DWC DIVISION OF WORKERS' COMPENSATION
CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS

Division of Workers' Compensation
Department of Industrial Relations
State of California

Form UR-01

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

Select: ☐New Plan ☐Material Modification

1. UR Plan Information

Name of UR Plan Applicant: AF Group

Address: P.O. Box 40790 City: Lansing

State: MI Zip Code: 48901 Telephone Number: 844-462-2344

Fax Number: 877-607-7419 E-mail address: urauthorizationsafgroup@afgroup.com

Type of Entity Filing: Choose an item.

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2. UR Plan Contact Person Information

First Name: KIm Middle Initial: Last Name: Malisa

Title: Director Medical Management Claims

Address: 200 N. Grand Ave City: Lansing

State: MI Zip Code: 48901 Telephone Number: 517-708-6425

Fax Number: 877-607-7419 E-mail address: Kim.malisa@afgroup.com

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3. Medical Director Information

First Name: Marcos Middle Initial: A Last Name: Iglesias

Address: P.O. Box 40790 City: Lansing

State: MI Zip Code: 48901 Telephone Number: 3056194119

Fax Number: 877-607-7419 E-Mail Address: Marcos.Iglesias@afgroup.com

CA License No.: A 96655 NPI: 1073528428

Board Certified Specialty (if any): Family Medicine 095666

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4. URAC Accreditation: Choose an item.

Accreditation Status: Full URAC accreditation

Original accreditation date: 10/1/20

Most recent accreditation date: 10/1/23 Expiration Date: 10/1/26

Comments:

Currently in the re-accredidation process

5. UR Plan Client and Vendor Information

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

Accident Fund General Insurance Company
Accident Fund National Insurance Company
United Wisconsin Insurance Company
Third Coast Insurance Company
CompWest Insurance Company

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

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

Prior Authorization - Concurrent Review- Peer to Peer Review- Appeals - Reconsiderations Contracted vendors, Peerlink Medical, Dr. Benson Wu, Dr. Michael Randall, Dr. Gary Taff - All CA licensed and board certified.

6. Material Modification to UR Plan

If applicable, describe the changes that were made.

NA

Signature of authorized individual: I, the undersigned Medical Director of the UR Plan named herein, have signed this document with knowledge of its contents, and verify that they are true and correct to the best of my knowledge and belief. I further understand that the DWC's approval of the UR plan identified herein does not equate to approval of policies and procedures that are contrary to law, and any such approval is unintended.

Name of Medical Director: Marcos Iglesias, M.D.

Date: 7/30/26 Signature: Marcos A Iglesias MD

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Name of Medical Director: Marcos Iglesias, M.D.

Date: 7/30/26 Signature: Marcos A Iglesias MD

CERTIFICATE OF AWARD

in recognition of

Compwest Insurance Co
200 N. Grand Ave.
Lansing, Michigan 48901

for compliance with

Workers' Compensation Utilization Management 8.1 Accreditation Program

is awarded

Full Accreditation

Effective from 10/01/2023 through 10/01/2026

Shawn Griffin, MD
President & Chief Executive Officer

Certificate Number: WUM010005

ACCREDITED

URAC accreditation is assigned to the organization and address named in this certificate and is not transferable to subcontractors or other affiliated entities not accredited by URAC.

URAC accreditation is subject to the representations contained in the organization's application for accreditation. URAC must be advised of any changes made after the granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of URAC and shall be returned upon request.

AF GROUP

Utilization Review Plan

Revised 7/30/2026

Medical Director

Marcos Iglesias, MD

Table of Contents

Introduction

Purpose:
The Utilization Review Program of AF Group is predicated on the need for appropriate medical care for the injured worker based on realistic evidence-based criteria, which is reasonably medically necessary to cure or relieve the effects of that injury or illness. It is the goal of AF Group to enhance communication between the necessary parties to support the medical standards and guidelines used in the decision.

Document Scope:
The following document will provide a description of the Utilization Review Program and the processes necessary to fulfill the intent of the program including:

1. Utilization review criteria documentation
2. The medical team participating in the decisions
3. The communication management guidelines
4. The timeframes and processes followed to manage compliance with the regulations

Utilization Review Definitions:

ACOEM Practice Guidelines means the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Second Edition.

Authorization means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed "Request for Authorization," as defined in this section, that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, sections 9792.9.1 through 9792.12.

Claims Administrator is a self-administered workers' compensation insurer of an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator or other entity subject to Labor Code § 4610, the California Insurance Guarantee Association, and the director of the Department of Industrial Relations as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF). "Claims administrator" includes any utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities.

Concurrent review means utilization review conducted during the hospital stay.

Course of treatment means the course of medical treatment set forth in the treatment plan contained on the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, found at California Code of Regulations, title 8, section 14006.1, or on the applicable physician reporting forms authorized by section 9785.

Denial means a decision by a physician reviewer that the requested treatment or service is not authorized.

Dispute liability means an assertion by the claims administrator that a factual, medical or legal basis exists, other than medical necessity, that precludes compensability on the part of the claims administrator

for an occupational injury, a claimed injury to any part or parts of the body, or a requested medical treatment.

Emergency health care services means health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy.

Expedited review means utilization review or independent medical review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process would be detrimental to the injured worker's life or health or could jeopardize the injured worker's permanent ability to regain maximum function.

Expert reviewer means a medical doctor, a doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner, licensed in any state or District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment services and where these services are within the individual’s scope of practice qualifications, who has been consulted by the reviewer or the utilization review medical director to provide specialized review of medical information.

Health care provider means a provider of medical services, as well as related services or goods, including but not limited to an individual provider or facility, a health care service plan, a health care organization, a member of a preferred provider organization or medical provider network as provided in Labor Code section 4616.

Immediately means within one business day.

Material modification is when the claims administrator changes utilization review vendor or makes a change to the utilization review standards as specified in section 9792.7 or changes its medical director, address, company name, or corporate structure.

Medical director is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California who holds an unrestricted license to practice medicine in the State of California. The medical director is responsible for all decisions made in the utilization review process.

Medical services are those goods and services provided pursuant to Article 2 (commencing with Labor Code section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code.

Medical treatment utilization schedule means the standards of care adopted by the administrative director pursuant to Labor Code § 5307.27 and set forth in Article 5.5.2 of this Subchapter, beginning with section 9792.20.

Modification is a decision by a physician reviewer that part of the requested treatment or service is not medically necessary.

MTUS Drug Formulary refers to the list of drugs approved for use in the **Medical Treatment Utilization Schedule (MTUS)**, which is the set of regulations (8 CCR §§ 9792.20–9792.27.23) that establish the standards for determining what is reasonable and necessary medical care for injured workers.

Normal business day or "business day" does not include Saturday, Sunday, or any day that is declared by the Governor to be an official state holiday or a holiday listed on the Department of Human Resources internet website.

Prospective review means any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services.

Request for authorization means a written request for authorization of a specific course of proposed medical treatment that meets all of the following criteria:

(1) Unless accepted by a claims administrator under section 9792.9.1(b), a request for authorization must be set forth on a "Request for Authorization (DWC Form RFA)" as contained in California Code of Regulations (CCR), title 8, section 9785.5, completed by a treating physician and as further outlined in this subdivision and in section 9785(h).

(2) "Completed," for the purpose of this section and for purposes of investigations and penalties, means that the request for authorization identifies both the employee and the requesting provider; identifies with specificity all the recommended treatments in the designated section for requests for authorization if a form is used, or, on the first page if a narrative report is used; and is accompanied by documentation, issued or created no earlier than 30 days before the date of submission of the request for authorization, that substantiates the need for the requested treatment. A request for authorization shall be deemed completed following receipt of information, test results, or a specialized consultation requested under section 9792.9.6.

(3) The request for authorization must be signed by the treating physician and may be mailed, faxed, or, if available, sent electronically through the use of an encrypted email system or via electronic data interchange (EDI) to the address, fax number, e-mail address, or clearinghouse designated by the claims administrator under section 9781(d)(5) for this purpose. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

Retrospective review is a utilization review conducted after medical services have been provided and for which approval has not already been given.

Reviewer means a medical doctor, doctor of osteopathy, psychologist, acupuncturists, optometrist, dentist, podiatrist or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate specific clinical issues involved in the medical treatment services, where these services are within the scope of the reviewer's practice.

"Non-physician reviewer" means an individual designated by the claims administrator or utilization review organization to assist in determining the medical necessity of the requested treatment. A non-physician reviewer may not modify or deny a treatment request.

Utilization review process means utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, treatment recommendations by physicians, as defined in Labor Code section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Labor Code section 4600. The utilization review process begins when a completed request for authorization, or a request for authorization accepted as complete under section 9792.9.1(b), is first received by the claims administrator, or in the case of prior authorization, when the treating physician satisfies the conditions described in the utilization review plan for prior authorization.

Written includes communication transmitted by facsimile or in paper form. Electronic mail may be used by agreement of the parties although an employee's health records shall not be transmitted via electronic mail.

Utilization Review Standards

AF Group conducts utilization review in accordance with Labor Code section 4610 and California Code of Regulations, Title 8, sections 9792.6.1 through 9792.15, including sections 9792.9.1 through 9792.9.8, as amended effective April 1, 2026.

Requests for authorization, utilization review determinations, approvals, modifications, denials, deferrals, extensions, notifications, and all utilization review timeframes shall be administered in accordance with applicable California workers' compensation utilization review regulations.

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 regarding any further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment, unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Utilization Review Policy and Procedure
Prospective, Concurrent and Retrospective Review

Pursuant to Labor Code section 4610, AF Group will conduct utilization review in accordance with Labor Code section 4610 and California Code of Regulations, Title 8, Division of Workers' Compensation, Subchapter 1, Article 5.5.1, Utilization Review Standards, including sections 9792.6.1 through 9792.15, as amended. These regulations are incorporated herein by reference.

