

Sedwick Claims Management Services, Inc

California Utilization Management Plan

For all dates of injury occurring on or after January 1, 2018

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Prepared for California Utilization Review Program Documentation

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Revisions Table

Revision Dates				
3/25/08	7/27/2011	11/18/04	5/27/08	6/22/2026
1/5/2012	1/5/05	6/3/08	4/11/2012	10/12/2026
3/24/05	7/21/08	6/11/2012	6/8/05	10/20/2026
8/8/2008	1/30/2013	7/18/05	8/25/08	
4/01/2013	12/19/05	10/2/08	10/14/2013	
12/13/06	12/2/08	2/14/2014	1/23/07	
01/19/09	4/30/2015	2/13/07	3/9/09	
11/11/2015	5/18/07	4/07/09	03/18/2016	
6/1/07	5/18/09	08/01/2016	6/18/07	
7/13/09	10/28/2016	7/09/07	8/24/09	
12/15/2017	7/11/07	1/11/10	02/15/2018	
8/08/07	5/05/10	07/02/2021	8/22/07	
7/07/10	10/29/2021	11/07/07	8/27/10	
5/5/2022	11/25/2024	1/15/2026	4/17/2026	

Utilization Management Program Description

Sedgwick Claims Management Services, Inc. ("Sedgwick"), a national workers' compensation utilization management organization, has developed and implemented this Utilization Management ("UM") Plan to promote the delivery of medically necessary health care services in an effective, timely, evidence-based, and cost-efficient manner. This Plan is designed to ensure compliance with California workers' compensation laws and regulations, including Labor Code §§ 4600, 4610, 4610.5, 5307.27, and Title 8 California Code of Regulations §§ 9792.6 through 9792.15, as amended effective April 1, 2026. The Plan establishes processes for monitoring, evaluating, and improving the appropriateness, quality, and consistency of medical treatment decisions and utilization review activities.

California-specific regulatory requirements applicable to utilization review activities are incorporated into and made part of this Plan. Sedgwick will maintain and administer its Utilization Review ("UR") Program in accordance with all applicable statutory and regulatory requirements and shall retain responsibility for oversight of all delegated utilization review functions.

The complete Plan, including all policies, procedures, and descriptions of utilization review processes, shall be filed with the Administrative Director as required by California regulations. Sedgwick shall file any material modifications to its Utilization Review Plan with the Administrative Director within thirty (30) calendar days following implementation of the modification. Material modifications include, but are not limited to, changes in the Medical Director, organizational structure, company name, address, delegated utilization review arrangements, or other changes identified in applicable regulations.

Upon request, Sedgwick shall make available the complete Utilization Review Plan, including policies, procedures, and descriptions of the utilization review process, as required by California law. Sedgwick may charge reasonable copying and mailing expenses associated with providing copies of the Plan, consistent with applicable regulatory requirement.

Contracted Provider Requirements: All professional and institutional providers participating directly or indirectly in the delivery of medical services subject to utilization review are required to comply with the provisions of this Utilization Management Plan. Information regarding utilization review criteria, medical necessity standards, treatment guidelines, authorization procedures, and appeal rights shall be made available to providers, injured workers, authorized representatives, employers, payors, and other parties as required by applicable law.

Pharmacy Utilization Review and MTUS Drug Formulary: Pharmacy utilization management activities are conducted in accordance with Labor Code §§4610 and 5307.27, the Medical Treatment Utilization Schedule (MTUS) Drug Formulary, and applicable California workers' compensation regulations effective April 1, 2026. Pharmacy review activities are integrated into the Utilization Review Program and are performed using evidence-based clinical guidelines and formulary requirements established by the Division of Workers' Compensation.

Prescription drug requests are evaluated using the MTUS Drug Formulary and applicable statutory exemptions from utilization review. Processes are maintained to identify medications designated as Exempt Drugs under the MTUS Formulary and to ensure such medications are administered in accordance with California law. Requests for medications that are not exempt from utilization review are reviewed for medical necessity using the MTUS Drug Formulary, MTUS treatment guidelines, and other evidence-based medical criteria authorized under California workers' compensation regulations.

Consistent with the April 1, 2026 regulations implementing Assembly Bill 1124, procedures are maintained to recognize and process formulary medications that qualify for statutory exemption from utilization review while ensuring compliance with applicable documentation, prescribing, dispensing, and claims administration requirements. Exempt drugs are administered in accordance with California formulary requirements and Division of Workers' Compensation regulations.

Pharmacists, pharmacy clinical staff, nurse reviewers, and physician reviewers may be utilized, as appropriate, to support formulary compliance, medication safety, drug utilization management, opioid stewardship, evidence-based prescribing practices, and regulatory compliance. Clinical recommendations regarding medication therapy are based on medical necessity, patient safety considerations, formulary status, MTUS guidance, and current evidence-based standards of care.

When a brand-name medication is approved and a therapeutically equivalent generic substitute is available, determination notices shall include the required generic substitution language consistent with applicable California regulations and MTUS Drug Formulary requirements, unless the prescriber has appropriately documented that substitution is not permitted.

Requests for Non-Exempt Drugs, unlisted drugs, compounded drugs, and other medication requests requiring prospective review are evaluated for medical necessity in accordance with the MTUS Drug Formulary, MTUS Treatment Guidelines, and other evidence-based medical criteria authorized under California workers' compensation regulations. Modification and denial determinations shall include all information required by applicable California utilization review regulations, including supporting clinical rationale, applicable guideline citations, and Independent Medical Review (IMR) notice requirements.

Limitations: Nothing in this Utilization Management Plan limits Sedgwick's authority to review and evaluate treatment recommendations, health care services, professional providers, or institutional providers in accordance with applicable laws, regulations, contractual requirements, and Plan provisions. Nothing contained in this Plan shall interfere with, substitute for, or otherwise affect a provider's independent medical judgment in rendering medically appropriate treatment to an injured worker. Medical necessity determinations made through utilization review do not dictate the practice of medicine and are intended solely to determine authorization of requested services under applicable workers' compensation requirements.

Accreditation and Regulatory Compliance: This Plan has been developed and is maintained in accordance with California Utilization Review Standards and all applicable statutory and regulatory requirements. Sedgwick shall revise, amend, or supplement its policies and procedures as necessary to maintain compliance with changes in California or federal law.

Consistent with Labor Code §4610 and the regulations effective April 1, 2026, Sedgwick maintains URAC Workers' Compensation Utilization Management Accreditation and complies with all applicable utilization review plan filing, reporting, oversight, and quality management requirements established by the California Division of Workers' Compensation.

Amendments: This Plan may be modified, supplemented, or amended by Sedgwick as necessary to maintain regulatory compliance, improve operational effectiveness, incorporate evidence-based practices, or address changes in applicable laws and regulations. Material modifications to the Plan shall be submitted to the California Division of Workers' Compensation in accordance with applicable filing requirements and regulatory timeframes.

Quality Management Program and Annual Evaluation: Sedgwick maintains an ongoing Quality Management Program designed to assess the effectiveness, consistency, timeliness, accuracy, and regulatory compliance of utilization management activities. The UM Program is subject to periodic review, audit, monitoring, and performance measurement activities.

At least annually, Sedgwick evaluates the effectiveness of its Utilization Management Program, including utilization review operations, decision-making consistency, reviewer qualifications, regulatory compliance, quality indicators, appeals, Independent Medical Review outcomes, pharmacy management activities, and opportunities for process improvement. Findings and recommendations are reviewed through the organization's quality management structure and incorporated into ongoing quality improvement initiatives.

Confidentiality: All activities involving the review or evaluation of medical treatment, health care services, records, or information relating to an injured worker are confidential and shall be conducted in accordance with applicable federal and state privacy and confidentiality laws.

All Sedgwick clinical and non-clinical personnel participating in utilization management or utilization review activities are required to execute confidentiality agreements and acknowledge their responsibility to protect confidential information. Access to confidential information is restricted based upon job responsibilities and legitimate business need. Initial and annual privacy and confidentiality training is mandatory for all personnel participating in utilization review activities.

Sedgwick maintains administrative, physical, and technical safeguards designed to ensure the confidentiality, integrity, and security of protected health information and other confidential records generated or obtained during utilization management and utilization review activities.

Purpose and Scope

Purpose

The purpose of the Sedgwick Utilization Review Program is to ensure that health care services provided to injured workers are medically necessary to cure or relieve the effects of an industrial injury, appropriate to the accepted industrial condition, consistent with the Medical Treatment Utilization Schedule (MTUS), MTUS Drug Formulary, and applicable evidence-based treatment guidelines, and provided in accordance with California workers' compensation laws and regulations.

The Utilization Review Program promotes quality, timely, and cost-effective medical care through standardized review processes, evidence-based clinical criteria, qualified reviewer oversight, and ongoing monitoring of program performance. The Program is established and administered pursuant to California Labor Code §4610 and related statutory and regulatory requirements governing utilization review. The Program supports compliance with Labor Code §§4600, 4610, 4610.5, and 5307.27, and Title 8, California Code of Regulations §§9792.6 through 9792.15.

The program administers prospective, concurrent, retrospective, and expedited utilization review processes and ensures that utilization review determinations are rendered in accordance with applicable statutory and regulatory requirements, including notification, documentation, appeal, and Independent Medical Review (IMR) requirements. The Program also incorporates applicable MTUS Drug Formulary requirements, including pharmacy utilization review processes and statutory exemptions from prospective utilization review established under California law.

This Utilization Review Plan is submitted in accordance with California Labor Code §4610 and the Division of Workers' Compensation utilization review regulations effective April 1, 2026.

Scope

- California workers' compensation claims for which Sedgwick performs utilization review or utilization management services.
- Employers, insurers, self-insured employer, public entities, joint power authorities, third-party administrator, and other clients identified in Appendix C, as updated from time to time.
- Prospective, concurrent, retrospective, expedited, pharmacy, appeal, and Independent Medical Review (IMR) related utilization review activities.
- Review of Requests for Authorization (RFAs) and determinations of medical necessity based on the Medical Treatment Utilization Schedule (MTUS), MTUS Drug Formulary, applicable evidence-based treatment guidelines, and other medical evidence permitted under California law.
- Pharmacy utilization review activities, including formulary compliance and applicable statutory exemptions from utilization review.
- Program governance, quality management, confidentiality, reviewer qualifications, utilization review oversight, and required communications with injured workers, providers, employers, claims administrators, purchasers, and payors.

Definitions

For purposes of this Utilization Review Plan, the following definitions shall apply. To the extent a definition is specifically established by California statute or regulation, the regulatory definition shall control. These definitions are intended to be consistent with Labor Code §4610 and Title 8 California Code of Regulations §9792.6.1, effective April 1, 2026.

Term	Definition
Administrative Director (AD)	The Administrative Director of the California Division of Workers' Compensation (DWC) responsible for oversight and enforcement of California workers' compensation utilization review requirements.
Appeal / Internal UR Appeal	A voluntary process through which the requesting physician, injured worker, or authorized representative may seek reconsideration of a utilization review decision that modifies or denies requested treatment.
Claims Administrator	An insurer, self-insured employer, third-party administrator, or other entity responsible for administration of workers' compensation claims, including utilization review activities.
Completed Request For Authorization	A Request for Authorization (RFA) that identifies the injured worker and requesting provider, specifies the requested treatment or service, and includes documentation supporting medical necessity consistent with applicable California workers' compensation regulations.
Concurrent Review	Utilization review conducted during an injured worker's course of treatment, including hospitalization or ongoing care, while treatment is being provided and the patient's condition remains under active review.
Coverage Decision	A determination regarding whether a requested service is a covered workers' compensation benefit, separate and distinct from a medical necessity determination.
Denial	A utilization review decision that refuses, in whole or in part, a request for authorization because the requested treatment or service does not meet applicable medical necessity requirements.
Dispute of Liability or Liability Dispute	A dispute concerning whether an employer is legally responsible for a claimed injury, condition, body part, treatment, or workers' compensation benefit under California law.
Emergency Health Care Services	Health care services provided for a medical condition manifesting acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the patient's health or serious impairment of bodily functions.
Expedited Review	Utilization review conducted when the injured worker's condition is such that application of standard review timeframes could seriously jeopardize the worker's life, health, recovery, or ability to regain maximum function.
Expert Reviewer	A medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia who is competent to evaluate the specific clinical issues involved in the requested treatment and whose consultation has been requested by the claims administrator or utilization review organization for a specialized review requiring an extension of time prior to a determination of medical necessity.
Independent Medical Review (IMR)	The independent review process established under Labor Code §4610.5 through which an injured worker may request review of a utilization review decision modifying or denying medical treatment.
Injured Worker	An individual who has sustained an industrial injury or occupational illness arising out of and in the course of employment and who is entitled to workers' compensation benefits.
Material Modification	A significant change to the Utilization Review Plan requiring filing with the Administrative Director, including changes to the Medical Director, company name, corporate structure, address, delegated utilization review arrangements, or other modifications identified by regulation.
Medical Director	A physician licensed in California who is responsible for oversight of the Utilization Review Program, including clinical decision-making, reviewer oversight, quality activities, and regulatory compliance.
Medical Necessity	Health care services reasonably required to cure or relieve the effects of an industrial injury or illness, as determined in accordance with the MTUS and other applicable evidence-based medical treatment guidelines.
Modification	A utilization review decision that authorizes a treatment, service, or medication different from that requested by the treating physician.
MTUS Drug Formulary	The Medical Treatment Utilization Schedule Drug Formulary adopted by the Administrative Director pursuant to Labor Code §5307.27, including provisions governing formulary medications, non-formulary medications, and medications exempt from prospective utilization review.

Non-Physician Reviewer	An individual designated by the Utilization Review Organization to participate in the utilization review process and assist in determining medical necessity. A non-physician reviewer may not independently modify or deny a treatment request.
Normal Business Day / Business Day	Monday through Friday, excluding California state holidays, during Sedgwick's established business hours.
Working Day	A day on which the Utilization Review Organization is open and conducting utilization review activities consistent with applicable California regulations.
Physician Reviewer	A physician licensed by an appropriate licensing authority and competent to evaluate the specific clinical issues involved in the requested treatment who renders utilization review determinations in accordance with California law.
Prospective Review	Utilization review conducted before the provision of requested medical treatment or services to determine medical necessity.
Provider	A physician, practitioner, facility, or other health care professional or entity licensed or otherwise authorized to provide health care services within the scope of licensure.
Request for Authorization (RFA)	A written, electronic, or other request submitted by a treating physician seeking authorization for medical treatment, services, diagnostics, procedures, medications, durable medical equipment, or other health care interventions. A request for authorization may be submitted by a primary treating physician or secondary treating physician in accordance with applicable California regulations.
Retrospective Review	Utilization review conducted after medical treatment or services have been provided to determine medical necessity.
Reviewer	A physician reviewer or non-physician reviewer participating in the utilization review process. Only a qualified physician reviewer may issue a determination modifying or denying treatment.
URAC	The independent accreditation organization recognized under California workers' compensation regulations for purposes of utilization management accreditation requirements.
Utilization Management Plan (Plan)	The written document developed and maintained by Sedgwick Claims Management Services, Inc. describing the policies, procedures, clinical criteria, reviewer qualifications, and processes used to evaluate the medical necessity and appropriateness of requested health care services.
Utilization Review (UR)	The process used by a claims administrator or utilization review organization to review and evaluate requested medical treatment and determine whether the requested care is medically necessary based upon applicable treatment guidelines and regulatory requirements.
Utilization Review Organization (URO)	The entity performing utilization review services on behalf of a claims administrator. For purposes of this Plan, Sedgwick Claims Management Services, Inc. serves as the Utilization Review Organization.
Utilization Review Plan	The written plan maintained by Sedgwick describing its utilization review program, policies, procedures, quality management activities, reviewer qualifications, and compliance measures required under California law.
Utilization Review Process	The systematic process by which Sedgwick receives, evaluates, reviews, approves, modifies, or denies requests for medical treatment or services based on medical necessity, clinical information, evidence-based medicine, MTUS guidelines, and applicable regulatory requirements. The process includes prospective, concurrent, retrospective, expedited, pharmacy, appeal, and applicable IMR-related activities.

Utilization Review Process

General Procedures and Intake Process (8 CCR §9792.9.1)

Submission of Requests for Authorization (RFA)

Requests for Authorization (RFAs) and supporting clinical documentation are accepted from treating physicians and authorized providers through designated submission channels established to ensure timely receipt and processing of utilization review requests. RFAs may be submitted by:

- Secure facsimile transmission;
- Secure electronic mail (email);
- Electronic data interchange (EDI) or other approved electronic submission platforms;
- Designated utilization review portals, where available; and
- Other methods authorized by Sedgwick and permitted by applicable California workers' compensation regulations.

Requests for Authorization may be submitted by a Primary Treating Physician or a Secondary Treating Physician in accordance with applicable California regulations effective April 1, 2026.

For RFAs submitted by facsimile, electronic mail, or electronic data interchange (EDI), the request shall be deemed received on the date it is received and electronically date-stamped by the designated receiving system. If no electronic date stamp is recorded, the date of transmission shall be deemed the date of receipt. RFAs transmitted after 5:30 p.m. Pacific Time shall be deemed received on the next business day, except for expedited or concurrent review requests. Documentation submitted by facsimile, email, or EDI must include evidence of transmission, including the date and time of transmission and the destination facsimile number, email address, clearinghouse, or other electronic recipient. Requesting providers must clearly indicate when expedited review is requested.

Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a claims administrator, non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or mark it "not complete" and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) business days from receipt.

If an RFA is determined to be incomplete or requires additional information to support review, Sedgwick shall process the request in accordance with applicable California utilization review requirements. Incomplete RFAs will be returned to the requesting provider informing of incomplete status and will indicate missing criteria as indicated in the April 1, 2026 updated regulation. If the RFA is complete but additional documentation is required, the needed documentation will be requested. Requests for additional reasonable and necessary information, examinations, or specialized consultations shall be made within the regulatory timeframes established by Title 8 California Code of Regulations. Receipt of requested information may result in an extension of the utilization review determination period as permitted by applicable regulations.

Acknowledgment of Receipt

Procedures are maintained to document receipt of all RFAs and associated medical documentation. Requests received through designated submission channels are date and time stamped upon receipt and assigned for utilization review processing.

Receipt of an RFA may be acknowledged through electronic confirmation, facsimile confirmation, system-generated notification, or other documented means when required by law, regulation, contractual obligation, or operational procedures.

Receipt of an RFA initiates the applicable utilization review timeframe, subject to any regulatory provisions permitting extension or tolling of the review period.

Tracking and Logging

An electronic utilization review management system is maintained that records, tracks, and monitors all utilization review activities and regulatory timeframes.

Upon receipt, all RFAs are:

- Date and time stamped;
- Logged into the Sedgwick utilization review management system;
- Assigned a unique tracking or reference number;
- Routed for clinical review, when appropriate; and
- Monitored for compliance with applicable California utilization review timeframes.

The tracking system records key utilization review activities including:

- Date of receipt of the RFA;
- Review type (prospective, concurrent, retrospective, expedited, pharmacy, or appeal);
- Requests for additional information, examinations, or expert consultation;
- Dates of reviewer assignment;
- Utilization review determinations;
- Communication of decisions; and
- Appeal and Independent Medical Review (IMR) related activities.

Tracking and monitoring processes are utilized to support compliance with Labor Code §4610 and Title 8 California Code of Regulations §§9792.6 through 9792.15.

Dispute of Liability; Deferral (8 CCR §9792.9.2)

A dispute of liability exists when there is a question regarding compensability of the injury, body part, medical condition, treatment request, or other workers' compensation benefit for which the claims administrator may not be legally responsible.

A deferral notice may be issued when permitted by California workers' compensation law and regulations. Deferral of utilization review is limited to circumstances authorized by statute or regulation and shall not be used in place of a medical necessity determination when liability for the requested treatment has been accepted.

Examples of circumstances that may result in a deferral include:

- A dispute regarding whether the claimed injury arose out of and occurred in the course of employment;
- A dispute regarding whether the requested treatment relates to the accepted industrial injury;
- A dispute concerning liability for a specific body part or medical condition;
- A question regarding employee status or entitlement to workers' compensation benefits;
- Circumstances in which compensability of the claim or treatment remains under investigation; or
- Other liability disputes recognized under California workers' compensation law.

In addition, a deferral notice may be issued when Labor Code §4610(k) applies to a treatment recommendation previously denied through utilization review and no documented material change in facts has been provided by the requesting physician. If the requesting physician documents a material change in facts supporting the treatment recommendation, the request shall be referred for utilization review in accordance with applicable regulations.

When a request is deferred, Sedgwick shall provide notice to the requesting physician and all required parties in accordance with applicable California regulatory requirements. Deferral notices shall identify the basis for the deferral and include all information required by Labor Code §4610 and applicable regulations.

If the claims administrator disputes liability as permitted under California regulations, utilization review may be deferred, and a written deferral decision shall be issued no later than five (5) business days from receipt of the Request for Authorization (RFA). The written decision shall be provided to the requesting physician, the injured worker, and, if represented, the injured worker's attorney, and shall include:

1. The date on which the Request for Authorization was first received;
2. A description of the specific course of proposed medical treatment for which authorization was requested;
3. A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability for either the injury, claimed body part or parts, or the recommended treatment;
4. A plain-language statement advising the injured employee that the dispute shall be resolved either by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board; and

5. The following mandatory employee notice:

"You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me (insert claims adjuster'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."

Determinations regarding liability remain the responsibility of the claims administrator and are separate from determinations regarding medical necessity.

Timeframe for Decision Making (§9792.9.3)

Prospective, Concurrent, and Retrospective Reviews

Prospective, concurrent, and retrospective utilization review is conducted in accordance with California Labor Code §4610 and Title 8 California Code of Regulations §§9792.9.3 through 9792.9.5.

For purposes of calculating utilization review timeframes, the first day in counting any timeframe requirement is the first normal business or working day following receipt of a completed Request for Authorization (RFA) or a request accepted as complete, except when the applicable timeframe is measured in hours. When a timeframe is measured in hours, the time for compliance shall be calculated from the time of receipt of the Request for Authorization.

- **Prospective Review:** Prospective utilization review decisions shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed **five (5) business days** from receipt of a completed Request for Authorization (RFA).
- **Concurrent Review:** Concurrent review determinations shall be made in a timely manner appropriate to the injured worker's condition and the circumstances of the treatment under review, and generally within **five (5) business days** of receipt of the completed request, subject to applicable regulatory extensions
- **Retrospective Review:** Retrospective review decisions shall be made within **thirty (30) calendar days** of receipt of the information reasonably necessary to make the determination.

All review activities are documented and monitored to ensure compliance with statutory and regulatory requirements.

Concurrent Review

Timely decision-making is essential to ensure continuity of care for injured workers is recognized for receiving ongoing treatment. Concurrent review is performed when treatment is currently being provided and additional services, continued treatment, or extension of care is requested.

When a concurrent review decision involves the modification, suspension, or termination of an ongoing course of treatment previously approved, the requesting physician shall be notified of the decision within **24 hours of the determination** by telephone, facsimile, or, if agreed to by the parties, encrypted electronic mail. Written notice of the decision shall be issued to the injured worker, and, if applicable, the injured worker's representative, and attorney within 24 hours of the decision.

When the concurrent review determination modifies, suspends, or terminates an ongoing course of treatment and the requesting physician believes the determination warrants an expedited review because the injured worker faces an imminent and serious threat to health, the requesting physician may request an expedited review in accordance with applicable California utilization review requirements.

Sedgwick shall ensure that concurrent review determinations are communicated in a manner that minimizes disruption of medically necessary care and complies with all applicable California notice requirements.

Sedgwick may request additional information, examinations, or expert consultation when reasonably necessary to determine medical necessity and permitted by applicable regulations.

Expedited Reviews

Expedited utilization review is provided when the injured worker's condition is such that the standard utilization review timeframe could seriously jeopardize the worker's life, health, recovery, ability to regain maximum function, or subject the worker to severe pain that cannot be adequately managed without the requested treatment.

For expedited review requests, Sedgwick shall make a utilization review determination as soon as medically necessary, but no later than **seventy-two (72) hours** after receipt of the request for authorization.

Expedited determinations may initially be communicated by telephone, fax, electronic transmission, or other expeditious means, followed by written notification to the requesting physician, injured worker, and other required parties as required by California law.

Sedgwick maintains procedures to identify, prioritize, track, and monitor expedited review requests to ensure compliance with all applicable California utilization review requirements and facilitate timely access to medically necessary care.

Notices for Initial Decisions

Written Decision Content Requirements

Approval Notices (§9792.9.4)

Written approval notices shall be issued for Requests for Authorization (RFAs) in accordance with Labor Code §4610 and Title 8 California Code of Regulations §9792.9.4, effective April 1, 2026. Approval notices shall include, as applicable:

- Identification of the injured worker.
- Date the Request for Authorization was first received.
- Description of the medical treatment, service, medication, or item requested.
- Description of the medical treatment, service, medication, or item authorized.
- Date of the utilization review determination.
- Effective period, duration, quantity, frequency, or other authorization parameters, when applicable.
- If applicable, the written decision shall include the date a request for additional information, examination, or consultation was made under to section 9792.9.6(a)(1)(A), (B), or (C), and the date the information, examination report, or consultation was received.
- Other information required by California workers' compensation statutes and regulations.

