California

Utilization Review Agent Plan

Certification No. 037

06/25/2026

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Program Goals

StrataCare Solutions LLC (StrataCare) performs utilization review in the State of California as a service to our utilization review and managed care clients. The services performed are based upon account protocols and the delegation of specific claims and services. Our clients and their Third-Party Administrators may utilize an approval and/or prior authorization program for certain treatment requests based on the client's established criteria. StrataCare acts upon treatment requests within the statutory requirements when received by the claim payor or by StrataCare, whichever is sooner. StrataCare assists in the healthcare management of patients to ensure quality care in the appropriate setting. The goals of the UR Program are:

- Assure injured workers receive timely and appropriate care in the appropriate setting.
- To optimize health resource utilization through the pursuit of quality, medical necessity and cost-effective medical care.
- Provision of utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, 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 pursuant to Labor Code Section 4600.
- Utilization review is limited to a review based on medical necessity and does not include determinations of the work-relatedness of the injury or disease, or bill review for the purpose of determining whether the medical services were accurately billed.
- Compliance with 8 CCR § 9792.9.1 et seq.
- In compliance with Labor Code 4610(g)(4), StrataCare is URAC Accredited with an expiration of 04/01/2027.
- To provide a system to monitor the utilization of health resources within the appropriate continuum of care.
- The utilization review plan, including any appeal requirements, shall be conducted in accordance with URAC and state required standards or guidelines approved by the Medical Director.
- StrataCare does not utilize artificial intelligence (AI) or machine learning (ML) medial software in our utilization review process.

Overview

This Plan communicates how StrataCare conducts utilization review in accordance with state laws and regulations. This Plan presents the policies, procedures, requirements and plan responsibilities of StrataCare and does not represent the policies, procedures, requirements and plan responsibilities of any other organization engaged in full or partial utilization review activities. StrataCare will share this plan where required by state law and/or governing state agency regulation.

Requests for utilization review are received telephonically, via fax, email, or mail. StrataCare conducts utilization reviews for our clients on request(s) that come directly from the providers, carriers, and employers.

A currently California licensed and board certified National Medical Director is responsible for the oversight and audit of the Utilization Review process.

The UR nurse (RN or LVN/LPN) is responsible for the first level review of all medical information and for the certification of any treatment or procedure requested by the treating physician based on clinical information and evidence-based treatment guidelines, as specified in California regulations.

If a treatment request fails to meet, or exceeds, stated treatment guidelines then the request is assigned to a Clinical Peer Reviewer (CPR).

Our internal appeals process affords the injured worker and their attorney, if represented, and requesting physician the opportunity to appeal all decisions made by a clinical peer reviewer as well as meet regulatory timeframes and requirements.

StrataCare utilizes Medical Treatment Utilization Schedule (MTUS) adopted California guidelines as having presumptive weight in determining the review approval, modification, or denial of outcomes. If a treatment request is not covered in the MTUS, other applicable evidenced based treatment guidelines (such as ODG) may be used in the determination.

A determination is completed within the specific timeframes for the prospective, concurrent, or retrospective review performed and a written notification is sent to all required parties.

StrataCare holds accreditation with URAC for Workers' Compensation Utilization Management. StrataCare follows the URAC accreditation standards; however, if the state in which we are providing services has stricter requirements, the strictest requirements are practiced.

Prior Authorization Process Program (PAPP) [8 CCR 9792.7 (a)(5)]

StrataCare has implemented a PAPP on behalf of our clients with select medical providers. This PAPP is defined as "the claims Administrator's practice of any prior authorization process, including but not limited to where authorization is provided without the submission of the Request for Authorization (RFA). It also means "assurance that appropriate reimbursement will be made [to the treating physician] for an approved specific course of proposed medical treatment"

This process is available to StrataCare's clients by custom design. Some items that are part of a client-specific PAPP include:

- X-rays
- Initial CT/MRI's
- PT/OT/chiropractic services – 6-12 sessions (based on the client's established criteria)
- Acupuncture initial 6 visits
- Injections (Trigger point, epidural steroid injection, SI joint injection (based on the client's established criteria)
- Initial EMG/NCV
- DME less than $300.00

Accounts with PAPPs	
Crum & Forster	Ryder
Employers (EIG)	Salvation Army
Randstad	

Emergency Healthcare Services [8 CCR §9792.9.5]

Any emergency healthcare service is defined as a healthcare service 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. These emergency services will not require prior certification through utilization review.

Failure to obtain prior certification for emergency healthcare 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.

Medical Treatment – First 30 Days [8 CCR §9792.9.7.]