This Utilization Review Process will be coordinated through the services of utilization review nurses, physician advisors, medical advisors and/or the medical director. The MTUS (Medical Treatment Utilization Guidelines), since its adoption as of April 15, 2007, and the guidelines adopted into the MTUS, are considered presumptively correct on the issue of extent and scope of medical treatment. The presumption is rebuttable and may be controverted by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury. For all conditions or injuries not addressed by MTUS, authorized treatment shall be in accordance with other established evidence-based medical treatment guidelines, including but not limited to the ACOEM Practice Guidelines, the medical disability advisor (Presley-Reed, M.D.), the Official Disability Guidelines (O.D.G.) or Interquel. Any of these guidelines should be applied to cases where the MTUS does not cover the specific injury sustained by the injured employee. Subscriptions to each of the guidelines indicated above have been secured which provide updates as developed. These updates are

incorporated into the review process as they are issued. Review criteria shall be updated automatically to include any and all changes in said guidelines upon notification of any such published changes. AF Group shall contact each of the above-named publishers a minimum of every six months to determine if any changes have occurred and obtain said information immediately. These guidelines and procedures will be in accordance with all the rules, regulations, laws and guidelines of the State of California, as adopted by the California governing bodies.

For all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury, shall be authorized without prospective utilization review, except as provided in subdivision (c). The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. In the event that the employee is not subject to treatment with a medical provider network, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the employee shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a physician or facility selected by the employer. For treatment rendered by a medical provider network physician, health care organization physician, a physician predesignated pursuant to subdivision (d) of Section 4600, or an employer selected physician, the report required under Section 6409 and a complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation.

Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

(1)Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27
(2)Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.
(3)Psychological treatment services
(4)Home health care services
(5)Imaging and radiology services, excluding X-rays
(6)All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical fee schedule
(7)Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies
(8)Any other service designated and defined through rules adopted by the administrative director

A utilization review process that modifies or denies requests for authorization of medical treatment shall be accredited on or before July 1, 2018, and shall retain active accreditation while providing utilization review services, by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including, but not limited to, timeliness in issuing a utilization review decision, the scope of medical material used in issuing a utilization review decision, peer-to-peer consultation, internal appeal procedure, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision. The administrative director shall adopt rules to implement the selection of an independent, nonprofit organization for those accreditation purposes. Until those rules are adopted, the

administrative director shall designate URAC as the accrediting organization. The administrative director may adopt rules to do any of the following:

(A) Require additional specific criteria for measuring the quality of a utilization review process for purposes of accreditation.

(B) Exempt nonprofit, public sector internal utilization review programs from the accreditation requirement pursuant to this section, if the administrative director has adopted minimum standards applicable to nonprofit, public sector internal utilization review programs that meet or exceed the accreditation standards developed pursuant to this section.

The following Medical Treatment Utilization Schedule (MTUS) has been included in the Utilization Review Plan Effective June 1, 2007, as amended:

Workers' Compensation Final Regulations
Medical Treatment Utilization Schedule Regulations
Title 8, California Code of Regulations
Sections 9792.20 - 9792.26

Additional regulations were filed with Secretary of State on June 18, 2009, Effective July 18, 2009, as subsequently amended, including amendments effective April 1, 2026

Article 5.5.2 Medical Treatment Utilization Schedule, inclusive of all Sections:

Section 9792.20 – Medical Treatment Utilization Schedule – Definitions
(a) – (l) – inclusive of all subsections
Section 9792.21 – Medical Treatment Utilization Schedule
(a) – (c) – inclusive of all subsections
Section 9792.22 – General Approaches
Section 9792.23 – Clinical Topics
(a) – (b) – inclusive of all subsections

Regulations Effective May 2007

The following Medical Treatment Utilization Schedule (MTUS) has been included in the Utilization Review Plan Effective July 18, 2007 as amended:

Article 5.5.2 Medical Treatment Utilization Schedule, inclusive of all Sections:

Section 9792.24 – Special Topics – Inclusive of all subsections
Section 9792.24.1 – Acupuncture Medical Treatment Guidelines (a) – (e) – inclusive of all subsections
Section 9792.24.2 – Chronic Pain Medical Treatment Guidelines
(a) – (e) – inclusive of all subsections

Regulations Effective July 18, 2009, in addition as other guidelines are adopted by MTUS, these will also be considered as primary, as well.

1. Upon receipt of the request for Utilization Review, the Utilization Review Process is initiated within one (1) business day. Where the request is submitted by the patient, attending provider, or facility rendering service the process is initiated within one (1) business day of receipt.

   A. When the UR Nurse receives a telephone call or written correspondence from the treating physician, requesting authorization for a proposed treatment the UR nurse, the medical director, or other medical advisor, shall obtain the medical information necessary to make a determination to certify, modify or deny a request for services. However, only a licensed physician can make the decision to modify or deny decisions.

      Treatment recommendations must be from physicians, as defined in Labor Code section 3209.3. Requests for authorization shall be submitted in accordance with the applicable physician reporting forms authorized by California Code of Regulations, Title 8, section 9785 and applicable utilization review requirements.

      Authorization of requested service means the assurance that the appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code.

   B. In the event there is a requirement for emergency health care services, defined as health care services for a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to place the patient's health in serious jeopardy, the Utilization Review Process shall be initiated within one (1) business day after notification of such an event. Documentation for emergency health care services shall be made available.

2. Information collected will include:

   Patient name, address, phone number, date of birth, insurance ID number; employee name, social security number, address, phone number, employer group; treating physician, address, phone number and tax ID number; facility name, address phone number and tax ID number; and diagnosis, proposed treatment plan and medical information to support the treatment plan. Data is entered into a secure computer application, and information is shared with all disciplines within the UR department that have a need to know to complete the review process.

   A. When conducting prospective review, concurrent review or retrospective review, the UR nurse:

      (1) Will collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services.

      (2) Will request from hospitals, physicians, and other providers the numerical code of the diagnosis (ICD-9) or procedure (CPT code) to be considered for certification.

      (3) May request appropriate information which is necessary to render a decision that was not provided with the original request for authorization.

      (4) Requires only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service, or length of anticipated inability to return to work; and

B. In situations where there is insufficient information to conduct the review, the UR Nurse will make at least two (2) attempts to notify the requesting physician within the UR process timeframes required by law, of the need for additional information, the information needed, and the method by which to submit it. One attempt must be by fax or mail, as well as by phone.

- The requesting physician shall provide the requested information within fourteen (14) days of the request for prospective or concurrent review, or within thirty (30) days of the request for retrospective review.

- If the requested information necessary to make a utilization review determination is not received within fourteen (14) days of the request 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 the applicable rules in section 9792.9.6.

Our non-certification correspondence indicates reason for non-certification and is accompanied with our appeals process and forwarded to the requesting physician, injured worker and injured worker's attorney within one (1) business day of the determination. If the treatment plan is non-certified for lack of information and the patient, attending provider, provider or facility rendering service subsequently provides complete clinical information within the allowable timeframe, the UR nurse can certify the treatment plan. If the UR nurse is unable to certify the treatment plan, the original medical advisor or medical director who denied the treatment plan for lack of information can re-review the treatment plan to make a determination.

3. The Initial clinical review is conducted by a UR Nurse who reviews the proposed treatment plan for medical appropriateness and necessity using **MTUS** and/or other medically recognized criteria when an MTUS guideline does not address the condition or requested treatment**. MTUS must be used first, then if the treatment or condition is not addressed in MTUS, the other evidence-based criteria may be used** If the treatment plan is not supported by the initial clinical information provided, or if the provider is unable to be contacted. Then the case will be referred to for physician peer clinical review within 24 hours. No person other than a California licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve ("reasonably medically necessary"). A. Peer clinical reviews are only performed by individuals who:

(1) Are licensed physicians qualified, as determined by the medical director or clinical director, to render a clinical opinion about the medical condition, procedures, and treatment under review.

(2) Reside in California and hold a current and valid license to practice medicine in the State of California in the same license category as the ordering provider; some of the peer reviewers also hold licenses in other states; and

(3) Meet all applicable State Utilization Review requirements.

B. Health professionals conducting peer clinical reviews will be available, by telephone, or in person, to discuss review determinations with attending physicians or other ordering providers.

4. UR process timeframes are inclusive of the entire UR process from receipt of the request for a UR decision to the issuance of the decision. Issuance of review determinations are made in accordance with the following timeframes:

A. For prospective review, AF Group will issue a determination:

(1) Within five business days of the request for a utilization management determination, if it is a non-urgent case. However, if appropriate information which is necessary to render a decision is not provided with the original request, such information may be requested within the first five days of receipt of the RFA to make the proper determination, but in no event shall the determination be made more than fourteen (14) calendar days from the date of the original request by the provider. The request must be addressed within the initial five business day rule or sooner, if possible. If the utilization Review determination is a denial based upon the lack of receipt of the requested appropriate information within fourteen (14) days to make the proper determination, upon receipt of such reasonable information all requests will be reconsidered and the normal time frames for a prospective review shall be applied.

(1)(a) Expedited reviews shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination. The requesting physician must certify in writing and document the need for expedited review upon submission of the request. A request for expedited review that is not reasonably supported by evidence establishing the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under 9792.9.3(b) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe in submission (b).

B. For concurrent review, defined as utilization review conducted during an inpatient stay, AF Group will issue a determination:

(1) Within five working days of the request for a utilization management determination, if it is a non-urgent case. However, if appropriate information which is necessary to render a decision is not provided with the original request, such information may be requested within the first five business days of receipt of the RFA to make the proper determination, but in no event shall the determination be made more than 14 calendar days from the date of the original request by the provider. If the utilization review determination is a denial based upon the lack of receipt of the requested appropriate information within fourteen (14) calendar days to make the proper determination, upon receipt of such reasonable information all requests will be reconsidered and the normal time frames for a concurrent review shall be applied. If a denial due to lack of information has been sent and then requested information is received after 14 days, the request will be considered and a decision rendered within five working days from the date of receipt of the requested necessary information.