Approval determinations shall be communicated to the requesting physician and other required parties within applicable regulatory timeframes.

Modification and Denial Notices (§9792.9.5)

All modification and denial determinations shall be made by a qualified physician reviewer and communicated in writing in accordance with California workers' compensation requirements.

Modification and denial notices shall include, as applicable:

- Identification of the injured worker.
- Date the Request for Authorization was first received.
- Description of the treatment, service, medication, or item requested.
- If the timeframe for decision was extended pursuant to section 9792.9.6, the written decision shall also include a specific description of the information needed to make a medical necessity determination of the treatment request; the date(s) and time(s) the request(s) for information, examination, or expert consultation under section 9792.9.6(a)(1)(A), (B), or (C) were made; the manner in which the requests were made; and the date the requested information, examination report, or consultation was first received.
- Description of the treatment, service, medication, or item modified or denied.
- A list of all medical records reviewed.
- A specific description of the medical treatment service approved, if any.
- Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision.
- Date of the utilization review determination.
- Clear clinical rationale supporting the determination.
- Specific medical necessity criteria, guidelines, studies, or evidence relied upon in reaching the decision, including applicable MTUS provisions, MTUS Drug Formulary provisions, or other evidence-based treatment guidelines authorized by law.
- The evaluator's clinical reasons for the decision.
- The reviewer's name and specialty, the reviewer's California license number, a telephone number where the reviewer or the reviewer's designee may be contacted, and the hours of availability of the reviewer or the reviewer's designee for discussion of the determination with the requesting

physician. Such availability shall be provided for a minimum of four (4) hours per week during normal business hours, defined as 9:00 a.m. to 5:30 p.m. Pacific Time.

- The Application for Independent Medical Review, DWC Form IMR (Rev. 04/01/2026), which is hereby incorporated by reference. All fields of the form, except for the signature of the employee, must be completed by the claims administrator. The written decision provided to the injured worker, shall include an addressed envelope, which may be postage-paid for mailing to the Administrative Director or his or her designee.
- 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
- The notice shall also include details regarding the claims administrator's internal utilization review appeals process for the requesting physician, if any, including disputes regarding the necessity of or availability of requested information, and a clear statement that any internal utilization review appeals process is voluntary and neither triggers nor precludes the injured worker's right to pursue Independent Medical Review pursuant to Labor Code §§ 4610.5 and 4610.6. Participation in any internal appeals process is optional and may be pursued concurrently with, before, or instead of the statutory Independent Medical Review process, as permitted by applicable law.
- The written determination shall include the following mandatory language advising the injured employee:

"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 adjusters 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."

"For information about the workers' compensation claims process and your rights and obligations, go to [Division of Workers' Compensation](#) 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."

Any additional notices, disclosures, information, forms, and attachments required by Labor Code § 4610, Labor Code §§ 4610.5 and 4610.6, and applicable California utilization review and Independent Medical Review regulations.

Notice language and content shall comply with California Labor Code § 4610 and Title 8, California Code of Regulations § 9792.9.5, as amended effective April 1, 2026. Written modification or denial notices shall include all information required by section 9792.9.5(e), including but not limited to: the date the completed or accepted Request for Authorization was received; any extension information required under section 9792.9.6; a description of the treatment, service, medication, or item requested; the clinical reasons for the determination; the criteria or guidelines relied upon in making the determination; the reviewing physician's name, specialty, California license number, contact information, and hours of availability; information regarding the requesting physician's right to discuss the determination with the reviewer; a description of the injured worker's rights regarding Independent Medical Review (IMR), including applicable deadlines and procedures; details regarding any voluntary internal utilization review appeals process; the mandatory employee notices required by section 9792.9.5(e)(12); and any other notices, disclosures, forms, attachments, or information required by Labor Code §§ 4610, 4610.5, and 4610.6 and applicable regulations.

Extension of Timeframe for Decision (§9792.9.6)

When Sedgwick determines that an extension of the utilization review decision timeframe is necessary, the timeframe may be extended only under one or more of the following circumstances:

1. The claims administrator or reviewer is not in receipt of all information reasonably necessary to make a determination;
2. The reviewer has requested an additional examination or test to be performed upon the injured worker that is reasonable and consistent with professionally recognized standards of medical practice; or
3. The reviewer requires a specialized consultation and review of medical information by an expert reviewer.

If the reviewer or non-physician reviewer determines that additional information is reasonably necessary to make a determination, the requested information shall be sought from the treating physician within five (5) business days from the date of receipt of the Request for Authorization (RFA).

If the physician reviewer determines that an additional examination or test is required, or that a specialized consultation is necessary, the physician reviewer shall, within five (5) business days from receipt of the completed or accepted Request for Authorization, provide written notice to the requesting physician, the injured worker, and, if represented, the injured worker's attorney, that the reviewer cannot make a decision within the required timeframe and shall request the additional examination or test required or indicate that consultation by an expert reviewer is needed. When an expert consultation is requested, the specialty of the expert reviewer shall be identified.

If the information reasonably necessary to make a determination that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed or accepted Request for Authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, a physician reviewer shall deny the request in accordance with California Code of Regulations section 9792.9.5(e).

If the results of the additional examination or test, or the specialized consultation requested by the physician reviewer, are not received within thirty (30) days from the date of the Request for Authorization, the physician reviewer shall deny the treating physician's request in accordance with California Code of Regulations section 9792.9.5(e).

Upon receipt of the information requested pursuant to section 9792.9.6(a)(1)(A), (B), or (C):

- For prospective or concurrent review, the decision to approve, modify, or deny the Request for Authorization shall be made within five (5) business days of receipt of the information
- For expedited review, the decision to approve, modify, or deny the Request for Authorization shall be made within seventy-two (72) hours of receipt of the information.
- For retrospective review, the decision to approve, modify, or deny the Request for Authorization shall be made within thirty (30) calendar days of receipt of the information.

All requests for additional information, examinations, tests, or expert consultation, including the date, time, and manner of the request and the date the requested information, examination results, or consultation was received, shall be documented in the utilization review record.

MTUS Drug Formulary Decisions (§9792.9.8)

Pharmacy utilization review and formulary determinations are administered in accordance with the MTUS Drug Formulary and regulations effective April 1, 2026.

When applicable, utilization review notices involving prescription medications shall clearly identify:

- Whether the medication is a formulary drug.
- Whether the medication qualifies for a statutory exemption from prospective utilization review.
- Whether the medication is Exempt per MTUS Drug Formulary.
- **"Generic Substitute Authorized"** when applicable
- Any applicable formulary status affecting authorization.
- The medical necessity rationale supporting approval, modification, or denial when utilization review is required.

Sedgwick shall utilize all required formulary-related notice language, labeling, and disclosure requirements established by the Division of Workers' Compensation for MTUS Drug Formulary determinations.

Duplicate Requests and Prior Utilization Review Determinations (§§9792.9.2(a) and 9792.9.5(g))

Pursuant to Labor Code §4610(k) and applicable California regulations, a prior utilization review denial may remain effective for twelve (12) months with respect to the same treatment recommendation from the same physician.

Sedgwick may issue a deferral notice when:

- The treatment request seeks authorization for the same treatment previously denied through utilization review;
- The prior denial remains within the applicable 12-month period; and
- The subsequent request does not contain documentation establishing a material change in facts relevant to the prior denial.

The twelve (12) month rule shall not apply when the repeat treatment request includes an express or unequivocal statement by the requesting physician indicating that there has been a change in facts material to the basis of the prior utilization review denial and includes documentation supporting the change.

When a requesting physician documents a material change in facts supporting the treatment recommendation, Sedgwick shall process the request through utilization review and obtain a medical necessity determination in accordance with applicable California workers' compensation laws and regulations.

Sedgwick shall provide all required notices regarding duplicate requests, prior denials, and applicability of Labor Code §4610(k) in accordance with the regulations effective April 1, 2026.

Regulatory Decision Timeframes

Sedgwick shall issue utilization review determinations within the timeframes required by California Labor Code §4610 and applicable regulations.

- Prospective and concurrent review decisions shall generally be made within five (5) working days from receipt of a completed Request for Authorization and in no event more than fourteen (14) calendar days from receipt of the request, except as otherwise permitted by regulation.
- Retrospective review decisions shall be made within thirty (30) calendar days of receipt of the information reasonably necessary to make the determination.
- Expedited review decisions shall be made as soon as medically necessary and no later than seventy-two (72) hours following receipt of the request.

Utilization Review Criteria(8 CCR §9792.8)

Medical Necessity

All utilization review determinations shall be based on medical necessity in accordance with California Labor Code §§4600, 4610, and 5307.27 and applicable utilization review regulations. Requested treatment shall be evaluated to determine whether the service is reasonably required to cure or relieve the effects of the industrial injury or illness. Medical necessity determinations shall be based upon the best available evidence and the hierarchy of evidence established under California workers' compensation law.

The primary basis for medical necessity determinations shall be the Medical Treatment Utilization Schedule (MTUS), including applicable treatment guidelines, chronic pain guidelines, specialty guidelines, and other evidence-based treatment recommendations adopted by the Administrative Director. When MTUS does not specifically address a requested treatment, Sedgwick shall apply the evaluation methodology and evidence standards authorized by California law and regulation.

Authorized Treatment

Requests for Authorization (RFAs) shall be approved, modified or denied based upon medical necessity, applicable MTUS guidelines, the MTUS Drug Formulary, and other evidence-based medical criteria permitted under California workers' compensation law.

Utilization review determinations shall be made by qualified reviewers and shall be supported by documented clinical rationale. All decisions shall be consistent with applicable statutory and regulatory requirements and communicated within required regulatory timeframes. Approval, modification, and denial decisions shall include the documentation and notice requirements established under California utilization review regulations.

First 30-Day Exemption (§9792.9.7)

Certain medical treatment may qualify for exemption from prospective utilization review during the first thirty (30) days following the date of injury when the conditions established by California law and regulation are satisfied. Medically necessary treatment that is consistent with the MTUS and otherwise qualifies for the statutory exemption may be provided without prospective utilization review during this period.

Requests shall be administered subject to the first 30-day exemption in accordance with Labor Code §4610 and Title 8 California Code of Regulations §9792.9.7, as effective April 1, 2026. Treatment requests that do not qualify for the exemption remain subject to utilization review requirements. Specifically, unless previously authorized by the claims administrator or rendered as emergency medical treatment, the following services are not exempt and require prospective utilization review:

1. Pharmaceuticals, except those expressly exempt from prospective review under the MTUS Drug Formulary;
2. Nonemergency surgery and surgical services provided in any setting, including inpatient hospital, outpatient hospital, surgical clinic, ambulatory surgical center, or physician's office, including all necessary and routine pre-operative, intra-operative, and post-operative services;
3. Psychological or psychiatric treatment services, including diagnostic services, psychotherapy, other behavioral health services, and psychiatric pharmaceuticals not expressly exempt under the MTUS Drug Formulary;
4. Home health care services, including healthcare and other medically necessary services provided in the injured worker's residence;
5. Imaging and radiology services, excluding X-rays;
6. Durable medical equipment, prosthetics, orthotics, and supplies where the purchase or rental cost exceeds \$250, as determined under the Official Medical Fee Schedule (OMFS), or where an unlisted item exceeds a billed amount of \$250;
7. Electrodiagnostic medicine services, including electromyography (EMG), nerve conduction studies, and other neurology and neuromuscular diagnostic procedures; and
8. Spinal injections, including therapeutic medial branch nerve block injections, facet joint injections, intradiscal injections, epidural injections, and sacroiliac joint injections.

Treatment requests falling within any of the categories above shall be subject to prospective utilization review and processed in accordance with California utilization review requirements.

Drug Authorization

Pharmacy utilization review is administered in accordance with the MTUS Drug Formulary, Labor Code §§4610 and 5307.27, and the California utilization review regulations effective April 1, 2026. Medication requests shall be evaluated based upon formulary status, medical necessity, FDA-approved indications when applicable, clinical appropriateness, patient safety considerations, and applicable MTUS guidance.

Drugs identified as exempt under the MTUS Drug Formulary and applicable California regulations shall be processed in accordance with statutory and regulatory exemption requirements. Requests for medications that are not exempt from utilization review shall be reviewed for medical necessity using the MTUS Drug Formulary, MTUS treatment guidelines, and other evidence-based medical criteria authorized by California law.

Pharmacists, nurse reviewers, physician reviewers, and other qualified clinical personnel may be utilized to support formulary compliance, medication safety, opioid stewardship, and evidence-based prescribing practices. Approval, modification, and denial determinations involving prescription medications shall include all notices, rationale, and disclosures required by California workers' compensation laws and regulations, including applicable Independent Medical Review (IMR) rights.

Medication requests requiring utilization review shall be processed within the timeframes established by California Labor Code §4610 and applicable regulations. Prospective and concurrent review determinations shall be made in a timely manner appropriate to the injured worker's condition and generally within five (5) working days of receipt of a completed Request for Authorization. Requests containing both prescription medications and non-pharmaceutical treatment services shall be processed as mixed treatment requests and reviewed under the general utilization review timeframes and procedures established by California Labor Code §4610 and applicable regulations. Retrospective review determinations shall be made within thirty (30) calendar days of receipt of the information reasonably necessary to make the determination.

Expedited review determinations involving prescription medications shall be made as soon as medically necessary, but no later than seventy-two (72) hours after receipt of the request.

Prescription medications designated as exempt from prospective utilization review pursuant to the MTUS Drug Formulary, Assembly Bill 1124, and applicable California regulations shall be processed in accordance with the exemption provisions established by law and shall not be subject to prospective utilization review when the regulatory requirements for exemption have been satisfied.

Procedures shall be maintained to identify formulary medications, non-formulary medications, and medications eligible for exemption from prospective utilization review and shall communicate formulary-related determinations in accordance with applicable California workers' compensation notice and documentation requirements

Appeal and Independent Medical Review

Injured workers and treating providers have the right to challenge utilization review determinations is recognized in accordance with California Labor Code §§ 4610 and 4610.5 and Title 8 California Code of Regulations §§ 9792.10.1 et seq., effective April 1, 2026. Utilization review decisions modifying or denying requested treatment shall include information regarding applicable appeal rights and Independent Medical Review (IMR) procedures.

Internal Review and Administrative Director Appeals

A requesting physician may utilize Sedgwick's internal utilization review appeal process, to discuss or seek reconsideration of a utilization review determination, including disputes regarding the necessity of or availability of requested information. Any request for an internal appeal must be submitted within ten (10) days after receipt of the utilization review determination. Internal appeals shall be completed within thirty (30) days of receipt of the appeal request. If the dispute involves only a drug listed on the MTUS Drug List, the internal appeal shall be completed within ten (10) days of receipt of the appeal request. Any internal utilization review appeal process is voluntary and neither triggers nor bars use of the dispute resolution procedures set forth in Labor Code §§ 4610.5 and 4610.6. Participation in the internal appeal process does not extend, toll, replace, or otherwise affect the statutory timeframes applicable to Independent Medical Review (IMR).

An injured worker who disagrees with a utilization review decision may request Independent Medical Review (IMR) by submitting an Application for Independent Medical Review. The completed IMR application must be filed within thirty (30) days of the mailing date of the utilization review determination. For disputes involving a utilization review decision concerning a drug subject to the MTUS Drug Formulary, the injured worker must request Independent Medical Review within ten (10) days of the mailing date of the utilization review determination. The IMR application and supporting documentation must be submitted in accordance with the instructions accompanying the utilization review determination and applicable California workers' compensation laws and regulations.

Procedures are maintained for the review and handling of disputes involving utilization review determinations as permitted under applicable California workers' compensation laws and regulations.

Upon receipt of an appeal, dispute, regulatory inquiry, or Administrative Director request for review, Sedgwick shall:

- Log and track the matter within its utilization review management system;
- Assign appropriate personnel to coordinate the response;
- Gather and review all documentation related to the utilization review determination, including the Request for Authorization (RFA), supporting medical records, reviewer notes, correspondence, and applicable treatment guidelines;
- Coordinate with the reviewing physician, Medical Director, claims administrator, and other appropriate parties, as necessary;
- Prepare and submit required documentation to the Administrative Director within applicable regulatory timeframes; and
- Maintain records of the appeal, review, and disposition in accordance with applicable record retention requirements.

Sedgwick shall cooperate fully with any review, audit, investigation, or appeal process conducted by the Administrative Director and shall provide requested documentation and information in accordance with applicable California regulations.

Independent Medical Review (IMR)

An injured worker may request Independent Medical Review (IMR) of a utilization review decision that modifies or denies a requested medical treatment pursuant to Labor Code §4610.5 and applicable California regulations. IMR is administered by the Division of Workers' Compensation through an independent review organization designated by the Administrative Director and is the process for resolving disputes regarding medical necessity.

For all utilization review decisions subject to IMR, Sedgwick shall:

- Include the DWC-required IMR application and all required notices with the modification or denial determination.
- Provide notice of the injured worker's right to request Independent Medical Review.
- Include information regarding IMR filing requirements, applicable deadlines, and submission instructions.
- Maintain records demonstrating compliance with IMR notification requirements.
- Cooperate with the claims administrator, Administrative Director, and Independent Medical Review organization throughout the IMR process.

IMR Filing Process

An injured worker may request Independent Medical Review (IMR) of a utilization review decision that modifies or denies requested treatment pursuant to Labor Code §4610.5 and applicable California regulations.

To request IMR, the injured worker, the injured worker's representative, or other authorized individual must complete and submit the required IMR Application to the Division of Workers' Compensation along with a copy of the utilization review determination and any supporting documentation.

The completed Independent Medical Review (IMR) application must be filed within thirty (30) days of the mailing date of the utilization review decision modifying or denying the requested treatment to the injured worker. Failure to submit the application within the required timeframe may result in dismissal of the application unless otherwise permitted by law or regulation.

For disputes involving a utilization review decision concerning a drug subject to the MTUS Drug Formulary, the injured worker must request Independent Medical Review within ten (10) days of service of the utilization review determination.

Any internal utilization review appeal process available to the requesting physician is voluntary and may be used to discuss or seek reconsideration of a utilization review determination, including disputes regarding the necessity of or availability of requested information. Participation in the internal appeal process neither triggers nor bars use of the dispute resolution procedures set forth in Labor Code §§ 4610.5 and 4610.6. Participation in an internal appeal process does not extend, toll, replace, or otherwise affect any statutory or regulatory deadlines for requesting Independent Medical Review.

Upon receipt of a completed application, the Administrative Director will determine whether the dispute is eligible for Independent Medical Review. If eligibility requirements are satisfied, the matter will be assigned to an Independent Medical Review organization designated by the Administrative Director.

IMR Timeline and Sedgwick's Responsibilities

Upon notification that an Independent Medical Review (IMR) application has been accepted for review by the Administrative Director, shall immediately initiate its IMR coordination process and collect all records required for submission. Sedgwick shall submit utilization review records, medical records, treatment guidelines, reviewer reports, correspondence, and other supporting documentation to the Administrative Director or designated Independent Medical Review organization within the timeframes required by applicable California law and regulation.

Procedures are maintained that are designed to ensure the timely and complete submission of all materials required for Independent Medical Review, including coordination among utilization review staff, physician reviewers, compliance personnel, and the claims administrator, as appropriate.

All IMR requests, record submissions, determinations, and outcomes shall be logged and tracked through the Sedgwick utilization review management system. IMR activity and outcomes shall be reviewed as part of the Sedgwick Quality Management Program to evaluate decision-making consistency, identify trends, monitor regulatory compliance, and support continuous quality improvement initiatives.

EFFECT OF IMR DETERMINATION

Sedgwick shall implement and administer IMR determinations in accordance with California workers' compensation law and applicable regulatory requirements. IMR decisions shall be maintained in the utilization review record and incorporated into ongoing quality monitoring and compliance activities.

Recordkeeping and Monitoring

Sedgwick tracks and monitors appeals, Administrative Director inquiries, and Independent Medical Review activities through its utilization review management system. Appeal and IMR outcomes are reviewed as part of the Sedgwick Quality Management Program to identify trends, ensure regulatory compliance, evaluate consistency of decision-making, and support continuous process improvement

Personnel and Qualification (§9792.7)

Medical Director

Dr. Latifat Apatira MD MPH

Address: 8125 Sedgwick Way
Memphis, TN
Specialty: Physician and Surgeon
Licensure: A 118881

Qualifications: Dr. Apatira is licensed to practice medicine in the State of California and meets all qualifications required under Labor Code §4610 and applicable California workers' compensation utilization review regulations. Dr. Apatira possesses education, training, experience, and clinical expertise sufficient to oversee utilization review activities and ensure compliance with applicable medical necessity and treatment guideline requirements.

Responsibilities: The Medical Director is responsible for:

- Clinical oversight of the Sedgwick Utilization Review Program.
- Oversight of physician reviewers, non-physician reviewers, and expert reviewers.
- Ensuring utilization review determinations are based upon medical necessity and evidence-based treatment guidelines.
- Monitoring utilization review quality, consistency, and regulatory compliance.
- Reviewing utilization review policies and procedures.
- Supporting quality management, regulatory reporting, audits, and accreditation activities.
- Ensuring compliance with California Labor Code §4610 and Title 8 California Code of Regulations §§9792.6 through 9792.15.
- Providing consultation and clinical leadership regarding utilization review operations.

Changes in Medical Director shall be reported and filed with the Division of Workers' Compensation as required by applicable California workers' compensation regulations.

Physician Reviewers

Sedgwick utilizes qualified physician reviewers to perform utilization review determinations involving medical necessity.

All physician reviewers shall:

- Hold an unrestricted professional license in a state of the United States or the District of Columbia.
- Be competent to evaluate the specific clinical issues associated with the treatment under review.
- Possess education, training, experience, and expertise appropriate to the clinical condition and requested treatment.
- Maintain all required licensure and professional credentials.
- Comply with applicable California workers' compensation statutes and regulations.

When a utilization review determination involves modification or denial of requested treatment based upon medical necessity, the determination shall be made only by a physician reviewer competent to evaluate the specific clinical issues presented by the request.

Physician reviewers may:

- Approve requested treatment.
- Modify requested treatment based upon medical necessity.
- Deny requested treatment based upon medical necessity.
- Conduct peer-to-peer discussions with treating physicians.
- Provide clinical recommendations consistent with applicable utilization review requirements.

Reviewer assignments shall be made to ensure that the reviewer possesses expertise appropriate to the injured worker's condition and the treatment being requested.

Non-Physician Reviewers

Sedgwick may utilize non-physician reviewers in accordance with California regulations effective April 1, 2026.

Non-physician reviewers may include nurses, pharmacists, or other qualified clinical personnel who assist in the utilization review process through:

- Intake and review of Requests for Authorization (RFAs).
- Collection and evaluation of clinical documentation.
- Application of administrative and clinical screening criteria.
- Communication and coordination with providers and claims personnel.
- Support of pharmacy and formulary review activities.
- Preparation of cases for physician review when required.

Non-physician reviewers may approve treatment requests when permitted by applicable policies and regulatory requirements. Non-physician reviewers shall not independently modify or deny a request for authorization based on medical necessity. Any utilization review determination involving modification or denial shall be referred to a qualified physician reviewer for review and determination.

Expert Reviewer Consultants

Sedgwick may utilize Expert Review Consultants when specialized clinical expertise is reasonably necessary to evaluate a treatment request, medical condition, diagnostic issue, or other clinical matter requiring review beyond the expertise of the assigned reviewer.

An Expert Reviewer may be a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, chiropractic practitioner, pharmacist, or other licensed health care professional who is competent to evaluate the specific clinical issues involved in the requested treatment and whose consultation is within the individual's scope of licensure and expertise.

Expert Review Consultants may be utilized when:

- Specialized clinical expertise is required to evaluate the requested treatment;
- The treatment recommendation involves a highly specialized condition, procedure, medication, or service;
- Additional clinical input is necessary to determine medical necessity;
- A specialized consultation is required pursuant to applicable California utilization review regulations; or
- An expert consultation is necessary to support a utilization review determination.

Selection of an Expert Review Consultant shall be based upon the individual's:

- Professional licensure and credentials;
- Education and training;
- Clinical specialty;
- Professional experience;
- Board certification, when applicable; and
- Demonstrated expertise relevant to the treatment, diagnosis, body system, or clinical issue under review.

When utilized, an Expert Review Consultant provides specialized clinical input to assist in the evaluation of medical necessity. Expert Review Consultants do not independently render utilization review determinations unless otherwise qualified and acting in the capacity of a physician reviewer consistent with California workers' compensation requirements.