For the first 30 days after a work injury, the treating doctor can give the injured worker the medical care they need without waiting for prior approval, as long as these conditions are met:

1. The injury is accepted by the insurance company (the claims administrator) as work-related.
2. The treatment follows official medical guidelines (MTUS).
3. The initial treating physician timely submits a detailed report to the claim's administrator about the planned treatment on a "Doctor's First Report of Occupational Injury or Illness"
4. The doctor also lists all treatments and medications expected in those first 30 days on an authorization request form and sends it at the same time as the Doctor's First Report of Occupational Injury or Illness. If another doctor treats the worker during this period, they must also submit a request after their first visit.
5. The treating physician's medical treatment bill for the non-emergency treatment rendered or services provided under this section is submitted to the claim's administrator within thirty (30) days of the date the service was provided. Medical treatment bills for emergency treatment services shall be submitted within 180 days of the date that the treatment was provided.

The following medical treatment services, unless previously authorized by the claims administrator or rendered as emergency medical treatment, cannot be provided under this section and will require prospective utilization review:

- Pharmaceuticals, that are not expressly exempt from prospective review under the MTUS Drug Formulary.
- Nonemergency surgery and surgical services provided in any setting, including
    - inpatient hospital,
    - outpatient hospital,
    - surgical clinic,
    - ambulatory surgical center, or
    - physician's office.

  This includes all necessary and routine pre-operative, intra-operative, and post-operative services performed for the purpose of surgery including, but not limited to,
    - Related diagnostic tests or procedures,

  - rehabilitation services,
  - durable medical equipment or supplies, and
  - routine post-surgical pain management treatment or services.

- Psychological or psychiatric treatment services, which include diagnostic services, psychotherapy, and other services or procedures to an individual or group in all care settings provided by a physician or other qualified health care provider, and including psychiatric pharmaceuticals, to the extent they are not expressly exempt from prospective utilization review under the MTUS Drug Formulary.
- Home health care services, including health care and other medically necessary services provided to the injured worker in the residential setting.
- Imaging and radiology services, excluding X-rays.
- All durable medical equipment, prosthetics, orthotics, and supplies where the purchase or rental cost of the item with necessary supplies, if any, for the expected course of treatment is greater than $250.00 as determined by the DWC Official Medical Fee Schedule (OMFS), or, for an unlisted item, where the billed amount will be greater than $250.00.
- Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
- (8) Spinal injections including therapeutic medial branch nerve block injections; facet joint injections; intradiscal injections; epidural injections; and sacroiliac joint injections.

Pattern and Practice of Failing to Render Treatment Consistent with MTUS

If the claims administrator determines, after retrospective review, that a physician providing treatment has a pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, the claims administrator may:

- Remove the ability of the physician to render treatment exempt from prospective review to any injured worker whose claim is adjusted or administered by the claim's administrator. The claims administrator must provide written notice to the physician that:
  a. documents, based on retrospective review, the physician's pattern and practice of failing to render treatment that is consistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary.
  b. advises that based on the documented failure the physician can no longer render exempt treatment to any injured worker whose claims are adjusted or administered by the claims administrator; and
  c. advises of the requirement of prospective utilization review for all subsequent medical treatment.
- Remove the physician as the injured worker's primary treating physician by filing a petition for change of primary treating physician under section 9786.
- Terminate the physician from the claims administrator's or employer's medical provider network or health care organization.

Per the DWC, "pattern and practice" means when treatment has been rendered inconsistent with the Medical Treatment Utilization Schedule, including the MTUS Drug Formulary, for twenty (20) separate and unrelated recommended medical services or goods with ten (10) or

more injured workers over the course of three (3) months; or for eight (8) separate and unrelated medical services or goods with two (2) or less injured workers within a month.

Doctor's First Report of Occupational Injury or Illness, DIR Form 5021

If a physician renders treatment without timely submitting the "Doctor's First Report of Occupational Injury or Illness," DIR Form 5021, to the claims administrator, or without timely submitting a complete request for authorization, the claims administrator may remove the physician's ability to provide further medical treatment that is exempt from prospective review to the employee for the remainder of the thirty-day time period referenced at subdivision by issuing written notice to the physician. The written notice must identify that the physician either failed to timely submit the DIR Form 5021 or failed to timely submit a complete request for authorization, advise that the physician can no longer render exempt treatment to the injured worker for the remainder of the thirty days, and advise that any such treatment is subject to prospective utilization review.

Any dispute between the treating physician and the claims administrator regarding application of the provisions as allowed under subdivision (c) or (d) shall be resolved by the Workers' Compensation Appeals Board.