(2) Expedited reviews shall be made in a timely fashion appropriate to the injured worker's condition, not to exceed 72 hours after the receipt of the written information reasonably

necessary to make the determination. The requesting physician must certify in writing and document the need for an expedited review upon submission of the request. A request for expedited review is not reasonably supported by evidence establishing that the injured worker faced an imminent and serious threat to his or her health, or that the timeframe for utilization review under 9792.9.3(b) would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe in subdivision(b).

(3) In the case of concurrent review, medical care shall not be discontinued until the requested physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the injured worker.

C. For retrospective review, AF Group will issue a determination:

(1) Within 30 calendar days of the request for a utilization review determination.

D. Extension of Timeframe for Decision

(1) The timeframes set forth in section 9792.9.3 may be extended only if:
   a. The claims administrator or reviewer is not in receipt of all information reasonably necessary to make a determination;
   b. The reviewer has requested a reasonable and professionally recognized medical examination or test necessary to make a determination; or
   c. The reviewer requires consultation and review by an expert reviewer in an appropriate specialty

(2) If the reviewer is not in receipt of all information reasonably and necessary to make a determination, the reviewer shall request the missing information from the treatment physician within five (5) business days of the receipt of the request for authorization.
(3) If an additional examination, test or expert review is required, the physician reviewer shall notify the treating physician, the injured worker, and the injured worker's attorney, if any, within 5 business days of receipt of the request for authorization that the reviewer cannot make a determination within the required timeframe and shall identify the examination, test, or specialty consultation needed.
(4) If the information requested is not received within fourteen (14) days for prospective or concurrent review, or thirty (30) days for retrospective review, the request shall be denied in accordance with rules in section 9792.9.5 (e)
(5) If the result of the requested examination, test, or expert review are not received within thirty (30) days of the request, the reviewer shall deny the treatment physicians request in accordance with the applicable requirements under section 9792.9.5(e).

5. Decisions to approve, modify or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to injured workers, shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in approval, modifications or denial of all or part of the requested health care services shall be communicated to physicians initially by telephone or facsimile, and to the physician, injured worker, and if the injured worker is represented by counsel, the injured worker's attorney, in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review. In addition, the non-physician provider of goods

or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying or denying a request for authorization that shall **not** include the rationale, criteria or guidelines used for the decision. AF Group will only notify the provider of the goods or facility, the decision rendered.

A. The UR nurse will recommend certification of the proposed treatment plan that appears medically appropriate, according to medical criteria.

(1) Notification of Certification decision is communicated to the requesting physician within 24 hours of the decision and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician within 24 hours of the decision for concurrent review and within 2 (two) business days for prospective review. (California Code of Regulations, Title 8, section 9792.9.4)

(2) Confirmation of certification for continued hospitalization or services includes the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

(3) All decisions to approve a request for authorization shall specify

a. The date on which the completed DWC Form RFA was first received
b. The date on which the decision was made
c. A description of the specific course of proposed medical treatment for which authorization was requested; and
d. A specific description of the medical treatment service approved
e. If applicable, the date a request was made for additional information, examination, or consultation pursuant to section 9792.9.6 and the date the information was received;
f. For drug approvals where the request did not indicate “Do Not Substitute” or “Dispense as Written,” the written decision shall state “generic substitute authorized” or equivalent language;
g. For drug approvals of items exempt under MTUS Drug Formulary. The written decision shall state “Exempt per MTUS Drug Formulary” or equivalent language; and
h. For non-drug treatment approvals under the 30-day exemption, the written decision shall identify the exempt treatment as a “30-day exemption or equivalent language.

(4) For retrospective review:

a. The written approval must be communicated to:
b. The requesting physician who provided the medical services.
c. The individual who received the medical services.
d. The individual’s attorney/designee, if applicable

In Non-Certification decisions, notification is provided to the attending physician or other ordering provider rendering service through a method that will be received within 24 hours of the noncertification decision and will be communicated to the requesting physician initially by telephone, facsimile or electronic mail. The communication by telephone shall be followed by written notice to the requesting physician, the injured worker, and if injured worker is represented by counsel, the injured worker’s attorney within 24 hours of the decision for

concurrent review and within 2 (two) business days for prospective review and for expedited review within 72 hours of the receipt of the request. Failure to obtain authorization prior to providing emergency health care services shall not be an acceptable basis for refusal to cover medical services provided to treat and stabilize an injured worker presenting for emergency health care services. Emergency health care services may be subjected to retrospective review. Documentation for emergency health care services shall be made available to the claims administrator upon request. California Code of Regulations, Title 8, section 9792.9.5.

For retrospective review written decisions modifying or denying treatment authorization shall be communicated to the requesting physician who provided the medical services and to the individual who received medical services, and his or her attorney/designee if applicable, within thirty (30) calendar days of the receipt of the request for authorization.

(1) In addition, the non-physician provider of goods or services identified in the request for authorization, and for whom contact information has been included, shall be notified in writing of the decision modifying or denying a request for authorization that shall not include the rationale, criteria or guidelines used for the decision.

(2) The written decision modifying or denying treatment authorization shall be provided to the requesting physician, the injured worker, the injured worker's representative, and if the injured worker is represented by counsel, the injured worker's attorney. The written decision shall be signed by either the claims administrator or the reviewer, and shall only contain the following information specific to the request:

A) The date on which the DWC Form RFA was first received

B) If the timeframe for decision was extended under section 9792.9.6, 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, exam, or consultation under subdivision (a)(1)(A), (B), or (C) of section 9792.9.6 were requested; the manner in which the requests were made; and the date the information was first received.

C) The date on which the decision is made

D) A description of the specific course of proposed medical treatment for which authorization was requested

E) A list of all medical records provided

F) A specific description of the medical treatment service approved, if any

G) A clear, concise and appropriate explanation in plain language where possible of the reasons for the reviewing physician's decision, including the clinical reasons regarding medical necessity or; if applicable, that the requesting physician did not provide sufficient information with the request in order to reasonably make a medical necessity determination, and, if so, identification of the missing information, and a statement that the requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation.

Where the requesting physician has expressly opined that prerequisite treatment or criteria, as recommended under applicable treatment guidelines, should be

overlooked or is irrelevant to the requested treatment, the reviewing physician shall provide an explanation for why the requesting physician's explanation is insufficient.

H) For decisions based on medical necessity, a citation to and a description of the relevant medical criteria or guidelines used to reach the decision

I) Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision

J) The Application for Independent Medical Review, DWC Form IMR. 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. Prior to March 1, 2014, any version of the DWC Form IMR adopted by the administrative director under section 9792.10.2 may be used by the claims administrator in a written decision modifying or denying treatment authorization.

K) A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code § 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.

L) 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 adjuster's or appropriate contact's name in parentheses). at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me."
And
"For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401."

M) Details about the claims administrator's internal utilization review appeals process for the requesting physician, if any, including with respect to disputes over the necessity of or availability of the requested information and a clear statement that the internal appeals process is a voluntary process that neither triggers nor bars use of the dispute resolution procedures of Labor Code § 4610.5 and 4610.6, but may be pursued on an optional basis.

N) The written decision modifying or denying treatment authorization provided to the requesting physician shall also contain the name and specialty of the reviewer or expert reviewer, and the telephone number in the United States of the reviewer or expert reviewer. The written decision shall also disclose the hours of availability of either the reviewer, the expert reviewer or the medical director for the treating physician to discuss the decision, which shall be, at minimum, four (4) hours per week during normal business hours, 9 a.m. to 5:30 p.m. Pacific Time, or an agreed-upon scheduled time to discuss the decision

with the requesting physician. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

(C)When a determination is made to issue a non-certification and no peer-to-peer conversation has occurred, AF Group will provide, within one (1) business day of a request by the attending physician or ordering provider, the opportunity to discuss the non-certification decision with the clinical peer advisor making the initial determination, or, with a different clinical peer if the original clinical peer advisor cannot be available within one (1) business day.

6. Prospective and concurrent review determinations are solely based on the information obtained by the UR Nurse or Peer Reviewer at the time of the review determination; for retrospective review, the determinations are solely based on medical information available to the attending or ordering provider at the time medical care was provided. A reverse of certification can only occur when there is receipt of additional medical information that is materially different from that which was reasonably available at the time of the original determination. Based on Labor Code § 4610.3 which states an employer that authorizes medical treatment shall not rescind or modify that authorization after the medical treatment has been provided based on that authorization for any reason, including but not limited to, the employer's subsequent determination that the physician treating the employee was not eligible to treat that injured employee. If there is a series of treatments, only those treatments not completed may be rescinded or modified.

7. The frequency of reviews for the extension of initial determinations is based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

8. Upon request by the public, AF Group shall make available the complete utilization review plan, consisting of the policies and procedures and a description of the utilization review process.

A. AF Group may make available the complete Utilization Review Plan, consisting of the policies and procedures and a description of the utilization review process through electronic means. If a member of the public requests a hard copy of the utilization review plan, AF Group may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed $.25 per page plus actual postage costs.

All utilization review procedures will be in accordance with any applicable rules, regulations, guidelines or laws in the state of California.

TELEPHONE # 1 888-266-7937
FACSIMILE # 1 877-607-7419

Appeals Procedure

The Appeals process letter will advise the injured employee that any dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code § 4610.5 and 4610.6 (as stated previously) and that an objection to the utilization review decision must be communicated by the

injured worker, the injured worker's representative or injured worker's attorney on behalf of the injured worker on the enclosed Application of Independent Review (IMR) DWC Form.

IMR REGULATIONS: If the employee objects to a decision made pursuant to Labor Code § 4610 to modify, or deny a treatment recommendation, the dispute shall be resolved by independent medical review pursuant to Labor Code § 4610.5, if applicable, or otherwise pursuant to Labor Code § 4062. If an RFA is not approved in full, "disputes shall be resolved in accordance with Section 4610.5 [IMR], if applicable, or otherwise in accordance with Labor Code § 4062." Labor Code § 4610(i)(5) states in part that: "If a [UR] decision to deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed."