Consultation with an Expert Review Consultant may be requested by the Utilization Review Organization when specialized review is reasonably necessary and may support an extension of the utilization review timeframe as permitted by applicable California regulations. Any utilization review determination involving modification or denial of treatment shall comply with all applicable requirements governing physician reviewer qualifications and decision-making authority.

Sedgwick maintains procedures to ensure that Expert Review Consultants possess qualifications appropriate to the clinical issues under review and comply with applicable confidentiality, conflict-of-interest, licensure, credentialing, and regulatory requirements.

Reviewer Qualifications and Credentialing Documentation

Sedgwick maintains processes to ensure that all personnel participating in utilization review activities meet applicable qualification, licensure, training, and competency requirements. Sedgwick maintains documentation of reviewer qualifications, licensure, training, competency assessments, and credential verification for reviewers directly employed or retained by Sedgwick.

Sedgwick may also utilize contracted physician reviewers, non-physician reviewers, pharmacists, nurse reviewers, and expert reviewers through delegated entities and URAC-accredited organizations. In such cases, the delegated entity is responsible for maintaining reviewer credentialing files, licensure verification, training records, competency assessments, and other documentation required by applicable law, regulation, accreditation standards, and contractual requirements.

Sedgwick maintains oversight of delegated utilization review activities and requires delegated entities to demonstrate compliance with applicable California workers' compensation regulations, URAC accreditation standards, and credentialing requirements. Documentation regarding reviewer qualifications and credentialing maintained by Sedgwick or its delegated entities shall be made available to regulatory agencies, accreditation organizations, or other authorized entities upon request.

Clinical Unit Accessibility and Hours of Operation

Clinical Unit Accessibility and Hours of Operation

Sedgwick maintains procedures to ensure reasonable accessibility of utilization review personnel and timely communication with treating physicians, injured workers, claims administrators, and other authorized parties.

Provider Access

A representative is personally available by telephone from 9:00 a.m. to 5:30 p.m. Pacific Time on normal business days to receive communications regarding Requests for Authorization and utilization review activities.

Telephone and Electronic Accessibility

Secure voicemail, facsimile transmission, electronic mail, and other approved communication methods are available to receive Requests for Authorization and related communications during and after normal business hours. Requests received outside normal business hours shall be processed in accordance with applicable California utilization review regulations.

Reviewer Availability

Physician reviewers, expert reviewers, or the Medical Director shall be available for peer-to-peer discussion with requesting physicians for a minimum of four (4) hours per week during normal business hours, or at another mutually agreed upon time, consistent with applicable California regulations.

After-Hours Communications

Communications received after normal business hours, weekends, or holidays are logged upon receipt and processed on the next working day unless expedited review requirements apply. Procedures are maintained to identify and prioritize urgent and expedited requests requiring immediate attention.

Phone and Fax Numbers

- toll-free phone number: 866-286-0281
- fax number: 877-922-7236

Plan Submission and Modifications

Initial Submission

Sedgwick Claims Management Services, Inc. submits this Utilization Review (UR) Plan to the California Division of Workers' Compensation (DWC) in accordance with Labor Code §4610 and Title 8 California Code of Regulations §9792.7. This UR Plan is submitted in a searchable electronic format together with all required forms, attestations, accreditation documentation, and supporting materials required by the Administrative Director. The Plan is maintained and administered in accordance with the utilization review regulations effective April 1, 2026.

Material Modifications

Sedgwick shall notify the Administrative Director and submit any required amendments to the Utilization Review Plan within thirty (30) calendar days following implementation of a material modification, as required by applicable California utilization review regulations.

Material modifications may include, but are not limited to:

- Change in ownership
- Change in Medical Director
- Change in company name
- Change in address
- Change in corporate structure
- Change in delegated utilization review arrangements
- Change in utilization review processes affecting regulatory compliance
- Change in accreditation status
- Other material changes identified by applicable law or regulation

Consistent with the April 1, 2026 regulations, changes in the Medical Director, address, company name, or corporate structure constitute material modifications requiring appropriate filing with the Division of Workers' Compensation.

Certification of Continued Compliance

Sedgwick certifies that any modified Utilization Review Plan submitted to the Administrative Director shall continue to comply with California Labor Code §4610 and all applicable utilization review regulations, including Title 8 California Code of Regulations §§9792.6.1 through 9792.12, as amended. Sedgwick further certifies that all utilization review activities shall continue to be conducted in accordance with applicable statutory requirements, regulatory standards, accreditation requirements, and Division of Workers' Compensation rules governing utilization review.

Quality Assurance and Compliance Monitoring

Internal Audits

Sedgwick maintains an ongoing Quality Management and Compliance Monitoring Program designed to evaluate the effectiveness, consistency, accuracy, timeliness, and regulatory compliance of its Utilization Review (UR) Program. Internal audits are conducted on a periodic basis to assess compliance with California Labor Code §4610, applicable utilization review regulations, accreditation standards, and internal policies and procedures.

Audit activities may include review of:

- Utilization review timeliness and regulatory turnaround requirements;
- Accuracy and consistency of medical necessity determinations;
- Compliance with MTUS and MTUS Drug Formulary requirements;
- Completeness of utilization review documentation and notices;
- Physician reviewer and non-physician reviewer qualifications;
- Independent Medical Review (IMR) and appeal activities;
- Pharmacy utilization review activities;
- Delegated utilization review functions; and
- Corrective actions implemented in response to identified deficiencies.

Audit findings are reviewed by management and, when appropriate, corrective action plans are developed, implemented, monitored, and documented as part of Sedgwick' continuous quality improvement activities.

Accreditation Requirements

Sedgwick shall maintain compliance with all applicable accreditation requirements governing utilization review activities.

Consistent with California Labor Code §4610 and the utilization review regulations effective April 1, 2026, Sedgwick and any Utilization Review Organization (URO) performing utilization review determinations that result in modifications or denials shall maintain URAC Workers' Compensation Utilization Management (WCUM) Accreditation or otherwise satisfy applicable regulatory requirements. Sedgwick shall maintain documentation demonstrating accreditation status and shall provide such documentation to the Division of Workers' Compensation upon request.

Sedgwick monitors accreditation status, compliance activities, performance standards, and corrective action requirements to ensure continued conformity with applicable accreditation standards and California regulatory requirements.

Delegated Utilization Review Functions

Sedgwick may contract with qualified external Utilization Review Organizations (UROs), physician review organizations, pharmacy benefit management organizations, specialty review vendors, and other qualified entities to perform designated utilization review functions.

Delegated entities performing utilization review services on behalf of Sedgwick shall:

- Maintain all licenses, certifications, and qualifications required by applicable law;
- Maintain URAC Workers' Compensation Utilization Management Accreditation when required by California law and regulation;
- Comply with all applicable California workers' compensation statutes and regulations;
- Maintain reviewer credentialing, licensure verification, training, and competency records;
- Permit oversight, monitoring, and auditing by Sedgwick; and
- Provide data, reports, and records requested by Sedgwick for quality and compliance purposes.

Sedgwick retains ultimate responsibility and oversight for all delegated utilization review activities and maintains procedures for monitoring delegated entities to ensure compliance with contractual obligations, accreditation standards, and regulatory requirements.

DELEGATED UTILIZATION REVIEW ORGANIZATIONS

External utilization review organizations utilized by Sedgwick to perform delegated utilization review functions, if any, shall be identified in an attached exhibit or maintained in Sedgwick's records and provided to the Administrative Director as required pursuant to 8 CCR §9792.7(c)(1).

Financial Incentive Policy

Sedgwick is committed to ensuring that all utilization review determinations are made independently and solely on the basis of medical necessity, applicable treatment guidelines, clinical evidence, and regulatory requirements.

Consistent with Labor Code §4610(g)(3)(B)(i) and Labor Code §4610(g)(4), neither Sedgwick nor any delegated utilization review organization, contractor, reviewer, Medical Director, physician reviewer, non-physician reviewer, expert reviewer, pharmacist, nurse reviewer, or other individual participating in utilization review activities shall be compensated, rewarded, evaluated, or otherwise incentivized based upon:

- The number of treatment requests modified or denied;
- Reductions in medical treatment utilization;
- Reductions in treatment costs;
- The outcome of utilization review determinations;
- The frequency of approvals, modifications, or denials; or
- Any other factor that could improperly influence a medical necessity determination.

Compensation, performance evaluations, productivity standards, incentive programs, vendor agreements, and contractual arrangements shall not encourage or reward utilization review decisions that are inconsistent with medical necessity, applicable treatment guidelines, or California workers' compensation laws and regulations.

All utilization review determinations shall be made based solely upon the clinical information available for review, applicable evidence-based treatment guidelines, and the independent professional judgment of qualified reviewers. Sedgwick maintains processes to monitor compliance with this policy and investigate any concerns regarding potential conflicts of interest or improper influence on utilization review decisions.

Documentation and Recordkeeping

Records Retention

Records related to utilization review activities are maintained in accordance with applicable California workers' compensation laws, regulations, accreditation standards, and record retention requirements.

Records maintained by Sedgwick may include, but are not limited to:

- Requests for Authorization (RFAs);
- Medical records and supporting clinical documentation;
- Utilization review determinations;
- Physician reviewer and non-physician reviewer notes;
- Peer-to-peer communications;
- Extension requests and supporting documentation;
- Appeal and Independent Medical Review (IMR) records;
- Utilization review correspondence and notices;
- Quality management and audit records; and
- Regulatory filings and accreditation documentation.

Records shall be maintained in a manner that permits timely retrieval, review, auditing, reporting, and regulatory inspection. Electronic records shall be protected through appropriate administrative, physical, and technical safeguards designed to preserve record integrity, confidentiality, and availability.

When utilization review functions are delegated to external entities, Sedgwick shall maintain oversight processes to ensure that required utilization review records are retained and available in accordance with applicable contractual, regulatory, and accreditation requirements.

Confidentiality

The organization is committed to protecting the confidentiality, integrity, and security of medical, personal, and proprietary information obtained or created during utilization review activities.

All utilization review activities involving the review, evaluation, processing, storage, disclosure, or transmission of medical records and health information shall be conducted in accordance with applicable federal and state privacy and confidentiality requirements, including HIPAA and California workers' compensation laws and regulations.

All colleagues participating in utilization review activities, including employees, contractors, physician reviewers, non-physician reviewers, pharmacists, nurses, consultants, and delegated entities, are required to:

- Execute confidentiality agreements or otherwise acknowledge confidentiality obligations;
- Complete required privacy and confidentiality training upon hire or engagement and periodically thereafter;
- Access confidential information only as necessary to perform assigned job responsibilities; and
- Protect confidential information from unauthorized access, use, disclosure, alteration, or destruction.

Access to confidential information shall be limited to individuals with a legitimate business need to know and authority to receive such information.

Provider & Patient Communications

Procedures are maintained to ensure timely, accurate, and compliant communications with treating providers, injured workers, claims administrators, authorized representatives, employers, and other parties entitled to receive utilization review information.

Communications may include Requests for Authorization acknowledgements, requests for additional information, approval notices, modification notices, denial notices, deferral notices, formulary determinations, appeal communications, Independent Medical Review notices, and other communications required by California workers' compensation laws and regulations.

All utilization review communications shall be documented and maintained as part of the utilization review record.

Appendices

Appendix A – DWC Form UR-01

Sedgwick shall maintain and submit the current DWC Form UR-01, and all supporting documentation required by the California Division of Workers' Compensation for Utilization Review Plan approval, amendment, renewal, material modification, and ongoing regulatory compliance. Such documentation may include Medical Director information, accreditation records, delegated utilization review information, certifications, and other materials required by applicable California workers' compensation laws and regulations.

Appendix B – Sample Decision Letter Templates

Sedgwick maintains standardized utilization review notice templates designed to comply with California Labor Code §4610 and applicable utilization review regulations. Sample templates maintained by Sedgwick may include, but are not limited to:

- Adverse Determination
- Appeal Overturned
- Appeal Partial Approved
- Appeal Upheld
- Approval
- Inappropriate Duplicate Request
- Incomplete RFA letter
- Request Medical
- Request Medical Pharmacy

Sedgwick reviews and updates utilization review notice templates periodically to ensure continued compliance with applicable statutory, regulatory, accreditation, and operational requirements.

ADVERSE DETERMINATION

Sedgwick
<User Address>

<Primary Recipient Name> <Today's Date>
<Primary Recipient Address>

Claimant: <Claimant_Name>
Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")
Adjuster: <CE_Name>
Claims File #: <ClaimNum_SCMS>

Employer: <Name>
Sedgwick on Behalf of Writing Co: <CarrierName>
Date of Injury: <Date_Injury>
Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service which does not meet established standards of medical necessity based on the information presented by the medical provider as listed below:

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

<Additional_Text("Please provide any additional information")>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGrid2>

<PA_Received_Date>
Final UR Decision Date: <Final_UR_Decision_Date>

The treating physician may receive a copy of the complete guidelines used in this review by forwarding a written request to the Sedgwick address listed on this letter.

To keep all parties informed, Sedgwick has notified the medical provider, injured worker, injured worker's attorney (if applicable), and the workers' compensation payor of the review determination.

If you disagree with this decision, you or your representative may submit a request for an internal appeal through Sedgwick's voluntary appeal process. To appeal this determination, submit a written request within 10 calendar days of receipt of this decision, and provide additional information which explains the medical necessity of the service(s). Please send the appeal request and information to the Sedgwick address listed on this letter. If you believe this determination warrants an expedited appeal, you or your representative may request this by calling Sedgwick at <User_Toll_Free_With_Ext>. The fax number, <User_Fax> is available 24 hours a day 7 days a week to receive requests. Utilization review personnel are available between 9:00 a.m. and 5:30 p.m. Pacific Standard Time (PST) on normal business days at the toll free number listed on this letter. We will respond to your appeal within 30 calendar days of the date of this utilization review decision.

The internal appeals process is voluntary and does not trigger or bar the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6, but may be used on an optional basis.

Any dispute will be resolved in accordance with the independent medical review provision of Labor Code 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by you, your representative or attorney, if you are represented, on the enclosed Application for Independent Medical Review, DWC Form IMR, within **<TP>** Days_to_Dispute> calendar days from the mailing date of the utilization review decision to the employee, as indicated on the last page of the application. This deadline must be met even if participating in the internal utilization review appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope, is again included with this notice if you have not yet filed for IMR.

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 any questions about the information in this notice, please call me, <CE_Name> at <CE_Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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 decision shall remain in effect for twelve months from the date of the decision without further action with regard to any further recommendation by the same physician for the same treatment unless the recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

This review applies only to the specific service listed above. Any additional service(s) will require a separate review process.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

Sedgwick Claims Management Services, Inc.

<CC_Detailed_List>

Enclosure: Application for Independent Medical Review
Self-Addressed Envelope for employee's use only

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

PLEASE USE THE DWC FORM RFA FOR ALL TREATMENT REQUESTS

**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE
“DWC FORM RFA” IN ORDER TO BE CONSIDERED**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We appreciate your cooperation.

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 Type of Utilization Review:

<TP_Standard_Review> Regular

<TP_Expedited_Review> Expedited

<TP_Mod_after_Appeal> Modification after Appeal

<Additional_Text(""
Please enter X if
review is for MTUS
formulary
medication
only.")>
Medication Only –
MTUS Formulary
Drug List

<Additional_Text(""
Please enter X if
review is Retro for
Exempt Treatment
(Non-Drug).")>
Retrospective for
Exempt Treatment
(Non-Drug)

<Additional_Text(""
Please enter X if
review is Retro for
Exempt Treatment
(Drug).")>
Retrospective for
Exempt Treatment
(Drug)

Employee Information:

First Name: <Claimant_FirstName> Middle Initial: Last Name: <Claimant_LastName>
Address: <Claimant_Address> City: <Claimant_City>
State: <Claimant_State> Zip Code: <Claimant_ZipCode> Telephone Number: <Claimant_home_phone>
Fax Number: Date of Injury: <Date_Injury>
Insurance Claim Number: <ClaimNum_SCMS>_ EAMS Case Number: <EAMS>
WCIS Jurisdictional Claim Number (if assigned): <ClaimNum_State>
Employee Attorney (if known): <Plaintiff_Attorney_Name>
Address: <Plaintiff_Attorney_Address> City: <Plaintiff_Attorney_City>
State: <Plaintiff_Attorney_State> Zip Code: <Plaintiff_Attorney_ZipCode> Telephone Number: <Plaintiff_Attorney_Phone>
Fax Number: <Plaintiff_Attorney_Fax_Number>

Requesting Physician Information:

Physician First Name: <Provider_FirstName> Middle Initial: Last Name: <Provider_LastName>
Practice Name: <CA_IMR_Provider_Company_Name>
Address: <CA_IMR_Provider_Address> City: <CA_IMR_Provider_City>
State: <CA_IMR_Provider_State> Zip Code: <CA_IMR_Provider_ZipCode> Telephone Number: <CA_IMR_Provider_Phone_Number>
Fax Number: <CE_Fax_Number> Specialty: <CA_IMR_Provider_Specialty>

Claims Administrator Information:

Employer Name: <Name>

Name of Administrator: Sedgwick Claims Management Services, Inc. Contact Name: <CE_Name>
Address: <CE_Address> City: <CE_City> State: <CE_State> Zip Code: <CE_ZipCode>
Telephone Number: <CE_Phone> Fax Number: <CE_Fax_Number>

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):
<TP_Dx_Codes>* Mailing Date of the Utilization Review Determination Letter: <TP_Date_UR_Decision>

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity?

<Additional_Text("Please enter X if CE Disputing Liability for requested medical treatment besides question of medical necessity.")> Yes

<Additional_Text("Please enter X if CE isn't Disputing Liability.")> No

Reason:

<Additional_Text("Please enter why liability is being disputed.")>

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.

1. <TP_First_Treatment>
2. <TP_Second_Treatment>
3. <TP_Third_Treatment>
4. <TP_Fourth_Treatment>

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:

☒ <TP_Days_to_Dispute> days from the mailing date of the written determination letter.

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.

<Append_PA_Report>

APPEAL OVERTURNED

Sedgwick
<User Address>

<Today's_Date>

<Primary_Recipient_Name>
<Primary_Recipient_Address>

Claimant: <Claimant_Name>
Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")
Adjuster: <CE_Name>
Claims File #: <ClaimNum_SCMS>

Employer: <Name>
Sedgwick on Behalf of Writing Co: <CarrierName>
Date of Injury: <Date_Injury>
Date of Birth: <DateBirth>
Date Request First Received: <SCMSReceivedDate>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service:

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGrid(Appeal Overturned)>

<Additional_Text("Please enter details about the specified procedure.")>

<PA_Received_Date>
Final UR Decision Date: <Final_UR_Decision_Date>

As requested, a physician who was not involved in the original non-certification has reviewed the medical necessity of the above-named claimant's health care services.

This involved review of the original information, supplemented by discussion(s) with the treating provider and/or review of written medical records. The second physician has determined that the above health care service in question is certified as medically necessary.

The claimant, treating provider, claim payor and agency/service provider have been notified of this determination.

This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process. If this request is for medication, a therapeutically equivalent generic substitute is authorized. Authorization of the brand-name medication requires documentation of medical necessity and prior approval. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

<User_Name>
<User_Title>
<User_Toll_Free_With_Ext>



<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE
SUBMITTED ON THE "DWC FORM RFA" FOR CONSIDERATION**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We have attached a copy for your convenience and we ask that you submit all future requests for treatment authorization on the form. We appreciate your cooperation.

APPEAL PARTIAL APPROVAL

Sedgwick
<User Address>

<Today's_Date>

<Primary_Recipient_Name>
<Primary_Recipient_Address>

Claimant: <Claimant_Name>
Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")
Adjustor: <CE_Name>
Claims File #: <ClaimNum_SCMS>

Employer: <Name>
Sedgwick on Behalf of Writing Co.: <CarrierName>
Date of Injury: <Date_Injury>
Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service(s). As requested, a physician who was not involved in the original non-certification has reviewed the medical necessity of the above reference information, supplemented by discussion (s) with the attending physician and / or review of the claimant's medical records. A second physician has made the following determination regarding the health care services(s) listed below has been established. This decision applies only to the specific service(s) listed below. Any additional service(s) will require a separate review process:

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGridNegotiated>

<PA_Received_Date>
Final UR Decision Date: <Final_UR_Decision_Date>

<Additional_Text("Please provide any additional information")>

To keep all parties informed, Sedgwick has notified the medical provider, injured worker, injured worker's attorney (if applicable) and the workers' compensation payor of the review determination. This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the Utilization Review process. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

When a medication request is approved, a therapeutically equivalent generic is authorized. Approval of the brand-name medication requires prior authorization and documentation of medical necessity.

The internal appeals process is voluntary and does not trigger or bar the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6, but may be used on an optional basis.

Any dispute will be resolved in accordance with the independent medical review provision of Labor Code 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by you, your representative or attorney, if you are represented, on the Application for Independent Medical Review, DWC Form IMR, within <TP_Days_to_Dispute> days from the mailing date of the utilization review decision to the employee. This deadline must be met even if participating in the internal utilization review appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope, was included with the initial decision.

You have a right to disagree with decisions affecting your claim which includes seeking Independent Medical Review of the decision. If you have any questions about the information in this notice, please call me, <CE_Name> at <CE_Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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 decision shall remain in effect for twelve months from the date of the decision without further action with regard to any further recommendation by the same physician for the same treatment unless the recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

Sedgwick Claims Management Services, Inc.

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE
“DWC FORM RFA” FOR CONSIDERATION**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> We appreciate your cooperation.

APPEAL UPHELD

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjuster: <CE_Name>

Claim Number: <ClaimNum_SCMS>

Employer: <Name>

Sedgwick on Behalf of Writing Co.: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service(s). As requested, a physician who was not involved in the original non-certification has reviewed the medical necessity of the above reference information, supplemented by discussion (s) with the attending physician and / or review of the claimant's medical records. A second physician has upheld the original non-certification. This review applies only to the specific service(s) listed below. Any additional service(s) will require a separate review process:

Request for Authorization First Received: <SCMSReceivedDate>

 <RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGrid2>

Rationale: <Additional_Text("Please enter details about the specified procedure.")>

This recommendation is supported by <Additional_Text("Please enter guidelines.")>

<PA_Received_Date>

Final UR Decision Date: <Final_UR_Decision_Date>

To keep all parties informed, Sedgwick has notified the medical provider, injured worker, injured worker's attorney (if applicable) and the workers' compensation payor of the review determination.

This decision shall remain in effect for twelve months from the date of the decision without further action with regard to any further recommendation by the same physician for the same treatment unless the recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

Sedgwick Claims Management Services, Inc.

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE
“DWC FORM RFA” FOR CONSIDERATION**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We appreciate your cooperation.

APPROVAL

Sedgwick
<User Address>

<Today's_Date>

<Primary_Recipient_Name>
<Primary_Recipient_Address>

Claimant: <Claimant_Name>
Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")
Adjuster: <CE_Name>
Claims File #: <ClaimNum_SCMS>

Employer: <Name>
Sedgwick on Behalf of Writing Co: <CarrierName>
Date of Injury: <Date_Injury>
Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

Request for Authorization First Received: <SCMSReceivedDate>

 <RFM_All_Values>

This correspondence pertains to the review of the following health care service:

Specific Request: <TP_Treatment_Requested> |

<ProcedureCodeGrid(Certified by Nurse, Certified by PA)>

<Additional_Text("Please enter details about the description of service or treatment approved; i.e. "MRI of lumbar spine approved".")>

Final UR Decision Date: <Final_UR_Decision_Date>

After review of a request for authorization, it has been determined that the specific service(s) meets established criteria for medical necessity based on the information presented by the medical provider.

The medical provider, injured worker and workers' compensation payor have been notified of this decision.

This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process.

Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

If this request is for a medication, a therapeutically equivalent generic substitute is authorized. Authorization of the brand-name medication requires documentation of medical necessity and prior approval.

This review applies only to the specific service(s) listed. Additional services require separate review.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

<User_Name>

<User_Title>

<User_Toll_Free_With_Ext>

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE "DWC FORM RFA" FOR CONSIDERATION

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We appreciate your cooperation.

DUPLICATE REQUEST

Sedgwick
<User Address>

<Primary_Recipient_Name> <Today's_Date>
<Primary_Recipient_Address>

Claimant: <Claimant_Name>
Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")
Adjuster: <CE_Name>
Claims File #: <ClaimNum_SCMS>

Employer: <Name>
Sedgwick on Behalf of Writing Co: <CarrierName>
Date of Injury: <Date_Injury>
Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

Request for Authorization First Received: <SCMSReceivedDate>

This correspondence pertains to the request for authorization we received on the above mentioned date.

Specific Request: <TP_Treatment_Requested>

There has already been an initial denial and/or a denial upon appeal of this same pre-authorization request.

Date of initial non-certification: <Additional_Text("Please enter date of initial denial.")>

Date of non-certification upon appeal: <Additional_Text("Please enter date of appeal upheld if applicable, or N/A.")>

Date non-certification upheld by IMR, if applicable: <Additional_Text("Please enter date when IMR upheld denial, if applicable or N/A.")>

In accordance with California Labor Code 4610(k):

A utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a 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.