Prospective Review [8 CCR §9792.9.7], [8 CCR §9792.9.5]

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

The time for the claims administrator to conduct prospective utilization review shall commence from the date of the claims administrator's receipt of a request for authorization after the final determination of liability.

Pursuant to Labor Code 4610(c), unless authorized by the employer or rendered as emergency medical treatment, the medical treatment services listed in the previous section , 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.

For information on prospective review of exempt and non-exempt drugs, see the "MTUS – Drug Formulary" Section of this Plan

A determination to the non-expedited request will be sent within the state recommended timeframe, as provided in the "Timeframes for Decisions" section of this plan, from the date of receipt of the RFA.

A utilization review decision to modify or deny a request for authorization of medical treatment on the basis of medical necessity shall remain effective for 12 months from the date of the decision without further action by the claims administrator with regard to any further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Concurrent Review [8 CCR § 9792.6.1]

Concurrent review means utilization review conducted during an inpatient stay. Medical care provided during a concurrent review shall be treatment that is medically necessary to cure or relieve from the effects of the industrial injury.

A period of at least forty-eight (48) hours following an emergency admission, service, or procedure will be provided to the injured worker or the injured worker's representative to notify the utilization review agent and request certification or continuing treatment for the condition involved in the admission, service, or procedure.

The UR Nurse will respond to the non-expedited request within the state recommended timeframe, as provided in the "Timeframes for Decisions" section of this plan, from the date of receipt of the RFA or prior to the end of their previously authorized confinement.

Medical care will not be discontinued until the treating physician has been notified of the decision and a care plan has been agreed upon by the treating physician that is appropriate for the medical needs of the injured worker. The treating physician is afforded the opportunity to discuss the determination with the clinical review staff in the case of an adverse determination and may follow the appeals process.

Retrospective Review [8 CCR § 9792.6.1], [8 CCR §9792.7]

Retrospective review is a request for the review of services that have already been performed. Examples of services include outpatient surgeries, drug utilization, procedures, medical services, diagnostics, and therapies, including physical, occupational, and chiropractic.

The retrospective review process is dependent upon jurisdictional requirements.

StrataCare Solutions' process for retrospective review follows our same procedures for initial and/or secondary review. A determination is made no later than the state recommended timeframe, as provided in the "Timeframes for Decisions" section of this plan, from receipt of all requested documentation.

The adjuster can initiate the retrospective review process, but all retrospective review requests should be channeled through the UR Nurse.

Failure to obtain prior certification for 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.

Expedited Review [8 CCR § 9792.6.1], [8 CCR §9792.7]

The requesting provider must certify in writing and document the need for an expedited review on the RFA if the injured worker's condition is such that he/she 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.

An expedited review request that is not reasonably supported by evidence establishing that the injured worker faces an imminent and serious threat to his or her health, or that the timeframe for utilization review under the Prospective or Concurrent criteria would be detrimental to the injured worker's condition, shall be reviewed by the claims administrator under the timeframe set forth in Prospective or Concurrent timeframes.

The UR nurse / CPR makes a determination within the state recommended timeframe, as provided in the "Timeframes for Decisions" section of this plan, after the receipt of the written information reasonably necessary to make the determination.

MTUS – Drug Formulary [8 CCR §9792.9.8]

Notwithstanding sections 9792.9.1 – 9792.9.7, the following drugs can be dispensed to an injured worker without obtaining authorization through prospective review:

A Drugs identified on the MTUS Drug List as exempt under section 9792.27.15.
B Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Special Fill policy under section 9792.27.12; and
C Drugs identified on the MTUS Drug List as subject to and when dispensed in accordance with the Perioperative Fill policy under section 9792.27.13.

Exempt drugs identified above must still be set forth in a request for authorization as required under section 9792.6.1(u), or in a manner agreed upon by the treating physician and the claims administrator.

The claims administrator may conduct retrospective review of a drug prescribed or dispensed to the injured worker as described above only for the purpose of determining whether the use of the drug is consistent with the recommendations set forth in the applicable guideline of the medical treatment utilization schedule adopted by the administrative director.

For a drug not covered under this section, regardless of whether a drug is prescribed and dispensed within 30 days from the date of injury, the treating physician must request authorization through prospective utilization review by submitting a request for authorization.

Prospective decisions to approve, modify, or deny a request for authorization for a drug not covered under in this section shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) business days from the date of receipt of the request for treatment. The reviewer or non-physician reviewer may request the treating physician to provide additional information reasonably necessary to make a determination as follows:

A The reviewer or physician reviewer shall request the information from the treating physician within four (4) business days from the date of receipt of the request for authorization.
B If the information is not received within five (5) business days from the date of the request for authorization of treatment, a physician reviewer may deny the request in accordance with section 9792.9.5, subdivision (e).

