public requests a hard copy of the UR plan, the claims administrator and/or Encompass may charge reasonable copying and postage expenses related to disclosing the complete plan. Such a charge shall not exceed \$0.25 per page plus actual postage costs.

The objectives of this UR Plan include:

- Ensures treatment decisions are based on the Medical Treatment Utilization Schedule (MTUS) and other evidence-based medical guidelines as permitted by law. Additional evidence-based guidelines:
 - Official Disability Guidelines (ODG) - <https://www.odgbymcg.com/>
 - PubMed - <https://pubmed.ncbi.nlm.nih.gov/>
 - DailyMed - <https://dailymed.nlm.nih.gov/dailymed/index.cfm>
 - UptoDate - <https://www.uptodate.com/>
- Provides timely, consistent, and compliant determinations for all treatment requests
- Promotes clear communication among the injured worker, medical community, claims administrators, and ancillary service providers
- Reduces unnecessary delays in care through proactive and efficient review processes

This UR Plan applies to all requests for medical treatment, including but not limited to:

- Prospective review: Evaluation of treatment requests prior to the provision of services
- Concurrent review: Ongoing review of treatment during a hospital stay
- Retrospective review: Review of treatment after services have been rendered

The scope of this plan includes all covered medical services and treatment requests submitted for review, including physician services, pharmaceuticals, diagnostic testing, durable medical equipment, and other medically necessary interventions. The plan applies to all utilization review activities conducted on behalf of the Encompass client and ensures compliance with all applicable timelines, procedural requirements, and documentation standards under California law.

V. UTILIZATION REVIEW DEFINITIONS

Core UR Definitions

- Authorization – Approval of a requested course of treatment, indicating reimbursement will be provided if services are rendered, subject to Labor Code and UR requirements.
- Request for Authorization (RFA) – A written request for specific medical treatment submitted by the treating physician that meets regulatory completeness requirements.
- Utilization Review (UR) – The process of evaluating treatment recommendations to determine medical necessity.
- Utilization Review Decision – A determination to approve, modify, or deny a treatment request.
- Emergency Health Care Services - Treatment for acute conditions requiring immediate attention to avoid serious health jeopardy.

Types of Review

- Prospective Review – UR conducted prior to treatment.
- Concurrent Review – UR conducted during an inpatient stay.
- Retrospective Review – UR conducted after services have been provided.
- Expedited Review – UR conducted when delay could seriously jeopardize the injured worker's health.

Determination Outcomes

- Approval – Treatment is authorized as requested.
- Modification – Treatment is partially approved or altered.
- Denial – Treatment is not authorized.
- Disputed Medical Treatment – Treatment modified or denied through UR.

Liability & Deferral

- Dispute of Liability – Compensability is in question for non-medical necessity reasons.
- Deferral – Decision not to conduct UR due to liability or non-medical issues.

Roles & Responsibilities

- Claims Administrator – Entity responsible for claim and UR process.
- Medical Director – CA-licensed physician overseeing UR.
- Physician Reviewer – Licensed physician making determinations.
- Expert Reviewer – Specialist consulted for complex cases.
- Non-Physician Reviewer – Assists but cannot deny/modify.
- Health Care Professional (HCP) – Internal non-physician reviewer role.

Process & Timing

- Complete Request – Meets requirements and triggers timelines.
- Incomplete Request – Returned with explanation.
- Business Day – Mon–Fri excluding holidays.
- Immediately – Within one business day.

Medical Framework

- Medical Necessity – Treatment to cure/relieve per MTUS.
- MTUS – Evidence-based guidelines.
- Medical Services – Services under Labor Code §4600.
- Health Care Provider – Entity providing treatment.

Pharmacy / Formulary

- Brand Name Drug – FDA NDA/BLA approved.
- Generic Drug – FDA ANDA approved.
- Compounded Drug – Prepared per law.
- Combination Drug – Multiple active ingredients.
- Prescription Drug – Requires prescription.
- OTC Drug – No prescription required.
- Exempt Drug – No prospective UR required.
- Non-Exempt Drug – Requires UR.
- Special Fill – Exception dispensing.
- Perioperative Fill – Exception perioperative dispensing.
- Off-Label Use – Outside FDA labeling.

Administrative

- UR Plan – Written UR program.
- UR Process – System for review types.
- Material Modification – Significant program change.
- Written – Includes electronic communication.

All terms not specifically defined herein shall be interpreted in accordance with California Labor Code and Title 8 CCR utilization review and MTUS Drug Formulary regulations.

VI. UTILIZATION REVIEW PROCESS

- **General Procedures & Intake Process (§9792.9.1)**

- 1. Submission of Requests for Authorization**

Physician and Client Access for Authorization Requests:

Physicians and Encompass clients may submit Requests for Authorization (RFAs) during standard business hours, Monday through Friday 8am to 5:30pm, via the following methods:

- Telephone: (888) 822-7211
- Fax: (844) 927-4450
- Email: ur@encompasswc.com

After-Hours Access:

Encompass provides after-hours access through voicemail and fax. RFAs received after 5:30 PM Pacific Time will be processed the next business day.

Telephone RFAs are not accepted as valid Requests for Authorization and must be followed by a written RFA in accordance with regulatory requirements.

Referrals:

Referrals for UR treatment review must be submitted in writing and include all required supporting documentation necessary to evaluate medical necessity.

Incomplete RFAs:

Upon receipt of an RFA that does not meet the definition of a complete request under CCR §9792.6.1(u), Encompass shall:

- Mark the request as “not complete”
- Return the request to the requesting physician
- Specify the information required to complete the request

This shall occur no later than five (5) business days from receipt.

A request accepted as complete shall be subject to investigation and potential administrative penalties if incomplete documentation is later identified.

- 2. Acknowledgment of Receipt**

All RFAs are date-stamped upon receipt and logged into the utilization review system. Receipt of the RFA establishes the start of applicable regulatory timeframes.

- 3. Tracking and Logging**

Encompass maintains tracking using Arriba Data Systems for all RFAs, which includes:

- Date of receipt
- Type of review (prospective, concurrent, retrospective, expedited)
- Date of decision
- Reviewer information
- Determination outcome

- **Dispute of Liability; Deferral (§9792.9.2)**

Utilization review may be deferred when there is a valid dispute of liability.

A deferral notice shall be issued within five (5) business days of receipt of the RFA and shall include:

- A statement explaining the basis for the liability dispute
- Notice that no utilization review decision has been made
- Instructions regarding next steps

- **Timeframe for Decision Making (§9792.9.3)**

- 1. Prospective, Concurrent, and Retrospective Reviews**

Encompass shall adhere to the following timelines:

- Prospective and concurrent review: within five (5) business days
- Expedited review: within seventy-two (72) hours
- Retrospective review: within thirty (30) calendar days

- 2. Concurrent Review**

Concurrent review is conducted during an inpatient stay or ongoing course of treatment.

Medical treatment shall not be discontinued until:

- The requesting physician has been notified of the determination
- A safe and appropriate transition plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker.

- 3. Expedited Reviews**

Expedited review is appropriate when there is a risk of significant deterioration of the injured worker's condition. A request for expedited review shall be identified by the requesting physician on the RFA and must include written certification and documentation supporting the need for expedited review.

An expedited review is appropriate when the documentation establishes that:

- The injured worker faces an imminent and serious threat to their health; or
- Review under the standard five-business-day timeframe would be detrimental to the injured worker's condition.

If the request is not reasonably supported by documentation establishing either criterion, the request will be processed under the standard prospective or concurrent utilization review timeframe.

Delay in treatment could result in:

- Loss of function
- Worsening of the condition
- Need for more invasive treatment
- The treating physician indicates that the request is urgent based on clinical circumstances

A determination shall be made as soon as reasonably possible or no later than seventy-two (72) hours from receipt of the request

VII. NOTICES FOR INITIAL DECISIONS

1. Written Decision Content Requirements

- **Approval Notices (§9792.9.4)**

Approval notices shall include:

- Date of receipt of the RFA
- Description of the treatment requested
- Description of the treatment approved
- Date of the decision

Approvals of a request for authorization of non-drug treatment that are exempt under section 9792.9.7 shall be clearly identified.

Communication of Approval Determinations

Approval determinations initially be communicated to the requesting physician within 24 hours of the decision by phone, fax, or if agreed by both parties, encrypted email. If the initial communication is by telephone, written communication shall be issued to the requesting physician within 24 hour of the decision for concurrent review and within two business days for prospective review.

Written approval notices shall include all information required under §9792.9.4, including the date of receipt of the Request for Authorization, the treatment requested, the treatment approved, and the date of the decision.

- **Modification and Denial Notices (§9792.9.5)**

All modification and denial decisions shall:

- Be made by a physician reviewer
- Include a clear and concise clinical rationale
- Reference applicable medical treatment guidelines
- Identify the reviewer and their qualifications

Each notice shall include:

1. Date RFA received — the date the completed, or accepted-as-complete, RFA was first received.
2. Extension/additional-information details, if applicable — if §9792.9.6 was used, identify what information was needed, when it was requested, how it was requested, and when it was received.
3. Decision date.
4. Treatment requested — description of the specific course of treatment on the RFA.
5. Medical records reviewed — list all records reviewed.
6. Treatment approved, if any — particularly relevant to a modification/partial approval.

7. Clinical rationale in plain language — clear, concise explanation of why the physician modified/denied. If there was insufficient information, identify what was missing and explain that the treatment will be reconsidered upon receipt of a new RFA containing the additional information. If the requesting physician specifically argues that prerequisite guideline criteria should be disregarded, the reviewer must also explain why that reasoning is insufficient.
8. Guideline/criteria citation and description — for medical-necessity decisions, cite and describe the relevant medical criteria/guideline used.
9. URAC entity identification — identify the DWC-approved, URAC-accredited entity liable for the UR decision.
10. Completed IMR application — include DWC Form IMR (Rev. 04/01/2026), with all fields except the employee's signature completed, plus an addressed envelope for submission to the Administrative Director/designee.
11. IMR dispute statement — A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the 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, within the timeframe indicated on the last page of the application.

12. Mandatory language:

"You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name in parentheses) at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me."

and

"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."

13. Internal UR appeal information — for the requesting physician, describe the claims administrator's internal UR appeal process, if one exists, including disputes concerning the necessity/availability of requested information. Include the process is voluntary and neither triggers nor prevents the IMR process.
14. Reviewer information for the requesting physician — name and specialty of the reviewer/expert reviewer, telephone number, and hours available for physician discussion. Availability must be at least 4 hours per week during normal business hours, 9:00 AM–5:30 PM Pacific. If that reviewer isn't available, another appropriately competent physician reviewer may discuss the decision.

Communication of Adverse Determinations

For all modification or denial decisions, Encompass shall communicate the determination to the requesting physician by telephone, facsimile, electronic mail, or other expeditious method within twenty-four (24) hours of the decision.

Written notice of the utilization review determination shall be provided to the requesting physician, the injured worker, and if represented, the injured worker's attorney, within 24 hours of the decision for concurrent review, within two business days for prospective review, and, for expedited review within 72 hours of receipt of the request.

All written modification or denial notices shall comply with the content requirements of §9792.9.5 and include all applicable appeal and Independent Medical Review (IMR) rights and instructions.

Note - failure to obtain authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services.