This same request will not be processed again, absent objective documentation of a substantial change in the injured employee's medical condition.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me, <CE_Name>, at <CE_Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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.

Sincerely,

Sedgwick Claims Management Services, Inc.

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

INCOMPLETE RFA LETTER

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjuster: <CE_Name>

Claims File #: <ClaimNum_SCMS>

State Claim#: <ClaimNum_State>

Employer: <Name>

Employer Entity Name: <Entity_Name>

Sedgwick on Behalf of Writing Co.: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Notice of Incomplete Request for Authorization

Dear <Primary_Recipient_Name>:

This letter is to notify you that the Request for Authorization (RFA) received on <SCMSReceivedDate> for the above-referenced injured worker cannot be reviewed at this time because it does not meet the definition of a "completed" request for authorization under California Code of Regulations, Title 8, section 9792.6.1(u). Pursuant to 8 CCR §9792.6.1(u), a request for authorization is considered completed only when it:

- Identifies both the injured employee and the requesting provider;
- Identifies with specificity all recommended medical treatment; and
- Is accompanied by documentation issued or created no earlier than 30 days prior to submission that substantiates the medical necessity of the requested treatment.

Based on our review, the following required element(s) were missing or incomplete:

<Incomplete_RFA_Reasons>

Required Action

For utilization review to proceed, the entire Request for Authorization (RFA) must be resubmitted along with the missing information identified above.

Under California Code of Regulations, Title 8, section 9792.6.1(u), a request for authorization is deemed completed only when all required elements are submitted together. Accordingly, submission of partial documentation without a fully completed RFA does not constitute a completed request for authorization and cannot be reviewed.

The request will be deemed completed only upon receipt of a new, fully completed RFA accompanied by all required supporting documentation, at which time utilization review timeframes will begin pursuant to 8 CCR §9792.9.3.

To prevent further delay, please correct and resubmit the information by fax to 877-922-7236.

Important Notice

This correspondence does not constitute a utilization review approval, modification, or denial. No determination regarding medical necessity has been made at this time due to the incomplete nature of the request.

If you have questions regarding this notice or the information required to complete the request, please contact the claims administrator listed above or the Utilization Review department directly at 866-286-0281.

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You have the right to file a complaint by contacting the Utilization Review Department toll-free at 866-286-0281, by fax at 877-922-7236, or mailing to the address on this notice. We will respond to your complaint as quickly as possible, but no longer than 30 days.

Sincerely,

<User_Name>

<User_Title>

<User_Toll_Free_With_Ext>

<CC_Detailed_List>

REQUEST MEDICAL

Sedgwick
<User Address>

<Today's _Date>

<Primary_Recipient_Name>
<Primary_Recipient_Address>

To assist us in reviewing a request for authorization, please return the requested documentation by the date

Claimant: <Claimant_Name>
Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")
Adjuster: <CE_Name>
Claims File #: <ClaimNum_SCMS>

Employer: <Name>
Sedgwick on Behalf of Writing Co: <CarrierName>
Date of Injury: <Date_Injury>
Date of Birth: <DateBirth>
Date Request First Received: <SCMSReceivedDate>

Dear <Primary_Recipient_Name>,

Request for Medical Documentation

On <SCMSReceivedDate>, Sedgwick received a request for authorization of <Additional_Text("Please enter description of service or treatment being requested.")>.. In order to review the request for authorization, additional information is needed to base a determination of medical necessity.

Please submit medical information as follows:

- | | |
|---|--|
| ☐ Current PR-2 | ☐ CPT and ICD-10 Codes |
| ☐ Initial Evaluation | ☐ Current Treatment Plan |
| ☐ Prior Treatment and Response | ☐ Plans for Discharge |
| ☐ Operative Report(s) | ☐ Number of Visits/Treatments to Date |
| ☐ Laboratory Results | ☐ Start of Care Date |
| ☐ All Available Diagnostic Studies | ☐ Additional Progress Notes |
| ☐ Progress Report(s) | ☐ <Additional_Text("Please enter any additional information needed, if applicable.")> |

California Administrative Rules allow a delay of not more than 14 days when additional information is required to make a decision concerning a request for authorization. If the required information is not received in the Utilization Review Department by <Additional_Text("Please enter the date the information is due by.")>, the request will be sent to a physician for review and could possibly result in denial of services based on lack of information. If the request is denied because of lack of information, the request will be reconsidered once the requested information is received.

Please reply to me by FAX at <User_Fax>. If you have any questions regarding this request, please call me at <User_Toll_Free_With_Ext>.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

<User_Name>

<User_Title>

|CC_LIST|

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE
SUBMITTED ON THE "DWC FORM RFA" FOR CONSIDERATION**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We have attached a copy for your convenience and we ask that you submit all future requests for treatment authorization on the form. We appreciate your cooperation.

REPORT MEDICAL - PHARMACY

Sedgwick
<User Address>

<Today's_Date>

<Primary_Recipient_Name>
<Primary_Recipient_Address>

PRESCRIPTION PENDING
Your prompt response is
appreciated.

Claimant: <Claimant_Name>
Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")
Adjuster: <CE_Name>
Claims File #: <ClaimNum_SCMS>

Employer: <Name>
Sedgwick on Behalf of Writing Co: <CarrierName>
Date of Injury: <Date_Injury>
Date of Birth: <DateBirth>
Date Request First Received: <SCMSReceivedDate>

Dear <Primary_Recipient_Name>,

Request for Pharmacy Authorization

On <SCMSReceivedDate>, Sedgwick received a notification that <Claimant_Name> is attempting to fill a prescription for <Additional_Text("Please enter medications requested.")>. Our records indicate that you have not submitted an RFA for this prescription. In order to avoid delay in dispensing the prescription, please submit an RFA ("request for authorization") along with pertinent medical records to substantiate the request.

Sedgwick applies the definition of "request for authorization" as stated in 9792.6.1 (u) of the California Code of Regulations. Please submit your request for authorization on a completed DWC form RFA. It must be signed by the prescribing physician for consideration of medical necessity prior to commencing treatment. A copy is also attached for your convenience.

Please send the RFA and required medical documentation via FAX to (859)280-3263. If you have any questions regarding this request, please call (866) 286-0281.

Sincerely,

Sedgwick Pharmacy Utilization Review

|CC_LIST|

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE "DWC FORM RFA" FOR CONSIDERATION

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at https://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMR_FormRFAClean.pdf . We appreciate your cooperation.

Appendix C – Clients and Delegated Utilization Review Vendors

Sedgwick performs utilization review and utilization management services for employers, insurers, self-insured employers, third-party administrators, public entities, joint powers authorities, and other clients identified in this appendix or maintained in Sedgwick's records.

Sedgwick may utilize delegated Utilization Review Organizations (UROs), physician review organizations, pharmacy benefit managers, specialty review vendors, and other qualified entities to perform certain utilization review-related functions. Delegated entities shall comply with all applicable California workers' compensation laws and regulations, URAC accreditation requirements, contractual obligations, and Sedgwick's oversight requirements.

Sedgwick retains responsibility for oversight and monitoring of all delegated utilization review activities.

The Client List and Delegated Vendor List may be updated periodically to reflect additions, removals, mergers, acquisitions, or other organizational changes and shall be maintained by Sedgwick in accordance with applicable California utilization review filing requirements.

CLIENT LIST

3M Company	Amentum Govt Services Parent Holdings
7-Eleven, Inc.	American Airlines Group
AbbVie, Inc.	American Airlines LUS Premerger
Abercrombie & Fitch	American National Red Cross
ABM Industries, Inc.	American States Water Company
AccentCare, Inc.	American Textile Maintenance Company
ACIG Insurance Company	Ametek, Inc
ACTS-Aviation Security, Inc.	Amgen
Adecco, Inc.	AMRIZE
Advantage Sales & Marketing LLC	Anderson Media Corporation
Adventist Health System/West	Anheuser-Busch Companies, LLC
AECOM	Anson Industries
AES Corporation	Antelope Valley Care Center, ET AL
AGGCAP ARCH #1	Aon Corporation
AGGCAP ARCH #2	Apex Insurance, Ltd.
AGGCAP ARCH #3	Apple Inc.
AGILENT TECHNOLOGIES, INC.	Apple Valley Fire Protection
AIR CANADA	Applied Composites Holdings, LLC
Air Distribution Technologies Inc.(ADII)	Applied Materials, Inc.
Air Methods Corporation	Arakelian Enterprises AKA Athens
AXMetal Workers B&B	ARCADIS US INC
Alaska Air Group	ARCH ALUMINUM & GLASS
Albertsons Companies WC CA-HI	Archdiocese of Los Angeles
Albertsons LLC	Argo Retail and Grocery Program
Alhambra USD	ASCIP
Allegiant Travel Company	Ascot Group-Non Core States
Allianz of America, Inc.	Aspire Casualty, LTD
Allianz Reinsurance America, Inc.	Astrus Insurance Solutions, LLC
AltaMed Health Services Corporation	AT&T Services, Inc.
Amazon.com	ATI

ATI Restoration, LLC	Career Education Corporation
ATLANTIC AVIATION FBO, INC.	Cargill, Inc.
Atlas Air Worldwide Holdings, Inc	Carvana Co.
Atlas General Insurance	Cascade Drilling, L.P.
Automobile Club of Southern California	Catalyst Brands
Auxiliary Organizations WC Plan	CEC Entertainment, Inc.
Avaya Inc.	Cencora, Inc
Avelo Airlines, Inc.	Centinela South Bay
AVMAC LLC	Cenveo Inc.
AXA XL Construction	CH2M HILL Companies Ltd.
AXA XL Mid-Market	Change Healthcare Holdings, LLC
Azusa Unified Sch District	Charter Oak UFD
Banfield Pet Hospitals	Chick-fil-A, Inc.
Bank of America	Chico Produce Inc
Bassett Unified Sch District	Chino Valley Ind. Fire Dist.
Bayer US LLC	Chiquita Brands International, Inc.
BBX Capital Corporation	Chubb & Son, a division of Federal Insurance
Bellus ALC Holdings	Chubb Group of Insurance Companies
Berkley Asset Protection	Cintas Corporation
Bertelsmann Inc.	Cisco Systems, Inc.
Berwind Corporation	City of Beaumont
Best Buy Co., Inc.	City of Calexico
Big Lots	City of Concord
Blue Origin, LLC	City of Cupertino
Blue Shield of California	City of Milpitas
BLUESCOPE STEEL NORTH AMERICA	City of Newark
Bob Evans Farms, Inc.	City of Ridgecrest
Bonita Unified School District	City of Santa Clara
Bragg Investment Company, Inc.	City of Santa Cruz
BrightSpring Health Services	City of Thousand Oaks - WC
Bristol Farms, Inc	City of Torrance WC
British Airways, PLC	Claim Jumper Restaurants, LLC
Build Group, Inc.	Claremont Unified School District
Burbank Glendale Pasadena Airport Auth.	Clarendon
Burbank USD - Self Insured	Clean Harbors Environmental Services Inc
Cabinetworks Group	Clear Spring BTIS WC
California Institute of Technology	Clear Spring Property & Casualty-Paragon
California Psychcare	Clovis Unified School District
California State University	CoEfficient Underwriters-Top Tier Health
Cal-Southampton Captive	Color Spot Nurseries, Inc.
Cambridge Integrated Services Group, Inc	Comcast Corporation
CAPRI Workers Comp	CommonSpirit Health
Cardinal Health	CommScope, Inc
Cardinal Logistics Management Corp	Community Memorial Health System, Corp

Compass Group, Inc.	Dreyer's Grand Ice Cream, Inc.
Compucom	Drill Tech Drilling & Shoring Inc.
Conagra Brands, Inc.	DSG Holdco LLC
Conejo Recreation & Park District	Dunn-Edwards Corporation
Consolidated Freightways Corporation	East Bay Regional Park District
Corelogic, Inc	East Penn Manufacturing Co.
CORNERSTONE C&M, INC.	Eaton Corporation
County of San Diego	ECOBAT HOLDINGS, INC.
County of Santa Cruz	Ecology Auto Parts, Inc.
County of Ventura	Efmark Services, LLC
Covina Valley USD	El Dorado County
Crate & Barrel Holdings, Inc	Elite Comp Program
CSC Serviceworks	Elite Distributors Insurance Company
CSRM JPA	Emcor Group, Inc
CTI Foods Holding Co., LLC	ENDEAVOR AIR
Cummins Inc.	EnPro Industries, Inc.
CVS Pharmacy, Inc.	Enstar QBE 2 & 3
Cygnus Home Service, LLC	Enterprise Holdings, Inc.
Dairy Farmers of America, Inc.	Envista
Dameron Hospital Association	EOS Investors, LLC
Danaher Corporation	ERS Insurance
Davidson Hotel Company, LLC	Essex Property Trust Inc.
DaVita Inc.	EssilorLuxottica USA Inc.
Day & Zimmermann	Everest Insurance Company
Deacon Construction, LLC	Everest National Insurance Company
Dealer Management Group, Inc.	Evolution Insurance Company, Ltd.
Dean Foods Bankruptcy - Chubb	Express Services, Inc.
Del Monte Foods	Extra Space Storage Inc.
Delivery Service Providers	Family Dollar, LLC
Delta Air Lines, Inc.	Farmers Group, Inc.
DESILVA GATES CONSTRUCTION	FedEx Freight, Inc
DHL	Fidelity National Financial, Inc.
Diamond Pet Foods	Fidelity National Information Services
Dimension Hospitality	Flatiron/Dragados/Sukut Joint Venture
DIRECTV, LLC	Flatiron-Skanska-Stacy & Witbeck CCIP
Diverse Staffing, Inc.	Fluor Corporation
Dnata Catering US LLC	Fogo de Chao
Dole Food Company, Inc.	Foley Family Wines, Inc.
Dole Packaged Foods, LLC	Follett Corporation
Dollar General Corporation	Foodservice Risk Management, Inc.
Dollar Tree Stores, Inc.	Foothill DeAnza CCD
DOLPHIN HOTEL MANAGEMENT LLC	Fortis Insurance (Cayman) Ltd.
Domino's Pizza, LLC	Fortive Corporation
Dragados-Flatiron CA High Speed JV	Fortune Brands Innovations, Inc.

Freeman Companies	Hewlett Packard Enterprise
Fresh Express Incorporated	Hilton Grand Vacation Inc.
Frontier Communications Corporation	Hilton Worldwide Holdings, Inc.
Frontline Road Safety Holdings	HNI Corporation
FRY'S ELECTRONICS, INC.	Hobby Lobby Stores, Inc.
GameStop, Inc.	Holder Pankow TEC JV
Garnet GLC Re Group Captive	Home Renew Group Holdings, L.P.
Garnet Group Captive Programs	Homestead Insurance Company IC
Garvey Elementary School District	Honda
GAS Program	Horizon Personnel Services
GAT Airline Ground Support, Inc.	Howmet Aerospace Inc.
GATX Corporation	HSBC North America Holdings Inc
GE Appliances	Hub Group Inc
GE Vernova LLC	HUGHES AIRCRAFT CO, EL AL
General Motors Company	HumanGood
Genesis Healthcare, LLC	Ilitch Holdings, Inc.
Gilead Sciences Inc	Imperial Co. Office Of Ed
Glendale Unified School District	Independent Tire Dealers Group, LLC
Glendora Unified School District	Infineon Technologies Americas Corp.
Golf Entertainment Group Inc.	Inglewood Unified School District
Grainger	Inland Empire Utilities Agency
Granite Insurance, Ltd	Insperity Services, L.P.
Griffin Casualty, LTD.	Intel Corporation
Grossmont Cuyamaca CC	Inter-Con Security Systems Inc. Run off
Ground Services Intl, Inc. dba dNATA	Inter-Con Security Systems, Inc.
Growers Captive Group WC	InterMountain Management
Guitar Center Holdings, Inc.	International Aerospace Coatings
H&S Energy Products, LLC	International Coffee & Tea, LLC
HACLA	International Paper Company
Hajoca Corporation	IRVINE MANAGEMENT COMPANY
Hanover Programs-ArborMax Nova Casualty	ISP
Harrington Industrial Plastics, Inc.	J. Crew
Hartford Financial Services	J. G. Boswell Company
HARTFORD STEP	J. Smith Lanier & Company
Haworth Inc.	J.R. Simplot Company
HBUHSD Tail	JBS USA Food Company
HD Supply Management	JetBlue Airways Corporation
HDI Global Insurance Company Energi	JetSuite, Inc.
Health Net, Inc.	JOANN Inc.
Heidelberg Materials US, Inc	Jo-Ann Stores Inc.
Hellermann Tyton-Winchester Interconnect	Joby Aero, Inc.
Heraeus	Johnson Controls International, PLC
Heritage Grocers Group, LLC	JP Morgan Chase Bank, NA.
Hertz Corporation	Judicial Branch Workers' Comp. Program

Justworks	MHE US Holdings, LLC
Kaiser Foundation Health Plan	Mi Pueblo Food Center
Kay and Associates, Inc.	Michels Corporation
Keenan, Hopkins, Suder & Stowell	Mid-Coast Transit Constructors CCIP
Keysight Technologies, Inc	Midvale Indemnity Company
Kimco Staffing Services, Inc	Mobico PCC US LLC
KinderCare Education LLC	Mohawk Industries, Inc.
Kindred at Home	Momentum (UCP of LA & Ventura Counties)
Kindred Healthcare	Montebello U.S.D.
Kohl's, Inc.	Montgomery Ward/AIG
KSL Portfolio	Motivate LLC
L and R Auto Parks, Inc.	Mueller Industries, Inc.
LA County Office of Education	Myers & Sons Construction
Launch Management Services, LLC	Nabisco, Inc.
Lawrence Livermore National Laboratory	Nabors Industries
Leadership High School	Napa County
Legacy Coach USA	National Gypsum
Lend Lease Corporate (York)	NATIONAL SHUTTLEPOST, LLC
Les Schwab	National Tooling & Machine
Los Angeles Unified School District	Nations Roof, LLC
Lowe's Companies, INC	Nationwide Mutual Insurance Company
Lucent Insurance LTD Captive	Navigator Captive Arch
Lumen Technologies, Inc.	NESTLE US HOLDCO, INC
LVMH Moet Hennessy Louis Vuitton Inc.	Nestle Waters, Inc.
Macy's Inc.	NetJets, Inc.
Maersk Logistics & Services USA Inc.	Newtron Group, L.L.C.
MAIN STREET AND MAIN	Next Workers Compensation
Malcolm Drilling Company, Inc.	Nibbi Brothers General Contractors
Management & Training Corporation	NMB (USA) Inc
Marathon Petrol OCIP	Noble House Hotels & Resorts
Marathon Petroleum Company LP	NonProfits United
MarBorg Industries	Norms Restaurants LLC
MARLEY COMPANY	Nortek, Inc
Marten Transport, LTD.	NTS Consolidated Holdings, Inc.
Maxim Crane Works	NUCOR CORPORATION
McClatchy Company, LLC	Numotion
McKesson Corporation	Old Republic Construction Program Group
Meggitt - USA, Inc.	Olympus Captive SBP US Lumber
Member Insurance Agency, Inc.	Olympus Captive-National Construction
MemorialCare Health System	Onex York Holdings Corporation
Mendocino Forest Products	Ontario Montclair SD
Meruelo Group Grand Sierra	Option Care
Metropolis Technologies, Inc	Orange Unified School District
METROPOLITAN WATER DISTRICT	Pacific Aviation Corporation

Pacific Union Conf of 7th-Day Adventists	Resideo Technologies, Inc.
Packaging Corporation of America	Restaurant Franchise Captive Program
Pactiv Corporation	Restaurant Safety Group Arch
Pan Pacific Retail Management Co.	Revelyst
Panda Restaurant Group, Inc.	Revolution Insurance, Ltd.
Paramount U.S.D.	Reyes Holdings, L.L.C.
Pathway Insurance Company	Reynolds Consumer Products LLC
PCAM LLC	Riverside U.S.D
PCL Webcor JV-L.A. Convention Center	Riverside USD
Pearson Education, Inc.	Riverstone International Insurance
Pegasus Trucking LLC	Riverstone-QBE LPT
Penhall Company	Riviana Foods and New World Pasta
Penhall International Corp	Robertsons Ready Mix, LTD.
PepsiCo	Rolocap
Peralta Community College	Ross Stores, Inc.
Performance Food Group	Roth Staffing Companies
PESTSURE ASSOCIATION	Roto-Rooter Services Company
Peterson Manufacturing/Renzenberger	RTW Retailwinds, Inc.
PetSmart LLC	Ruiz Food Products, Inc.
Pfizer Inc	RXO, Inc
Pilgrim's Stand Alone	Ryan - USLH WC
Pilkington North America, Inc.	S.R. Bray dba Power Plus
Pitney Bowes, Inc.	Saddleback Valley USD
Pomona Unified School District	Safelite Group, Inc
Port of Stockton	Saint Gobain Corporation - US
Powerhouse Retail Services, LLC	San Joaquin Regional Transit District
PPG Industries Inc	San Mateo County Community Col
Precision Castparts Corp.	Santa Clara Valley Transit Authority
Premium Brands Services LLC	Saputo Cheese USA Inc
PrimeFlight Aviation Services, Inc.	Save Mart Supermarkets
Production Resource Group, L.L.C.	Schneider Enterprise Resources, LLC.
Public Storage	Schwan's Company
QBE Americas, Inc.	Scripps Health
Quanta Aviation Services, LLC.	SCSRM (Coregis)
Ralliant Corporation	SCSRM (Self Insured)
Rancho Santiago CC	Securitas Security Services USA, Inc.
REDWOOD FAMILY CARE NETWORK	Sedgwick Claims Management Services, Inc
Redwood Services Holdco, LLC	See's Candies
Regis Corporation	Self-Insured for Imperial
Reimagined Parking Inc.	Sensient Technologies Corporation
RelaDyne	Serco
Rent-A-Center	Sevita
Renzenberger Inc.	Shared Agency Risk Pool (SHARP)
REPUBLIC NATIONAL DISTRIBUTING COMPANY	Sharp Health Care

Shell USA, Inc.	TelevisaUnivision, Inc.
Signature Aviation	Tenet Healthcare Corporation
SIRMA1	Terra Group
SkyHop Global, LLC	Terumo Medical Corporation
SkyWest Airlines, Inc.	Tetra Tech, Inc.
Smart & Final	The Allstate Corporation (Runoff)
Smurfit Westrock	The Allstate Corp-TPA Program
Solventum	The Anschutz Corporation
Sonepar USA Holdings, Inc	The Bay Club Company, LLC
Sonic Automotive, Inc.	The Boeing Company
Sony Corporation of America	The Charles Schwab Corporation
Southern Minnesota Beet Sugar Co-op	The Church of Jesus Christ of LDS
Southland Transit Inc.	The Kinetic Group
Southwest Airlines	The Kroger Co.
Southwest Key Programs, Inc	The Parking Spot
Spancion Inc.	The Procter & Gamble Company
Sprouts Farmers Markets Holdings, LLC	The Stepping Stones Group LLC
St. George Trucking & Warehouse, Inc.	The Trump Organization
Stanford Hospital	Titan Insurance, Ltd.
Stanislaus Food Products	TK Elevator Corporation
Stanley Black & Decker	TNC (US) Holdings, Inc.
Starr Aviation Agency, Inc.	Top Tier
Starr Bundled	Torrance Unified School District
Starr Companies	Towne Park
State Farm Mutual Auto Insurance Company	TOYOTA
State Farm Mutual Automobile Ins. Co.	Trader Joe's Company
STG Logistics, Inc	Tradesmen International, Inc.
Stryker Corporation	Traffic Management, LLC
Summit School Services	TransForce, Inc.
Sun Pacific	Transformco
Sunrise Senior Living, LLC.	Triangle Services, Inc
Sunstate Equipment	Trident Seafoods Corporation
Superior National	Trinity Health
Svenhard's Swedish Bakery	Triumph Aerostructures-Vought Aircraft D
Sweeping Corporation of America, LLC	Tropicana Brands Group
Swisher International Group Inc.	Truly Nolen of America, Inc.
Swiss Re - COLA Tranche 1	Tyson Foods, Inc.
Swiss Re - COLA Tranche 2	U S A A/UNITED SERVICES AUTOMOBILE
Symantec Corporation	UES LLC/Obsidian Group Holdings
Tapestry, Inc.	Ulta Beauty Inc.
TARGET CORPORATION	Unisource Worldwide, Inc.
TBC Corporation	United Ground Express
TE Connectivity	UnitedHealth Group
Technicolor USA, Inc.	Univar Solutions USA LLC

Upland USD	WASHINGTON MUTUAL, INC.
US Airways Group, Inc.	Webcor L.P.
US FOODS INC.	Wells Fargo
Valence Surface Technologies LLC.	Western Digital Corporation
Valhalla Group Holdings, LLC	Western Orange Co. S.F.A
Vallen Distribution, Inc.	Westmont RRI
Varian Associates, Inc.	Westport Insurance Corporation
Varian, Inc.	Westview Services, Inc.
VCSSFA - Safety National	Whittier Area S.I.A.
Veralto Corporation	Whittier Union HS District
Verizon Communications	Wild Fork Foods
Verizon Takeover	Williams Scotsman, Inc.
Verizon Wireless	World Oil Corp.
Vertex Service Partners, LLC	WORLD PAC, LLC
Vestis Corporation	Worldwide Flight Services
Victus Insurance Ltd	Xanterra Leisure Holding, LLC
Virginia Surety Company, Inc./ Combined	XEROX CORPORATION
Volt Information Sciences	XL Construction RoCCIP 2
Walgreen Co.	XPO Logistics, Inc.
Walnut Valley Unified School D	Yellow Corporation
Warner Bros. Discovery, Inc	(intentionally blank)

DELEGATED UTILIZATION REVIEW VENDORS

- Dane Street, LLC
- MES Solution, Inc.
- Network Medical Review Company, Ltd. (NMR)
- Shearwater

Appendix D – Sample Client Letter Templates

The sample client letter templates contained in this Appendix were developed and are maintained at the request of Sedgwick's clients to support claim administration, utilization review oversight, regulatory compliance, and communication regarding utilization review activities.