Pursuant to section 9792.9.8(c), a treating physician must request authorization through prospective review for a drug not listed on the MTUS Drug List by submitting a RFA regardless of whether a drug is prescribed or dispensed within 30 days from the date of injury. Prospective decisions to approve, modify, or deny a request for authorization of a drug not listed on the MTUS Drug List shall be made in a timely fashion as outlined in the Timeframes section of this

plan. The decision will be communicated as outlined in the Contents of Written Notification section of this plan

A request for authorization that requests both drugs and non-pharmaceutical treatment related to the same injury or illness shall be reviewed under the timeframes set in the Time Frames for Decisions section of this plan

Treatment Guidelines and Medically-Based Review Criteria [8 CCR § 9792.8] [8 CCR §9792.7] [8 CCR §9792.2.1]

StrataCare utilizes evidence-based clinical treatment guidelines adopted by the state of jurisdiction as the primary source for guidelines and criteria. The state-mandated treatment guidelines and review criteria will be utilized when applicable.

Pursuant to 8 CCR §9792.2.1 StrataCare UR nurses and CPRs shall conduct the following medical evidence search sequence for the evaluation and treatment of injured workers.

1. Search the recommended guidelines set forth in the current MTUS to find a recommendation applicable to the injured worker's medical condition or injury.
2. In the event the medical condition or injury is not addressed by the MTUS or if the MTUS' presumption of correctness is being challenged, then:
    a. Search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then
    b. Search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then
    c. Search for current studies that are scientifically based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured worker's medical condition or injury. Choose the recommendation that is supported with the best available evidence according to the MTUS Methodology for Evaluating Medical Evidence set forth in section 9792.25.1

After conducting the medical evidence search in the sequence specified above, if a modified or denied determination is rendered, StrataCare CPRs shall include a citation to the guideline or study containing the recommendation he or she believes guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

The citation provided by the CPR shall be the primary source relied upon which he or she believes contains the recommendation that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury.

If the CPR provides more than one citation, then a narrative shall be included by the reviewing physician in the Utilization Review decision explaining how each guideline or study cited provides additional information that guides the reasonableness and necessity of the requested treatment that is applicable to the injured worker's medical condition or injury but is not addressed by the primary source cited.

If the CPR cited different guidelines or studies containing recommendations that are at variance with one another, the MTUS Methodology for Evaluating Medical Evidence shall be applied by the reviewing physician to determine which one of the recommendations is supported by the best available evidence.

The format of the citations provided by the CPR shall include the following

1. When citing the MTUS:
    a. Indicate the MTUS is being cited and the effective year of the guideline.
    b. Title of chapter (e.g., Low Back Complaints); and
    c. Section of chapter (e.g., Surgical Considerations).
2. When citing other medical treatment guidelines:
    a. Title of organization publishing the guideline (e.g., ACOEM or ODG);
    b. Year of publication.
    c. Title of chapter; and
    d. Section of chapter.
3. (3) When citing a peer-reviewed study:
    a. First author's last name and first name initial.
    b. Published article title.
    c. Journal title (standard abbreviations may be used).
    d. Volume number.
    e. Year published; and
    f. Page numbers.

Employers and their representatives, at their discretion, may approve medical treatment beyond what is covered in the MTUS or supported by the best available medical evidence in order to account for medical circumstances warranting an exception.

StrataCare's Utilization Management Program undergoes a review and update of their standards, procedures, and treatment guidelines annually. All nurses undergo training courses in the use of the treatment guidelines.

StrataCare provides a copy of the Clinical Peer Review Report with the adverse determination that discloses the criteria, guidelines and rational utilized to all parties involved (except for letters to non-physician providers).

Nothing in this section precludes authorization of medical treatment beyond what is covered in the medical treatment utilization schedule or supported by the best available medical evidence in order to account for medical circumstances warranting an exception in accordance with section 9792.21.1(e).

Initial Screening of Requests for Authorization [8 CCR §9792.9.1], [8 CCR § 9792.6.1]

Anyone may initiate the utilization review process as determined relevant by state law or regulation, or as determined by the workers' compensation insurer or claims administrator.

A request for authorization can be made by the primary treating physician or a secondary physician.

A RFA is a written request for a specific course of proposed medical treatments. The RFA will be considered complete if it:

- Unless accepted by a claim's administrator under section 9792.9.1, a request for authorization must be submitted on a "Request for Authorization (DWC Form RFA)".
- The form must be completed by a treating physician.
- Identify both the employee and
- Identifies 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.
- 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.