2. Extension of Timeframe for Decision (§9792.9.6)

Timeframes for a UR decision may be extended only when:

- Required medical information is not available
- An additional examination or diagnostic test is needed
- A specialty consultation (expert reviewer) is required

Request for Additional Information

- If information is missing, the reviewer must request it in writing to the requesting physician, the injured worker and the injured worker's attorney if applicable within 5 business days from the receipt of the RFA. If the requested information is not received:
 - Prospective/Concurrent Review: Deny after 14 days
 - Retrospective Review: Deny after 30 days
 - Denials will state that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam, test or specialized consultation.

Additional Exam or Expert Consultation

- If an specialty consult, diagnostic or expert review is required:
 - The reviewer must notify the:
 - Requesting physician
 - Injured worker
 - Applicant attorney (if represented)

- Notification must occur within 5 business days and include:
 - Reason a decision cannot be made
 - Request for exam/test or
 - Identification of the expert reviewer specialty
- If results are not received within 30 days, the request may be denied per §9792.9.5

Decision Timeframes After Information Is Received

- Upon receipt of requested information:
 - Prospective/Concurrent Review: Decision within 5 business days
 - Expedited Review: Decision within 72 hours
 - Retrospective Review: Decision within 30 calendar days
- All requests for additional information must be communicated to the requesting provider and claims administrator.

MTUS Drug Formulary Decisions (§9792.9.8)

All medication requests shall be reviewed in accordance with the Medical Treatment Utilization Schedule (MTUS) Drug Formulary. Medications will be classified as:

- Exempt (formulary) drugs
- Non-Exempt (non-formulary) drugs

Utilization review determinations shall be made consistent with formulary status, applicable guidelines, and regulatory requirements.

Exempt drugs may be dispensed without prior prospective utilization review, provided that:

- The medication is consistent with MTUS guidelines
- The prescription complies with formulary conditions, including indication, dosage, and duration

In accordance with California Code of Regulations Title 8 §9792.9.4:

- When a medication request identifies a brand-name drug, and the request does not include “dispense as written” (DAW) or “do not substitute.” The approval shall specify that the generic equivalent is approved and the generic substitution is authorized.

Required Approval Language

The determination shall include language referencing the exempt status based on MTUS and include the following:

- “Generic equivalent approved; generic substitution authorized.”

3. Duplicate Requests (12 month rule)

A utilization review decision to modify or deny a request for authorization of medical treatment on the basis of medical necessity 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, or another physician within the requesting physician's practice group, 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.

The 12-month rule does not apply to a repeat treatment request if the request includes an express or unequivocal statement by the requesting physician that indicates or opines that there has been a change in facts material to the basis of the prior denial of such same treatment and includes documentation of the change.
(9792.9.5(g))

A duplicate request is a Request for Authorization (RFA) for the same treatment or service that has been previously denied.

Utilization review is not required for a duplicate request when:

- The request is for the same treatment or service, and
- The prior request was denied, and
- The subsequent request is made within twelve (12) months of the prior denial, and
- The request does not include documentation of a material change in the injured worker's condition or circumstances

The HCP will identify the request for authorization as a "duplicate" and return to the requesting provider which includes:

- Date of prior denial
- Statement regarding no material change
- No new utilization review determination is required

4. Prior Authorization / Fast Track Approval Process

Certain clients utilize prior authorization for specifically identified treatment or services. The circumstances and treatment eligible for prior authorization are established by the individual client and may include designated fast-track treatment, predefined treatment or diagnostic services meeting established criteria, or services that are automatically authorized following approval of a related course of treatment. Client specific prior authorization are noted in the Appendices.

The specific prior authorization criteria applicable to each client are communicated to the UR team and incorporated into the client's authorization workflow. Requests not approved through such processes, or requests requiring medical necessity review, shall be processed through utilization review in accordance with California Labor Code §4610 and applicable utilization review regulations.

Nothing in this process permits modification or denial of treatment outside the utilization review procedures required under applicable law.

VIII. UTILIZATION REVIEW CRITERIA

1. Medical Necessity

The following describe what is considered “medically necessary or appropriate”. The procedure, test or service is:

- Necessary to cure or relieve the effects of the injury
- Safe and effective
- Consistent with the patient’s symptoms, diagnoses, condition, or injury
- Likely to provide a clinically meaningful benefit
- Likely to produce the intended health result
- Likely to be more effective than more conservative or less costly services
- Provided not only as a convenience to the patient or the provider
- Represents a benefit that outweighs any risk
- Reasonably expected to diagnose, correct, cure, alleviate or prevent the worsening of illnesses or injuries
- Enables the patient to make reasonable progress in treatment
- Meets the prevailing standard for medical care as outlined in the MTUS or other accepted evidence-based guidelines

2. Authorized Treatment

All determinations shall be based on evidence-based medical guidelines, including the Medical Treatment Utilization Schedule, which shall be applied as the primary standard for evaluating medical necessity.

Where MTUS does not address the requested treatment, other nationally recognized, evidence-based guidelines may be used, consistent with applicable law.

Approval

A treatment request shall be approved when the requested treatment is:

- Consistent with MTUS or other applicable evidence-based guidelines:
 - o Official Disability Guidelines (ODG) - <https://www.odgbymcg.com/>
 - o PubMed - <https://pubmed.ncbi.nlm.nih.gov/>
 - o DailyMed - <https://dailymed.nlm.nih.gov/dailymed/index.cfm>
 - o UptoDate - <https://www.uptodate.com/>
- Supported by the clinical documentation provided
- Reasonably required to cure or relieve the effects of the industrial injury

Modification

A treatment request shall be modified when:

- Part of the requested treatment is medically necessary, but changes are required to align with evidence-based guidelines

Modifications may include, but are not limited to:

- Adjustments to frequency, duration, or intensity of treatment
- Substitution of a clinically appropriate alternative treatment
- Approval of a generic equivalent medication when appropriate

All modifications are made by a physician reviewer, including a clear clinical rationale and guideline reference

Denial

A treatment request shall be denied when the requested treatment:

- Is not supported by MTUS or other applicable evidence-based guidelines
- Lacks sufficient clinical documentation to establish medical necessity
- Is not reasonably required to cure or relieve the effects of the industrial injury

All denials are made by a physician reviewer, including a clear clinical rationale and guideline reference.

3. First 30-Day Exemption (§9792.9.7)

Encompass acknowledges in accordance with §9792.9.7 medically necessary treatment consistent with the Medical Treatment Utilization Schedule may be provided without prior prospective utilization review during the first thirty (30) days following the date the claim form is filed, subject to the conditions set forth in regulation.

Treatment that falls outside the scope of the exemption, or that is subject to specific regulatory requirements, shall be reviewed through the standard utilization review process. Examples but not limited to:

- Non-formulary (non-exempt) medications
- Advanced diagnostic imaging (e.g., MRI, CT scans)
- Non-emergency surgical procedures (inpatient or outpatient)
- Psychological or behavioral health treatment
- Spinal injections and other invasive procedures
- Electrodiagnostic studies (e.g., EMG/NCS)
- Durable Medical Equipment (DME) exceeding applicable thresholds
- Home health care services

4. Drug Authorization

All medication requests shall be reviewed in accordance with §9792.9.8 and the Medical Treatment Utilization Schedule Drug Formulary. Medications shall be classified as either:

- Exempt (formulary) drugs, or
- Non-Exempt (non-formulary) drugs

Authorization of medications shall be based on formulary status, clinical indication, and consistency with evidence-based guidelines.

Exempt (Formulary) Drugs

Drugs designated as Exempt under the MTUS Drug Formulary may be dispensed without prospective utilization review, provided that:

- The medication is prescribed for an approved indication consistent with MTUS
 - Exempt drugs listed on the MTUS Drug List
 - Special Fill drugs when dispensed in accordance with §9792.27.12
 - Perioperative Fill drugs when dispensed in accordance with §9792.27
- The prescription complies with formulary guidelines, including:
 - Diagnosis
 - Dosage
 - Frequency
 - Duration
 - Generic Substitution

When a medication request identifies a brand-name drug and does not include “dispense as written” or “do not substitute”:

- The approval shall specify that the generic equivalent is approved and that generic substitution is authorized.

If clinical documentation supports the necessity of the brand-name medication:

- The determination shall include documentation of:
 - Medical necessity for brand
 - Statement that generic substitution is not appropriate

Non-Exempt (Non-Formulary) Drugs

Drugs designated as Non-Exempt, or not listed in the MTUS Drug Formulary, require prospective utilization review prior to dispensing.

Authorization shall be based on:

- Documented medical necessity
- Consistency with MTUS or other applicable evidence-based guidelines

- Clinical justification for use, including:
 - Failure of first-line therapies
 - Contraindications to formulary alternatives
 - Severity and duration of condition
 - Indications Required for Approval

Medication approvals shall be based on clearly documented clinical indications, including:

- A supported diagnosis consistent with MTUS recommendations
- Documentation of prior treatment history, when applicable
- Evidence of functional improvement or expected clinical benefit
- Appropriate dose and duration consistent with guidelines

Requests lacking sufficient clinical information may be subject to:

- Request for additional information
- Modification or denial, as appropriate

Decision Timeframes for Medication Requests

Requests for authorization involving medications listed as Non-Exempt drugs on the MTUS Drug Formulary shall be processed in accordance with California Code of Regulations, Title 8, §9792.9.8.

For Non-Exempt drugs listed on the MTUS Drug Formulary:

- Utilization review decisions shall be made within five (5) business days from receipt of the Request for Authorization (RFA)
- Requests for additional information necessary to make a determination shall be made within four (4) business days of receipt of the RFA
- If the information requested is not received within five (5) business days from the request for additional information, the request may be denied by a physician reviewer
- Standard utilization review extensions under §9792.9.6 do not apply to these requests

Requests for medications that are not listed on the MTUS Drug Formulary shall be processed in accordance with the standard utilization review timeframes and extension provisions set forth in §§9792.9.3 and 9792.9.6.

IX. Appeal and Independent Review

Encompass will include the Independent Medical Review (IMR) application form and required appeal rights language with all modification and denial determinations.

Encompass' responsibilities are limited to:

- Providing the IMR application form with the determination to all stakeholders
- Ensures all required appeal rights and instructions are included in the written notice
- Maintains documentation of the determination and notice provided

Encompass does not:

- Process or adjudicate IMR requests
- Submit documentation directly to the Administrative Director or IMR organization
- Track or manage IMR filing deadlines

All IMR processing, submission of records, and coordination with the Administrative Director shall be the responsibility of the claims administrator.

UR Reconsiderations and Internal Appeals

A "Reconsideration" of a treatment request is when additional information which had been previously requested is received for review. This information may be reviewed by the Health Care Professional and approved if guidelines are satisfied. If the additional information received does not meet guidelines it will be referred to the Reviewer (which may be the same physician who denied the original treatment request due to lack of information.) A decision will be rendered within 10 days from date of receipt.

An internal appeal may occur when an original treatment request was modified or denied on guidelines criteria other than lack of information. An appeal will go to a Reviewer, who did not deny the first request and may be an Expert Reviewer dependent upon the case, and the Medical Director's discretion. This voluntary internal appeal process neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6 and may be pursued on an optional basis.

An internal appeal may be requested by an injured worker, or their attorney, the requesting physician, or the facility in writing within 10 days of receipt of the UR review decision, pursuant to 9792.10.1. The 10-day time limit may be extended for good cause or by agreement of the parties.