Sedgwick retains copies of approved client communication templates and implements revisions as necessary to maintain compliance with applicable workers' compensation laws, regulations, accreditation standards, and client requirements.

Albertsons

- CA Appeal Overturned Letter
- CA Appeal Partial Approval Letter
- CA Approval Letter
- CA Partial Approval Letter

ASCIP

- Appeal Overturned
- Appeal Partial Approval
- Appeal Upheld
- Approval
- Partial Approval

Atlas General

- Appeal Overturned
- Appeal Partial Approval
- General Approval
- General Partial Approval

Kroger

- Appeal Overturned
- Approval
- Partial Approval

Everest

- Approval

Tenet

- Appeal Overturned
- Appeal Partial
- Approval Letter
- Partial Approval

ALBERTSONS

APPEAL OVERTURNED

Sedgwick
<User Address> \ <Today's_Date>

<Primary_Recipient_Name>
<Primary_Recipient_Address>

Claimant: <Claimant_Name>
Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")
Adjuster: <CE_Name>
Claims File #: <ClaimNum_SCMS>

Employer: <Name>
Sedgwick on Behalf of Writing Co.: <CarrierName>
Date of Injury: <Date_Injury>
Date of Birth: <DateBirth>
Date Request First Received: <SCMSReceivedDate>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service:

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGrid(Appeal Overturned)>

<Additional_Text("Please enter details about the specified procedure.")>

<PA_Received_Date>
Final UR Decision Date: <Final_UR_Decision_Date>

As requested, a physician who was not involved in the original non-certification has reviewed the medical necessity of the above-named claimant's health care services.

This involved review of the original information, supplemented by discussion(s) with the treating provider and/or review of written medical records. The second physician has determined that the above health care service in question is certified as medically necessary.

The claimant, treating provider, claim payor and agency/service provider have been notified of this determination.

This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

If this request is for medication, a therapeutically equivalent generic substitute is authorized. Authorization of the brand-name medication requires documentation of medical necessity and prior approval.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

<User_Name>

<User_Title>

<User_Toll_Free_With_Ext>

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE
SUBMITTED ON THE "DWC FORM RFA" FOR CONSIDERATION**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We have attached a copy for your convenience and we ask that you submit all future requests for treatment authorization on the form. We appreciate your cooperation.



Dear Provider:

Thank you for caring for our Albertsons Companies injured employees. In California, we operate under the following banners: Albertsons, Andronico's, Pak 'n Save, Pavilions, Plated, Safeway, and Vons. As a participating provider in the Safeway Medical Provider Network (MPN), we are providing contact information for billing and reporting.

- **BILLS & REPORTS:** Sedgwick is the Third-Party Administrator (TPA) for Albertsons/Safeway. Please send bills and reports to:

Sedgwick Claims Services
PO Box 14442
Lexington, KY 40512-4514
Ph: 800-854-6188
Fax: 833-875-6679

- **AUTHORIZATION REQUESTS:** To obtain authorization for all medical services please send requests to Sedgwick's **UR fax: 859-225-2004**
- **PHYSICAL THERAPY, OCCUPATIONAL THERAPY, MASSAGE THERAPY, FCE'S, WORK HARDENING/CONDITIONING, CHIROPRACTIC, ACUPUNCTURE, after authorization** Sedgwick will notify:

MedRisk
Ph: 888-637-4751
Fax: 877-389-6139
Email: Sedgwickreferrals@medrisknet.com

(Note: billing for PT/OT/FCE's/Work hardening, conditioning/Chiro/Acupuncture should go directly through MedRisk)

- **DIAGNOSTICS & RADIOLOGY: after authorization** Sedgwick will notify:

Careworks Network
Ph: (800) 821-5364
Fax: (727) 535-0955
Email: ancillaryreferral@sedgwick.com

(Note: initial/simple x-rays may be done at the clinic)

- **DURABLE MEDICAL EQUIPMENT & SUPPLIES (DME): after authorization**

Sedgwick will notify:

Careworks Network
Ph: (866) 535-0905
Fax: (614) 717-6500
Email: ancillaryreferral@sedgwick.com

- **PRESCRIPTIONS:** Prescription medications should not be dispensed from your office/clinic for non-emergency conditions; Instead, please refer to the closest Safeway, Albertsons, Pavilions, Sav-On or Vons. Cadence RX is the Pharmacy Benefits Manager and their phone number is: 877-776-3600
- **Referrals** to Specialist Physicians, Chiropractors or Acupuncturists must be within the Safeway MPN, fax request for referral to the UR fax numbers above.
- **To find a Safeway MPN physician:**
<https://goperspecta.com/VPD/AlbertsonLLC/public/ProviderSearch/Main>

For ADR claims, please access

<https://goperspecta.com/VPD/safewaympn/public/ProviderSearch/Main> **for MPN providers.**

- **For Bill Review Questions** please email Sedgwick at NationalBillReview@sedgwick.com
- **For questions about the Safeway MPN only,** please contact:
MPNCoordinators@sedgwick.com
(Only for questions about the Safeway MPN, not billing questions).

APPEAL PARTIAL APPROVED

Sedgwick
<User Address> \ <Today's_Date>

<Primary_Recipient_Name>
<Primary_Recipient_Address>

Claimant: <Claimant_Name>
Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")
Adjustor: <CE_Name>
Claims File #: <ClaimNum_SCMS>

Employer: <Name>
Sedgwick on Behalf of Writing Co.: <CarrierName>
Date of Injury: <Date_Injury>
Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service(s). As requested, a physician who was not involved in the original non-certification has reviewed the medical necessity of the above reference information, supplemented by discussion (s) with the attending physician and / or review of the claimant's medical records. A second physician has made the following determination regarding the health care services(s) listed below has been established. This decision applies only to the specific service(s) listed below. Any additional service(s) will require a separate review process:

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGridNegotiated>

<PA_Received_Date>

Final UR Decision Date: <Final_UR_Decision_Date>

<Additional_Text("Please provide any additional information")>

To keep all parties informed, Sedgwick has notified the medical provider, injured worker, injured worker's attorney (if applicable) and the workers' compensation payor of the review determination. This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the Utilization Review process. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

When a medication request is approved, a therapeutically equivalent generic is authorized. Approval of the brand-name medication requires prior authorization and documentation of medical necessity.

The internal appeals process is voluntary and does not trigger or bar the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6, but may be used on an optional basis.

Any dispute will be resolved in accordance with the independent medical review provision of Labor Code 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by you, your representative or attorney, if you are represented, on the Application for Independent Medical Review, DWC Form IMR, within <TP_Days_to_Dispute> days from the mailing date of the utilization review decision to the employee, as indicated on the last page of the application. This deadline must be met even if participating in the internal utilization review

appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope was included with the original decision.

You have a right to disagree with decisions affecting your claim which includes seeking Independent Medical Review of the decision. If you have any questions about the information in this notice, please call me, <CE_Name> at <CE_Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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 decision shall remain in effect for twelve months from the date of the decision without further action with regard to any further recommendation by the same physician for the same treatment unless the recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

Sedgwick Claims Management Services, Inc.

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE
"DWC FORM RFA" FOR CONSIDERATION**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We appreciate your cooperation.



Dear Provider:

Thank you for caring for our Albertsons Companies injured employees. In California, we operate under the following banners: Albertsons, Andronico's, Pak 'n Save, Pavilions, Plated, Safeway, and Vons. As a participating provider in the Safeway Medical Provider Network (MPN), we are providing contact information for billing and reporting.

- **BILLS & REPORTS:** Sedgwick is the Third-Party Administrator (TPA) for Albertsons/Safeway. Please send bills and reports to:

Sedgwick Claims Services
PO Box 14442
Lexington, KY 40512-4514
Ph: 800-854-6188
Fax: 833-875-6679

- **AUTHORIZATION REQUESTS:** To obtain authorization for all medical services please send requests to Sedgwick's UR fax: 859-225-2004
- **PHYSICAL THERAPY, OCCUPATIONAL THERAPY, MASSAGE THERAPY, FCE'S, WORK HARDENING/CONDITIONING, CHIROPRACTIC, ACUPUNCTURE, after authorization** Sedgwick will notify:
MedRisk
Ph: 888-637-4751
Fax: 877-389-6139
Email: Sedgwickreferrals@medrisknet.com

(Note: billing for PT/OT/FCE's/Work hardening, conditioning/Chiro/Acupuncture should go directly through MedRisk)

- **DIAGNOSTICS & RADIOLOGY: after authorization** Sedgwick will notify:

Careworks Network
Ph: (800) 821-5364
Fax: (727) 535-0955
Email: ancillaryreferral@sedgwick.com

(Note: initial/simple x-rays may be done at the clinic)

- **DURABLE MEDICAL EQUIPMENT & SUPPLIES (DME): after authorization**

Sedgwick will notify:

Careworks Network
Ph: (866) 535-0905
Fax: (614) 717-6500

Email: ancillaryreferral@sedgwick.com



- **PRESCRIPTIONS:** Prescription medications should not be dispensed from your office/clinic for non-emergency conditions; Instead, please refer to the closest Safeway, Albertsons, Pavilions, Sav-On or Vons. Cadence RX is the Pharmacy Benefits Manager and their phone number is: 877-776-3600
- **Referrals** to Specialist Physicians, Chiropractors or Acupuncturists must be within the Safeway MPN, fax request for referral to the UR fax numbers above.
- **To find a Safeway MPN physician:**
<https://goperspecta.com/VPD/AlbertsonLLC/public/ProviderSearch/Main>

For ADR claims, please access

<https://goperspecta.com/VPD/safewaympn/public/ProviderSearch/Main> **for MPN providers.**

- **For Bill Review Questions** please email Sedgwick at NationalBillReview@sedgwick.com
- **For questions about the Safeway MPN only,** please contact:
MPNCoordinators@sedgwick.com
(Only for questions about the Safeway MPN, not billing questions).

APPROVAL

Sedgwick
<User Address> \ <Today's_Date>

<Primary_Recipient_Name>
<Primary_Recipient_Address>

Claimant: <Claimant_Name>
Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")
Adjuster: <CE_Name>
Claims File #: <ClaimNum_SCMS>

Employer: <Name>
Sedgwick on Behalf of Writing Co.: <CarrierName>
Date of Injury: <Date_Injury>
Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

This correspondence pertains to the review of the following health care service:

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGrid(Certified by Nurse, Certified by PA)>

<Additional_Text("Please enter details about the description of service or treatment approved; i.e. "MRI of lumbar spine approved".")>

Final UR Decision Date: <Final_UR_Decision_Date>

After review of a request for authorization, it has been determined that the specific service(s) meets established criteria for medical necessity based on the information presented by the medical provider.

The medical provider, injured worker and workers' compensation payor have been notified of this decision.

This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

If this request is for medication, a therapeutically equivalent generic substitute is authorized. Authorization of the brand-name medication requires documentation of medical necessity and prior approval.

This review applies only to the specific service(s) listed. Additional services require separate review.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

<User_Name>

<User_Title>

<User_Toll_Free_With_Ext>

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE "DWC FORM RFA" FOR CONSIDERATION

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We appreciate your cooperation.

Dear Provider:

Thank you for caring for our Albertsons Companies injured employees. In California, we operate under the following banners: Albertsons, Andronico's, Pak 'n Save, Pavilions, Plated, Safeway, and Vons. As a participating provider in the Safeway Medical Provider Network (MPN), we are providing contact information for billing and reporting.

- **BILLS & REPORTS:** Sedgwick is the Third-Party Administrator (TPA) for Albertsons/Safeway. Please send bills and reports to:

Sedgwick Claims Services
PO Box 14442
Lexington, KY 40512-4514
Ph: 800-854-6188
Fax: 833-875-6679

- **AUTHORIZATION REQUESTS:** To obtain authorization for all medical services please send requests to Sedgwick's **UR fax: 859-225-2004**

- **PHYSICAL THERAPY, OCCUPATIONAL THERAPY, MASSAGE THERAPY, FCE'S, WORK HARDENING/CONDITIONING, CHIROPRACTIC, ACUPUNCTURE, after authorization** Sedgwick will notify:

MedRisk
Ph: 888-637-4751
Fax: 877-389-6139
Email: Sedgwickreferrals@medrisknet.com

(Note: billing for PT/OT/FCE's/Work hardening, conditioning/Chiro/Acupuncture should go directly through MedRisk)

- **DIAGNOSTICS & RADIOLOGY: after authorization** Sedgwick will notify:

Careworks Network
Ph: (800) 821-5364
Fax: (727) 535-0955
Email: ancillaryreferral@sedgwick.com

(Note: initial/simple x-rays may be done at the clinic)

- **DURABLE MEDICAL EQUIPMENT & SUPPLIES (DME): after authorization** Sedgwick will notify:

Careworks Network
Ph: (866) 535-0905
Fax: (614) 717-6500
Email: ancillaryreferral@sedgwick.com

- **PRESCRIPTIONS:** Prescription medications should not be dispensed from your office/clinic for non-emergency conditions; Instead, please refer to the closest Safeway, Albertsons, Pavilions, Sav-On or Vons. Cadence RX is the Pharmacy Benefits Manager and their phone number is: 877-776-3600
- **Referrals** to Specialist Physicians, Chiropractors or Acupuncturists must be within the Safeway MPN, fax request for referral to the UR fax numbers above.
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<https://goperspecta.com/VPD/AlbertsonLLC/public/ProviderSearch/Main>

For ADR claims, please access

<https://goperspecta.com/VPD/safewaympn/public/ProviderSearch/Main> **for MPN providers.**

- **For Bill Review Questions** please email Sedgwick at NationalBillReview@sedgwick.com
- **For questions about the Safeway MPN only,** please contact:
MPNCoordinators@sedgwick.com
(Only for questions about the Safeway MPN, not billing questions).

PARTIAL APPROVAL LETTER

Sedgwick
<User Address>

<Today's_Date>

<Primary_Recipient_Name>
<Primary_Recipient_Address>

Claimant: <Claimant_Name>
Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")
Adjustor: <CE_Name>
Claims File #: <ClaimNum_SCMS>

Employer: <Name>
Sedgwick on Behalf of Writing Co.: <CarrierName>
Date of Injury: <Date_Injury>
Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

After peer review of the medical information presented and/or discussion with the ordering practitioner, the following determination regarding the health care services(s) listed below has been established. This decision applies only to the specific service(s) listed below.

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested> |

<ProcedureCodeGridNegotiated>

<Additional_Text("Enter details about the specified procedure. Physician Reviewer Summary, Decision, Rationale and Guideline")>

<PA_Received_Date>
Final UR Decision Date: <Final_UR_Decision_Date>

To keep all parties informed, Sedgwick has notified the ordering practitioner, injured worker, the injured worker's attorney, if applicable, and workers' compensation payor of our review determination. This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

When a medication request is approved, a therapeutically equivalent generic is authorized. Approval of the brand-name medication requires prior authorization and documentation of medical necessity.

The review was made based on guidelines which are developed from current clinical principals and processes to ensure consistency in the review process. You may receive a copy of the complete clinical rationale used to make this decision by calling the number provided or forwarding a written request to the Sedgwick address listed on this letter.

If you disagree with this decision, you or your representative may submit a request for an internal appeal through Sedgwick's voluntary appeal process. To appeal this determination, submit a written request within 10 calendar days of the receipt of this decision, and provide additional information which explains the medical necessity of the service(s). Please send the appeal request and information to the Sedgwick address listed on this letter.

If you believe this determination warrants an expedited appeal, you or your representative may request this by calling Sedgwick at <User_Toll_Free_With_Ext>. The fax number, <User_Fax> is available 24 hours a day 7 days a week to receive requests. Utilization review personnel are available between 9:00 a.m. and 5:30 p.m. Pacific Standard Time (PST) on normal business days at the toll free number listed on this letter. We will respond to your appeal within 30 calendar days of the date of this utilization review decision.

The internal appeals process is voluntary and does not trigger or bar the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6, but may be used on an optional basis.

Any dispute will be resolved in accordance with the independent medical review provision of Labor Code 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by you, your representative or attorney, if you are represented, on the enclosed Application for Independent Medical Review, DWC Form IMR, within <TP> Days to Dispute> calendar days from the mailing date of the utilization review decision to the employee, as indicated on the last page of the application. This deadline must be met even if participating in the internal utilization review appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope, is again included with this notice if you have not yet filed for IMR.

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 any questions about the information in this notice, please call me, <CE_Name> at <CE_Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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 decision shall remain in effect for twelve months from the date of the decision without further action with regard to any further recommendation by the same physician for the same treatment unless the recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Contact the claims adjuster for an explanation of coverage. This review applies only to the specific service(s) listed. Additional services require separate review.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

Sedgwick Claims Management Services, Inc.

<CC_Detailed_List>

Enclosure: Application for Independent Medical Review
Self-Addressed Envelope

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE
"DWC FORM RFA" FOR CONSIDERATION**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We appreciate your cooperation.

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 Type of Utilization Review:**

<TP_Standard_Review> Regular
Appeal

<TP_Expedited_Review> Expedited

<TP_Mod_after_Appeal> Modification after

<Additional_Text("
Please enter X if
review is for MTUS
formulary
medication
only.")>
Medication Only –
MTUS Formulary
Drug List

<Additional_Text("
Please enter X if
review is Retro for
Exempt Treatment
(Non-Drug).")>
Retrospective for
Exempt Treatment
(Non-Drug)

<Additional_Text("
Please enter X if
review is Retro for
Exempt Treatment
(Drug).")>
Retrospective for
Exempt Treatment
(Drug)

Employee Information:

First Name: <Claimant_FirstName> Middle Initial: Last Name: <Claimant_LastName>

Address: <Claimant_Address> City: <Claimant_City>

State: <Claimant_State> Zip Code: <Claimant_ZipCode> Telephone Number: <Claimant_home_phone>

Fax Number: Date of Injury: <Date_Injury>

Insurance Claim Number: <ClaimNum_SCMS>_ EAMS Case Number: <EAMS>

WCIS Jurisdictional Claim Number (if assigned): <ClaimNum_State>

Employee Attorney (if known): <Plaintiff_Attorney_Name>

Address: <Plaintiff_Attorney_Address> City: <Plaintiff_Attorney_City>

State: <Plaintiff_Attorney_State> Zip Code: <Plaintiff_Attorney_ZipCode> Telephone Number: <Plaintiff_Attorney_Phone>

Fax Number: <Plaintiff_Attorney_Fax_Number>

Requesting Physician Information:

Physician First Name: <Provider_FirstName> Middle Initial: Last Name: <Provider_LastName>

Practice Name: <CA_IMR_Provider_Company_Name>

Address: <CA_IMR_Provider_Address> City: <CA_IMR_Provider_City>

State: <CA_IMR_Provider_State> Zip Code: <CA_IMR_Provider_ZipCode> Telephone Number: <CA_IMR_Provider_Phone_Number>

Fax Number: <Phone_Fax> Specialty: <CA_IMR_Provider_Specialty>

Claims Administrator Information:

Employer Name: <Name>

Name of Administrator: Sedgwick Claims Management Services, Inc. Contact Name: <CE_Name>

Address: <CE_Address> City: <CE_City> State: <CE_State> Zip Code: <CE_ZipCode>

Telephone Number: <CE_Phone> Fax Number: <CE_Fax_Number>

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

<TP_Dx_Codes>

* Mailing Date of the Utilization Review Determination Letter: <TP_Date_UR_Decision>

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity?

<Additional_Text("Please enter X if CE Disputing Liability for requested medical treatment besides question of medical necessity.")> Yes

<Additional_Text("Please enter X if CE isn't Disputing Liability.")> No

Reason:

<Additional_Text("Please enter why liability is being disputed.")>

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.

5. <TP_First_Treatment>
6. <TP_Second_Treatment>
7. <TP_Third_Treatment>
8. <TP_Fourth_Treatment>

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:

_Days_to_Dispute> days from the mailing date of the written determination letter.

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.

Dear Provider:

Thank you for caring for our Albertsons Companies injured employees. In California, we operate under the following banners: Albertsons, Andronico's, Pak 'n Save, Pavilions, Plated, Safeway, and Vons. As a participating provider in the Safeway Medical Provider Network (MPN), we are providing contact information for billing and reporting.

- **BILLS & REPORTS:** Sedgwick is the Third-Party Administrator (TPA) for Albertsons/Safeway. Please send bills and reports to:

Sedgwick Claims Services
PO Box 14442
Lexington, KY 40512-4514
Ph: 800-854-6188
Fax: 833-875-6679

- **AUTHORIZATION REQUESTS:** To obtain authorization for all medical services please send requests to Sedgwick's **UR fax: 859-225-2004**
- **PHYSICAL THERAPY, OCCUPATIONAL THERAPY, MASSAGE THERAPY, FCE'S, WORK HARDENING/CONDITIONING, CHIROPRACTIC, ACUPUNCTURE, after authorization** Sedgwick will notify:
MedRisk
Ph: 888-637-4751
Fax: 877-389-6139
Email: Sedgwickreferrals@medrisknet.com

(Note: billing for PT/OT/FCE's/Work hardening, conditioning/Chiro/Acupuncture should go directly through MedRisk)

- **DIAGNOSTICS & RADIOLOGY: after authorization** Sedgwick will notify:
Careworks Network
Ph: (800) 821-5364
Fax: (727) 535-0955
Email: ancillaryreferral@sedgwick.com
(Note: initial/simple x-rays may be done at the clinic)

- **DURABLE MEDICAL EQUIPMENT & SUPPLIES (DME): after authorization** Sedgwick will notify:
Careworks Network
Ph: (866) 535-0905
Fax: (614) 717-6500
Email: ancillaryreferral@sedgwick.com

- **PRESCRIPTIONS:** Prescription medications should not be dispensed from your office/clinic for non-emergency conditions; Instead, please refer to the closest Safeway, Albertsons, Pavilions, Sav-On or Vons. Cadence RX is the Pharmacy Benefits Manager and their phone number is: 877-776-3600
- **Referrals** to Specialist Physicians, Chiropractors or Acupuncturists must be within the Safeway MPN, fax request for referral to the UR fax numbers above.
- **To find a Safeway MPN physician:**
<https://goperspecta.com/VPD/AlbertsonLLC/public/ProviderSearch/Main>

For ADR claims, please access

<https://goperspecta.com/VPD/safewaympn/public/ProviderSearch/Main> **for MPN providers.**

- **For Bill Review Questions** please email Sedgwick at NationalBillReview@sedgwick.com
- **For questions about the Safeway MPN only**, please contact:
MPNCoordinators@sedgwick.com
(Only for questions about the Safeway MPN, not billing questions).

ASCIP

APPEAL OVERTURNED

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjuster: <CE_Name>

Claims File #: <ClaimNum_SCMS>

Employer: <Name>

Employer Entity Name: <Entity_Name>

Sedgwick on Behalf of Writing Co: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Date Request First Received: <SCMSReceivedDate>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service:

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGrid(Appeal Overturned)>

<Additional_Text("Please enter details about the specified procedure.")>

<PA_Received_Date>

Final UR Decision Date: <Final_UR_Decision_Date>

As requested, a physician who was not involved in the original non-certification has reviewed the medical necessity of the above named claimant's health care services.

This involved review of the original information, supplemented by discussion(s) with the treating provider and/or review of written medical records. The second physician has determined that the above health care service in question is certified as medically necessary.

This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process.

Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

If this request is for medication, a therapeutically equivalent generic substitute is authorized. Authorization of the brand-name medication requires documentation of medical necessity and prior approval.

The claimant, treating provider, claim payor and agency/service provider have been notified of this determination.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

<User_Name>

<User_Title>

<User_Toll_Free_With_Ext>

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE
SUBMITTED ON THE "DWC FORM RFA" FOR CONSIDERATION**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We appreciate your cooperation.