[LC4610.5(h)(1)(A-B)] The employee may submit a request for independent medical review to the division. The request may be made electronically under rules adopted by the administrative director. The request shall be made no later than as follows:

A) For formulary disputes, 10 days after the service of the utilization review decision to the employee

B) For all other medical treatment disputes, 30 days after the service of the utilization review decision to the employee

AF Group's voluntary internal utilization review appeal process is available only to the requesting physician. Participation in this process is strictly voluntary and neither triggers nor bars the right of an injured worker, or the injured worker's authorized representative, to pursue Independent Medical Review or other dispute resolution procedures available under Labor Code sections 4610.5 and 4610.6. Any internal appeal must be submitted in writing and received within twenty (20) days of the utilization review determination. Reconsideration applies only to determinations involving a denial due to lack of information. **Reconsideration is not an appeal**.

1. In the event that the requesting physician has additional medical information that may impact an initial non-certification/denial or modification recommendation, he/she may submit a written request to AF Group within twenty (20) days of receipt of any such determination, unless timeframes otherwise mandated by state statutes, to have the additional medical information reviewed via an expedited or standard appeals process by a medical/clinical peer who did not make the original determination not to certify or to modify.

(a) Copies of the medical record documentation supporting the additional medical information must be included with the request for the standard appeal. UR vendor will take into account all documents, records, or other information submitted by the patient, provider, or facility rendering service relating to the case, without regard to whether such information was submitted or considered in the initial consideration of the case.

(b) Appeals consideration is conducted by a board-certified (if applicable) clinical peer holding an active, unrestricted license to practice medicine in the State of California in the same profession, similar specialty as typically manages the medical condition, procedure or treatment as mutually deemed appropriate, AND is neither the individual who made the original non-certification decision, nor the subordinate of such an individual.

2. Appeal timeframes are inclusive of the entire appeals process from receipt of the request to issuance of a written determination. All requests for appeal are completed and issuance of the appeal decision in accordance with the following timeframes:

(a) Expedited appeals are completed as soon as possible, and no later than 72 hours after the initiation of the appeals process.

(b) Standard appeals are completed within 30 calendar days of the initiation of the appeal process.

(c) Any decision made by the initial utilization reviewer after the appeal with a denial will remain in force for one year following the decision unless it is overturned by the IMR review board of Maximus. Additionally, no further action is done unless there is a documented change in the facts material to the basis of the utilization review decision.

3. AF Group will notify the Attending Physician or other Ordering Provider rendering service of the appeals determination through a method that will be received within 24 hours of the appeals determination (types of notification include verbal, voicemail, email, fax or letter); and issues written notification within one (1) business day of the appeals determination to the patient and attending physician or other ordering provider and facility rendering service (if applicable). If the patient is a child under the age of 18, the notification will go to the insured. (children may work in entertainment industry)

(a) Written notification of adverse appeals determinations includes the principal reasons for the determination to uphold the non-certification; a statement that the clinical rationale used in making the appeal decision will be provided, in writing, upon request (exception--the written notification shall not include the rationale, criteria or guidelines used for the decision for any non-physician provider of goods or services); and in the case of expedited appeals, the method to initiate the standard appeal process.

(b) Upon request, AF Group will provide the attending physician or other ordering provider and patient who has been unsuccessful in an attempt to reverse a determination not to certify, the clinical rationale for that determination in writing.

4. The medical advisor, medical director or clinical peer will be available within one business day to discuss by telephone the determination with the attending physician and/or other ordering provider.

5. Records will be kept for each appeal that include:

(a) Name of the patient, provider, and/or facility rendering service.

(b) Copies of all correspondence from the patient, provider, or facility rendering service and UR vendor regarding the appeal.

(c) Dates of appeal reviews, documentation of actions taken, and final resolution; and

(d) Minutes or transcripts of appeal proceedings (if any)

6. It is the policy of AF Group that an appeal can be submitted with new information, which might impact the reviewers' decision. Once the review has been performed and there is still a non-certification (denial) or modification, further reviews will not be undertaken. There will be a letter of notice to all parties as required by the current law.

Requests for Reconsideration

1. Any time an initial determination not to certify treatment is made and no contact has occurred with the attending physician or ordering provider, the attending physician or ordering provider can request reconsideration by the clinical peer that made the initial determination. Reconsideration can occur when the initial denial is a result of the lack of information only.

   A. The UR Nurse or a Peer Reviewer informs the attending physician or ordering provider that within one (1) business day the original Peer Reviewer or designated physician (if the original is not available) will contact them.

   B. The UR Nurse will inform their supervisor and Peer Reviewer of the attending physician or ordering provider's reconsideration request.

   C. The UR nurse will maintain documentation of the attending physician or ordering provider's reconsideration request, including date and time.

   D. The Medical Director or Peer Reviewer will be notified and given all case information.

   E. If the Peer Reviewer or Medical Director and the attending physician/ordering provider are not in agreement, the attending physician/ordering provider will be notified immediately of their right to initiate an expedited or standard appeal.

   F. All results of the reconsideration will be maintained by AF Group.

   G. The attending physician/provider, injured worker and/or patient can request the disclosure of information.

   H. The attending physician/provider, injured worker and/or patient can request the disclosure of criteria used to render non-certification.

   I. The name of the criteria, edition and diagnosis of the criteria will be supplied in writing upon request within one (1) business day.

   J. Only a UR Nurse or Peer Reviewer, medical advisor or medical director can release this information.

   K. The disclosure of criteria used to render non-certification will be in compliance with the laws of California.

Utilization Review Miscellaneous Policies and Procedures

AF Group will maintain a toll-free number that the review staff can be accessed from between 9 a.m. to 5:30 p.m. Pacific Time of each standard business day (Monday through Friday) in the provider's local time zone. The dedicated fax number is 877 607-7419.

1. The Medical Director shall bear responsibility for oversight of the Utilization Review Program and all processes, including compliance with applicable California workers' compensation utilization review

regulations contained in Title 8, California Code of Regulations, sections 9792.6.1 through 9792.15, as amended.

2. The Medical director is responsible for all decisions made in the utilization review process in accordance with applicable California utilization review regulations.

2a. The URO Medical Director for AF Group is:

Marcos Iglesias, M.D
PO Box 40790

Lansing, MI 48901-7990

Phone: 305-619-4119
California License # A 96655

The Medical Director of AF Group is responsible for the oversight of all utilization activities, ensures that the utilization review process is in accordance with this document, consistent with the applicable Labor Codes of the state of California. The medical director is responsible for all decisions made in the utilization review process. The medical director is a board-certified physician with an unrestricted license to practice in California. A staff of licensed RNs support the program under the management of Kim Malisa, Director of Medical Management.

The AF Group Medical Director is responsible for:

x Developing and disseminating the overall policy and philosophy of the UR program x Responsible for the quality assurance program governing the UR decisions x Responsible for all decisions made in the utilization review process

x Provides periodic review of the UR database including identifying the educational opportunities for the staff

x Oversees the clinical guidelines used in the decision making for the utilization team and conducts the management of the State specific guidelines, such as the MTUS and ACOEM

x Evaluating the performance of both the internal utilization team and the contracted providers associated with the functions of utilization.

2b. Physician advisors: California licensed physicians, doctor of osteopathy, chiropractic practitioners, psychologist, acupuncturist, optometrist, dentist or podiatrist.

The physician advisors are competent to evaluate the specific clinical issues involved in medical treatment services within the scope of the physician advisor's practice. Board Certified by a specialty board recognized by the American Board of Medical Specialties or its Osteopathic equivalent.

- May receive referrals, directly from the Medical Director or his designee, for medical and surgical cases not initially approved during the First Level review process.
- Currently have an active practice in the major clinical area being reviewed. Admitting privileges and direct patient care responsibilities in medical treatment facilities.
- Serve as a resource for the AF Group Case Management Service
- Is available by telephone to discuss review determinations with physicians

AF Group currently contracts with a specialty physician review panel, **Peerlink Medical** for peer specialty physician advisor reviews as outlined above.

11. Requests for utilization reviews must be made via mail to:

AF Group
PO BOX 40790
Lansing, MI 48901-7990

OR

Requests for utilization reviews may be made via fax to:

AF Group
877-607-7419
Email: urauthorizationsafgroup@afgroup.com or
urauthorizations@compwestinsurance.com

Telephone access will be made available by AF Group from 9:00 a.m. to 5:30 p.m. Pacific Time on normal business days. For requests made outside of these hours, AF Group shall maintain a voicemail system to handle incoming requests and messages.

All outgoing communications related to utilization management will be conducted during providers reasonable and normal business hours, unless otherwise mutually agreed.

4. The review staff will identify themselves when calling by name, title and name of organization when contacting attending physician/provider, enrollee/patient/injured worker, facility, claims payor or patient representative.

5. There will be access to the 888-266-7937 line after hours with the capability to leave a message on a recorder.

6. If AF Group is closed due to unforeseen emergencies, such as inclement weather or catastrophes, a detailed message will be left on the recorder, providing the caller with applicable directions for medical care or treatment or methods to obtain authorization for care.

7. All calls that are received during business hours from providers and patients/injured workers will be returned within one business day.

8. Upon request, utilization review staff member(s) orally inform patients, injured workers, designated facility personnel, the attending physician and other ordering providers of specific utilization review requirements, and patient, injured workers, hospitals, physicians and other health professionals of AF Group review procedures.

9. The preauthorization protocol in the automated software, DecisionUR, follows the initial allowance recommended in the MTUS directive of allowances suggested in the current treatment programs for the first 30 days of treatment following the initial injury. For treatments provided per Labor Code §4610(b), we forward the doctor's first report of injury to Decision UR to log any treatments provided by a MPN doctor within the first 30 days. Any treatment provided outside of the guidelines will be referred for a retro UR. All claim handlers are allowed to certify any treatment requests without sending to UR, however, it is a recommendation that an RFA be submitted for any treatment requests and forward to UR.

10. The quality assurance program practiced by AF Group follows the recommendation of the URAC accreditation policy and procedures. The URAC accreditation is filed with California and is posted to the AF Group website for each individual brand.