X. PERSONNEL AND QUALIFICATIONS (§9792.7)

1. Medical Director

The Utilization Review program is overseen by a Medical Director who is a physician licensed by the Medical Board of California or the Osteopathic Medical Board of California and holds an unrestricted license.

Medical Director:

Michael Weiner, MD License #G51395

PO Box 7140, Folsom, CA 95763

888-822-7211

Medical Director Responsibility

The Medical Director is responsible for all decisions made in the utilization review process in accordance with 8 CCR §9792.6.1(o). The Medical Director provides oversight of the utilization review process and ensures that utilization review decisions are made in accordance with applicable California workers' compensation laws, regulations, and utilization review standards.

Additional responsibilities include:

- Supervising physician reviewers
- Participating in quality assurance activities

2. Physician Reviewers

Physician Reviewer Qualifications: A physician reviewer shall be a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia. The reviewer must be competent to evaluate the specific clinical issues involved in the requested medical treatment or services, and the treatment or services under review must be within the scope of the reviewer's practice.

3. Non-Physician Reviewers

Health Care Professional(s): Encompass Health Care Professionals are Registered Health Care Professionals ("RN") or Licensed Vocational Health Care Professionals ("LVN"), Doctor of Chiropractic ("DC") who provide first level utilization review. The HCP do not modify or deny requests for authorization. The HCP will assess the medical information available, review referral for completeness, request additional medical information as necessary within timeframes, and prepare the medical records for the physician reviewer in the event the request requires physician review.

4. Expert Reviewers

Expert Reviewer Qualifications: An expert reviewer shall be a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia. The expert reviewer shall be competent to evaluate the specific clinical issues involved in the requested medical treatment or services, and the services reviewed shall be within the individual's scope of practice.

An expert reviewer may be consulted when a specialized review is necessary and the consultation requires an extension of the utilization review timeframe pursuant to 8 CCR §9792.9.6.

XI. PLAN SUBMISSION AND MODIFICATIONS

1. Initial Submission

This Utilization Review Plan is submitted to the California Division of Workers' Compensation (DWC) in compliance with California Labor Code §4610 and Title 8, California Code of Regulations §§9792.6.1 through 9792.12.

This plan is provided in a searchable electronic format and includes all required components, attachments, and supporting documentation as required by applicable regulations.

2. Material Modifications

Encompass shall submit any material modifications to this Utilization Review Plan to the Administrative Director within thirty (30) calendar days of such changes.

Material modifications include, but are not limited to:

- Changes in ownership or corporate structure
- Changes to the Medical Director
- Changes to utilization review processes or procedures that may affect compliance
- Changes in address or company name
- Changes in utilization review standards
- Changes involving delegated utilization review functions or vendors

3. Certification of Compliance

Encompass certifies that this Utilization Review Plan, and any subsequent modifications, complies with all applicable requirements set forth in California Labor Code §4610 and Title 8, California Code of Regulations §§9792.6.1 through 9792.12.

Encompass further certifies that all utilization review activities conducted under this plan shall adhere to these requirements and any updates thereto.

XII. QUALITY ASSURANCE & COMPLIANCE MONITORING

Encompass maintains a comprehensive quality assurance and compliance monitoring program to ensure that all utilization review activities are conducted in accordance with California Labor Code §4610 and Title 8, California Code of Regulations §§9792.6.1 through 9792.12.

1. Internal Audits and Monitoring

Encompass conducts ongoing internal audits and monitoring of utilization review activities to ensure compliance with regulatory requirements and internal policies. These activities include, but are not limited to:

- Review of utilization review determinations for clinical appropriateness and regulatory compliance
- Monitoring of timeliness standards for prospective, concurrent, expedited, and retrospective reviews
- Verification of proper notice content and delivery
- Identification and correction of process deficiencies

Findings from internal audits are documented and used to support continuous quality improvement initiatives.

Quality Improvement

Encompass utilizes audit findings, performance metrics, and stakeholder feedback to implement continuous quality improvement measures. Corrective actions may include:

- Process enhancements
- Policy updates
- Targeted staff training
- Increased oversight of specific functions or personnel

2. Accreditation

Encompass shall maintain compliance with applicable accreditation standards, including URAC Workers' Compensation Utilization Management (WCUM) Accreditation, where required.

Accreditation status, if applicable, shall be monitored and maintained in accordance with regulatory and contractual requirements.

3. Delegated Utilization Review Functions

Encompass may utilize delegated utilization review organizations or vendors to perform certain utilization review functions.

When such delegation occurs, Encompass shall:

- Ensure that all delegated entities are qualified and, where applicable, appropriately accredited

- Maintain oversight of delegated functions to ensure compliance with all applicable laws and regulations
- Monitor performance and compliance of delegated entities through periodic review and evaluation

If no delegated utilization review functions are utilized, Encompass retains full responsibility for all utilization review activities.

Encompass utilizes the services of P&S Network for specialty match physician reviews.

P&S Network
8447 Wilshire Blvd Suite 202
Beverly Hills, CA 90211
URAC Accredited IRO and WCUM

4. Financial Incentive Policy

Encompass maintains policies to ensure that utilization review decisions are made independently and are not influenced by financial considerations.

No financial incentives or compensation shall be provided to physician reviewers, non-physician reviewers, or any other personnel that are based on:

- The denial or modification of treatment requests
- The reduction of medical costs
- Any outcome that could compromise clinical objectivity

All utilization review determinations are based solely on medical necessity, consistent with applicable laws, regulations, and evidence-based guidelines.

XIII. PENALTIES & ENFORCEMENT

Encompass is committed to full compliance with all applicable utilization review requirements under California Labor Code §4610 and related regulations. Encompass maintains a proactive approach to continuous improvement and regulatory compliance, ensuring that audit findings are addressed timely and effectively.

In the event of an adverse audit finding Encompass will:

- Promptly review and assess all identified deficiencies
- Develop and implement a corrective action plan within required timeframes
- Provide targeted education and training to staff, as appropriate
- Conduct ongoing monitoring and quality assurance reviews to ensure sustained compliance
- Take additional actions as necessary to prevent recurrence

XIV. DOCUMENTATION & RECORDKEEPING

Encompass maintains comprehensive documentation and recordkeeping practices to ensure compliance with all applicable utilization review requirements under California Labor Code §4610 and Title 8, California Code of Regulations §§9792.6.1 through 9792.12.

1. Records Retention

All utilization review records shall be maintained in accordance with applicable statutory and regulatory requirements.

Records maintained include, but are not limited to:

- Requests for Authorization (RFAs)
- All supporting medical documentation submitted for review
- Utilization review determinations (approvals, modifications, denials, and deferrals)
- Documentation of communications with providers, claims administrators, and injured workers
- Internal review notes and audit records

Records shall be retained for a period sufficient to comply with regulatory requirements and to support audits, investigations, and dispute resolution processes.

2. Confidentiality

Encompass ensures that all medical and personal information obtained during the utilization review process is handled in a confidential manner and in compliance with all applicable privacy laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

Access to confidential information is limited to authorized personnel involved in the utilization review process. Appropriate administrative, technical, and physical safeguards are maintained to protect the integrity and confidentiality of all records.

3. Provider and Injured Worker Communications

Encompass maintains documentation of all communications related to utilization review, including:

- Notifications to requesting physicians regarding determinations
- Written notices to injured workers and their representatives
- Communications with claims administrators
- Documentation of physician-to-physician discussions

All communications are conducted in accordance with regulatory requirements and are documented to ensure transparency, accountability, and compliance.

XV. APPENDICES

UR-01 Form

Appendix A – Sample Decision Letter Templates

Form UR-01

Submit two copies of the completed, signed application and the complete Utilization Review (UR) Plan in compact discs or flash drives in word-searchable PDF format to:
Division of Workers' Compensation, Attn: Medical Unit: Utilization Review Plan Approval, PO Box 71010, Oakland, CA 94612.

1. UR Plan Information

Name of UR Plan Applicant:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: E-mail address:

Type of Entity Filing: Utilization Review Organization

2. UR Plan Contact Person Information

First Name: Middle Initial: Last Name:

Title:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: E-mail address:

3. Medical Director Information

First Name: Middle Initial: Last Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: E-Mail Address:

CA License No.: NPI:

Board Certified Specialty (if any):

4. URAC Accreditation

Accreditation Status: Full URAC accreditation

Original accreditation date: 5/1/2022

Most recent accreditation date: 7/1/2025 Expiration Date: 7/1/2028

Comments:

Workers' Compensation Utilization Management 8.1

5. UR Plan Client and Vendor Information

List all entities that utilize or contract for UR Plan services. Use additional pages if necessary.

Kaiser Permanente Medical Group, Loma Linda University Health, Schools Insurance Authority

Does the UR Plan delegate any UR functions? ☐ YES ☒ NO

If yes, indicate to whom and which function for each delegation. Use additional pages if necessary.

Signature of authorized individual: "I, the undersigned Medical Director of the UR Plan Applicant, have read and signed this application and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this application is true and correct."

Name of Medical Director:

Micheal Weiner

Date: 4/1/2026

Signature:



Appendix A – Sample Decision Letter Templates



NOTICE OF UTILIZATION REVIEW DETERMINATION

Date: {{REVIEW_COMPLETIONDATE}}

{{ADDRESSTO_NAME}} {{if ADDRESSTO_CREDENTIAL}} {{ADDRESSTO_CREDENTIAL}}{{endif}}
{{if ADDRESSTO_LOCATION}} {{ADDRESSTO_LOCATION}} {{endif}}
{{if ADDRESSTO_ADDRESS}} {{ADDRESSTO_ADDRESS}} {{endif}}
Fax #: {{ADDRESSTO_FAX}}

Regarding Employee:

{{CLAIMANT_FIRSTNAME}} {{CLAIMANT_LASTNAME}}
{{if CLAIMANT_ADDRESS}} {{CLAIMANT_ADDRESS}} {{endif}}
{{if CLAIMANT_PHONENUMBER}} Phone: {{CLAIMANT_PHONENUMBER}} {{endif}}

Claim Number: {{CLAIM_CLAIMNUMBER}}

DOI: {{CLAIM_INJURYDATE}}
Client: {{CUSTOMER_NAME}}
Claims Adjuster: {{ADJUSTER_NAME}}
Phone: {{ADJUSTER_PHONENUMBER}}

Reference #: {{REFERRAL_REFERRALNO}}

Dear {{ADDRESSTO_NAME}} {{if ADDRESSTO_CREDENTIAL}} {{ADDRESSTO_CREDENTIAL}} {{endif}},

The {{REFERRAL_SOURCEREFERRALDATE}} request for medical treatment was first received on {{REFERRAL_UROREFERRALRECIEVEDDATE}} and reviewed {{if CALIFORNIA}} in accordance with Title 8, California Code of Regulations Section 9792.6.1(d) {{endif}}. On {{REVIEW_COMPLETIONDATE}} a decision was made in regard to the requested medical treatment. The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision
{{loop TREATMENTREQU ESTS}} {{TreatmentReque stNumber}}	{{Description}} Qty: {{RequestedQuantity}} {{if IsMedication}} Refills: {{RequestedRefills}} {{endif}}	{{DeterminedDescription}} Qty: {{DeterminedRequestedQuantity}} {{if IsMedication}} Refills: {{DeterminedRequestedRefills}} {{endif}}	{{RequestDetermin ation}} {{endloop}}

{{if REVIEW_RIN_SENT}} **Request for information sent:** {{REVIEW_RIN_SENTDATE}} with a due-date of {{REVIEW_RIN_DUEDATE}}.