APPEAL PARTIAL APPROVAL

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjustor: <CE_Name>

Claims File #: <ClaimNum_SCMS>

Employer: <Name>

Employer Entity Name: <Entity_Name>

Sedgwick on Behalf of Writing Co.: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service(s). As requested, a physician who was not involved in the original non-certification has reviewed the medical necessity of the above reference information, supplemented by discussion (s) with the attending physician and / or review of the claimant's medical records. A second physician has made the following determination regarding the health care services(s) listed below has been established. This decision applies only to the specific service(s) listed below. Any additional service(s) will require a separate review process:

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGrid2>

<Additional_Text("Enter details about the specified procedure. Physician Reviewer Summary, Decision, Rationale and Guideline")>

<PA_Received_Date>

Final UR Decision Date: <Final_UR_Decision_Date>

This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process.

Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

When a medication request is approved, a therapeutically equivalent generic is authorized. Approval of the brand-name medication requires prior authorization and documentation of medical necessity.

To keep all parties informed, Sedgwick has notified the medical provider, injured worker, injured worker's attorney (if applicable) and the workers' compensation payor of the review determination.

The internal appeals process is voluntary and does not trigger or bar the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6, but may be used on an optional basis.

Any dispute will be resolved in accordance with the independent medical review provision of Labor Code 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by you, your representative or attorney, if you are represented, on the Application for Independent Medical Review, DWC Form IMR, within <TP_Days_to_Dispute> calendar days from the mailing date of the utilization review decision to the employee, as indicated on the last page of the application. This deadline must be met even if participating in the internal utilization review appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope, was included with the original decision.

You have a right to disagree with decisions affecting your claim which includes seeking Independent Medical Review of the decision. If you have any questions about the information in this notice, please call me, <CE_Name> at <CE_Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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 decision shall remain in effect for twelve months from the date of the decision without further action with regard to any further recommendation by the same physician for the same treatment unless the recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

Sedgwick Claims Management Services, Inc.

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE
"DWC FORM RFA" FOR CONSIDERATION**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf>. We appreciate your cooperation.

APPEAL UPHELD

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjuster: <CE_Name>

Claim Number: <ClaimNum_SCMS>

Employer: <Name>

Employer Entity Name: <Entity_Name>

Sedgwick on Behalf of Writing Co.: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service(s). As requested, a physician who was not involved in the original non-certification has reviewed the medical necessity of the above reference information, supplemented by discussion (s) with the attending physician and / or review of the claimant's medical records. A second physician has upheld the original non-certification. This review applies only to the specific service(s) listed below. Any additional service(s) will require a separate review process:

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGrid2>

Rationale: <Additional_Text("Please enter details about the specified procedure.")>

This recommendation is supported by <Additional_Text("Please enter guidelines.")>

<PA_Received_Date>

Final UR Decision Date: <Final_UR_Decision_Date>

To keep all parties informed, Sedgwick has notified the medical provider, injured worker, injured worker's attorney (if applicable) and the workers' compensation payor of the review determination.

This decision shall remain in effect for twelve months from the date of the decision without further action with regard to any further recommendation by the same physician for the same treatment unless the recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

Sedgwick Claims Management Services, Inc.

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE
“DWC FORM RFA” FOR CONSIDERATION**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf>. We appreciate your cooperation.

APPROVAL

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjuster: <CE_Name>

Claims File #: <ClaimNum_SCMS>

Employer: <Name>

Employer Entity Name: <Entity_Name>

Sedgwick on Behalf of Writing Co: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service:

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested> |

<ProcedureCodeGrid(Certified by Nurse, Certified by PA)>

<Additional_Text("Please enter details about the description of service or treatment approved; i.e. "MRI of lumbar spine approved".")>

Final UR Decision Date: <Final_UR_Decision_Date>

After review of a request for authorization, it has been determined that the specific service(s) meets established criteria for medical necessity based on the information presented by the medical provider. This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

If this request is for medication, a therapeutically equivalent generic substitute is authorized. Authorization of the brand-name medication requires documentation of medical necessity and prior approval.

The medical provider, injured worker and workers' compensation payor have been notified of this decision.

This review applies only to the specific service(s) listed. Additional services require separate review.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

<User_Name>

<User_Title>

<User_Toll_Free_With_Ext>

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE "DWC FORM RFA" FOR CONSIDERATION

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We appreciate your cooperation.

PARTIAL APPROVAL

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjustor: <CE_Name>

Claims File #: <ClaimNum_SCMS>

Employer: <Name>

Employer Entity Name: <Entity_Name>

Sedgwick on Behalf of Writing Co.: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

After peer review of the medical information presented and/or discussion with the ordering practitioner, the following determination regarding the health care services(s) listed below has been established. This decision applies only to the specific service(s) listed below.

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGridNegotiated>

<Additional_Text("Enter details about the specified procedure. Physician Reviewer Summary, Decision, Rationale and Guideline")>

<PA_Received_Date>

Final UR Decision Date: <Final_UR_Decision_Date>

This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law. When a medication request is approved, a therapeutically equivalent generic is authorized. Approval of the brand-name medication requires prior authorization and documentation of medical necessity.

To keep all parties informed, Sedgwick has notified the ordering practitioner, injured worker, the injured worker's attorney, if applicable, and workers' compensation payor of our review determination.

The review was made based on guidelines which are developed from current clinical principals and processes to ensure consistency in the review process. You may receive a copy of the complete clinical rationale used to make this decision by calling the number provided or forwarding a written request to the Sedgwick address listed on this letter.

If you disagree with this decision, you or your representative may submit a request for an internal utilization review appeal through Sedgwick's voluntary appeal process. To appeal this determination, submit a written request within 10 calendar days of the receipt of this decision, and provide additional information which explains the medical necessity of the service(s). Please send the appeal request and information to the Sedgwick address listed on this letter. If you believe this determination warrants an expedited appeal, you or your representative may request this by calling Sedgwick at <User_Toll_Free_With_Ext>. The fax number, <User_Fax> is available 24 hours a day 7 days a week to receive requests. Utilization review personnel are available between 9:00 a.m. and 5:30 p.m. Pacific Standard Time (PST) on normal business days at the toll free number listed on this letter. We will respond to your appeal within 30 calendar days of the date of this utilization review decision.

The internal appeals process is voluntary and does not trigger or bar the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6, but may be used on an optional basis.

Any dispute will be resolved in accordance with the independent medical review provision of Labor Code 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by you, your representative or attorney, if you are represented, on the enclosed Application for Independent Medical Review, DWC Form IMR, within <TP> Days_to_Dispute> calendar days from the mailing date of the utilization review decision to the employee, as indicated on the last page of the application. This deadline must be met even if participating in the internal utilization review appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope, is again included with this notice if you have not yet filed for IMR.

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 any questions about the information in this notice, please call me, <CE_Name> at <CE_Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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 decision shall remain in effect for twelve months from the date of the decision without further action with regard to any further recommendation by the same physician for the same treatment unless the recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Contact the claims adjuster for an explanation of coverage. This review applies only to the specific service(s) listed. Additional services require separate review.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

Sedgwick Claims Management Services, Inc.

<CC_Detailed_List>

Enclosure: Application for Independent Medical Review
Self-Addressed Envelope

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append PA Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE
"DWC FORM RFA" FOR CONSIDERATION**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at

<http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We appreciate your cooperation.

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 Type of Utilization Review:

<TP_Standard_Review> Regular
Appeal

<TP_Expedited_Review> Expedited

<TP_Mod_after_Appeal> Modification after

<Additional_Text("
Please enter X if
review is for MTUS
formulary
medication
only.")>
Medication Only –
MTUS Formulary
Drug List

<Additional_Text("
Please enter X if
review is Retro for
Exempt Treatment
(Non-Drug).")>
Retrospective for
Exempt Treatment
(Non-Drug)

<Additional_Text("
Please enter X if
review is Retro for
Exempt Treatment
(Drug).")>
Retrospective for
Exempt Treatment
(Drug)

Employee Information:

First Name: <Claimant_FirstName> Middle Initial: Last Name: <Claimant_LastName>

Address: <Claimant_Address> City: <Claimant_City>

State: <Claimant_State> Zip Code: <Claimant_ZipCode> Telephone Number: <Claimant_home_phone>

Fax Number: Date of Injury: <Date_Injury>

Insurance Claim Number: <ClaimNum_SCMS>_ EAMS Case Number: <EAMS>

WCIS Jurisdictional Claim Number (if assigned): <ClaimNum_State>

Employee Attorney (if known): <Plaintiff_Attorney_Name>

Address: <Plaintiff_Attorney_Address> City: <Plaintiff_Attorney_City>

State: <Plaintiff_Attorney_State> Zip Code: <Plaintiff_Attorney_ZipCode> Telephone Number: <Plaintiff_Attorney_Phone>

Fax Number: <Plaintiff_Attorney_Fax_Number>

Requesting Physician Information:

Physician First Name: <Provider_FirstName> Middle Initial: Last Name: <Provider_LastName>

Practice Name: <CA_IMR_Provider_Company_Name>

Address: <CA_IMR_Provider_Address> City: <CA_IMR_Provider_City>

State: <CA_IMR_Provider_State> Zip Code: <CA_IMR_Provider_ZipCode> Telephone Number: <CA_IMR_Provider_Phone_Number>

Fax Number: <CE_Fax_Number> Specialty: <CA_IMR_Provider_Specialty>

Claims Administrator Information:

Employer Name: <Name>

Name of Administrator: Sedgwick Claims Management Services, Inc. Contact Name: <CE_Name>

Address: <CE_Address> City: <CE_City> State: <CE_State> Zip Code: <CE_ZipCode>

Telephone Number: <CE_Phone> Fax Number: <CE_Fax_Number>

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

<TP_Dx_Codes>

* Mailing Date of the Utilization Review Determination Letter: <TP_Date_UR_Decision>

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity?

<Additional_Text("Please enter X if CE Disputing Liability for requested medical treatment besides question of medical necessity.")> Yes

<Additional_Text("Please enter X if CE isn't Disputing Liability.")> No

Reason:

<Additional_Text("Please enter why liability is being disputed.")>

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.

9. <TP_First_Treatment>
10. <TP_Second_Treatment>
11. <TP_Third_Treatment>
12. <TP_Fourth_Treatment>

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:

<TP_Days_to_Dispute> days from the mailing date of the written determination letter.

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.

ATLAS GENERAL**APPEAL OVERTURNED**

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjuster: <CE_Name>

Claims File #: <ClaimNum_SCMS>

Employer: <Name>

Sedgwick on Behalf of Writing Co: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Date Request Received: <SCMSReceivedDate>

Dear <Primary_Recipient_Name>,

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGridNegotiated>

<PA_Received_Date>

<Additional_Text("Please provide any additional information")>

Final UR Decision Date: <Final_UR_Decision_Date>

As requested, a physician who was not involved in the original non-certification has reviewed the medical necessity of the above named claimant's health care services.

This involved review of the original information, supplemented by discussion(s) with the treating provider and/or review of written medical records. The second physician has determined that the above health care service in question is certified as medically necessary.

This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process.

Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

When a medication request is approved, a therapeutically equivalent generic is authorized. Approval of the brand-name medication requires prior authorization and documentation of medical necessity.

The claimant, treating provider, claim payor and agency/service provider have been notified of this determination.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

<User_Name>

<User_Title>

<User_Toll_Free_With_Ext>

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE
SUBMITTED ON THE “DWC FORM RFA” FOR CONSIDERATION**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> We appreciate your cooperation.

Preferred Vendor List

To provide the best possible care, **Titan Claims Management** has developed partnerships with national providers due to their proven performance with workers' compensation cases. **The below services should be coordinated through the claim adjuster or directly with the vendor at the contact information provided below.**

Diagnostic Testing

CareWorks can assist with finding local providers to conduct your **MRI, CT scan, EMG, X-rays**, and other diagnostic testing requested by your primary treating physician.

Phone (800) 821-5364

Email: ancillaryreferral@sedgwick.com

Durable Medical Equipment (DME)

CareWorks can assist in providing equipment requested by your primary treating physician including braces, canes, crutches, walkers, slings, commode chairs, etc.

Phone (800) 821-5364

Email: titanclaims@careworks.com

Pharmacy / Medication

myMatrixx has partnered with Titan Claims Management to fill prescriptions for your claim. Most pharmacies, including Walgreens, and all major chains such as CVS, Rite-aid, Lucky, Costco, Walmart, and more are included in the network. Help Line: (866) 590-5882

Physical Medicine

MedRisk has a nationwide network of providers to manage your **physical therapy, chiropractic, occupational therapy, and acupuncture** treatments. Contact them to find the nearest provider.

Phone: (888) 637-4751

Email: sedgwickrequests@medrisknet.com

Interpreting/Translation

Careworks has a nationwide network of providers to provide **interpreting or translation** needs. Contact them to find the nearest provider. **Phone: (800) 821-5364** **Email:** ancillaryreferral@sedgwick.com

Transportation

Careworks has a nationwide network of providers to coordinate **transportation** needs. Contact them to find the nearest provider. **Phone: (800) 821-5364** **Email:** ancillaryreferral@sedgwick.com

Dental

Careworks has a nationwide network of providers to manage your dental needs. Contact them to find the nearest provider. **Phone: (800) 821-5364** **Email:** ancillaryreferral@sedgwick.com

APPEAL PARTIAL APPROVAL

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjustor: <CE_Name>

Claims File #: <ClaimNum_SCMS>

Employer: <Name>

Sedgwick on Behalf of Writing Co: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service(s). As requested, a physician who was not involved in the original non-certification has reviewed the medical necessity of the above reference information, supplemented by discussion (s) with the attending physician and / or review of the claimant's medical records. A second physician has made the following determination regarding the health care services(s) listed below has been established. This decision applies only to the specific service(s) listed below. Any additional service(s) will require a separate review process:

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGrid2>

<PA_Received_Date>

Final UR Decision Date: <Final_UR_Decision_Date>

<Additional_Text("Please provide any additional information")>

To keep all parties informed, Sedgwick has notified the medical provider, injured worker, injured worker's attorney (if applicable) and the workers' compensation payor of the review determination.

This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

When a medication request is approved, a therapeutically equivalent generic is authorized. Approval of the brand-name medication requires prior authorization and documentation of medical necessity.

The internal appeals process is voluntary and does not trigger or bar the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6, but may be used on an optional basis.

Any dispute will be resolved in accordance with the independent medical review provision of Labor Code 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by you, your representative or attorney, if you are represented, on the Application for Independent Medical Review, DWC Form IMR, within <TP_Days_to_Dispute> calendar days from the mailing date of the decision, as indicated on the last page of the application. This deadline must be met even if participating in the internal utilization review appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope, was included with the original decision.

You have a right to disagree with decisions affecting your claim which includes seeking Independent Medical Review of the decision. If you have any questions about the information in this notice, please call me, <CE_Name> at <CE_Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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 decision shall remain in effect for twelve months from the date of the decision without further action with regard to any further recommendation by the same physician for the same treatment unless the recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

Sedgwick Claims Management Services, Inc.

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE
"DWC FORM RFA" FOR CONSIDERATION**

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The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> We appreciate your cooperation.

Preferred Vendor List

To provide the best possible care, Titan Claims Management has developed partnerships with national providers due to their proven performance with workers' compensation cases. **The below services should be coordinated through the claim adjuster or directly with the vendor at the contact information provided below.**

Diagnostic Testing

CareWorks can assist with finding local providers to conduct your **MRI, CT scan, EMG, X-rays**, and other diagnostic testing requested by your primary treating physician.

Phone: (800) 821-5364

Email: ancillaryreferral@sedgwick.com

Durable Medical Equipment (DME)

CareWorks can assist in providing equipment requested by your primary treating physician including braces, canes, crutches, walkers, slings, commode chairs, etc.

Phone: (800) 821-5364

Email: titanclaims@careworks.com

Pharmacy / Medication

myMatrixx has partnered with Titan Claims Management to fill prescriptions for your claim. Most pharmacies, including Walgreens, and all major chains such as CVS, Rite-aid, Lucky, Costco, Walmart, and more are included in the network. Help Line: (866) 590-5882

Physical Medicine

MedRisk has a nationwide network of providers to manage your **physical therapy, chiropractic, occupational therapy, and acupuncture** treatments. Contact them to find the nearest provider.

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GENERAL APPROVAL

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjuster: <CE_Name>

Claims File #: <ClaimNum_SCMS>

Employer: <Name>

Sedgwick on Behalf of Writing Co: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

DEar <Primary_Recipient_Name>,

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGrid(Certified by Nurse,Certified by PA)>

<PA_Received_Date>

Final UR Decision Date: <Final_UR_Decision_Date>

<Additional_Text("Please provide any additional information")>

After review of a request for authorization, it has been determined that the specific service(s) meets established criteria for medical necessity based on the information presented by the medical provider. This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

If this request is for medication, a therapeutically equivalent generic substitute is authorized. Authorization of the brand-name medication requires documentation of medical necessity and prior approval.

The medical provider, injured worker and workers' compensation payor have been notified of this decision.

This review applies only to the specific service(s) listed. Additional services require separate review.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

<User_Name>

<User_Title>

<User_Toll_Free_With_Ext>

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

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Email: titanclaims@careworks.com

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Email: sedgwickrequests@medrisknet.com

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Phone: (800) 821-5364 **Email:** ancillaryreferral@sedgwick.com

Dental

Careworks has a nationwide network of providers to handle your **dental** needs. Contact them to find the nearest provider.

Phone: (800) 821-5364 **Email:** ancillaryreferral@sedgwick.com

GENERAL PARTIAL APPEAL

Sedgwick
<User Address>

<Today's_Date>

<Primary_Recipient_Name>
<Primary_Recipient_Address>

Claimant: <Claimant_Name>
Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")
Adjustor: <CE_Name>
Claims File #: <ClaimNum_SCMS>

Employer: <Name>
Sedgwick on Behalf of Writing Co: <CarrierName>
Date of Injury: <Date_Injury>
Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

After peer review of the medical information presented and/or discussion with the ordering practitioner, the following determination regarding the health care services(s) listed below has been established. This decision applies only to the specific service(s) listed below.

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGridNegotiated>

<PA_Received_Date>
Final UR Decision Date: <Final_UR_Decision_Date>

<Additional_Text("Please provide any additional information")>

To keep all parties informed, Sedgwick has notified the ordering practitioner, injured worker, the injured worker's attorney, if applicable, and workers' compensation payor of our review determination.

This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved by the utilization review process.

Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

When a medication request is approved, a therapeutically equivalent generic is authorized. Approval of the brand-name medication requires prior authorization and documentation of medical necessity.

The review was made based on guidelines which are developed from current clinical principals and processes to ensure consistency in the review process. You may receive a copy of the complete clinical rationale used to make this decision by calling the number provided or forwarding a written request to the Sedgwick address listed on this letter.

If you disagree with this decision, you or your representative may submit a request an internal appeal through Sedgwick's voluntary appeal process. To appeal this determination, submit a written request within 10 calendar days of the receipt of this decision, and provide additional information which explains the medical necessity of the service(s). Please send the appeal request and information to the Sedgwick address listed on this letter. If you believe this determination warrants an expedited appeal, you or your representative may request this by calling Sedgwick at <User_Toll_Free_With_Ext>. The fax number, <User_Fax> is available 24 hours a day 7 days a week to receive requests.

Utilization review personnel are available between 9:00 a.m. and 5:30 p.m. Pacific Standard Time (PST) on normal business days at the toll free number listed on this letter. We will respond to your appeal within 30 calendar days of the date of this utilization review decision.

The internal appeals process is voluntary and does not trigger or bar the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6, but may be used on an optional basis.

Any dispute will be resolved in accordance with the independent medical review provision of Labor Code 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by you, your representative or attorney, if you are represented, on the enclosed Application for Independent Medical Review, DWC Form IMR, within **<TP>** Days_to_Dispute> calendar days from the mailing date of the utilization review decision to the employee, as indicated on the last page of the application. This deadline must be met even if participating in the internal utilization review appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope, is again included with this notice if you have not yet filed an IMR.

You have the right to disagree with decisions affecting your claim which includes seeking Independent Medical Review of the decision. (See attached application). If you have any questions about the information in this notice, please call me, <CE_Name> at <CE_Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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 decision shall remain in effect for twelve months from the date of the decision without further action with regard to any further recommendation by the same physician for the same treatment unless the recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Contact the claims adjuster for an explanation of coverage. This review applies only to the specific service(s) listed. Additional services require separate review.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

Sedgwick Claims Management Services, Inc.

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

Enclosure: Application for Independent Medical Review
Self-Addressed Envelope

<Append_PA_Report>

LEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE "DWC FORM RFA" FOR CONSIDERATION

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> We appreciate your cooperation.

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 Type of Utilization Review:**

<TP_Standard_Review> Regular
Appeal

<TP_Expedited_Review> Expedited

<TP_Mod_after_Appeal> Modification after

<Additional_Text("
Please enter X if
review is for MTUS
formulary
medication
only.")>
Medication Only –
MTUS Formulary
Drug List

<Additional_Text("
Please enter X if
review is Retro for
Exempt Treatment
(Non-Drug).")>
Retrospective for
Exempt Treatment
(Non-Drug)

<Additional_Text("
Please enter X if
review is Retro for
Exempt Treatment
(Drug).")>
Retrospective for
Exempt Treatment
(Drug)

Employee Information:

First Name: <Claimant_FirstName> Middle Initial: Last Name: <Claimant_LastName>

Address: <Claimant_Address> City: <Claimant_City>

State: <Claimant_State> Zip Code: <Claimant_ZipCode> Telephone Number: <Claimant_home_phone>

Fax Number: Date of Injury: <Date_Injury>

Insurance Claim Number: <ClaimNum_SCMS>_ EAMS Case Number: <EAMS>

WCIS Jurisdictional Claim Number (if assigned): <ClaimNum_State>

Employee Attorney (if known): <Plaintiff_Attorney_Name>

Address: <Plaintiff_Attorney_Address> City: <Plaintiff_Attorney_City>

State: <Plaintiff_Attorney_State> Zip Code: <Plaintiff_Attorney_ZipCode> Telephone Number: <Plaintiff_Attorney_Phone>

Fax Number: <Plaintiff_Attorney_Fax_Number>

Requesting Physician Information:

Physician First Name: <Provider_FirstName> Middle Initial: Last Name: <Provider_LastName>

Practice Name: <CA_IMR_Provider_Company_Name>

Address: <CA_IMR_Provider_Address> City: <CA_IMR_Provider_City>

State: <CA_IMR_Provider_State> Zip Code: <CA_IMR_Provider_ZipCode> Telephone Number: <CA_IMR_Provider_Phone_Number>

Fax Number: <CE_Fax_Number> Specialty: <CA_IMR_Provider_Specialty>

Claims Administrator Information:

Employer Name: <Name>

Name of Administrator: Sedgwick Claims Management Services, Inc. Contact Name: <CE_Name>

Address: <CE_Address> City: <CE_City> State: <CE_State> Zip Code: <CE_ZipCode>

Telephone Number: <CE_Phone> Fax Number: <CE_Fax_Number>

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

<TP_Dx_Codes>

* Mailing Date of the Utilization Review Determination Letter: <TP_Date_UR_Decision>

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity?

<Additional_Text("Please enter X if CE Disputing Liability for requested medical treatment besides question of medical necessity.")> Yes

<Additional_Text("Please enter X if CE isn't Disputing Liability.")> No

Reason:

<Additional_Text("Please enter why liability is being disputed.")>

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.

13. <TP_First_Treatment>

14. <TP_Second_Treatment>

15. <TP_Third_Treatment>

16. <TP_Fourth_Treatment>

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:

<TP_Days_to_Dispute> days from the mailing date of the written determination letter.

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.

In order to provide the best possible care, Titan Claims Management has developed partnerships with national providers due to their proven performance with workers' compensation case. The below services should be coordinated through the claim adjuster or directly with the vendor at the contact information provided below.

Diagnostic Testing

Careworks can assist with finding local providers to conduct your **MRI, CT scan, EMG, x-rays**, and other diagnostic testing requested by your primary treating physician.

Phone: (800) 821-5364

Email: ancillaryreferral@sedgwick.com

Durable Medical Equipment (DME)

Careworks can assist with obtaining equipment requested by your primary treating physician including **braces, canes, crutches, walkers, slings, commode chairs, etc.**

Phone: (800) 821-5364

Email: titanclaims@careworks.com

Pharmacy / Medication

myMatrixx has partnered with Titan Claims Management for filling **prescriptions** for your claim. Most pharmacies, including Walgreens and all major chains such as CVS, Rite-aid, Lucky, Costco, Walmart, and more are included in the network. **Help Line: (866) 590-5882**

Physical Medicine

MedRisk has a nationwide network of providers to handle your **physical therapy, chiropractic, occupational therapy, and acupuncture** treatments. Contact them to find the nearest provider.