UR Dispute Resolution

All disputes are addressed by LC section 4610.5 and LC 4610.6 and that any 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 form/Application for Independent Review, DWC Form IMR within 10 days after the service of the utilization review decision for formulary requests and within 30 calendar days after the service of the utilization review decision for all other medical treatment disputes.

Notice to Injured Worker

All utilization disputes will be resolved in accordance with 4610.5, 4610.6 (b) If the employee objects to a decision made pursuant to Section 4610 to modify or deny a request for authorization of a medical treatment recommendation made by a treating physician, the objection shall be resolved only in accordance with the independent medical review process established in Section 4610.5. The DWC form IMR will be attached to all non-certification/modified letters to be completed by the injured worker, representative or designee including 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 adjuster's or appropriate contact's name in parentheses). at (insert telephone number). However, if you are represented by an attorney, please contact your attorney instead of me."

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.

Medical Provider Network

If the employee is subject to the rules governing the Medical Provider Network (MPN) and he/ she disputes the diagnosis or treatment of the primary treating physician, the employee may seek the

opinion of another physician in accordance with Labor Code § 4616.3. These disputes are not considered utilization review disputes.

Confidentiality Procedures/Statement

All patient information obtained during the utilization review process is considered part of the AF Group business record. All medical information is subject to state and federal regulations protecting confidentiality of medical information and is subject to release only within strict guidelines of confidentiality. Medical information is released only within the requirements of such regulations and in accordance with strict corporate guidelines. Listed below are the procedures in place to protect the confidentiality of the patient's medical information.

1. Employees are required to review our confidentiality and non-disclosure agreement upon employment. This agreement is to be signed by the new employee and yearly thereafter and is kept in the employee's personnel file.

2. Upon request, there is a patient confidentiality of medical information form that is forwarded to the patient describing how the medical information will be kept confidential while utilization review is being completed.

3. Detailed patient-identified information is released only with the patient's authorization or, where applicable, state laws, rules and regulations provide authorization. This includes all communications and records transmitted or stored, including cellular phones, fax or electronic systems.

4. All medical information will be maintained in a secure environment, which has a sophisticated security system. Only authorized personnel can access the system with appropriate password codes.

5. Each state and federal statute regarding confidentiality and non-disclosure is adhered to and updated when applicable.

6. Provider-specific data obtained during the review process is not publicly released. It can be shared only with those agencies that have the legal and contractual authority to receive such information. This includes all communications and records transmitted or stored, including cellular phones, fax or electronic systems.

A. Special care is taken when faxing information that includes patient specific medical and identifying information. All fax correspondence cover pages will contain a confidentiality clause statement.

B. All email transmissions will contain a confidentiality clause statement. Utilization review letters and activity notes may only be emailed to authorized parties.

7. Medical information collected is used solely for the purpose of utilization review, quality assurance, discharge planning and catastrophic case management.

8. UR patient information includes any information captured within the utilization review process such as demographics, medical treatment requests/approvals, provider and case activities/results.

Worker specific information includes injury cause, job type and any return-to-work information. Provider-specific information is any clinical, treatment outcomes or provider specific information capture through the utilization process for a specific patient.

9. Review notifications containing information that might suggest a diagnosis such as non-certification rationale, are sent only to the patient, physician, facility or other health care provider. Review notifications to employers do not contain medical information.

Statement of Regulatory Compliance

Utilization Review and Independent Medical Review regulations contained in California Code of Regulations, Title 8, including sections 9785, 9785.1, 9792.6.1 through 9792.15, as amended.

Exhibits

AF Group
PO Box 40790
Lansing, MI 48901-7990
AFGroup.com
AccidentFund UnitedHeartland CompWest ThirdCoast Underwriters

Notice of Determination- Certification

Fax:

Telephone:

RE: Employee:

Claim #:

Referral #:

Employer:

Injury Date:

Diagnosis:

PROVIDER REQUEST DATE:

RFA FIRST RECEIVED DATE:

DATE ADDITIONAL INFORMATION REQUESTED IF APPLICABLE:

AF Group has received a request(s) for treatment of the above named employee.

PROPOSED MEDICAL TREATMENT	BODY PART	DETERMINATION	DECISION DATE

For further information, you may contact the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/, or the claims administrator.

Please see below contact information for our selected vendors:

Services	Vendor	Phone	Fax	Referral Emails/Website
DME & Home Health Care Vendors (Medical supplies, equipment, orthotics and HHC services)	MTI America	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	VGM HomeLink	1-877-711-3171	1-844-851-6419	afgrouphomelink@vgm.com
	Orchid DBA Careworks	1-866-888-6724	1-866-246-8587	referrals@careworks.com
	Optum(Helios,PMSI,HealthCare Solutions, Cypress Care)	1-844-880-0565	1-800-774-4111	owcaorders@optum.com
Orthotics/Prosthetics	OneCall	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
Medical Imaging (MRI,CAT scans, EMG's, Age imaging assessments)	MTI America	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	Orchid DBA Careworks	1-866-888-6724	1-866-246-8587	referrals@careworks.com
	One Call Care Mgt	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
Pharmacy Program	My Matrixx-Express Scripts	1-866-499-1903 or 1-888-786-9640		
Translation Services	ProCare	1-866-941-7878	1-813-769-3883	www.theprocare.com
	MTI America- All States	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	Health Plus Trans	1-877-296-2285		afgroup@healthplustrans.com
	World Services	1-404-486-5986		info@worldservicesusa.com
Transportation Services	MTI America- All States	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	OneCall Care Mgt (Relay Ride)	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
	ProCare	1-866-941-7878	1-813-769-3883	www.theprocare.com
	Health Plus Trans	1-877-296-2285		afgroup@healthplustrans.com
Physical Therapy Acupuncture Chiropractor	OneCall / Align Networks	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com

List of all medical records reviewed:

Summary:

This certification is valid for 60 days from the date of this notice.

Additional needs beyond what has been authorized should be requested at least 5 days before treatment.

"Certification" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed "Request for

Authorization," as defined in California Code of Regulations, title 8, section 9792.6.1, that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, sections 9792.9.1 through 9792.12.

This decision will remain effective for 12 months unless additional recommendation is received from you with documented change in the facts material to the basis of the Utilization Review decision.

Sincerely,

This decision was made by:

Toll Free Number: 888-266-7937

AF Group General Fax: 866-506-5800

AF Group UR Authorization Fax: 877-607-7419

Hours: Monday – Friday 8:00 AM to 5:30 PM

The hours of availability of the reviewer, expert reviewer or the medical director for the treating physician to discuss the decision include 9am, until 3pm PST, Monday through Friday, during normal business hours. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Cc:

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF ORANGE

I am a citizen of the United States and a resident of the aforesaid. I am over the age of eighteen years and not a party to the within entitled action. My mailing address is P.O. Box 40790 Lansing, MI 48901-7990.

On , I served within: Notice of Determination

On the interested parties in said action by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States mail addressed as follows:

I declare, under penalty of perjury, that the foregoing is true and correct.

Executed on , at La Palma, California.

_____

Maria Hernandez

AF Group
PO Box 40790
Lansing, MI 48901-7990
AFGroup.com
AccidentFund UnitedHeartland CompWest ThirdCoast Underwriters

Notice of Medical Authorization

Date

Name

Address

Address

Fax:

Telephone:

RE: Employee:

Claim #:

Referral #:

Employer:

Injury Date:

Diagnoses:

IMR CASE NUMBER:

IMR DETERMINATION DATE:

TREATMENT AUTHORIZED:

This is a notice of medical authorization based on an **IMR Determination**.

Please be advised with respect to this injured worker's medical treatment, CompWest has elected to implement a Medical Provider Network (MPN) to provide treatment for workers' compensation illnesses and injuries. Medical treatment for the Injured Worker may be required to be provided by a MPN provider. Please utilize providers within our medical provider network (MPN) for any consults, physical/ occupational therapy or chiropractic care. To access the provider directory, please visit www.compwestinsurance.com, - Services– Claims- Medical Provider Network Search.

For further information, you may contact the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/, or the claims administrator.

Please see below contact information for our selected vendors:

Services	Vendor	Phone	Fax	Referral Emails/Website
DME & Home Health Care Vendors (Medical supplies, equipment, orthotics and HHC services)	MTI America	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	VGM HomeLink	1-877-711-3171	1-844-851-6419	afgrouphomelink@vgm.com
	Orchid DBA Careworks	1-866-888-6724	1-866-246-8587	referrals@careworks.com
	Optum(Helios,PMSI,HealthCare Solutions, Cypress Care)	1-844-880-0565	1-800-774-4111	owcaorders@optum.com
Orthotics/Prosthetics	OneCall	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
Medical Imaging (MRI,CAT scans, EMG's, Age imaging assessments)	MTI America	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	Orchid DBA Careworks	1-866-888-6724	1-866-246-8587	referrals@careworks.com
	One Call Care Mgt	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
Pharmacy Program	My Matrixx-Express Scripts	1-866-499-1903 or 1-888-786-9640		
Translation Services	ProCare	1-866-941-7878	1-813-769-3883	www.theprocare.com
	MTI America- All States	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	Health Plus Trans	1-877-296-2285		afgroup@healthplustrans.com
	World Services	1-404-486-5986		info@worldservicesusa.com
Transportation Services	MTI America- All States	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	OneCall Care Mgt (Relay Ride)	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
	ProCare	1-866-941-7878	1-813-769-3883	www.theprocare.com
	Health Plus Trans	1-877-296-2285		afgroup@healthplustrans.com
Physical Therapy Acupuncture Chiropractor	OneCall / Align Networks	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com

This certification is valid for 60 days from the date of this notice.

Additional needs beyond what has been authorized should be requested at least 5 days before treatment.

"Certification" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, set forth on a completed "Request for Authorization," as defined in California Code of Regulations, title 8, section 9792.6.1, that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, sections 9792.9.1 through 9792.12.

This decision will remain effective for 12 months unless additional recommendation is received from you with documented change in the facts material to the basis of the Utilization Review decision.