The request included: {{REVIEW_RIN_REQUESTED_HTML}}.

{{if REVIEW_RIN_RESPONSEDATE}} **We received a response on:** {{REVIEW_RIN_RESPONSEDATE}}. {{endif}} {{if
not(REVIEW_RIN_RESPONSEDATE)}} **No response was received.** {{endif}} {{endif}}

{{if HASAPPROVALS}} **The approved treatment is certified as medically necessary.** Additional treatment will require a new Request for Authorization. {{endif}}

{{if HASADVERSEDECISIONS}} **Clinical Rationale for Modification/Denial:**

{{if MASTERTREATMENT}} {{MASTERTREATMENT.ReviewRationalPlain}} {{endif}} {{endif}}

{{if CALIFORNIA}} {{if HASADVERSEDECISIONS}} **MODIFIED or DENIED DECISIONS - DISPUTE INFORMATION**

To the Physician:

If you disagree with this decision and/or have additional information that was not available at the time of this review and desire to initiate a reconsideration, contact Encompass Health Solutions at PO Box 7140 Folsom, CA 95763-7140, Fax- 844-927-4450. Any additional information will be reviewed, and if necessary, sent to a Physician Reviewer for reconsideration according to the Utilization Review process. This reconsideration process is optional and must be initiated within ten (10) days after receipt of this utilization review decision. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

To the Employee (and their Attorney if represented):

The above-mentioned internal reconsideration process is optional. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

Any dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6, which state that an objection to the 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, within `{{if not(REFERRALFLAG_FORMULARY)}}30 {{endif}}{{if REFERRALFLAG_FORMULARY}}10 {{endif}}` days from the mailing date of the written determination letter.

The State of California requires this notice to include the following language:

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision (see attached application). If you have questions about the information in this notice, please call your claims adjuster, `{{ADJUSTER_NAME}}` at `{{ADJUSTER_PHONENUMBER}}`. However, if you are represented by an attorney, please contact your attorney.

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.
`{{endif}}{{endif}}`

This review determination does not guarantee compensability or claim acceptance. These are determined by your workers compensation insurance carrier.

Please forward all bill and payment questions to:

Sincerely,

`{{SIGNEDBY_SIGNATURE }}`

`{{SIGNEDBY_NAME }}`

`{{if SIGNEDBY_CREDENTIAL}}{{SIGNEDBY_CREDENTIAL}}{{endif}}`

`{{if SIGNEDBY_PHONENUMBER}}Phone: {{ SIGNEDBY_PHONENUMBER}}{{endif}}`

`{{if SIGNEDBY_EMAIL}}Email: {{ SIGNEDBY_EMAIL}}{{endif}}`

The reviewing physician or Medical Director is available to discuss this decision with the requesting physician at 888-822-7211

Option 3 during the following hours: Monday through Friday, 8am to 5:30pm

`{{if CALIFORNIA}}{{if HASADVERSEDECISIONS}}{{if not(ADR)}}`

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- Sign and date this application and consent to obtain medical records.
- Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:
Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270
- Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. **THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

Regular {{if not(REFERRALFLAG_FORMULARY)}} [X]{{endif}}

Expedited {{EXPEDITED_CHK}}

{{if APPEAL}}Modification after Appeal [X]{{endif}}

Medication Only – MTUS

Retrospective for Exempt

Retrospective for Exempt

Formulary Drug List {{if REFERRALFLAG_FORMULARY}} [X]{{endif}}

Treatment (Non-Drug) ☐

Treatment (Drug) ☐

Employee Information:

First Name: {{CLAIMANT_FIRSTNAME}} Middle Initial: {{CLAIMANT_MI}} Last Name:

{{CLAIMANT_LASTNAME}}

Address: {{CLAIMANT_ADDRESS1}}

Number/Unit: {{CLAIMANT_ADDRESS2}}

City: {{CLAIMANT_CITY}} State: {{CLAIMANT_STATE}} Zip Code: {{CLAIMANT_POSTALCODE}}

Telephone Number: {{CLAIMANT_PHONENUMBER}}

Fax Number:

Date of Injury: {{CLAIM_INJURYDATE}}

Insurance Claim Number: {{CLAIM_CLAIMNUMBER}}

EAMS Case Number:

{{CLAIM_COURTCASENUMBER}}

WCIS Jurisdictional Claim Number (if assigned): {{CLAIM_JURISDICTIONCLAIMNUMBER}}

Employee Attorney (if known): {{APPLICANTATTORNEY_NAME}}

Address: {{APPLICANTATTORNEY_ADDRESS1}}

Number/Unit:

{{APPLICANTATTORNEY_ADDRESS2}}

City: {{APPLICANTATTORNEY_CITY}} State: {{APPLICANTATTORNEY_STATE}} Zip Code:

{{APPLICANTATTORNEY_ZIP}}

Telephone Number:

{{APPLICANTATTORNEY_PHONENUMBER}}

Fax Number: {{APPLICANTATTORNEY_FAX}}

Requesting Physician Information:

Physician First Name: {{REQUESTINGPHYSICIAN_FIRSTNAME}} Middle Initial: Last Name:

{{REQUESTINGPHYSICIAN_LASTNAME}}

Practice Name: {{REQUESTINGPHYSICIAN_LOCATION}}

Address: {{REQUESTINGPHYSICIAN_ADDRESS1}}

Number/Unit:

{{REQUESTINGPHYSICIAN_ADDRESS2}}

City: {{REQUESTINGPHYSICIAN_CITY}} State: {{REQUESTINGPHYSICIAN_STATE}} Zip Code: {{REQUESTINGPHYSICIAN_ZIP}}
Telephone Number: {{REQUESTINGPHYSICIAN_PHONENUMBER}}

Fax Number: {{REQUESTINGPHYSICIAN_FAX}} Specialty: {{REQUESTINGPHYSICIAN_SPECIALTY}}

Claims Administrator Information:

Employer Name: {{EMPLOYER_NAME}}
Name of Administrator: {{CUSTOMER_NAME}} Contact Name: {{ADJUSTER_NAME}}
Address: {{ADJUSTER_ADDRESS1}} Number/Unit: {{ADJUSTER_ADDRESS2}}
City: {{ADJUSTER_CITY}} State: {{ADJUSTER_STATE}} Zip Code: {{ADJUSTER_ZIP}} Telephone Number: {{ADJUSTER_PHONENUMBER}}
Fax Number: {{ADJUSTER_FAX}}

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):
{{ICDCODES}}

* Mailing Date of the Utilization Review Determination Letter:
{{REVIEW_COMPLETIONDATE}}

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☒No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

{{loop TREATMENTREQUESTS}}{{if Adverse}}{{TreatmentRequestNumber}} - {{Description}}{{endif}}
{{endloop}}

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 consent to 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 _____

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☐ 30 days from the mailing date of the written determination letter.

☒ 10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" 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 OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) 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. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.
- If your physician requested the recommended medical treatment that was denied or modified to 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 within the stated deadline to:

DWC-IMR, c/o Maximus Federal Services, Inc.

PO Box 138009, Sacramento, CA 95813-8009

FAX Number: (916) 605-4270

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

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:

{{endif}}{{endif}}{{endif}}

PROOF OF SERVICE

[1] I am at least 18 years old, not a party to this action, and not a protected person listed in any of the orders.

[2] I have served copies of the following document[s]: Notice of Determination

[3] I have mailed them by regular post, email, or sent them by facsimile to the person[s] below:

{{if CONTACTS}}

{{loop CONTACTS}}

{{if FirstName}}{{FirstName}} {{endif}}{{if LastName}}{{LastName}}{{endif}}{{if Credentials}}, {{Credentials}}{{endif}}

{{if Address1}}{{Address1}}{{endif}}{{if Address2}}, {{Address2}}{{endif}}

{{if CityMunicipality}}{{CityMunicipality}},{{endif}} {{if StateProvince}} {{StateProvince}}{{endif}} {{if PostalCode}}

{{PostalCode}}{{endif}}

{{if IsEmailCheck}}Notified via email to: {{if EmailId}}{{EmailId}}{{endif}}{{endif}}

{{if IsFaxCheck}}Notified via fax to: {{if FaxNumber}}{{FaxNumber}}{{endif}}{{endif}}

{{endloop}}{{endif}}

[4] My Name, Address and Telephone Number:

{{CURRENTUSER_NAME}}

{{CURRENTUSER_ADDRESS}}

{{CURRENTUSER_PHONENUMBER}}

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

Date: {{REVIEW_COMPLETIONDATE}}



NOTICE OF UTILIZATION REVIEW DETERMINATION

Date: 08/06/2026

Doctor Name
Practice Name
Address
City, State, Zip
Fax #:

Regarding Employee:

Employee Name
Address
City, State, Zip

Claim Number:

DOI:
Client:
Claims Adjuster:
Phone:

Reference #: RF-00013242

Dear Doctor Name,

The 08/06/2026 request for medical treatment was first received on 08/06/2026 and reviewed in accordance with Title 8, California Code of Regulations Section 9792.6.1(d). On **08/06/2026** a decision was made in regard to the requested medical treatment. The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision
TR-00013242-001	Physical therapy Qty:12	Physical therapy Qty:12	Approved

The approved treatment is certified as medically necessary. Additional treatment will require a new Request for Authorization.

This review determination does not guarantee compensability or claim acceptance. These are determined by your workers compensation insurance carrier.

Please forward all bill and payment questions to:

Sincerely,

Email:

The reviewing physician or Medical Director is available to discuss this decision with the requesting physician at 888-822-7211 Option 3 during the following hours: Monday through Friday, 8am to 5:30pm

PROOF OF SERVICE

[1] I am at least 18 years old, not a party to this action, and not a protected person listed in any of the orders.

[2] I have served copies of the following document[s]: Notice of Determination

[3] I have mailed them by regular post, email, or sent them by facsimile to the person[s] below:

Employee Name

Address

City, State, Zip

Doctor Name

Address

City, State, Zip

Notified via fax to:

Notified via email to:

[4] My Name, Address and Telephone Number:

Jenna Baker

P.O. Box 7140

Folsom CA 95763

(888) 822-7211

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

Date: 08/06/2026



NOTICE OF UTILIZATION REVIEW DETERMINATION

Date: 08/24/2026

test doctor MD
Test
12345
Test, CA 12345
Fax #:

Regarding Employee:

Test Claimant

9876 Test
Test CA 12345
Phone: (000) 000-0000

Claim Number:

DOI:
Client: XYZ
Claims Adjuster: Test Adjuster
Phone:

Reference #: RF-00013715

Dear test doctor MD ,

The 08/19/2026 request for medical treatment was first received on 08/21/2026 and reviewed in accordance with Title 8, California Code of Regulations Section 9792.6.1(d). On **08/24/2026** a decision was made in regard to the requested medical treatment. The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision
TR-00013715-001	Additional acupuncture 2 times a week for 3 weeks for the right knee Qty:6	Additional acupuncture 2 times a week for 3 weeks for the right knee Qty:6	Denied
TR-00013715-002	Additional physical therapy 2 times a week for 3 weeks for the right knee Qty:6	Additional physical therapy 2 times a week for 3 weeks for the right knee Qty:6	Denied

Clinical Rationale for Modification/Denial:

Records reviewed: Medical progress reports dated 3/6/26, 5/11/26, 8/13/26 by Dr. Huang; and RFA dated 8/14/26 by Dr. Huang.