Phone: (888) 637-4751

Email: sedgwickrequests@medrisknet.com

Interpreting/Translation

Careworks has a nationwide network of providers to handle your interpreting or translation needs. Contact them to find the nearest provider. **Phone:** (800) 821-5364 **Email:** ancillaryreferral@sedgwick.com

Careworks has a nationwide network of providers to handle your **transportation** needs. Contact them to find the nearest provider. **Phone:** (800) 821-5364 **Email:** ancillaryreferral@sedgwick.com

Dental

Careworks has a nationwide network of providers to handle your **dental** needs. Contact them to find the nearest provider.

Phone: (800) 821-5364 **Email:** ancillaryreferral@sedgwick.com

KROGER**APPEAL OVERTURNED**

Sedgwick

<User Address>

<Today's Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjuster: <CE_Name>

Claims File #: <ClaimNum_SCMS>

Employer: <Name>

Sedgwick on Behalf of Writing Co: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Date Request First Received: <SCMSReceivedDate>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service:

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGridNegotiated>

<Additional_Text("Please enter details about the specified procedure.")>

<PA_Received_Date>

Final UR Decision Date: <Final_UR_Decision_Date>

As requested, a physician who was not involved in the original non-certification has reviewed the medical necessity of the above named claimant's health care services. This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

If this request is for medication, a therapeutically equivalent generic substitute is authorized. Authorization of the brand-name medication requires documentation of medical necessity and prior approval.

This involved review of the original information, supplemented by discussion(s) with the treating provider and/or review of written medical records. The second physician has determined that the above health care service in question is certified as medically necessary.

The claimant, treating provider, claim payor and agency/service provider have been notified of this determination.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

<User_Name>

<User_Title>

<User_Toll_Free_With_Ext>

<CC_Detailed_List>

Please note that all treatment (including consults, therapy, diagnostics, durable medical equipment, pharmacy, surgical procedures, etc.) must be provided within the Sedgwick/Harbor MPN - Kroger. The injured worker may locate a certified MPN provider/facility by accessing: www.harborsys.com/kroger and searching the Sedgwick/Harbor MPN - Kroger network. Please contact the claims examiner for questions or further explanation.

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

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The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We have attached a copy for your convenience and we ask that you submit all future requests for treatment authorization on the form. We appreciate your cooperation.

APPROVAL

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjuster: <CE_Name>

Claims File #: <ClaimNum_SCMS>

Employer: <Name>

Sedgwick on Behalf of Writing Co: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

Request for Authorization First Received: <SCMSReceivedDate>

 <RFM_All_Values>

This correspondence pertains to the review of the following health care service:

Specific Request: <TP_Treatment_Requested> |

<ProcedureCodeGrid(Certified by Nurse, Certified by PA)>

<Additional_Text("Please enter details about the description of service or treatment approved; i.e. "MRI of lumbar spine approved".")>

Final UR Decision Date: <Final_UR_Decision_Date>

After review of a request for authorization, it has been determined that the specific service(s) meets established criteria for medical necessity based on the information presented by the medical provider. This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

If this request is for medication, a therapeutically equivalent generic substitute is authorized. Authorization of the brand-name medication requires documentation of medical necessity and prior approval.

The medical provider, injured worker and workers' compensation payor have been notified of this decision.

This review applies only to the specific service(s) listed. Additional services require separate review.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

<User_Name>

<User_Title>

<User_Toll_Free_With_Ext>

<CC_Detailed_List>

Please note that all treatment (including consults, therapy, diagnostics, durable medical equipment, pharmacy, surgical procedures, etc.) must be provided within the Sedgwick/Harbor MPN - Kroger. The injured worker may locate a certified MPN provider/facility by accessing: www.harborsys.com/kroger and searching the Sedgwick/Harbor MPN - Kroger network. Please contact the claims examiner for questions or further explanation.

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<Append_PA_Report>

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The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf>. We appreciate your cooperation.

PARTIAL APPROVAL

Sedgwick
<User Address>

<Today's_Date>

<Primary_Recipient_Name>
<Primary_Recipient_Address>

Claimant: <Claimant_Name>
Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")
Adjustor: <CE_Name>
Claims File #: <ClaimNum_SCMS>

Employer: <Name>
Sedgwick on Behalf of Writing Co.: <CarrierName>
Date of Injury: <Date_Injury>
Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

After peer review of the medical information presented and/or discussion with the ordering practitioner, the following determination regarding the health care services(s) listed below has been established. This decision applies only to the specific service(s) listed below.

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGridNegotiated>

<Additional_Text("Enter details about the specified procedure. Physician Reviewer Summary, Decision, Rationale and Guideline")>

<PA_Received_Date>
Final UR Decision Date: <Final_UR_Decision_Date>

To keep all parties informed, Sedgwick has notified the ordering practitioner, injured worker, the injured worker's attorney, if applicable, and workers' compensation payor of our review determination.

The review was made based on guidelines which are developed from current clinical principals and processes to ensure consistency in the review process. You may receive a copy of the complete clinical rationale used to make this decision by calling the number provided or forwarding a written request to the Sedgwick address listed on this letter.

When a medication request is approved, a therapeutically equivalent generic is authorized. Approval of the brand-name medication requires prior authorization and documentation of medical necessity.

If you disagree with this decision, you or your representative may submit a request for an internal appeal through Sedgwick's voluntary appeal process. To appeal this determination, submit a written request within 10 calendar days of the receipt of this decision, and provide additional information which explains the medical necessity of the service(s). Please send the appeal request and information to the Sedgwick address listed on this letter. If you believe this determination warrants an expedited appeal, you or your representative may request this by calling Sedgwick at <User_Toll_Free_With_Ext>. The fax number, <User_Fax> is available 24 hours a day 7 days a week to receive requests. Utilization review personnel are available between 9:00 a.m. and 5:30 p.m. Pacific Standard Time (PST) on normal business days at the toll free number listed on this letter. We will respond to your appeal within 30 calendar days of the date of this utilization review decision.

The internal appeals process is voluntary and does not trigger or bar the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6, but may be used on an optional basis.

Any dispute will be resolved in accordance with the independent medical review provision of Labor Code 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by you, your representative or attorney, if you are represented, on the enclosed Application for Independent Medical Review, DWC Form IMR, within <TP> Days_to_Dispute> calendar days from the mailing date of the utilization review decision to the employee, as indicated on the last page of the application. This deadline must be met even if participating in the internal utilization review appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope, is again included with this notice if you have not yet filed for IMR.

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 any questions about the information in this notice, please call me, <CE_Name> at <CE_Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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 decision shall remain in effect for twelve months from the date of the decision without further action with regard to any further recommendation by the same physician for the same treatment unless the recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

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Sincerely,

Sedgwick Claims Management Services, Inc.

<CC_Detailed_List>

Enclosure: Application for Independent Medical Review
Self-Addressed Envelope

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- 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 Type of Utilization Review:**

<TP_Standard_Review> Regular
Appeal

<TP_Expedited_Review> Expedited

<TP_Mod_after_Appeal> Modification after

<Additional_Text("
Please enter X if
review is for MTUS
formulary
medication
only.")>
Medication Only –
MTUS Formulary
Drug List

<Additional_Text("
Please enter X if
review is Retro for
Exempt Treatment
(Non-Drug).")>
Retrospective for
Exempt Treatment
(Non-Drug)

<Additional_Text("
Please enter X if
review is Retro for
Exempt Treatment
(Drug).")>
Retrospective for
Exempt Treatment
(Drug)

Employee Information:

First Name: <Claimant_FirstName> Middle Initial: Last Name: <Claimant_LastName>
Address: <Claimant_Address> City: <Claimant_City>
State: <Claimant_State> Zip Code: <Claimant_ZipCode> Telephone Number: <Claimant_home_phone>
Fax Number: Date of Injury: <Date_Injury>
Insurance Claim Number: <ClaimNum_SCMS>_ EAMS Case Number: <EAMS>
WCIS Jurisdictional Claim Number (if assigned): <ClaimNum_State>
Employee Attorney (if known): <Plaintiff_Attorney_Name>
Address: <Plaintiff_Attorney_Address> City: <Plaintiff_Attorney_City>
State: <Plaintiff_Attorney_State> Zip Code: <Plaintiff_Attorney_ZipCode> Telephone Number: <Plaintiff_Attorney_Phone>
Fax Number: <Plaintiff_Attorney_Fax_Number>

Requesting Physician Information:

Physician First Name: <Provider_FirstName> Middle Initial: Last Name: <Provider_LastName>
Practice Name: <CA_IMR_Provider_Company_Name>
Address: <CA_IMR_Provider_Address> City: <CA_IMR_Provider_City>
State: <CA_IMR_Provider_State> Zip Code: <CA_IMR_Provider_ZipCode> Telephone Number: <CA_IMR_Provider_Phone_Number>
Fax Number: <CE_Fax_Number> Specialty: <CA_IMR_Provider_Specialty>

Claims Administrator Information:

Employer Name: <Name>
Name of Administrator: Sedgwick Claims Management Services, Inc. Contact Name: <CE_Name>
Address: <CE_Address> City: <CE_City> State: <CE_State> Zip Code: <CE_ZipCode>
Telephone Number: <CE_Phone> Fax Number: <CE_Fax_Number>

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):
<TP_Dx_Codes>

* Mailing Date of the Utilization Review Determination Letter: <TP_Date_UR_Decision>

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity?

<Additional_Text("Please enter X if CE Disputing Liability for requested medical treatment besides question of medical necessity.")> Yes

<Additional_Text("Please enter X if CE isn't Disputing Liability.")> No

Reason:

<Additional_Text("Please enter why liability is being disputed.")>

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.

17. <TP_First_Treatment>
18. <TP_Second_Treatment>
19. <TP_Third_Treatment>
20. <TP_Fourth_Treatment>

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:

<TP_Days_to_Dispute> days from the mailing date of the written determination letter.

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.

EVEREST

APPROVAL

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjuster: <CE_Name>

Claims File #: <ClaimNum_SCMS>

Employer: <Name>

Writing Co: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

This review applies only to the specific service listed. Additional services require separate review.

Request for Authorization First Received: <SCMSReceivedDate>

<REM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGrid(Certified by Nurse,Certified by PA)>

<PA_Received_Date>

Final UR Decision Date: <Final_UR_Decision_Date>

<Additional_Text("Please provide any additional information")>

After review of a request for authorization, it has been determined that the specific service(s) meets established criteria for medical necessity based on the information presented by the medical provider. This review is for medical necessity only. This letter does not guarantee that benefits will be payable under Workers Compensation coverage. Benefit payments are always subject to a determination by the claims adjuster at the time the service was rendered. Please note this authorization does not guarantee a payment amount as billed. All bills are subject to review by the claims administrator pursuant to State reimbursement guidelines related to the specific health care treatment and/or services authorized PPO contracted rates, including fee negotiations. Please submit all billing to Sedgwick. Please reference the claim number listed above in all written documentation related to this case. If you have any questions regarding this authorization, please feel free to contact <CE_Name>.

Everest Insurance ® has a MPN and the injured worker has been put on notice of the MPN. APPROVED SERVICES SHOULD BE SCHEDULED THROUGH OUR PREFERRED VENDORS LISTED ON THE ATTACHMENT

The medical provider, injured worker and workers' compensation payor have been notified of this decision.

Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

If this request is for medication, a therapeutically equivalent generic substitute is authorized. Authorization of the brand-name medication requires documentation of medical necessity and prior approval.

This review applies only to the specific service(s) listed. Additional services require separate review.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

<User_Name>

<User_Title>

<User_Toll_Free_With_Ext> |

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

Enclosure: Request for Authorization form (RFA)

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE "DWC FORM RFA" FOR CONSIDERATION

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We appreciate your cooperation.

Preferred Vendor List

In order to provide the best possible care, Everest Insurance has developed partnerships with national providers due to their proven performance with workers' compensation case. The below services should be coordinated through the claim adjuster or directly with the vendor at the contact information provided below.

Diagnostic Testing

OneCall Care Management can assist with finding local providers to conduct your **MRI, CT scan, x-rays**, and other diagnostic testing requested by your primary treating physician.

Phone: (800) 349-0117 **Email:** sedgwick@onecallcm.com

Durable Medical Equipment (DME)

HomeLink can assist with obtaining equipment requested by your primary treating physician including; braces, canes, crutches, walkers, commode chairs, etc. **HomeLink** is also the home health care provider for all in-home services including **in-home physical therapy**.

Phone: (877) 907-1507 **Email:** SedgwickHL@vgm.com **Fax:** (844) 740-3736

Pharmacy / Medication

Optum has partnered with Everest for filling **prescriptions** for your claim. Most pharmacies, including Walgreens and all major chains such as CVS, Rite-aid, Lucky, Costco, Walmart, and more are included in the network.

Phone: (800) 964-2531

Physical Medicine

OneCall PT (Align Network) has a nationwide network of providers to handle your **physical therapy, chiropractic, occupational therapy and acupuncture** treatments. Contact them to find the nearest provider.

Phone: (800) 349-0117 **Email:** Sedgwick@onecallcm.com

Primary Treating Physicians & Specialist

Everest has a network of trusted physicians and specialists throughout the country that provide superior outcomes. Visit www.everestnational.com/workcomp for the most updated listing. If you have questions or need additional assistance, please contact Everest's Medical Access Assistant.

Phone: (800) 608-9822

Email: everestmpn@everestre.com

Interpreting /Translation & Transportation

ProCare has a nationwide network of providers to handle your **interpreting** needs. Contact them to find the nearest provider. **Phone:** (866) 941-7878

Dental Care

OneCall has a nationwide network of dental providers to handle all dental needs. Contact them to find the nearest provider. **Phone:** (800) 349-0117 **Email:** Sedgwick@onecallcm.com

TENET

APPEAL OVERTURNED

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjuster: <CE_Name>

Claims File #: <ClaimNum_SCMS>

Employer: <Name>

Sedgwick on Behalf of Writing Co: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Date Request First Received: <SCMSReceivedDate>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service:

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGrid(Appeal Overturned)>

<Additional_Text("Please enter details about the specified procedure.")>

<PA_Received_Date>

Final UR Decision Date: <Final_UR_Decision_Date>

APPROVED SERVICES MAY BE SCHEDULED THROUGH THE LOCATIONS LISTED ON THE ATTACHMENT OR AT THE NEAREST TENET FACILITY

As requested, a physician who was not involved in the original non-certification has reviewed the medical necessity of the above-named claimant's health care services. This review is for medical necessity only. Fee/Pricing for treatment are not reviewed or approved via the utilization review process.

Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

If this request is for medication, a therapeutically equivalent generic substitute is authorized. Authorization of the brand-name medication requires documentation of medical necessity and prior approval.

This involved review of the original information, supplemented by discussion(s) with the treating provider and/or review of written medical records. The second physician has determined that the above health care service in question is certified as medically necessary.

The claimant, treating provider, claim payor and agency/service provider have been notified of this determination.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

<User_Name>

<User_Title>

<User_Toll_Free_With_Ext>

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

**EFFECTIVE JANAUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE
SUBMITTED ON THE "DWC FORM RFA" FOR CONSIDERATION**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We have attached a copy for your convenience and we ask that you submit all future requests for treatment authorization on the form. We appreciate your cooperation.

Facility Name	City	State	Phone	Freestanding Imaging	CT	MRI	Ultrasound	X-ray
Brookwood Baptist Princeton	Birmingham	AL	205.783.3000					Y
Brookwood Medical Center	Birmingham	AL	205.877.1000		Y	Y	Y	Y
Brookwood Baptist Imaging, LLC, d/b/a Brookwood Diagnostic Center-Hoover	Birmingham	AL	205-802-6900	Y				
Brookwood Diagnostic Imaging Center LLC	Birmingham	AL	205-802-6900	Y				
Brookwood Womens Diagnostic Center LLC	Birmingham	AL	205-802-6900	Y				
Abrazo Arizona Heart Hospital	Phoenix	AZ	602.532.1000		Y		Y	Y
Abrazo Arrowhead Campus	Glendale	AZ	623.561.1000		Y	Y	Y	Y
Abrazo Central Campus	Phoenix	AZ	602.249.0212		Y	Y	Y	Y
Abrazo Scottsdale Campus	Phoenix	AZ	602.923.5000		Y	Y	Y	Y
Abrazo West Campus	Goodyear	AZ	623.882.1500		Y		Y	Y
Carondelet	Tucson	AZ	520.873.3000		Y	Y	Y	Y
Desert Regional	Palm Springs	CA	760.323.6511		Y	Y	Y	Y
Doctors Hospital of Manteca	Manteca	CA	209.823.3111			Y	Y	Y
Doctors Hospital of Modesto	Modesto	CA	209.578.1211		Y		Y	Y
Emanuel Medical Center	TURLOCK	CA	209.667.4200		Y		Y	Y
Fountain Valley RH	FOUNTAIN VALLEY	CA	714.966.7200		Y	Y	Y	Y
Hi-Desert Medical Center	JOSHUA TREE	CA	760.366.3711		Y	Y	Y	Y
JFK MH	INDIO	CA	760.347.6191		Y	Y	Y	Y
Lakewood RMC	LAKEWOOD	CA	562.531.2550		Y		Y	Y
Placentia Linda	PLACENTIA	CA	714.993.2000		Y	Y	Y	Y
San Ramon	SAN RAMON	CA	925.275.9200		Y		Y	Y
Sierra Vista RMC	San Luis Obispo	CA	805.546.7600		Y		Y	Y
Turlock Imaging Services, LLC	Turlock	CA	209-669-0600	Y				
Twin Cities Community	Templeton	CA	805.434.3500		Y		Y	Y
Walker Street Imaging Care, Inc.	Cypress	CA	714-656-2130	Y				
Los Alamitos MC	LOS ALAMITOS	CA	562.598.1311		Y		Y	Y
Magnetic Resonance Imaging of San Luis Obispo, Inc.	San Luis Obispo	CA	805-546-7733	Y				
Modesto Radiology Imaging, Inc.	Modesto	CA	209-577-4444	Y				
Newhope Imaging Center, Inc.	Fountain Valley	CA	714-431-0303	Y				
Pleasanton Diagnostic Imaging, Inc.	Pleasanton	CA	925-467-1400	Y				
Templeton Imaging, Inc.	Templeton	CA	805-434-1491	Y				
Delray MC	Delray Beach	FL	561.498.4440		Y	Y	Y	Y
Good Samaritan	WEST PALM BEACH	FL	561.655.5511		Y	Y	Y	Y
Palm Beach Gardens MC	Palm Beach Gardens	FL	561.622.1411		Y	Y	Y	Y
St. Mary's MC	West Palm Beach	FL	561.844.6300		Y	Y	Y	Y
West Boca MC	Boca Raton	FL	561.488.8000		Y	Y	Y	Y
Metrowest Med Ctr - Framingham	Framingham	MA	508.383.1000					Y
Metrowest Med Ctr - Morse Campus	Natick	MA	508.650.7000		Y			Y
St. Vincent Hospital	Worcester	MA	508.363.5000		Y	Y	Y	Y
Sun View Imaging, LLC	Las Cruces	NM	575-522-6236	Y				
Coastal Carolina MC	Hardeeville	SC	843.784.8000		Y		Y	Y
East Cooper Medical Center	Mt. Pleasant	SC	843.881.0100		Y	Y	Y	Y
Hilton Head MC	HILTON HEAD	SC	843.681.6122		Y	Y		Y
Piedmont HC	Rock Hill	SC	803.329.1234		Y	Y	Y	Y
St Francis	Memphis	TN	901.765.1000		Y	Y	Y	Y
St Francis Bartlett	Bartlett	TN	901.820.7000		Y	Y	Y	Y
Baptist Health System - San Antonio	San Antonio	TX	866.309.2873		Y	Y	Y	Y
Hospitals of Providence East Campus	EL PASO	TX	915.832.2000		Y	Y	Y	Y
Hospitals of Providence Memorial Campus	EL PASO	TX	915.577.6011		Y	Y	Y	Y
Hospitals of Providence Sierra Campus	EL PASO	TX	915.747.4000		Y	Y	Y	Y
Hospitals of Providence Transmountain Campus	EL PASO	TX	915.877.8136		Y	Y		Y
Nacogdoches MC	Nacogdoches	TX	936.569.9481		Y		Y	Y
Resolute	New Braunfels	TX	830.500.6000		Y	Y	Y	Y
Valley Baptist MC - Brownsville	Brownsville	TX	956.698.5400		Y	Y	Y	Y
Valley Baptist MC - Harlingen	Harlingen	TX	956.389.1100		Y	Y	Y	Y
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-351-0784	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-351-0784	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-692-9824	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-590-5822	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-681-6474	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-521-2989	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-423-3950	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-403-1600	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-339-9401	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-730-9600	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-350-3115	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-961-3570	Y				
VHS San Antonio Imaging Partners, LP	New Braunfels	TX	830-327-1878	Y				

APPEAL PARTIAL CERT.

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjustor: <CE_Name>

Claims File #: <ClaimNum_SCMS>

Employer: <Name>

Sedgwick on Behalf of Writing Co.: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service(s). As requested, a physician who was not involved in the original non-certification has reviewed the medical necessity of the above reference information, supplemented by discussion (s) with the attending physician and / or review of the claimant's medical records. A second physician has made the following determination regarding the health care services(s) listed below has been established. This decision applies only to the specific service(s) listed below. Any additional service(s) will require a separate review process:

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGrid2>

<Additional_Text("Enter details about the specified procedure. Physician Reviewer Summary, Decision, Rationale and Guideline")>

<PA_Received_Date>

Final UR Decision Date: <Final_UR_Decision_Date>

APPROVED SERVICES MAY BE SCHEDULED THROUGH THE LOCATIONS LISTED ON THE ATTACHMENT OR AT THE NEAREST TENET FACILITY

When a medication request is approved, a therapeutically equivalent generic is authorized. Approval of the brand-name medication requires prior authorization and documentation of medical necessity. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

To keep all parties informed, Sedgwick has notified the medical provider, injured worker, injured worker's attorney (if applicable) and the workers' compensation payor of the review determination. This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process.

The internal appeals process is voluntary and does not trigger or bar the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6, but may be used on an optional basis.

Any dispute will be resolved in accordance with the independent medical review provision of Labor Code 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by you, your representative or

attorney, if you are represented, on the Application for Independent Medical Review, DWC Form IMR, within **<TP Days_to_Dispute>** calendar days from the mailing date of the utilization review decision to the employee, as indicated on the last page of the application. This deadline must be met even if participating in the internal utilization review appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope, was included with the original decision.

You have a right to disagree with decisions affecting your claim which includes seeking Independent Medical Review of the decision. If you have any questions about the information in this notice, please call me, **<CE_Name>** at **<CE_Phone>**. However, if you are represented by an attorney, please contact your attorney instead of me.

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 decision shall remain in effect for twelve months from the date of the decision without further action with regard to any further recommendation by the same physician for the same treatment unless the recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

Sedgwick Claims Management Services, Inc.

<CC_Detailed_List>

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<Append_PA_Report>

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The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We appreciate your cooperation.