Sincerely,

This decision was made by:
Marcos Iglesias
License #: 96655
Specialty: Family Medicine
I Marcos Iglesias hereby attest that the medical record entry for 05/18/2026 accurately reflects signature notations that I made in my capacity as reviewer. I hereby attest that this information is true, accurate and complete to the best of my knowledge and that I understand that any falsification, omission or concealment of material fact may subject me to administrative, civil or criminal liability.

Toll Free Number: 888-266-7937
AF Group General Fax: 866-506-5800
AF Group UR Authorization Fax: 877-607-7419
Hours: Monday – Friday 8:00 AM to 5:30 PM

This decision was made by: Marcos Iglesias License #96655 Specialty: Family Medicine

The hours of availability of the reviewer, expert reviewer or the medical director for the treating physician to discuss the decision include 9am, until 3pm PST, Monday through Friday, during normal business hours. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services

CC:

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF ORANGE

I am a citizen of the United States and a resident of the aforesaid. I am over the age of eighteen years and not a party to the within entitled action. My mailing address is P.O. Box 40790 Lansing, MI 48901-7990.

On , I served within: Notice of Medical Authorization

On the interested parties in said action by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States mail addressed as follows:

I declare, under penalty of perjury, that the foregoing is true and correct.

Executed on , at Santa Ana, California.

Maria Hernandez

AF Group
PO Box 40790
Lansing, MI 48901-7990
AFGroup.com
AccidentFund UnitedHeartland CompWest ThirdCoast Underwriters

Notice of Request for

Additional Information

Date

Name

Address

Address

Fax:

Telephone:

RE: Employee:

Claim #:

Referral #:

Employer:

Injury Date:

Diagnoses:

PROVIDER REQUEST DATE:

PROPOSED MEDICAL TREATMENT:

RFA FIRST RECEIVED DATE:

MEDICAL TREATMENT DETERMINATION: Incomplete

DECISION DATE:

AF Group has received a request for treatment of the above-named employee.

The request for the above services has been reviewed in accordance with AF Group's Utilization Review Program.

There is insufficient information to determine medical necessity for the requested treatment. We are asking the requesting physician, the injured worker and the injured worker's attorney (if there is one) to provide the additional information noted below to support the request.

Please fax your report to: 877-607-7419 and refer to review number 205882 on your cover page. Please send the requested information by 05/29/2026 (date of 14th day) to avoid non-certification of request for lack of information. If the information requested that is reasonably necessary to make a determination is not received within fourteen (14) days from receipt of the completed request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information. For additional tests, examinations, or specialty consultations required to complete utilization review, the decision shall be made within the timeframes required by applicable California utilization review regulations.

Please provide all relevant documentation such as:

DISCUSSION (Criteria/Rationale): There is insufficient information to review for the requested (treatment). Please fax supporting medical documentation and applicable physician reports to 877-607-7419.

List of all medical records reviewed:

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 (Sarah Davies) at (888-266-7937). 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,

This decision was made by:

Marcos Iglesias

License #: 96655

Specialty: Family Medicine

I Marcos Iglesias hereby attest that the medical record entry for 05/18/2026 accurately reflects signature notations that I made in my capacity as reviewer. I hereby attest that this information is true, accurate and complete to the best of my knowledge and that I understand that any falsification, omission or concealment of material fact may subject me to administrative, civil or criminal liability.

Toll Free Number: 888-266-7937

AF Group General Fax: 866-506-5800

AF Group UR Authorization Fax: 877-607-7419

Hours: Monday – Friday 8:00 AM to 5:30 PM

This decision was made by: Marcos Iglesias License #96655 Specialty: Family Medicine

The hours of availability of the reviewer, expert reviewer or the medical director for the treating physician to discuss the decision include 9am, until 3pm PST, Monday through Friday, during normal business hours. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

CC:

Notice of non-certification

Fax:

Telephone:

RE: **Employee:**

Claim #:

Referral #:

Employer:

Injury Date:

Diagnosis:

PROVIDER REQUEST DATE:

PROPOSED MEDICAL TREATMENT:

RFA FIRST RECEIVED DATE:

DATE ADDITIONAL INFORMATION REQUESTED IF APPLICABLE:

MEDICAL TREATMENT DETERMINATION: Non-Certification

DECISION DATE:

AF Group has received a request(s) for treatment of the above-named employee.

PROPOSED MEDICAL TREATMENT	BODY PART	DETERMINATION	DECISION DATE

For further information, you may contact the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/, or the claims administrator.

Please see below contact information for our selected vendors:

Services	Vendor	Phone	Fax	Referral Emails/Website
DME & Home Health Care Vendors (Medical supplies, equipment, orthotics and HHC services)	MTI America	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	VGM HomeLink	1-877-711-3171	1-844-851-6419	afgrouphomelink@vgm.com
	Orchid DBA Careworks	1-866-888-6724	1-866-246-8587	referrals@careworks.com
	Optum(Helios,PMSI,HealthCare Solutions, Cypress Care)	1-844-880-0565	1-800-774-4111	owcaorders@optum.com
Orthotics/Prosthetics	OneCall	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
Medical Imaging (MRI,CAT scans, EMG's, Age imaging assessments)	MTI America	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	Orchid DBA Careworks	1-866-888-6724	1-866-246-8587	referrals@careworks.com
	One Call Care Mgt	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
Pharmacy Program	My Matrixx-Express Scripts	1-866-499-1903 or 1-888-786-9640		
Translation Services	ProCare	1-866-941-7878	1-813-769-3883	www.theprocare.com
	MTI America- All States	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	Health Plus Trans	1-877-296-2285		afgroup@healthplustrans.com
	World Services	1-404-486-5986		info@worldservicesusa.com
Transportation Services	MTI America- All States	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	OneCall Care Mgt (Relay Ride)	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
	ProCare	1-866-941-7878	1-813-769-3883	www.theprocare.com
	Health Plus Trans	1-877-296-2285		afgroup@healthplustrans.com
Physical Therapy Acupuncture Chiropractor	OneCall / Align Networks	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com

Summary:

List of all medical records reviewed:

DISCUSSION (Criteria/Rationale);

NOTES

GUIDELINES

RECOMMENDED

Our determination does not mean that the patient should not receive further medical treatment or personal care and does not refer to compensability. For questions regarding compensability, please contact the employer or claim administrator.

Requesting physician: In the event of a non-certification/denial or modification of services decision, an appeal may be filed. You may appeal this decision direct by faxing the request to 877-607-7419 or mail the additional information to CompWest Insurance Company, PO Box 40790 Lansing, MI 48901-7990 within twenty (20) days of receipt of any such determination. Please clearly mark the document as an Appeal. AF Group's voluntary internal utilization review appeal process is available only to the requesting physician. Participation in this process is strictly voluntary and neither triggers nor bars the right of an injured worker, or the injured worker's authorized representative, to pursue Independent Medical Review or other dispute resolution procedures available under Labor Code sections 4610.5 and 4610.6. Any internal appeal must be submitted in writing and received within twenty (20) days of the utilization review

determination. Reconsideration applies only to determinations involving a denial due to lack of information. **Reconsideration is not an appeal**.

Injured worker: Any dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code sections 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 ten (10) days after the service of the utilization review decision for formulary requests and within thirty (30) calendar days after the service of the utilization review decision for all other medical treatment disputes.

This decision will remain effective for 12 months unless additional recommendation is received from you with documented change in the facts material to the basis of the Utilization Review decision.

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name) at (insert phone 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: www.dwc.ca.gov or contact an Information and Assistance (I&A) officer of the state Division of Workers' Compensation." For recorded information and list of offices, call toll-free 1-800-736-7401.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

Sincerely,

This decision was made by:

Toll Free Number: 888-266-7937

AF Group General Fax: 866-506-5800

AF Group UR Authorization Fax: 877-607-7419

Hours: Monday – Friday 8:00 AM to 5:30 PM

The hours of availability of the reviewer, expert reviewer or the medical director for the treating physician to discuss the decision include, during normal business hours. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services

Enclosures: Application for Independent Medical Review (DWC Form IMR-1)

Cc:

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) 606-4270
- **Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

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

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned):

Employee Attorney (if known):

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

***** Mailing Date of the Utilization Review Determination Letter:

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

Reason:

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

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the Claims Administrator named above. I consent to allow my health care providers and Claims Administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature Date

Deadline for Filing IMR Application

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

IMR Application Filing Deadline:

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

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

INSTRUCTIONS FOR COMPLETNG 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.

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF ORANGE

I am a citizen of the United States and a resident of the aforesaid. I am over the age of eighteen years and not a party to the within entitled action. My mailing address is P.O. Box 40790 Lansing, MI 48901-7990.

On , I served within: Notice of Determination

On the interested parties in said action by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States mail addressed as follows:

I declare, under penalty of perjury, that the foregoing is true and correct.

Executed on , at La Palma, California.

_____

Maria Hernandez

AF Group
PO Box 40790
Lansing, MI 48901-7990
AFGroup.com
AccidentFund UnitedHeartland CompWest ThirdCoast Underwriters

Notice of Modification

Fax:

Telephone:

RE: Employee:

Claim #:

Referral #:

Employer:

Injury Date:

Diagnosis:

PROVIDER REQUEST DATE:

PROPOSED MEDICAL TREATMENT:

RFA FIRST RECEIVED DATE:

DATE ADDITIONAL INFORMATION REQUESTED IF APPLICABLE:

MEDICAL TREATMENT DETERMINATION: Modified

DECISION DATE:

AF Group has received a request(s) for treatment of the above-named employee.

PROPOSED MEDICAL TREATMENT	BODY PART	DETERMINATION	DECISION DATE

For further information, you may contact the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/, or the claims administrator.