This is a 40 year-old female Lab Technician employed by XYZ who sustained an industrial injury to her right knee on 9/16/25 that resulted when she struck her knee against the handle of one of the cabinet doors when processing specimens. The claimant has come under the care of Dr. Steve Yau-E Huang, MD/occupational medicine who is treating the claimant for right knee sprain, and right knee medial meniscus tear. Co-morbidities were not described. The claimant has undergone an 11 month course of treatment which has included physical therapy, acupuncture chiropractic treatment, massage therapy, medications, activity modifications and other modalities. Despite the above noted course of treatment, the claimant has remained symptomatic and functionally impaired. MRI of the right knee dated 9/25/25 showed complete tear of the posterior horn and body of the medial meniscus in a small joint effusion. The claimant has been maintained on Salonpas and Tylenol. A current request is now made for Additional acupuncture 2 times a week for 3 weeks for the right knee (QTY: 6.00); and Additional physical therapy 2 times a week for 3 weeks for the right knee (QTY: 6.00). The request for authorization noted that the claimant had completed previous sessions of acupuncture demonstrating 30% decrease in pain and functional improvement with improved ADLs towards a return to work and recovery. It was also noted that the claimant has completed physical therapy treatments with decreased pain by 30% and improved function in ADLs

with decreased medication usage and decreased work restrictions.

According most recent medical progress report dated 8/14/26 by Dr. Huang, the claimant identifies subjective complaints of persistent right knee pain rated 7/10 and its worst that is increased with walking and standing for prolonged periods of time. The claimant is not taking pain medication is on modified duties but actually working full regular work duties. Physical therapy was reported to have been helpful completing 17/18 sessions. The claimant uses a knee brace intermittently. Objective findings include right knee swelling and limited range of motion due to pain with tenderness over the anterior knee, positive McMurray's and normal motor and reflex exam of the lower extremities with intact sensation. The claimant is said to have overall 65% improvement in symptoms with continued periods of flareup. It is noted the claimant is permanent and stationary with future medical care. Treatment plan recommendations include continued use of a cane and/or knee brace, Salonpas, and Tylenol, with permanent work restrictions. The claimant does not wish to have chiropractic treatment or massage therapy and has declined surgery. The claimant has attended 36 sessions of therapy and will be referred for six additional sessions of physical therapy and six additional sessions of acupuncture.

The claims examiner has submitted a request to review the medical necessity for Additional acupuncture 2 times a week for 3 weeks for the right knee (QTY: 6.00); and Additional physical therapy 2 times a week for 3 weeks for the right knee (QTY: 6.00).

Rationale:

ITEM 1: < Additional acupuncture 2 times a week for 3 weeks for the right knee (QTY: 6.00) >: The CA MTUS Knee Disorders (September 21, 2020), Diagnostic and Treatment Recommendations, Meniscal Tears, Treatment Recommendations, Allied Health Interventions notes that there is no recommendation for or against therapeutic ultrasound, diathermy, electrical stimulation, iontophoresis, phonophoresis, acupuncture, autologous blood injections, plasma rich platelet injections, and hyaluronic acid injections for meniscal tears. The CA MTUS Knee Disorders (September 21, 2020), Diagnostic and Treatment Recommendations, Knee Pain, Treatment Recommendations, Allied Health Interventions notes that there is no recommendation for or against the use of acupuncture for the treatment of acute or subacute knee pain.

The medical records submitted for review identified persistent right knee pain rated 7/10 and its worst and aggravated by weight-bearing activities which continues over 11 month post injury despite extensive conservative treatment that has included multiple sessions of physical therapy, acupuncture, chiropractic treatment and massage as well as medications and activity modifications. It was reported that previous sessions of acupuncture resulted in pain relief and functional improvement. Right knee examination showed somewhat restricted and painful range of motion with positive McMurray's. MRI imaging indicates presence of a medial meniscal tear. While there is now a request made for an additional 6 sessions of acupuncture to the right knee, there was NO DOCUMENTATION of (a) the total number of acupuncture treatments completed to date, or when the last acupuncture sessions was completed; (b) objective evidence of incremental functional gains that were specifically derived from the most recent course of acupuncture treatment completed as evidenced by improved range of motion/motor strength, improved tolerance to specified activities that was measured or advancement of work status. While it is acknowledged that the claimant has been reported to have responded favorably to acupuncture in the past, in the absence of clear documentation of recent functional gains derived from the most recent course completed, continued acupuncture treatment is unable to be supported. Therefore, based on the cited guidelines, the medical necessity for Additional acupuncture 2 times a week for 3 weeks for the right knee (QTY: 6.00) has not been established and is DENIED.

ITEM 2: < Additional physical therapy 2 times a week for 3 weeks for the right knee (QTY: 6.00) >: The MTUS does not address the course of physical therapy treatment recommended before surgery for treatment of meniscal tears. The ODG Knee & Leg Conditions (October 3, 2025) recommends 9 visits over 8 weeks for meniscal tears. Continued treatment is recommended when functional gains have been made and the claimant has not reached maximal improvement.

The medical records submitted for review identified persistent right knee pain rated 7/10 and its worst and aggravated by weight-bearing activities which continues over 11 month post injury despite extensive conservative treatment that has included multiple sessions of physical therapy, acupuncture, chiropractic treatment and massage as well as medications and activity modifications. It was reported that previous sessions of physical therapy resulted in pain relief and functional improvement including reduction in medication usage and advancement of work status. Right knee examination showed somewhat restricted and painful range of motion with positive McMurray's. MRI imaging indicates presence of a medial meniscal tear. While there is now a request made for

additional 6 sessions of physical therapy, there was NO DOCUMENTATION of (a) when the last course of approved physical therapy sessions was completed; or (b) objective evidence of incremental functional gains that were specifically derived from the most recent course of acupuncture treatment completed as evidenced by improved range of motion/motor strength, improved tolerance to specified activities that was measured or advancement of work status. While it is acknowledged that the claimant has been reported to have responded favorably to acupuncture in the past, in the absence of clear documentation of recent functional gains derived from the most recent course completed, continued acupuncture treatment is unable to be supported. Therefore, based on the cited guidelines, the medical necessity for Additional physical therapy 2 times a week for 3 weeks for the right knee (QTY: 6.00) has not been established and is DENIED.

MODIFIED or DENIED DECISIONS - DISPUTE INFORMATION

To the Physician:

If you disagree with this decision and/or have additional information that was not available at the time of this review and desire to initiate a reconsideration, contact Encompass Health Solutions at PO Box 7140 Folsom, CA 95763-7140, Fax- 844-927-4450. Any additional information will be reviewed, and if necessary, sent to a Physician Reviewer for reconsideration according to the Utilization Review process. This reconsideration process is optional and must be initiated within ten (10) days after receipt of this utilization review decision. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

To the Employee (and their Attorney if represented):

The above-mentioned internal reconsideration process is optional. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

Any dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6, which state that an objection to the 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, within 30 days from the mailing date of the written determination letter.

The State of California requires this notice to include the following language:

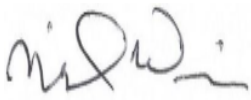
You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision (see attached application). If you have questions about the information in this notice, please call your claims adjuster, Test Adjuster at . However, if you are represented by an attorney, please contact your attorney.

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.

This review determination does not guarantee compensability or claim acceptance. These are determined by your workers compensation insurance carrier.

Please forward all bill and payment questions to:

Sincerely,



Michael Weiner, MD
Medical Director/Physician Reviewer
Emergency Medicine
Phone: (888) 822-7211
Email: m.weiner@encompasswc.com

The reviewing physician or Medical Director is available to discuss this decision with the requesting physician at 888-822-7211
Option 3 during the following hours: Monday through Friday, 8am to 5:30pm

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- Sign and date this application and consent to obtain medical records.
- Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:
Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270
- Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. **THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

Regular ☒

Expedited

Medication Only – MTUS
Formulary Drug List

Retrospective for Exempt
Treatment (Non-Drug) ☐

Retrospective for Exempt
Treatment (Drug) ☐

Employee Information:

First Name: Test Middle Initial: Last Name: Claimant

Address: 9876 Test Number/Unit:

City: Test State: CA Zip Code: 12345 Telephone Number: (000) 000-0000

Fax Number:

Date of Injury:

Insurance Claim Number:

EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned): NA

Employee Attorney (if known):

Address:

Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: test Middle Initial: Last Name: doctor

Practice Name: Test

Address: 12345

Number/Unit:

City: Test State: CA Zip Code: 12345 Telephone Number:

Fax Number: Specialty: Orthopedic Surgeon

Claims Administrator Information:

Employer Name:

Name of Administrator:

Contact Name: Test Adjuster

Address:

Number/Unit:

City: State:

Zip Code:

Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter:
08/24/2026

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☒No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

TR-00013715-001 - Additional acupuncture 2 times a week for 3 weeks for the right knee

TR-00013715-002 - Additional physical therapy 2 times a week for 3 weeks for the right knee

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 consent to 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 _____

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your

deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☒ 30 days from the mailing date of the written determination letter.

10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" 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 OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) 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. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.
- If your physician requested the recommended medical treatment that was denied or modified to 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 within the stated deadline to:

DWC-IMR, c/o Maximus Federal Services, Inc.

PO Box 138009, Sacramento, CA 95813-8009

FAX Number: (916) 605-4270

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

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:

PROOF OF SERVICE

[1] I am at least 18 years old, not a party to this action, and not a protected person listed in any of the orders.

[2] I have served copies of the following document[s]: Notice of Determination

[3] I have mailed them by regular post, email, or sent them by facsimile to the person[s] below:

Test Claimant

9876 Test

Test, CA 12345

test doctor, MD

12345

Test, CA 12345

Notified via fax to: 0000000000

Test Adjuster

Notified via email to:

[4] My Name, Address and Telephone Number:

Jenna Baker

P.O. Box 7140

Folsom CA 95763

(888) 822-7211

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

Date: 08/24/2026



NOTICE OF UTILIZATION REVIEW DETERMINATION

Date: 08/06/2026

Doctor Name
Practice Name
Address
City, State, Zip
Fax #:

Regarding Employee:

Employee Name
Address
City, State, Zip

Claim Number:

DOI:
Client:
Claims Adjuster:
Phone:

Reference #: RF-00013243

Dear Doctor Name ,

The 08/06/2026 request for medical treatment was first received on 08/06/2026 and reviewed in accordance with Title 8, California Code of Regulations Section 9792.6.1(d). On **08/06/2026** a decision was made in regard to the requested medical treatment. The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision
TR-00013243-001	Physical therapy Qty:12	Physical therapy Qty:12	Denied
TR-00013243-002	Massage Therapy Qty:12	Massage Therapy Qty:6	Modified

The approved treatment is certified as medically necessary. Additional treatment will require a new Request for Authorization.