Facility Name	City	State	Phone	Freestanding Imaging	CT	MRI	Ultrasound	X-ray
Brookwood Baptist Princeton	Birmingham	AL	205.783.3000					Y
Brookwood Medical Center	Birmingham	AL	205.877.1000		Y	Y	Y	Y
Brookwood Baptist Imaging, LLC, d/b/a Brookwood Diagnostic Center-Hoover	Birmingham	AL	205-802-6900	Y				
Brookwood Diagnostic Imaging Center LLC	Birmingham	AL	205-802-6900	Y				
Brookwood Womens Diagnostic Center LLC	Birmingham	AL	205-802-6900	Y				
Abrazo Arizona Heart Hospital	Phoenix	AZ	602.532.1000		Y		Y	Y
Abrazo Arrowhead Campus	Glendale	AZ	623.561.1000		Y	Y	Y	Y
Abrazo Central Campus	Phoenix	AZ	602.249.0212		Y	Y	Y	Y
Abrazo Scottsdale Campus	Phoenix	AZ	602.923.5000		Y	Y	Y	Y
Abrazo West Campus	Goodyear	AZ	623.882.1500		Y		Y	Y
Carondelet	Tucson	AZ	520.873.3000		Y	Y	Y	Y
Desert Regional	Palm Springs	CA	760.323.6511		Y	Y	Y	Y
Doctors Hospital of Manteca	Manteca	CA	209.823.3111			Y	Y	Y
Doctors Hospital of Modesto	modesto	CA	209.578.1211		Y		Y	Y
Emanuel Medical Center	TURLOCK	CA	209.667.4200		Y		Y	Y
Fountain Valley RH	FOUNTAIN VALLEY	CA	714.966.7200		Y	Y	Y	Y
Hi-Desert Medical Center	JOSHUA TREE	CA	760.366.3711		Y	Y	Y	Y
JFK MH	INDIO	CA	760 347 6191		Y	Y	Y	Y
Lakewood RMC	LAKEWOOD	CA	562 531 2550		Y		Y	Y
Placentia Linda	PLACENTIA	CA	714.993.2000		Y	Y	Y	Y
San Ramon	SAN RAMON	CA	925.275.9200		Y		Y	Y
Sierra Vista RMC	San Luis Obispo	CA	805.546.7600		Y		Y	Y
Turlock Imaging Services, LLC	Turlock	CA	209-669-0600	Y				
Twin Cities Community	Templeton	CA	805.434.3500		Y		Y	Y
Walker Street Imaging Care, Inc.	Cypress	CA	714-656-2130	Y				
Los Alamitos MC	LOS ALAMITOS	CA	562 598 1311		Y		Y	Y
Magnetic Resonance Imaging of San Luis Obispo, Inc.	San Luis Obispo	CA	805-546-7733	Y				
Modesto Radiology Imaging, Inc.	Modesto	CA	209-577-4444	Y				
Newhope Imaging Center, Inc.	Fountain Valley	CA	714-431-0303	Y				
Pleasanton Diagnostic Imaging, Inc.	Pleasanton	CA	925-467-1400	Y				
Templeton Imaging, Inc.	Templeton	CA	805-434-1491	Y				
Delray MC	Delray Beach	FL	561.498.4440		Y	Y	Y	Y
Good Samaritan	WEST PALM BEACH	FL	561.655.5511		Y	Y	Y	Y
Palm Beach Gardens MC	Palm Beach Gardens	FL	561.622.1411		Y	Y	Y	Y
St. Mary's MC	West Palm Beach	FL	561.844.6300		Y	Y	Y	Y
West Boca MC	Boca Raton,	FL	561.488.8000		Y	Y	Y	Y
Metrowest Med Ctr - Framingham	Framingham	MA	508.383.1000					Y
Metrowest Med Ctr - Morse Campus	Natick	MA	508.650.7000		Y			Y
St. Vincent Hospital	Worcester	MA	508.363.5000		Y	Y	Y	Y
Sun View Imaging, LLC	Las Cruces	NM	575-522-6236	Y				
Coastal Carolina MC	Hardeeville	SC	843.784.8000		Y		Y	Y
East Cooper Medical Center	Mt. Pleasant	SC	843.881.0100		Y	Y	Y	Y
Hilton Head MC	HILTON HEAD	SC	843.681.6122		Y	Y		Y
Piedmont HC	Rock Hill	SC	803.329.1234		Y	Y	Y	Y
St Francis	Memphis	TN	901.765.1000		Y	Y	Y	Y
St Francis Bartlett	Bartlett	TN	901.820.7000		Y	Y	Y	Y
Baptist Health System - San Antonio	San Antonio	TX	866.309.2873		Y	Y	Y	Y
Hospitals of Providence East Campus	EL PASO	TX	915.832.2000		Y	Y	Y	Y
Hospitals of Providence Memorial Campus	EL PASO	TX	915.577.6011		Y	Y	Y	Y
Hospitals of Providence Sierra Campus	EL PASO	TX	915.747.4000		Y	Y	Y	Y
Hospitals of Providence Transmountain Campus	EL PASO	TX	915 877 8136		Y	Y		Y
Nacogdoches MC	Nacogdoches	TX	936.569.9481		Y		Y	Y
Resolute	New Braunfel	TX	830.500.6000		Y	Y	Y	Y
Valley Baptist MC - Brownsville	Brownsville	TX	956.698.5400		Y	Y	Y	Y
Valley Baptist MC - Harlingen	Harlingen	TX	956.389.1100		Y	Y	Y	Y
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-351-0784	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-351-0784	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-692-9824	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-590-5822	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-681-6474	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-521-2989	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-423-3950	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-403-1600	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-339-9401	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-730-9600	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-350-3115	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-961-3570	Y				
VHS San Antonio Imaging Partners, LP	New Braunfels	TX	830-327-1878	Y				

APPROVAL LETTER

Sedgwick

<User Address>

<Today's_Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjuster: <CE_Name>

Claims File #: <ClaimNum_SCMS>

Employer: <Name>

Employer Entity Name: <Entity_Name>

Sedgwick on Behalf of Writing Co.: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

This correspondence pertains to the review of the following health care service:

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGrid(Certified by Nurse,Certified by PA)>

<Additional_Text("Please enter details about the description of service or treatment approved; i.e. "MRI of lumbar spine approved".")>

<PA_Received_Date>

Final UR Decision Date: <Final_UR_Decision_Date>

APPROVED SERVICES MAY BE SCHEDULED THROUGH THE LOCATIONS LISTED ON THE ATTACHMENT OR AT THE NEAREST TENET FACILITY

If this request is for medication, a therapeutically equivalent generic substitute is authorized. Authorization of the brand-name medication requires documentation of medical necessity and prior approval. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

After review of a request for authorization, it has been determined that the specific service(s) meets established criteria for medical necessity based on the information presented by the medical provider. This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process.

The medical provider, injured worker and workers' compensation payor have been notified of this decision.

This review applies only to the specific service(s) listed. Additional services require separate review.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

<User_Name>

<User_Title>

<User_Toll_Free_With_Ext>

<CC_Detailed_List>

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

<Append_PA_Report>

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS

EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE "DWC FORM RFA" FOR CONSIDERATION

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We have attached a copy for your convenience and we ask that you submit all future requests for treatment authorization on the form. We appreciate your cooperation.

Facility Name	City	State	Phone	Freestanding Imaging	CT	MRI	Ultrasound	X-ray
Brookwood Baptist Princeton	Birmingham	AL	205.783.3000					Y
Brookwood Medical Center	Birmingham	AL	205.877.1000		Y	Y	Y	Y
Brookwood Baptist Imaging, LLC, d/b/a Brookwood Diagnostic Center-Hoover	Birmingham	AL	205-802-6900	Y				
Brookwood Diagnostic Imaging Center LLC	Birmingham	AL	205-802-6900	Y				
Brookwood Womens Diagnostic Center LLC	Birmingham	AL	205-802-6900	Y				
Abrazo Arizona Heart Hospital	Phoenix	AZ	602.532.1000		Y		Y	Y
Abrazo Arrowhead Campus	Glendale	AZ	623.561.1000		Y	Y	Y	Y
Abrazo Central Campus	Phoenix	AZ	602.249.0212		Y	Y	Y	Y
Abrazo Scottsdale Campus	Phoenix	AZ	602.923.5000		Y	Y	Y	Y
Abrazo West Campus	Goodyear	AZ	623.882.1500		Y		Y	Y
Carondelet	Tucson	AZ	520.873.3000		Y	Y	Y	Y
Desert Regional	Palm Springs	CA	760.323.6511		Y	Y	Y	Y
Doctors Hospital of Manteca	Manteca	CA	209.823.3111			Y	Y	Y
Doctors Hospital of Modesto	Modesto	CA	209.578.1211		Y		Y	Y
Emanuel Medical Center	Turlock	CA	209.667.4200		Y		Y	Y
Fountain Valley RH	FOUNTAIN VALLEY	CA	714.966.7200		Y	Y	Y	Y
Hi-Desert Medical Center	JOSHUA TREE	CA	760.366.3711		Y	Y	Y	Y
JFK MH	INDIO	CA	760.347.6191		Y	Y	Y	Y
Lakewood RMC	LAKEWOOD	CA	562.531.2550		Y		Y	Y
Placentia Linda	PLACENTIA	CA	714.993.2000		Y	Y	Y	Y
San Ramon	SAN RAMON	CA	925.275.9200		Y		Y	Y
Sierra Vista RMC	San Luis Obispo	CA	805.546.7600		Y	Y	Y	Y
Turlock Imaging Services, LLC	Turlock	CA	209-669-0600	Y				
Twin Cities Community	Templeton	CA	805.434.3500		Y	Y	Y	Y
Walker Street Imaging Care, Inc.	Cypress	CA	714-656-2130	Y				
Los Alamitos MC	LOS ALAMITOS	CA	562.598.1311		Y		Y	Y
Magnetic Resonance Imaging of San Luis Obispo, Inc.	San Luis Obispo	CA	805-546-7733	Y				
Modesto Radiology Imaging, Inc.	Modesto	CA	209-577-4444	Y				
Newhope Imaging Center, Inc.	Fountain Valley	CA	714-431-0303	Y				
Pleasanton Diagnostic Imaging, Inc.	Pleasanton	CA	925-467-1400	Y				
Templeton Imaging, Inc.	Templeton	CA	805-434-1491	Y		Y		
Delray MC	Delray Beach	FL	561.498.4440		Y	Y	Y	Y
Good Samaritan	WEST PALM BEACH	FL	561.655.5511		Y	Y	Y	Y
Palm Beach Gardens MC	Palm Beach Gardens	FL	561.622.1411		Y	Y	Y	Y
St. Mary's MC	West Palm Beach	FL	561.844.6300		Y	Y	Y	Y
West Boca MC	Boca Raton,	FL	561.488.8000		Y	Y	Y	Y
Metrowest Med Ctr - Framingham	Framingham	MA	508.383.1000					Y
Metrowest Med Ctr - Morse Campus	Natick	MA	508.650.7000		Y			Y
St. Vincent Hospital	Worcester	MA	508.363.5000		Y	Y	Y	Y
Sun View Imaging, LLC	Las Cruces	NM	575-522-6236	Y				
Coastal Carolina MC	Hardeeville	SC	843.784.8000		Y		Y	Y
East Cooper Medical Center	Mt. Pleasant	SC	843.881.0100		Y	Y	Y	Y
Hilton Head MC	HILTON HEAD	SC	843.681.6122		Y	Y		Y
Piedmont HC	Rock Hill	SC	803.329.1234		Y	Y	Y	Y
St Francis	Memphis	TN	901.765.1000		Y	Y	Y	Y
St Francis Bartlett	Bartlett	TN	901.820.7000		Y	Y	Y	Y
Baptist Health System - San Antonio	San Antonio	TX	866.309.2873		Y	Y	Y	Y
Hospitals of Providence East Campus	EL PASO	TX	915.832.2000		Y	Y	Y	Y
Hospitals of Providence Memorial Campus	EL PASO	TX	915.577.6011		Y	Y	Y	Y
Hospitals of Providence Sierra Campus	EL PASO	TX	915.747.4000		Y	Y	Y	Y
Hospitals of Providence Transmountain Campus	EL PASO	TX	915.877.8136		Y	Y		Y
Nacogdoches MC	Nacogdoches	TX	936.569.9481		Y		Y	Y
Resolute	New Braunfels	TX	830.500.6000		Y	Y	Y	Y
Valley Baptist MC - Brownsville	Brownsville	TX	956.698.5400		Y	Y	Y	Y
Valley Baptist MC - Harlingen	Harlingen	TX	956.389.1100		Y	Y	Y	Y
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-351-0784	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-351-0784	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-692-9824	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-590-5822	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-681-6474	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-521-2989	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-423-3950	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-403-1600	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-339-9401	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-730-9600	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-350-3115	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-961-3570	Y				
VHS San Antonio Imaging Partners, LP	New Braunfels	TX	830-327-1878	Y				

PARTIAL APPROVAL

Sedgwick

<User Address>

<Today's _Date>

<Primary_Recipient_Name>

<Primary_Recipient_Address>

Claimant: <Claimant_Name>

Claims Payor: Sedgwick Claims Management Services, Inc. ("Sedgwick")

Adjustor: <CE_Name>

Claims File #: <ClaimNum_SCMS>

Employer: <Name>

Sedgwick on Behalf of Writing Co.: <CarrierName>

Date of Injury: <Date_Injury>

Date of Birth: <DateBirth>

Dear <Primary_Recipient_Name>,

After peer review of the medical information presented and/or discussion with the ordering practitioner, the following determination regarding the health care services(s) listed below has been established. This decision applies only to the specific service(s) listed below.

Request for Authorization First Received: <SCMSReceivedDate>

<RFM_All_Values>

Specific Request: <TP_Treatment_Requested>

<ProcedureCodeGridNegotiated>

<Additional_Text("Enter details about the specified procedure. Physician Reviewer Summary, Decision, Rationale and Guideline")>

<PA_Received_Date>

Final UR Decision Date: <Final_UR_Decision_Date>

APPROVED SERVICES MAY BE SCHEDULED THROUGH THE LOCATIONS LISTED ON THE ATTACHMENT OR AT THE NEAREST TENET FACILITY

When a medication request is approved, a therapeutically equivalent generic is authorized. Approval of the brand-name medication requires prior authorization and documentation of medical necessity. Treatment must be rendered by a provider within the MPN unless an exception applies under applicable California law.

To keep all parties informed, Sedgwick has notified the ordering practitioner, injured worker, the injured worker's attorney, if applicable, and workers' compensation payor of our review determination. This review is for medical necessity only. Fees/Pricing for treatment are not reviewed or approved via the utilization review process.

The review was made based on guidelines which are developed from current clinical principals and processes to ensure consistency in the review process. You may receive a copy of the complete clinical rationale used to make this decision by calling the number provided or forwarding a written request to the Sedgwick address listed on this letter.

If you disagree with this decision, you or your representative may submit a request for an internal appeal through Sedgwick's voluntary appeal process. To appeal this determination, submit a written request within 10 calendar days of the receipt of this decision, and provide additional information which explains the medical necessity of the service(s). Please send the appeal request and information to the Sedgwick address listed on this letter. If you believe this determination warrants an expedited appeal, you or your representative may request this by calling Sedgwick at <User_Toll_Free_With_Ext>. The fax number, <User_Fax> is available 24 hours a day 7 days a week to receive requests. Utilization review personnel are available between 9:00 a.m. and 5:30 p.m. Pacific Standard Time (PST) on normal business days at the toll free number listed on this letter. We will respond to your appeal within 30 calendar days of the date of this utilization review decision.

The internal appeals process is voluntary and does not trigger or bar the use of the dispute resolution procedures of Labor Code 4610.5 and 4610.6, but may be used on an optional basis.

Any dispute will be resolved in accordance with the independent medical review provision of Labor Code 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by you, your representative or attorney, if you are represented, on the enclosed Application for Independent Medical Review, DWC Form IMR, within <TP> Days_to_Dispute> calendar days from the mailing date of the utilization review decision to the employee, as indicated on the last page of the application. This deadline must be met even if participating in the internal utilization review appeals process. The Application for Independent Medical Review, DWC Form IMR, along with a self-addressed envelope, is again included with this notice if you have not yet filed for IMR.

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 any questions about the information in this notice, please call me, <CE_Name> at <CE_Phone>. However, if you are represented by an attorney, please contact your attorney instead of me.

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 decision shall remain in effect for twelve months from the date of the decision without further action with regard to any further recommendation by the same physician for the same treatment unless the recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Contact the claims adjuster for an explanation of coverage. This review applies only to the specific service(s) listed. Additional services require separate review.

You have the right to file a complaint by contacting the Utilization Review Department by calling toll-free 866-286-0281, fax 877-922-7236 or mailing to the address on this notice. We will respond to your complaint as quickly as possible but not longer than 30 days.

Sincerely,

Sedgwick Claims Management Services, Inc.

<CC_Detailed_List>

Enclosure: Application for Independent Medical Review
Self-Addressed Envelope

We value your privacy. For more on what personal information we may collect, how we may use this information, and other important areas relating to your privacy and data protection, please read our privacy notice at www.sedgwick.com.

PLEASE USE THE DWC FORM RFA FOR ALL FUTURE TREATMENT REQUESTS**EFFECTIVE JANUARY 1, 2015, ALL TREATMENT REQUESTS MUST BE SUBMITTED ON THE
“DWC FORM RFA” FOR CONSIDERATION**

Title 8 of the California Code of Regulations 9792.9.1 (c) (2) (A) and (B) allows the claims administrator to require a request for authorization to be submitted using the DWC Form RFA. The DWC Form RFA must be signed by the treating physician, identify with specificity a recommended treatment or treatments and be accompanied by documentation substantiating the need for the requested treatment. We agree to accept an electronic signature on the DWC Form RFA. (9792.6.1 (t) (1-3))

The DWC Form RFA can be accessed on the website at <http://www.dir.ca.gov/dwc/DWCPropRegs/IMR/IMRFormRFAClean.pdf> . We appreciate your cooperation.

Facility Name	City	State	Phone	Freestanding Imaging	CT	MRI	Ultrasound	X-ray
Brookwood Baptist Princeton	Birmingham	AL	205.783.3000					Y
Brookwood Medical Center	Birmingham	AL	205.877.1000		Y	Y	Y	Y
Brookwood Baptist Imaging, LLC, d/b/a Brookwood Diagnostic Center-Hoover	Birmingham	AL	205-802-6900	Y				
Brookwood Diagnostic Imaging Center LLC	Birmingham	AL	205-802-6900	Y				
Brookwood Womens Diagnostic Center LLC	Birmingham	AL	205-802-6900	Y				
Abrazo Arizona Heart Hospital	Phoenix	AZ	602.532.1000		Y		Y	Y
Abrazo Arrowhead Campus	Glendale	AZ	623.561.1000		Y	Y	Y	Y
Abrazo Central Campus	Phoenix	AZ	602.249.0212		Y	Y	Y	Y
Abrazo Scottsdale Campus	Phoenix	AZ	602.923.5000		Y	Y	Y	Y
Abrazo West Campus	Goodyear	AZ	623.882.1500		Y		Y	Y
Carondelet	Tucson	AZ	520.873.3000		Y	Y	Y	Y
Desert Regional	Palm Springs	CA	760.323.6511		Y	Y	Y	Y
Doctors Hospital of Manteca	Manteca	CA	209.823.3111			Y	Y	Y
Doctors Hospital of Modesto	modesto	CA	209.578.1211		Y		Y	Y
Emanuel Medical Center	TURLOCK	CA	209.667.4200		Y		Y	Y
Fountain Valley RH	FOUNTAIN VALLEY	CA	714.966.7200		Y	Y	Y	Y
Hi-Desert Medical Center	JOSHUA TREE	CA	760.366.3711		Y	Y	Y	Y
JFK MH	INDIO	CA	760 347 6191		Y	Y	Y	Y
Lakewood RMC	LAKEWOOD	CA	562 531 2550		Y		Y	Y
Placentia Linda	PLACENTIA	CA	714.993.2000		Y	Y	Y	Y
San Ramon	SAN RAMON	CA	925.275.9200		Y		Y	Y
Sierra Vista RMC	San Luis Obispo	CA	805.546.7600		Y		Y	Y
Turlock Imaging Services, LLC	Turlock	CA	209-669-0600	Y				
Twin Cities Community	Templeton	CA	805.434.3500		Y		Y	Y
Walker Street Imaging Care, Inc.	Cypress	CA	714-656-2130	Y				
Los Alamitos MC	LOS ALAMITOS	CA	562 598 1311		Y		Y	Y
Magnetic Resonance Imaging of San Luis Obispo, Inc.	San Luis Obispo	CA	805-546-7733	Y				
Modesto Radiology Imaging, Inc.	Modesto	CA	209-577-4444	Y				
Newhope Imaging Center, Inc.	Fountain Valley	CA	714-431-0303	Y				
Pleasanton Diagnostic Imaging, Inc.	Pleasanton	CA	925-467-1400	Y				
Templeton Imaging, Inc.	Templeton	CA	805-434-1491	Y				
Delray MC	Delray Beach	FL	561.498.4440		Y	Y	Y	Y
Good Samaritan	WEST PALM BEACH	FL	561.655.5511		Y	Y	Y	Y
Palm Beach Gardens MC	Palm Beach Gardens	FL	561.622.1411		Y	Y	Y	Y
St. Mary's MC	West Palm Beach	FL	561.844.6300		Y	Y	Y	Y
West Boca MC	Boca Raton,	FL	561.488.8000		Y	Y	Y	Y
Metrowest Med Ctr - Framingham	Framingham	MA	508.383.1000					Y
Metrowest Med Ctr - Morse Campus	Natick	MA	508.650.7000		Y			Y
St. Vincent Hospital	Worcester	MA	508.363.5000		Y	Y	Y	Y
Sun View Imaging, LLC	Las Cruces	NM	575-522-6236	Y				
Coastal Carolina MC	Hardeeville	SC	843.784.8000		Y		Y	Y
East Cooper Medical Center	Mt. Pleasant	SC	843.881.0100		Y	Y	Y	Y
Hilton Head MC	HILTON HEAD	SC	843.681.6122		Y	Y		Y
Piedmont HC	Rock Hill	SC	803.329.1234		Y	Y	Y	Y
St Francis	Memphis	TN	901.765.1000		Y	Y	Y	Y
St Francis Bartlett	Bartlett	TN	901.820.7000		Y	Y	Y	Y
Baptist Health System - San Antonio	San Antonio	TX	866.309.2873		Y	Y	Y	Y
Hospitals of Providence East Campus	EL PASO	TX	915.832.2000		Y	Y	Y	Y
Hospitals of Providence Memorial Campus	EL PASO	TX	915.577.6011		Y	Y	Y	Y
Hospitals of Providence Sierra Campus	EL PASO	TX	915.747.4000		Y	Y	Y	Y
Hospitals of Providence Transmountain Campus	EL PASO	TX	915 877 8136		Y	Y		Y
Nacogdoches MC	Nacogdoches	TX	936.569.9481		Y		Y	Y
Resolute	New Braunfel	TX	830.500.6000		Y	Y	Y	Y
Valley Baptist MC - Brownsville	Brownsville	TX	956.698.5400		Y	Y	Y	Y
Valley Baptist MC - Harlingen	Harlingen	TX	956.389.1100		Y	Y	Y	Y
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-351-0784	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-351-0784	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-692-9824	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-590-5822	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-681-6474	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-521-2989	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-423-3950	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-403-1600	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-339-9401	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-730-9600	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-350-3115	Y				
VHS San Antonio Imaging Partners, LP	San Antonio	TX	210-961-3570	Y				
VHS San Antonio Imaging Partners, LP	New Braunfels	TX	830-327-1878	Y				

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 Type of Utilization Review:**

<TP_Standard_Review> Regular
Appeal

<TP_Expedited_Review> Expedited

<TP_Mod_after_Appeal> Modification after

<Additional_Text("
Please enter X if
review is for MTUS
formulary
medication
only.")>
Medication Only –
MTUS Formulary
Drug List

<Additional_Text("
Please enter X if
review is Retro for
Exempt Treatment
(Non-Drug).")>
Retrospective for
Exempt Treatment
(Non-Drug)

<Additional_Text("
Please enter X if
review is Retro for
Exempt Treatment
(Drug).")>
Retrospective for
Exempt Treatment
(Drug)

Employee Information:

First Name: <Claimant_FirstName> Middle Initial: Last Name: <Claimant_LastName>
Address: <Claimant_Address> City: <Claimant_City>
State: <Claimant_State> Zip Code: <Claimant_ZipCode> Telephone Number: <Claimant_home_phone>
Fax Number: Date of Injury: <Date_Injury>
Insurance Claim Number: <ClaimNum_SCMS>_ EAMS Case Number: <EAMS>
WCIS Jurisdictional Claim Number (if assigned): <ClaimNum_State>
Employee Attorney (if known): <Plaintiff_Attorney_Name>
Address: <Plaintiff_Attorney_Address> City: <Plaintiff_Attorney_City>
State: <Plaintiff_Attorney_State> Zip Code: <Plaintiff_Attorney_ZipCode> Telephone Number: <Plaintiff_Attorney_Phone>
Fax Number: <Plaintiff_Attorney_Fax_Number>

Requesting Physician Information:

Physician First Name: <Provider_FirstName> Middle Initial: Last Name: <Provider_LastName>
Practice Name: <CA_IMR_Provider_Company_Name>
Address: <CA_IMR_Provider_Address> City: <CA_IMR_Provider_City>
State: <CA_IMR_Provider_State> Zip Code: <CA_IMR_Provider_ZipCode> Telephone Number: <CA_IMR_Provider_Phone_Number>
Fax Number: <CE_Fax_Number> Specialty: <CA_IMR_Provider_Specialty>

Claims Administrator Information:

Employer Name: <Name>
Name of Administrator: Sedgwick Claims Management Services, Inc. Contact Name: <CE_Name>
Address: <CE_Address> City: <CE_City> State: <CE_State> Zip Code: <CE_ZipCode>
Telephone Number: <CE_Phone> Fax Number: <CE_Fax_Number>

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):
<TP_Dx_Codes>

* Mailing Date of the Utilization Review Determination Letter: <TP_Date_UR_Decision>

Is the Claims Administrator disputing liability for the requested medical treatment for reasons besides the question of medical necessity?

<Additional_Text("Please enter X if CE Disputing Liability for requested medical treatment besides question of medical necessity.")> Yes

<Additional_Text("Please enter X if CE isn't Disputing Liability.")> No

Reason:

<Additional_Text("Please enter why liability is being disputed.")>

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.

- 21. <TP_First_Treatment>
- 22. <TP_Second_Treatment>
- 23. <TP_Third_Treatment>
- 24. <TP_Fourth_Treatment>

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:

<TP_Days_to_Dispute> days from the mailing date of the written determination letter.

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.