TO REQUEST INDEPENDENT MEDICAL REVIEW:

- **Sign and date this application and consent to obtain medical records.**
- **Mail or fax within the deadline for filing the application and a copy of the written determination letter you received that denied or modified the medical treatment requested by your physician to:**
  Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 605-4270
- **Mail or fax a copy of the signed application within the deadline for filing to your Claims Administrator. THE DEADLINE FOR FILING IS FOUND ON PAGE 2.**

Type of Utilization Review: Regular Expedited

Modification after Appeal Medication Only - MTUS Formulary Drug List:

Employee Name (First, MI, Last)

Address

Telephone Number E-mail

Claim Number Date of Injury (MM/DD/YYYY)

WCIS Jurisdictional Claim Number (if assigned)

Employee Attorney (if known)

Address

Telephone Number E-mail

Claims Administrator Name

Contact Name

Address

Telephone Number E-mail

Requesting Physician Name

Practice Name Specialty

Address

Telephone Number E-mail

DRAFT

Disputed Medical Treatment

Primary Diagnosis (Use ICD Code where practical)

Mailing Date of the Written 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 services, drug, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient.

1.

2.

3.

4.

Request for Review and Consent to Obtain Medical Records

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

Employee Signature Date

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 is 15 days from the mailing date of the determination letter. (See date above.) For all other disputes, the deadline is 35 days from the mailing date of the written determination letter. Both deadlines include additional days for mailing. However, under either deadline, add five (5) days if you live outside of California. Your deadline for filing this IMR Application is indicated in the checked box.

IMR Application Filing Deadline

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

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

DRAFT

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers' compensation Claims Administrator sent you a written determination letter that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review (IMR) of the medical treatment request by a physician who is not connected to your Claims Administrator. If the IMR is decided in your favor, your Claims Administrator must give you the service or treatment your physician requested.

IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL, DELAY, OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO ON PAGE TWO OF THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.

You can request independent medical review by signing and submitting this form with a copy of the written determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your Claims Administrator.

* The information on the form was filled in by your Claims Administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.

* If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. This person may sign the application for you and submit documents on your behalf.

* If the recommended medical treatment that was denied or modified must be provided to you immediately because you are facing an imminent and serious threat to your health, and your claims administrator did not perform an expedited or rushed review on your physician's request, this application must be submitted with a statement from your physician, supported by medical records, that confirms your condition.

* Mail or fax the application and a copy of the utilization review decision within the stated deadline to:

DWC-IMR, c/o Maximus Federal Services, Inc.
P.O. Box 138009, Sacramento, CA 95813-8009
FAX Number: (916) 605-4270

* Your IMR application, along with a copy of the written determination letter, must be received by Maximus Federal Services, Inc. within either thirty-five (35) days from the mailing date of the written determination letter, or fifteen (15) 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 15 days from the mailing date of the letter. For all other disputes, the deadline is 35 days from the mailing date of the letter. The application will indicate your filing deadline on Page Two.

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

Your Right to Provide Information

You have the right to submit, either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

* Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.

* Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.

* Evidence that the medical guidelines relied upon to deny or modify your physician's requested medical treatment does not apply to your condition or is scientifically incorrect.

* If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local e 1-800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.

DRAFT

Authorized Representative Designation for Independent Medical Review
(To accompany the Application for Independent Medical Review, DWC Form IMR)

Section I. To be completed by the Employee:

Employee Name (print)

I wish to designate

Name of Individual (print)

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application and to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the Independent 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. I allow the Independent Medical Review Organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

Employee Signature Date

Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee's behalf.

I accept the above designation to act as the above-named Employee's authorized representative regarding his or her Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be his or her authorized representative.

Name

I am a/an

(Professional status or relationship to the Employee, e.g., attorney, relative, etc.)

Address

City State Zip Code

Telephone Number E-mail

State Bar Number (if applicable)

Representative Signature Date

DRAFT