Clinical Rationale for Modification/Denial:

MODIFIED or DENIED DECISIONS - DISPUTE INFORMATION

To the Physician:

If you disagree with this decision and/or have additional information that was not available at the time of this review and desire to initiate a reconsideration, contact Encompass Health Solutions at PO Box 7140 Folsom, CA 95763-7140, Fax- 844-927-4450. Any additional information will be reviewed, and if necessary, sent to a Physician Reviewer for reconsideration according to the Utilization Review process. This reconsideration process is optional and must be initiated within ten (10) days after receipt of this utilization review decision. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

To the Employee (and their Attorney if represented):

The above-mentioned internal reconsideration process is optional. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the

Independent Medical Review.

Any dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6, which state that an objection to the 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, within 30 days from the mailing date of the written determination letter

The State of California requires this notice to include the following language:

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision (see attached application). If you have questions about the information in this notice, please call your claims adjuster, Test Test at . However, if you are represented by an attorney, please contact your attorney.

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.

This review determination does not guarantee compensability or claim acceptance. These are determined by your workers compensation insurance carrier.

Please forward all bill and payment questions to:

Sincerely,

Email:

The reviewing physician or Medical Director is available to discuss this decision with the requesting physician at 888-822-7211 Option 3 during the following hours: Monday through Friday, 8am to 5:30pm

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- Sign and date this application and consent to obtain medical records.
- Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:
Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270
- Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. **THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

Regular ☒

Expedited

Medication Only – MTUS
Formulary Drug List

Retrospective for Exempt
Treatment (Non-Drug) ☐

Retrospective for Exempt
Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned): NA

Employee Attorney (if known):

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address:

Number/Unit:

City: State:

Zip Code:

Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter:

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☒No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

TR-00013243-001 - Physical therapy

TR-00013243-002 - Massage Therapy

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 consent to 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 _____

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your

deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☒ 30 days from the mailing date of the written determination letter.

10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" 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 OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) 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. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.
- If your physician requested the recommended medical treatment that was denied or modified to 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 within the stated deadline to:

DWC-IMR, c/o Maximus Federal Services, Inc.

PO Box 138009, Sacramento, CA 95813-8009

FAX Number: (916) 605-4270

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

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:

PROOF OF SERVICE

[1] I am at least 18 years old, not a party to this action, and not a protected person listed in any of the orders.

[2] I have served copies of the following document[s]: Notice of Determination

[3] I have mailed them by regular post, email, or sent them by facsimile to the person[s] below:

Employee Name

Address

City, State, Zip

Doctor Name

Address

City, State, Zip

Notified via fax to:

Notified via email to:

[4] My Name, Address and Telephone Number:

Jenna Baker

P.O. Box 7140

Folsom CA 95763

(888) 822-7211

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

Date: 08/06/2026



NOTICE OF UTILIZATION REVIEW DETERMINATION

Date: 08/06/2026

Doctor Name
Practice Name
Address
City, State, Zip
Fax #:

Regarding Employee:
Employee Name
Address
City, State, Zip

Claim Number:
DOI:
Client:
Claims Adjuster:
Phone:

Reference #: RF-00013244

Dear Doctor Name,

The 08/06/2026 request for medical treatment was first received on 08/06/2026 and reviewed in accordance with Title 8, California Code of Regulations Section 9792.6.1(d). On **08/06/2026** a decision was made in regard to the requested medical treatment. The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision
TR-00013244-001	Lumbar Epidural Steroid Injection Qty:1	Lumbar Epidural Steroid Injection Qty:1	Denied/LOI

Clinical Rationale for Modification/Denial:

MODIFIED or DENIED DECISIONS - DISPUTE INFORMATION

To the Physician:

If you disagree with this decision and/or have additional information that was not available at the time of this review and desire to initiate a reconsideration, contact Encompass Health Solutions at PO Box 7140 Folsom, CA 95763-7140, Fax- 844-927-4450. Any additional information will be reviewed, and if necessary, sent to a Physician Reviewer for reconsideration according to the Utilization Review process. This reconsideration process is optional and must be initiated within ten (10) days after receipt of this utilization review decision. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

To the Employee (and their Attorney if represented):

The above-mentioned internal reconsideration process is optional. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

Any dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6, which state that an objection to the 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, within 30 days from the mailing date of the written determination letter.

The State of California requires this notice to include the following language:

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision (see attached application). If you have questions about the information in this notice, please call your claims adjuster, Test Test at . However, if you are represented by an attorney, please contact your attorney.

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.

This review determination does not guarantee compensability or claim acceptance. These are determined by your workers compensation insurance carrier.

Please forward all bill and payment questions to:

Sincerely,

Email:

The reviewing physician or Medical Director is available to discuss this decision with the requesting physician at 888-822-7211 Option 3 during the following hours: Monday through Friday, 8am to 5:30pm

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- Sign and date this application and consent to obtain medical records.
- Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:
Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270
- Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. **THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

Regular ☒

Expedited

Medication Only – MTUS
Formulary Drug List

Retrospective for Exempt
Treatment (Non-Drug) ☐

Retrospective for Exempt
Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address:

Number/Unit:

City: State:

Zip Code: Telephone Number:

Fax Number:

Date of Injury:

Insurance Claim Number:

EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned): NA

Employee Attorney (if known):

Address:

Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address:

Number/Unit:

City: State:

Zip Code:

Telephone Number:

Fax Number:

Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator:

Contact Name:

Address:

Number/Unit:

City: State:

Zip Code:

Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter:
08/06/2026

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☒No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

TR-00013244-001 - Lumbar Epidural Steroid Injection

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 consent to 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 _____

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☒ 30 days from the mailing date of the written determination letter.

10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" 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 OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) 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. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.
- If your physician requested the recommended medical treatment that was denied or modified to 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 within the stated deadline to:

DWC-IMR, c/o Maximus Federal Services, Inc.

PO Box 138009, Sacramento, CA 95813-8009

FAX Number: (916) 605-4270

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

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:

PROOF OF SERVICE

[1] I am at least 18 years old, not a party to this action, and not a protected person listed in any of the orders.

[2] I have served copies of the following document[s]: Notice of Determination

[3] I have mailed them by regular post, email, or sent them by facsimile to the person[s] below:

Employee Name

Address

City, State, Zip

Doctor Name

Address

City, State, Zip

Notified via fax to:

Notified via email to:

[4] My Name, Address and Telephone Number:

Jenna Baker

P.O. Box 7140

Folsom CA 95763

(888) 822-7211

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

Date: 08/06/2026



NOTICE OF UTILIZATION REVIEW DETERMINATION

Date: 08/24/2026

test doctor MD
Test
12345
Test, CA 12345
Fax #:

Regarding Employee:

Test Claimant

9876 Test
Test CA 12345
Phone: (000) 000-0000

Claim Number: 10242022

DOI: 10/20/2022

Client: XYZ

Claims Adjuster: Test Adjuster
Phone:

Reference #: RF-00013747

Dear test doctor MD ,

The 08/18/2026 request for medical treatment was first received on 08/20/2026 and reviewed in accordance with Title 8, California Code of Regulations Section 9792.6.1(d). On **08/24/2026** a decision was made in regard to the requested medical treatment. The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision
TR-00013747-001	Ibuprofen 800mg Qty:90 Refills: 0	Ibuprofen 800mg Qty:90 Refills:0	Denied

Clinical Rationale for Modification/Denial:

Outside of 90-days

MODIFIED or DENIED DECISIONS - DISPUTE INFORMATION

To the Physician:

If you disagree with this decision and/or have additional information that was not available at the time of this review and desire to initiate a reconsideration, contact Encompass Health Solutions at PO Box 7140 Folsom, CA 95763-7140, Fax- 844-927-4450. Any additional information will be reviewed, and if necessary, sent to a Physician Reviewer for reconsideration according to the Utilization Review process. This reconsideration process is optional and must be initiated within ten (10) days after receipt of this utilization review decision. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

To the Employee (and their Attorney if represented):

The above-mentioned internal reconsideration process is optional. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

Any dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6, which state that an objection to the 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, within 30 days from the mailing date of the written determination letter.

The State of California requires this notice to include the following language:

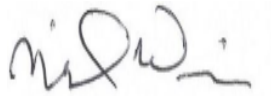
You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision (see attached application). If you have questions about the information in this notice, please call your claims adjuster, Test Adjuster at . However, if you are represented by an attorney, please contact your attorney.

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.

This review determination does not guarantee compensability or claim acceptance. These are determined by your workers compensation insurance carrier.

Please forward all bill and payment questions to:

Sincerely,

A handwritten signature in dark ink, appearing to read 'm. weiner', is written over a light gray rectangular background.

Michael Weiner, MD
Medical Director/Physician Reviewer
Emergency Medicine
Phone: (888) 822-7211
Email: m.weiner@encompasswc.com

The reviewing physician or Medical Director is available to discuss this decision with the requesting physician at 888-822-7211 Option 3 during the following hours: Monday through Friday, 8am to 5:30pm

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- Sign and date this application and consent to obtain medical records.
- Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:
Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270
- Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. **THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

Regular ☒

Expedited

Medication Only – MTUS
Formulary Drug List

Retrospective for Exempt
Treatment (Non-Drug) ☐

Retrospective for Exempt
Treatment (Drug) ☐

Employee Information:

First Name: Test Middle Initial: Last Name: Claimant

Address: 9876 Test Number/Unit:

City: Test State: CA Zip Code: 12345 Telephone Number: (000) 000-0000

Fax Number:

Date of Injury: 10/20/2022

Insurance Claim Number: 10242022

EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned): NA

Employee Attorney (if known):

Address:

Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: test Middle Initial: Last Name: doctor

Practice Name: Test

Address: 12345

Number/Unit:

City: Test State: CA Zip Code: 12345

Telephone Number:

Fax Number: Specialty: Orthopedic Surgeon

Claims Administrator Information:

Employer Name:

Name of Administrator:

Contact Name: Test Adjuster

Address:

Number/Unit:

City: State:

Zip Code:

Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter:
08/24/2026

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☒No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

TR-00013747-001 - Ibuprofen 800mg

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 consent to 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 _____

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☒ 30 days from the mailing date of the written determination letter.

10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" 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 OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) 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. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.
- If your physician requested the recommended medical treatment that was denied or modified to 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 within the stated deadline to:

DWC-IMR, c/o Maximus Federal Services, Inc.

PO Box 138009, Sacramento, CA 95813-8009

FAX Number: (916) 605-4270

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

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:

PROOF OF SERVICE

[1] I am at least 18 years old, not a party to this action, and not a protected person listed in any of the orders.