Please see below contact information for our selected vendors:

Services	Vendor	Phone	Fax	Referral Emails/Website
DME & Home Health Care Vendors (Medical supplies, equipment, orthotics and HHC services)	MTI America	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	VGM HomeLink	1-877-711-3171	1-844-851-6419	afgrouphomelink@vgm.com
	Orchid DBA Careworks	1-866-888-6724	1-866-246-8587	referrals@careworks.com
	Optum(Helios,PMSI,HealthCare Solutions, Cypress Care)	1-844-880-0565	1-800-774-4111	owcaorders@optum.com
Orthotics/Prosthetics	OneCall	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
Medical Imaging (MRI,CAT scans, EMG's, Age imaging assessments)	MTI America	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	Orchid DBA Careworks	1-866-888-6724	1-866-246-8587	referrals@careworks.com
	One Call Care Mgt	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
Pharmacy Program	My Matrixx-Express Scripts	1-866-499-1903 or 1-888-786-9640		
Translation Services	ProCare	1-866-941-7878	1-813-769-3883	www.theprocare.com
	MTI America- All States	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	Health Plus Trans	1-877-296-2285		afgroup@healthplustrans.com
	World Services	1-404-486-5986		info@worldservicesusa.com
Transportation Services	MTI America- All States	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	OneCall Care Mgt (Relay Ride)	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
	ProCare	1-866-941-7878	1-813-769-3883	www.theprocare.com
	Health Plus Trans	1-877-296-2285		afgroup@healthplustrans.com
Physical Therapy Acupuncture Chiropractor	OneCall / Align Networks	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com

Summary:

List of all medical records reviewed:

DISCUSSION (Criteria/Rationale);

NOTES

GUIDELINES

RECOMMENDED

This certification is valid for 60 days from the date of this notice.
Additional needs beyond what has been authorized should be requested at least 5 days before treatment.

"Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on either a completed "Request for Authorization," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2), that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the "Request for Authorization," DWC Form RFA if that form was initially submitted by the treating physician.

Please Note: any services rendered beyond what is authorized above may be denied. Certification is based on the information provided and covers medical necessity only. Determination of payment for this approved service is based upon eligibility, and any questions should be addressed to the claims administrator.

Our determination does not mean that the patient should not receive further medical treatment or personal care and does not refer to compensability. For questions regarding compensability, please contact the employer or claim administrator.

Requesting physician: In the event of a non-certification/denial or modification of services decision, an appeal may be filed. You may appeal this decision direct by faxing the request to 877-607-7419 or mail the additional information to CompWest Insurance Company, PO Box 40790 Lansing, MI 48901-7990 within twenty (20) days of receipt of any such determination. Please clearly mark the document as an Appeal. AF Group's voluntary internal utilization review appeal process is available only to the requesting physician. Participation in this process is strictly voluntary and neither triggers nor bars the right of an injured worker, or the injured worker's authorized representative, to pursue Independent Medical Review or other dispute resolution procedures available under Labor Code sections 4610.5 and 4610.6. Any internal appeal must be submitted in writing and received within twenty (20) days of the utilization review determination. Reconsideration applies only to determinations involving a denial due to lack of information. **Reconsideration is not an appeal**.

Injured worker: Any dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code sections 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 ten (10) days after the service of the utilization review decision for formulary requests and within thirty (30) calendar days after the service of the utilization review decision for all other medical treatment disputes.

This decision will remain effective for 12 months unless additional recommendation is received from you with documented change in the facts material to the basis of the Utilization Review decision.

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name) at (insert phone 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: www.dwc.ca.gov or contact an Information and Assistance (I&A) officer of the state Division of Workers' Compensation." For recorded information and list of offices, call toll-free 1-800-736-7401.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

Sincerely,

This decision was made by:

Toll Free Number: 888-266-7937

AF Group General Fax: 866-506-5800

AF Group UR Authorization Fax: 877-607-7419

Hours: Monday – Friday 8:00 AM to 5:30 PM

The hours of availability of the reviewer, expert reviewer or the medical director for the treating physician to discuss the decision include, during normal business hours. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services

Enclosures: Application for Independent Medical Review (DWC Form IMR-1)

Cc:

DIVISION OF WORKERS' COMPENSATION
CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS

Division of Workers' Compensation
Department of Industrial Relations
State of California

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) 606-4270
- **Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

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

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned):

Employee Attorney (if known):

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

***** Mailing Date of the Utilization Review Determination Letter:

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

Reason:

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

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the Claims Administrator named above. I consent to allow my health care providers and Claims Administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature Date

Deadline for Filing IMR Application

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

IMR Application Filing Deadline:

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

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

INSTRUCTIONS FOR COMPLETNG 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.

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF ORANGE

I am a citizen of the United States and a resident of the aforesaid. I am over the age of eighteen years and not a party to the within entitled action. My mailing address is P.O. Box 40790 Lansing, MI 48901-7990.

On , I served within: Notice of Determination

On the interested parties in said action by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States mail addressed as follows:

I declare, under penalty of perjury, that the foregoing is true and correct.

Executed on , at La Palma, California.

_____

Maria Hernandez

AF Group
PO Box 40790
Lansing, MI 48901-7990
AFGroup.com
AccidentFund UnitedHeartland CompWest ThirdCoast Underwriters

Medical Treatment Determination:

NON-CERTIFICATION DUE TO LACK OF INFORMATION

Fax:

Telephone:

RE: Employee:

Claim #:

Referral #:

Employer:

Injury Date:

Diagnosis:

PROVIDER REQUEST DATE:

PROPOSED MEDICAL TREATMENT:

RFA FIRST RECEIVED DATE:

MEDICAL TREATMENT DETERMINATION:

DECISION DATE:

AF Group has received a request for treatment of the above-named employee.

Following review of the request for authorization and all information received, the requested treatment is non-certified because information reasonably necessary to determine medical necessity was requested but not received within the applicable regulatory timeframe.

On [DATE], information reasonably necessary to make a medical necessity determination was requested from the treating provider pursuant to California Code of Regulations, Title 8, section 9792.9.6. The requested information was not received within the applicable regulatory timeframe.

Therefore, pursuant to California Code of Regulations, Title 8, Section 9792.9.6(c)(1), the request is non-certified due to lack of sufficient information.

Upon receipt of the previously requested information, the request for authorization will be reconsidered in accordance with California utilization review requirements.

For further information, you may contact the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/, or the claims administrator.

Please see below contact information for our selected vendors:

Services	Vendor	Phone	Fax	Referral Emails/Website
DME & Home Health Care Vendors (Medical supplies, equipment, orthotics and HHC services)	MTI America	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	VGM HomeLink	1-877-711-3171	1-844-851-6419	afgrouphomelink@vgm.com
	Orchid DBA Careworks	1-866-888-6724	1-866-246-8587	referrals@careworks.com
	Optum(Helios,PMSI,HealthCare Solutions, Cypress Care)	1-844-880-0565	1-800-774-4111	owcaorders@optum.com
Orthotics/Prosthetics	OneCall	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
Medical Imaging (MRI,CAT scans, EMG's, Age imaging assessments)	MTI America	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	Orchid DBA Careworks	1-866-888-6724	1-866-246-8587	referrals@careworks.com
	One Call Care Mgt	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
Pharmacy Program	My Matrixx-Express Scripts	1-866-499-1903 or 1-888-786-9640		
Translation Services	ProCare	1-866-941-7878	1-813-769-3883	www.theprocare.com
	MTI America- All States	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	Health Plus Trans	1-877-296-2285		afgroup@healthplustrans.com
	World Services	1-404-486-5986		info@worldservicesusa.com
Transportation Services	MTI America- All States	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	OneCall Care Mgt (Relay Ride)	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
	ProCare	1-866-941-7878	1-813-769-3883	www.theprocare.com
	Health Plus Trans	1-877-296-2285		afgroup@healthplustrans.com
Physical Therapy Acupuncture Chiropractor	OneCall / Align Networks	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com

DISCUSSION (Criteria/Rationale);

The requested treatment cannot be evaluated for medical necessity because information reasonably necessary to make a determination was requested but not received. Specifically, the reviewer requested:

- (Missing report)
- (Missing diagnostics results)
- (Missing PT notes)
- (Missing documentation supporting medical necessity for the requested treatment)

Because the requested clinical information was not received, a medical necessity determination could not be completed.

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name) 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: 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,

This decision was made by:

Toll Free Number: 888-266-7937

AF Group General Fax: 866-506-5800

AF Group UR Authorization Fax: 877-607-7419

Hours: Monday – Friday 8:00 AM to 5:30 PM

The hours of availability of the reviewer, expert reviewer or the medical director for the treating physician to discuss the decision include, during normal business hours. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

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) 606-4270
- **Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

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

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned):

Employee Attorney (if known):

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

***** Mailing Date of the Utilization Review Determination Letter:

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

Reason:

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

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the Claims Administrator named above. I consent to allow my health care providers and Claims Administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature Date

Deadline for Filing IMR Application

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

IMR Application Filing Deadline:

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

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

INSTRUCTIONS FOR COMPLETNG 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.

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF ORANGE

I am a citizen of the United States and a resident of the aforesaid. I am over the age of eighteen years and not a party to the within entitled action. My mailing address is P.O. Box 40790 Lansing, MI 48901-7990.

On , I served within: Notice of Determination

On the interested parties in said action by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States mail addressed as follows:

I declare, under penalty of perjury, that the foregoing is true and correct.

Executed on , at La Palma, California.

_____

Maria Hernandez

AF Group
PO Box 40790
Lansing, MI 48901-7990
AFGroup.com
AccidentFund UnitedHeartland CompWest ThirdCoast Underwriters

Notice of Appeal Determination Appeal Review Completed

Original Utilization Review Determination Upheld

Fax:

Telephone:

RE: Employee:

Claim #:

Referral #:

Employer:

Injury Date:

Diagnosis:

Provider Request Date:
RFA First Received Date:
Original UR Determination Date:
Appeal Received Date:

Appeal Review Date:
Additional Information Requested:
Additional Information Received:
Peer Consultation Requested:
Peer Consultation Completed:
Date Decision Issued:

Appeal Outcome:

Original Determination: Upheld

AF Group has received a request(s) for treatment of the above named employee.

For further information, you may contact the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/, or the claims administrator.