[2] I have served copies of the following document[s]: Notice of Determination

[3] I have mailed them by regular post, email, or sent them by facsimile to the person[s] below:

Test Claimant

9876 Test

Test, CA 12345

test doctor, MD

12345

Test, CA 12345

Notified via fax to: 0000000000

Test Adjuster

Notified via email to:

[4] My Name, Address and Telephone Number:

Jenna Baker

P.O. Box 7140

Folsom CA 95763

(888) 822-7211

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

Date: 08/24/2026



NOTICE OF UTILIZATION REVIEW DETERMINATION

Date: 08/24/2026

test doctor MD
Test
12345
Test, CA 12345
Fax #:

Regarding Employee:

Test Claimant

9876 Test
Test CA 12345
Phone: (000) 000-0000

Claim Number: 10242022

DOI: 10/20/2022

Client: XYZ

Claims Adjuster: Test Adjuster

Phone:

Reference #: RF-00013747

Dear test doctor MD ,

The 08/18/2026 request for medical treatment was first received on 08/20/2026 and reviewed in accordance with Title 8, California Code of Regulations Section 9792.6.1(d). On **08/24/2026** a decision was made in regard to the requested medical treatment. The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision
TR-00013747-001	Ibuprofen 800mg Qty:90 Refills: 0	Ibuprofen 800mg Qty:90 Refills:0	Denied

Clinical Rationale for Modification/Denial:

Outside of 90-days

MODIFIED or DENIED DECISIONS - DISPUTE INFORMATION

To the Physician:

If you disagree with this decision and/or have additional information that was not available at the time of this review and desire to initiate a reconsideration, contact Encompass Health Solutions at PO Box 7140 Folsom, CA 95763-7140, Fax- 844-927-4450. Any additional information will be reviewed, and if necessary, sent to a Physician Reviewer for reconsideration according to the Utilization Review process. This reconsideration process is optional and must be initiated within ten (10) days after receipt of this utilization review decision. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

To the Employee (and their Attorney if represented):

The above-mentioned internal reconsideration process is optional. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

Any dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6, which state that an objection to the 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, within 10 days from the mailing date of the written determination letter.

The State of California requires this notice to include the following language:

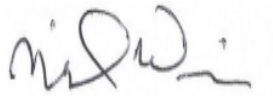
You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision (see attached application). If you have questions about the information in this notice, please call your claims adjuster, Test Adjuster at . However, if you are represented by an attorney, please contact your attorney.

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.

This review determination does not guarantee compensability or claim acceptance. These are determined by your workers compensation insurance carrier.

Please forward all bill and payment questions to:

Sincerely,

A handwritten signature in dark ink, appearing to read 'm. weiner', is written over a light gray rectangular background.

Michael Weiner, MD
Medical Director/Physician Reviewer
Emergency Medicine
Phone: (888) 822-7211
Email: m.weiner@encompasswc.com

The reviewing physician or Medical Director is available to discuss this decision with the requesting physician at 888-822-7211 Option 3 during the following hours: Monday through Friday, 8am to 5:30pm

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- Sign and date this application and consent to obtain medical records.
- Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:
Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270
- Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. **THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

Regular

Expedited

Medication Only – MTUS
Formulary Drug List ☒

Retrospective for Exempt
Treatment (Non-Drug) ☐

Retrospective for Exempt
Treatment (Drug) ☐

Employee Information:

First Name: Test Middle Initial: Last Name: Claimant

Address: 9876 Test Number/Unit:

City: Test State: CA Zip Code: 12345 Telephone Number: (000) 000-0000

Fax Number: Date of Injury: 10/20/2022

Insurance Claim Number: 10242022 EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned): NA

Employee Attorney (if known):

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: test Middle Initial: Last Name: doctor

Practice Name: Test

Address: 12345 Number/Unit:

City: Test State: CA Zip Code: 12345 Telephone Number:

Fax Number: Specialty: Orthopedic Surgeon

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name: Test Adjuster

Address:

Number/Unit:

City: State:

Zip Code:

Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter:
08/24/2026

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☒No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

TR-00013747-001 - Ibuprofen 800mg

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 consent to 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 _____

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

30 days from the mailing date of the written determination letter.

☒ 10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" 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 OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) 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. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.
- If your physician requested the recommended medical treatment that was denied or modified to 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 within the stated deadline to:

DWC-IMR, c/o Maximus Federal Services, Inc.

PO Box 138009, Sacramento, CA 95813-8009

FAX Number: (916) 605-4270

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

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:

PROOF OF SERVICE

[1] I am at least 18 years old, not a party to this action, and not a protected person listed in any of the orders.

[2] I have served copies of the following document[s]: Notice of Determination

[3] I have mailed them by regular post, email, or sent them by facsimile to the person[s] below:

Test Claimant

9876 Test

Test, CA 12345

test doctor, MD

12345

Test, CA 12345

Notified via fax to: 0000000000

Test Adjuster

Notified via email to:

[4] My Name, Address and Telephone Number:

Jenna Baker

P.O. Box 7140

Folsom CA 95763

(888) 822-7211

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

Date: 08/24/2026



NOTICE OF UTILIZATION REVIEW DETERMINATION

Date: 08/06/2026

Doctor Name
Practice Name
Address
City, State, Zip
Fax #:

Regarding

Employee:

Employee Name
Address
City, State, Zip

Claim Number:

DOI:

Client:

Claims Adjuster:

Phone:

Reference #: RF-00013247

Dear Doctor Name ,

The 08/06/2026 request for medical treatment was first received on 08/06/2026 and reviewed in accordance with Title 8, California Code of Regulations Section 9792.6.1(d). On **08/06/2026** a decision was made in regard to the requested medical treatment. The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision
TR-00013247-001	Appeal - radiofrequency ablation at L4-L5 and L5-S1, left Qty:1	Appeal Modified - radiofrequency ablation at L4-L5, left only Qty:1	Modified

The approved treatment is certified as medically necessary. Additional treatment will require a new Request for Authorization.

Clinical Rationale for Modification/Denial:

MODIFIED or DENIED DECISIONS - DISPUTE INFORMATION

To the Physician:

If you disagree with this decision and/or have additional information that was not available at the time of this review and desire to initiate a reconsideration, contact Encompass Health Solutions at PO Box 7140 Folsom, CA 95763-7140, Fax- 844-927-4450. Any additional information will be reviewed, and if necessary, sent to a Physician Reviewer for reconsideration according to the Utilization Review process. This reconsideration process is optional and must be initiated within ten (10) days after receipt of this utilization review decision. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

To the Employee (and their Attorney if represented):

The above-mentioned internal reconsideration process is optional. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

Any dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6, which state that an objection to the 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, within 30 days from the mailing date of the written determination letter.

The State of California requires this notice to include the following language:

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision (see attached application). If you have questions about the information in this notice, please call your claims adjuster, Test Test at . However, if you are represented by an attorney, please contact your attorney.

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.

This review determination does not guarantee compensability or claim acceptance. These are determined by your workers compensation insurance carrier.

Please forward all bill and payment questions to:

Sincerely,

Email:

The reviewing physician or Medical Director is available to discuss this decision with the requesting physician at 888-822-7211 Option 3 during the following hours: Monday through Friday, 8am to 5:30pm

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- Sign and date this application and consent to obtain medical records.
- Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:
Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270
- Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. **THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

Regular ☒	Expedited	Modification after Appeal ☒
Medication Only – MTUS Formulary Drug List	Retrospective for Exempt Treatment (Non-Drug) ☐	Retrospective for Exempt Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned): NA

Employee Attorney (if known):

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address:

Number/Unit:

City: State:

Zip Code:

Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter:
08/06/2026

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☒No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

TR-00013247-001 - Appeal - radiofrequency ablation at L4-L5 and L5-S1, left

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 consent to 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 _____

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☒ 30 days from the mailing date of the written determination letter.

10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" 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 OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) 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. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.
- If your physician requested the recommended medical treatment that was denied or modified to 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 within the stated deadline to:

DWC-IMR, c/o Maximus Federal Services, Inc.

PO Box 138009, Sacramento, CA 95813-8009

FAX Number: (916) 605-4270

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

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:

PROOF OF SERVICE

[1] I am at least 18 years old, not a party to this action, and not a protected person listed in any of the orders.

[2] I have served copies of the following document[s]: Notice of Determination

[3] I have mailed them by regular post, email, or sent them by facsimile to the person[s] below:

Employee Name

Address

City, State, Zip

Doctor Name

Address

City, State, Zip

Notified via fax to:

Test Test

Notified via email to:

[4] My Name, Address and Telephone Number:

Jenna Baker

P.O. Box 7140

Folsom CA 95763

(888) 822-7211

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

Date: 08/06/2026

From: UtilizationReview@encompasswc.com
To: [Jenna Baker](#)
Subject: Request For Information Notice - Referral #: RF-00013743 - Claim #: 10242022 | Test Claimant
Date: Monday, August 24, 2026 3:06:42 PM

[EXTERNAL EMAIL] DO NOT CLICK links or attachments unless you recognize the sender and know the content is safe.

Request For Information Notice

Referral No: RF-00013743

Claim No: 10242022

Request Date: 08/19/2026

Due Date: 09/02/2026

Requesting Physician: test doctor

Requested Treatment:

- TR-00013743-001: Physical Therapy

Please provide the following information no later than 08/28/2026 to complete the request for authorization:

1. RFA submitted without sepcific body part and number of sessions for physical therapy.
Please update RFA and resubmit with the missing information.

Please reply to this message with the requested information or fax to

Jenna Baker

Utilization Review Dept. / Encompass Workers' Comp Solutions

Phone: 888-822-7211 **UR Fax:** 888-235-4828

Email: UR@encompasswc.com

Corporate Office: PO Box 7140, Folsom, CA 95763



NOTICE OF UTILIZATION REVIEW DETERMINATION

Date: 08/25/2026

test doctor MD
Test
12345
Test, CA 12345
Fax #:

Regarding Employee:

Test Claimant

9876 Test
Test CA 12345
Phone: (000) 000-0000

Claim Number: 10242022

DOI: 10/20/2022

Client:

Claims Adjuster: Test Adjuster

Phone:

Reference #: RF-00013743

Dear test doctor MD ,

The 08/18/2026 request for medical treatment was first received on 08/20/2026 and reviewed in accordance with Title 8, California Code of Regulations Section 9792.6.1(d). On **08/25/2026** a decision was made in regard to the requested medical treatment. The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision
TR-00013743-001	Physical Therapy Qty:0	Physical Therapy Qty:0	Denied

Request for information sent: 08/24/2026 with a due-date of 08/28/2026.

The request included:

1. RFA submitted without sepcific body part and number of sessions for physical therapy. Please update RFA and resubmit with the missing information.

No response was received.

Clinical Rationale for Modification/Denial:

No response to RIN

MODIFIED or DENIED DECISIONS - DISPUTE INFORMATION

To the Physician:

If you disagree with this decision and/or have additional information that was not available at the time of this review and desire to initiate a reconsideration, contact Encompass Health Solutions at PO Box 7140 Folsom, CA 95763-7140, Fax- 844-927-4450. Any additional information will be reviewed, and if necessary, sent to a Physician Reviewer for reconsideration according to the Utilization Review process. This reconsideration process is optional and must be initiated within ten (10) days after receipt of this utilization review decision. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

To the Employee (and their Attorney if represented):

The above-mentioned internal reconsideration process is optional. It is a voluntary process that neither triggers, nor bars use of the dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may optionally be pursued before proceeding to the Independent Medical Review.

Any dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6, which state that an objection to the 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, within 30 days from the mailing date of the written determination letter.

The State of California requires this notice to include the following language:

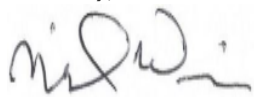
You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision (see attached application). If you have questions about the information in this notice, please call your claims adjuster, Test Adjuster at . However, if you are represented by an attorney, please contact your attorney.

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.

This review determination does not guarantee compensability or claim acceptance. These are determined by your workers compensation insurance carrier.

Please forward all bill and payment questions to:

Sincerely,



Michael Weiner, MD
Medical Director/Physician Reviewer
Emergency Medicine
Phone: (888) 822-7211
Email: m.weiner@encompasswc.com

The reviewing physician or Medical Director is available to discuss this decision with the requesting physician at 888-822-7211 Option 3 during the following hours: Monday through Friday, 8am to 5:30pm

Form IMR

REQUEST INDEPENDENT MEDICAL REVIEW:

- Sign and date this application and consent to obtain medical records.
- Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:
Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270
- Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. **THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

Regular ☒

Expedited

Medication Only – MTUS
Formulary Drug List

Retrospective for Exempt
Treatment (Non-Drug) ☐

Retrospective for Exempt
Treatment (Drug) ☐

Employee Information:

First Name: Test Middle Initial: Last Name: Claimant

Address: 9876 Test Number/Unit:

City: Test State: CA Zip Code: 12345 Telephone Number: (000) 000-0000

Fax Number:

Date of Injury: 10/20/2022

Insurance Claim Number: 10242022

EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned): NA

Employee Attorney (if known):

Address:

Number/Unit:

City: State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: test Middle Initial: Last Name: doctor

Practice Name: Test

Address: 12345

Number/Unit:

City: Test State: CA Zip Code: 12345

Telephone Number:

Fax Number: Specialty: Orthopedic Surgeon

Claims Administrator Information:

Employer Name:

Name of Administrator:

Contact Name: Test Adjuster

Address:

Number/Unit:

City: State:

Zip Code:

Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

* Mailing Date of the Utilization Review Determination Letter:
08/25/2026

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity? ☐Yes ☒No

Reason:

List each specific requested medical service, drug, goods, or items that were denied or modified in the space provided below. Use additional pages if the space below is insufficient.

TR-00013743-001 - Physical Therapy

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 consent to 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 _____

Deadline for Filing IMR Application

The deadline for filing an IMR Application is based on the type of medical treatment that is requested by the treating physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application pursuant to section 9792.10.1, is 10 days from the mailing date of the determination letter. (See date above marked with an asterisk.) For all other disputes, the deadline is 30 days from the mailing date of the written determination letter. If filed by mail, the deadlines are extended to 15 days and 35 days, respectively. If filed by mail from outside of California, the deadlines are extended to 20 and 40 days, respectively. Your deadline for filing this IMR Application is indicated in the checked box, below.

IMR Application Filing Deadline:

☒ 30 days from the mailing date of the written determination letter.

10 days from mailing date of written determination letter
(MTUS Drug List Medication only)

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter (sometimes called utilization review or "UR" 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 OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO IN THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this IMR Application form and a copy of the written (UR) 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. Completion of the authorized representative designation form allows the named person to sign the application for you and submit documents on your behalf.
- If your physician requested the recommended medical treatment that was denied or modified to 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 within the stated deadline to:

DWC-IMR, c/o Maximus Federal Services, Inc.

PO Box 138009, Sacramento, CA 95813-8009

FAX Number: (916) 605-4270

- Your signed IMR application, along with a copy of the written (UR) determination letter, must be received by Maximus Federal Services, Inc. within either thirty (30) days from the mailing date of the written determination letter, or ten (10) days from the mailing date of the letter, depending on the type of treatment that was recommended by your physician. If the disputed medical treatment only involves a drug that is listed on the Medical Treatment Utilization Schedule (MTUS) Formulary Drug List, the deadline for filing the IMR application is 10 days from the mailing date of the letter. For all other disputes, the deadline is 30 days from the mailing date of the letter. (Additional days may be added for mailing as indicated in the application form.) The application will indicate your filing deadline at the end of the form.

- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written (UR) determination letter to your Claims Administrator.

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:

PROOF OF SERVICE

[1] I am at least 18 years old, not a party to this action, and not a protected person listed in any of the orders.

[2] I have served copies of the following document[s]: Notice of Determination

[3] I have mailed them by regular post, email, or sent them by facsimile to the person[s] below:

Test Claimant

9876 Test

Test, CA 12345

test doctor, MD

12345

Test, CA 12345

Notified via fax to: 0000000000

Test Adjuster

Notified via email to:

[4] My Name, Address and Telephone Number:

Jenna Baker

P.O. Box 7140

Folsom CA 95763

(888) 822-7211

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

Date: 08/25/2026



NOTICE OF UTILIZATION REVIEW DETERMINATION

Date: 08/25/2026

test doctor MD
Test
12345
Test, CA 12345
Fax #:

Regarding Employee:

Test Claimant

9876 Test
Test CA 12345
Phone: (000) 000-0000

Claim Number: 10242022

DOI: 10/20/2022

Client: XYZ

Claims Adjuster: Test Adjuster

Phone:

Reference #: RF-00013743

Dear test doctor MD ,

The 08/18/2026 request for medical treatment was first received on 08/20/2026 and reviewed in accordance with Title 8, California Code of Regulations Section 9792.6.1(d). On **08/25/2026** a decision was made in regard to the requested medical treatment. The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision
TR-00013743-001	Physical Therapy for the lower back 2 times a week for 6 weeks Qty:12	Physical Therapy for the lower back 2 times a week for 6 weeks Qty:12	Approved

Request for information sent: 08/24/2026 with a due-date of 08/28/2026.

The request included:

1. RFA submitted without sepcific body part and number of sessions for physical therapy. Please update RFA and resubmit with the missing information.

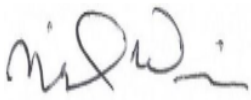
We received a response on: 08/25/2026.

The approved treatment is certified as medically necessary. Additional treatment will require a new Request for Authorization.

This review determination does not guarantee compensability or claim acceptance. These are determined by your workers compensation insurance carrier.

Please forward all bill and payment questions to:

Sincerely,



Michael Weiner, MD
Medical Director/Physician Reviewer
Emergency Medicine
Phone: (888) 822-7211
Email: m.weiner@encompasswc.com

The reviewing physician or Medical Director is available to discuss this decision with the requesting physician at 888-822-7211
Option 3 during the following hours: Monday through Friday, 8am to 5:30pm

PROOF OF SERVICE

[1] I am at least 18 years old, not a party to this action, and not a protected person listed in any of the orders.

[2] I have served copies of the following document[s]: Notice of Determination

[3] I have mailed them by regular post, email, or sent them by facsimile to the person[s] below:

Test Claimant

9876 Test

Test, CA 12345

test doctor, MD

12345

Test, CA 12345

Notified via fax to: 0000000000

Test Adjuster

Notified via email to:

[4] My Name, Address and Telephone Number:

Jenna Baker

P.O. Box 7140

Folsom CA 95763

(888) 822-7211

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

Date: 08/25/2026



NOTICE OF UTILIZATION REVIEW DETERMINATION

Date: 08/07/2026

Doctor Name
Practice Name
Address
City, State, Zip
Fax #:

Regarding

Employee:

Employee Name
Address
City, State, Zip

Claim Number:

DOI:

Client:

Claims Adjuster:

Phone:

Reference #: RF-00013314

Dear Doctor Name ,

The 08/07/2026 request for medical treatment was first received on 08/07/2026 and reviewed in accordance with Title 8, California Code of Regulations Section 9792.6.1(d). On **08/07/2026** a decision was made in regard to the requested medical treatment. The determination(s) are listed below.

Procedure(s):

Req. #	Requested Procedure	Determined Procedure	Decision
TR-00013314-001	MRI Cervical Spine Qty:1	MRI Cervical Spine Qty:1	Deferred

Items marked as Deferred above were not reviewed by UR. A utilization review determination has not been made because there is a dispute regarding liability/compensability for the claimed condition, injury, or body part. Accordingly, the request has been deferred pursuant to California Code of Regulations, Title 8, §9792.9.2. This notice is not an authorization, modification, or denial of medical treatment and does not address medical necessity. Please contact your claims adjuster, Test Test , at , regarding the status of the compensability/liability dispute.

This review determination does not guarantee compensability or claim acceptance. These are determined by your workers compensation insurance carrier.

Please forward all bill and payment questions to:

Sincerely,

Email:

The reviewing physician or Medical Director is available to discuss this decision with the requesting physician at 888-822-7211 Option 3 during the following hours: Monday through Friday, 8am to 5:30pm

PROOF OF SERVICE

[1] I am at least 18 years old, not a party to this action, and not a protected person listed in any of the orders.

[2] I have served copies of the following document[s]: Notice of Determination

[3] I have mailed them by regular post, email, or sent them by facsimile to the person[s] below:

Employee Name

Address

City, State, Zip

Doctor Name

Address

City, State, Zip

Notified via email to:

Notified via fax to:

Test Test

Notified via email to:

[4] My Name, Address and Telephone Number:

Jenna Baker

P.O. Box 7140

Folsom CA 95763

(888) 822-7211

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

Date: 08/07/2026



Notice of Duplicate Request for Authorization

Date: 08/25/2026

Number of pages including cover sheet:1

To:

Fax:

Phone:

From:

Phone:888-822-7211

Fax: 844-927-4450

RE:**Requested Treatment:**

TR-00013763-001 - Physical therapy

Claim No.:**DOI:** 01/01/2024**Reference #:**RF-00013763

We are returning your Request for Authorization dated 08/06/2026 because it is a **DUPLICATE** of a prior request.

Rationale:

RFA dated 8/6/2026 was previously reviewed and approved on 8/6/2026 RF-00013242

Per Title 8, California Code of Regulations, section 9792.9.1.(h) 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 unless there is a documented change in the facts material to the basis of the original utilization review decision.

Based on the information submitted, no documented change in the injured worker's condition or other material facts has been identified to support reconsideration of the prior utilization review decision.

No new utilization review determination has been made, as this request is considered a duplicate of a prior request.

If there has been a documented change in the injured worker's condition or other material facts, please submit a new Request for Authorization with supporting documentation for further review.

Encompass Workers' Comp Solutions
 PO Box 7140, Folsom, CA 95763
 Toll-Free: 888-822-7211 Option 3 or x2001
 Fax: 844-927-4450
 UR Email: ur@encompasswc.com



SAMPLE: Incomplete

Notice of Incomplete Request for Authorization

Date: 08/07/2026

Number of pages including cover sheet: #

To:

From:

Fax:

Phone: 888-822-7211

Phone:

Fax: 844-927-4450

RE:

Requested Treatment:

TR-00013312-001 - Physical Therapy

Claim No.:

DOI:

Reference #: RF-00013312

We are returning your Request for Authorization of Treatment of 08/07/2026 because it is **INCOMPLETE**.

In order to expedite the review of your requested treatment, please resubmit a new Request for Authorization with the missing documentation, listed below, as soon as possible and we will initiate the utilization review process upon receipt of a complete request.

Please include:

Per Title 8, California Code of Regulations, section 9785(g), a request for authorization must include documentation substantiating the need for the requested treatment.

As per Title 8, California Code of Regulations, section 9792.9.1(c)(2)(A), we are returning your Request for Authorization to you as INCOMPLETE, and you must submit a complete request for authorization with the missing documentation in order for your request to be considered by Utilization Review.

When we have received a complete request with the documentation substantiating the need for the requested treatment, we will begin the Utilization Review process as per Title 8, California Code of Regulations, section 9792.9.1. The utilization review timeframe will begin upon receipt of a complete Request for Authorization.

Encompass Workers' Comp Solutions
PO Box 7140, Folsom, CA 95763
Toll-Free: 888-822-7211 Option 3 or x2001
Fax: 844-927-4450
UR Email: ur@encompasswc.com