Please see below contact information for our selected vendors:

Services	Vendor	Phone	Fax	Referral Emails/Website
DME & Home Health Care Vendors (Medical supplies, equipment, orthotics and HHC services)	MTI America	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	VGM HomeLink	1-877-711-3171	1-844-851-6419	afgrouphomelink@vgm.com
	Orchid DBA Careworks	1-866-888-6724	1-866-246-8587	referrals@careworks.com
	Optum(Helios,PMSI,HealthCare Solutions, Cypress Care)	1-844-880-0565	1-800-774-4111	owcaorders@optum.com
Orthotics/Prosthetics	OneCall	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
Medical Imaging (MRI,CAT scans, EMG's, Age imaging assessments)	MTI America	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	Orchid DBA Careworks	1-866-888-6724	1-866-246-8587	referrals@careworks.com
	One Call Care Mgt	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
Pharmacy Program	My Matrixx-Express Scripts	1-866-499-1903 or 1-888-786-9640		
Translation Services	ProCare	1-866-941-7878	1-813-769-3883	www.theprocare.com
	MTI America- All States	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	Health Plus Trans	1-877-296-2285		afgroup@healthplustrans.com
	World Services	1-404-486-5986		info@worldservicesusa.com
Transportation Services	MTI America- All States	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	OneCall Care Mgt (Relay Ride)	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
	ProCare	1-866-941-7878	1-813-769-3883	www.theprocare.com
	Health Plus Trans	1-877-296-2285		afgroup@healthplustrans.com
Physical Therapy Acupuncture Chiropractor	OneCall / Align Networks	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com

Summary:

DISCUSSION (Criteria/Rationale);

NOTES

GUIDELINES

AF Group received and reviewed an appeal of the prior Utilization Review determination.

Additional clinical records, supporting documentation, and information submitted in connection with the appeal were reviewed by a qualified physician reviewer.

Following review of all information submitted, the original Utilization Review determination is upheld.

The additional information submitted does not support a change to the original determination.

Accordingly, the original determination is upheld and remains in effect.

List of all medical records reviewed:

Our determination does not mean that the patient should not receive further medical treatment or personal care and does not refer to compensability. For questions regarding compensability, please contact the employer or claim administrator.

This decision will remain effective for 12 months unless additional recommendation is received from you with documented change in the facts material to the basis of the Utilization Review decision.

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 list of offices, call toll-free 1-800-736-7401.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

Sincerely,

This decision was made by:

Toll Free Number: 888-266-7937

AF Group General Fax: 866-506-5800

AF Group UR Authorization Fax: 877-607-7419

Hours: Monday – Friday 8:00 AM to 5:30 PM

The hours of availability of the reviewer, expert reviewer, or medical director is available to discuss this determination with the requesting physician during normal business hours by calling the telephone number listed above.

In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services

AF Group
PO Box 40790
Lansing, MI 48901-7990
AFGroup.com
AccidentFund UnitedHeartland CompWest ThirdCoast Underwriters

Notice of Modification After Appeal

Fax:

Telephone:

RE: Employee:

Claim #:

Referral #:

Employer:

Injury Date:

Diagnosis:

PROVIDER REQUEST DATE:

PROPOSED MEDICAL TREATMENT:

RFA FIRST RECEIVED DATE:

ORIGINAL DATE:

APPEAL RECEIVED DATE:

MEDICAL TREATMENT DETERMINATION: Modified After Appeal

DECISION DATE:

AF Group has received a request(s) for treatment of the above-named employee.

An appeal of the prior Utilization Review determination was received and reviewed. Additional clinical documentation was considered, and the treatment request was re-evaluated.

For further information, you may contact the Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/, or the claims administrator.

Please see below contact information for our selected vendors:

Services	Vendor	Phone	Fax	Referral Emails/Website
DME & Home Health Care Vendors (Medical supplies, equipment, orthotics and HHC services)	MTI America	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	VGM HomeLink	1-877-711-3171	1-844-851-6419	afgrouphomelink@vgm.com
	Orchid DBA Careworks	1-866-888-6724	1-866-246-8587	referrals@careworks.com
	Optum(Helios,PMSI,HealthCare Solutions, Cypress Care)	1-844-880-0565	1-800-774-4111	owcaorders@optum.com
Orthotics/Prosthetics	OneCall	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
Medical Imaging (MRI,CAT scans, EMG's, Age imaging assessments)	MTI America	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	Orchid DBA Careworks	1-866-888-6724	1-866-246-8587	referrals@careworks.com
	One Call Care Mgt	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
Pharmacy Program	My Matrixx-Express Scripts	1-866-499-1903 or 1-888-786-9640		
Translation Services	ProCare	1-866-941-7878	1-813-769-3883	www.theprocare.com
	MTI America- All States	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	Health Plus Trans	1-877-296-2285		afgroup@healthplustrans.com
	World Services	1-404-486-5986		info@worldservicesusa.com
Transportation Services	MTI America- All States	1-877-512-5742	1-954-343-1779	afgroup@MTIamerica.com
	OneCall Care Mgt (Relay Ride)	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com
	ProCare	1-866-941-7878	1-813-769-3883	www.theprocare.com
	Health Plus Trans	1-877-296-2285		afgroup@healthplustrans.com
Physical Therapy Acupuncture Chiropractor	OneCall / Align Networks	1-877-225-6785	1-904-394-8369	AFGroup@onecallcm.com

Summary:

An appeal of the prior Utilization Review determination was received and reviewed.

Additional clinical documentation, medical records, and supporting information submitted in connection with the appeal were considered.

Following review of the appeal materials, the original Utilization Review determination was modified as outlined below.

List of all medical records reviewed:

DISCUSSION (Criteria/Rationale);

NOTES

GUIDELINES

RECOMMENDED

This certification is valid for 60 days from the date of this notice.
Additional needs beyond what has been authorized should be requested at least 5 days before treatment.

"Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on either a completed "Request for Authorization," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2), that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the "Request for Authorization," DWC Form

RFA if that form was initially submitted by the treating physician.

Please Note: any services rendered beyond what is authorized above may be denied. Certification is based on the information provided and covers medical necessity only. Determination of payment for this approved service is based upon eligibility, and any questions should be addressed to the claims administrator.

Our determination does not mean that the patient should not receive further medical treatment or personal care and does not refer to compensability. For questions regarding compensability, please contact the employer or claim administrator.

Requesting physician: In the event of a non-certification/denial or modification of services decision, an appeal may be filed. You may appeal this decision direct by faxing the request to 877-607-7419 or mail the additional information to CompWest Insurance Company, PO Box 40790 Lansing, MI 48901-7990 within twenty (20) days of receipt of any such determination. Please clearly mark the document as an Appeal. AF Group's voluntary internal utilization review appeal process is available only to the requesting physician. Participation in this process is strictly voluntary and neither triggers nor bars the right of an injured worker, or the injured worker's authorized representative, to pursue Independent Medical Review or other dispute resolution procedures available under Labor Code sections 4610.5 and 4610.6. Any internal appeal must be submitted in writing and received within twenty (20) days of the utilization review determination. Reconsideration applies only to determinations involving a denial due to lack of information. **Reconsideration is not an appeal**.

Injured worker: Any dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code sections 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 ten (10) days after the service of the utilization review decision for formulary requests and within thirty (30) calendar days after the service of the utilization review decision for all other medical treatment disputes.

This decision will remain effective for 12 months unless additional recommendation is received from you with documented change in the facts material to the basis of the Utilization Review decision.

You have a right to disagree with decisions affecting your claim, which includes seeking Independent Medical Review of the decision. (See attached application.) If you have questions about the information in this notice, please call me (insert claims adjuster's or appropriate contact's name) at (insert phone 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: www.dwc.ca.gov or contact an Information and Assistance (I&A) officer of the state Division of Workers' Compensation." For recorded information and list of offices, call toll-free 1-800-736-7401.

You may also consult an attorney of your choice. Should you decide to be represented by an attorney, you may or may not receive a larger award, but, unless you are determined to be ineligible for an award, the attorney's fee will be deducted from any award you might receive for disability benefits. The decision to be represented by an attorney is yours to make, but it is voluntary and may not be necessary for you to receive your benefits.

Sincerely,

This decision was made by:

Toll Free Number: 888-266-7937

AF Group General Fax: 866-506-5800

AF Group UR Authorization Fax: 877-607-7419

Hours: Monday – Friday 8:00 AM to 5:30 PM

The hours of availability of the reviewer, expert reviewer or the medical director for the treating physician to discuss the decision include, during normal business hours. In the event the reviewer is unavailable, the requesting physician may discuss the written decision with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services

Enclosures: Application for Independent Medical Review (DWC Form IMR-1)

Cc:

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) 606-4270
- **Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. THE DEADLINE FOR FILING IS AT THE END OF THE FORM.**

Type of Utilization Review:

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

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Date of Injury:

Insurance Claim Number: EAMS Case Number:

WCIS Jurisdictional Claim Number (if assigned):

Employee Attorney (if known):

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Requesting Physician Information:

Physician First Name: Middle Initial: Last Name:

Practice Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number: Specialty:

Claims Administrator Information:

Employer Name:

Name of Administrator: Contact Name:

Address: Number/Unit:

State: Zip Code: Telephone Number:

Fax Number:

Disputed Medical Treatment:

Primary Diagnosis (Use ICD Code where practical):

***** Mailing Date of the Utilization Review Determination Letter:

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

Reason:

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

Request for Review and Consent to Obtain Medical Records

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the Claims Administrator named above. I consent to allow my health care providers and Claims Administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature Date

Deadline for Filing IMR Application

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

IMR Application Filing Deadline:

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

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

INSTRUCTIONS FOR COMPLETNG 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.

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF ORANGE

I am a citizen of the United States and a resident of the aforesaid. I am over the age of eighteen years and not a party to the within entitled action. My mailing address is P.O. Box 40790 Lansing, MI 48901-7990.

On , I served within: Notice of Determination

On the interested parties in said action by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States mail addressed as follows:

I declare, under penalty of perjury, that the foregoing is true and correct.

Executed on , at La Palma, California.

_____

Maria Hernandez