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. By agreement of the parties, the treating physician may submit the request for authorization with an electronic signature.

If the RFA is sent by mail and does not have documentation of receipt, the request shall be considered received by the claim's administrator five (5) business days after the deposit in the mail.

If the RFA is delivered via certified mail, with return receipt mail and does not have documentation of receipt, the request shall be considered received by the claims administrator on the receipt date entered on the return receipt.

If there is no documentation of receipt, evidence of mailing or a dated return receipt, the RFA shall be considered received by the claim's administrator five (5) business days after the latest date the sender wrote on the document.

If the RFA does not meet the definition of a complete request for authorization, a claims administrator, non-physician reviewer or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements of utilization review or mark it "not complete" and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) business days from receipt.

StrataCare utilizes non-clinical staff in the initial screening of RFAs. This initial screening does not require clinical judgement and does not result in a determination. The non-clinical staff

does not evaluate or interpret clinical information; does not issue non-certifications; does assign RFA numbers via Strata care.

All non-clinical staff that perform initial screenings are trained in all applicable UM requirements and procedures and have access to licensed health professions for guidance as needed.

Nonclinical UR staff review RFAs for completeness of information, including demographic information on the injured worker and requesting physician/facility and any other non-clinical data and the transfer of that data to a nurse for the next step in the review process.

Utilization review of a request for authorization of medical treatment may be deferred if the claims administrator disputes liability for either the occupational injury for which the treatment is recommended or the recommended treatment itself on grounds other than medical necessity.

First Level Review [8 CCR §9792.9.1]

Upon receipt of a treatment request, the UR Nurse verifies that all pertinent information necessary to complete the review is available. This information includes identifying information about the injured worker, the treating healthcare provider and the facilities rendering care. In addition, clinical information regarding the diagnosis and the medical history of the injured worker relevant to the diagnosis of the compensable injury, and the treatment plan prescribed by the treating health care provider should be available.

If compensability of the claim or allowed body part is in question, the UR nurse will consult with the claims adjuster to allow the adjuster the opportunity to dispute liability for the requested medical service or treatment. If no dispute is indicated, utilization review will continue with the assumption of compensability within statutory timeframes.

Based on what information is available to us and what information may be missing on the RFA, the UR nurse may either mark it as "not complete" and return it to the requesting physician no later than five (5) business days from receipt, or they may accept it as complete and continue with the processing. If the RFA is returned as "Not Complete", the timeframe for the decision will begin once the RFA is completed and returned.

If the necessary information is available or once the requested additional information is received, the review will continue.

If an RFA does not meet applicable criteria or the UR nurse and requesting physician have agreed upon a change in the treatment request, the requesting physician may voluntarily withdraw and/or modify all or part of the request and submit either a signed and completed notice of withdrawal/modify request form or an amended RFA.

The UR nurse may discuss the treatment plan with the requesting physician. If the requesting physician decides to make a change in the RFA or in the treatment plan, the UR nurse will request documentation from the requesting physician of that change.

The UR Nurse determines if the requested treatment meets the treatment guidelines and, if so, certifies the request and notifies all parties. A determination is completed within the specific timeframes for the prospective, concurrent, or retrospective review performed, as provided in the "Timeframes for Decisions" section of this plan. If the requested procedure/service does

not meet stated treatment guidelines, the UR Nurse refers the request to a Clinical Peer Reviewer for the second level of review.

StrataCare nurses are not allowed to issue non-certifications as an outcome of a first level review. StrataCare does not issue non-certifications based on artificial intelligence and machine learning automated only determinations.

Request for Information [8 CCR §9792.9.1], [8 CCR §9792.9.6]

Extensions to the standard timeframes (See Timeframes for Decisions) may only be extended under one or more of the following circumstances:

- all reasonably necessary information has not been received.
- The clinical peer reviewer has asked that an additional examination or test be performed that is reasonable and consistent with professionally recognized standards of medical practice.
- The clinical peer reviewer needs a specialized consultation and review of medical information by an expert reviewer. Expert reviewer means a medical doctor, doctor of osteopathy, psychologist, acupuncturist, optometrist, dentist, podiatrist, or chiropractic practitioner licensed by any state or the District of Columbia, competent to evaluate the specific clinical issues involved in the medical treatment and where these services are within the individual's scope of practice, who has been consulted by the reviewer to provide specialized review of medical information.

If information reasonably necessary is not received with the RFA, the UR nurse will request such information via a Request for Information letter. This will be done within five (5) working days (or thirty (30) calendar days for retrospective review) from the date of receipt of the written request for authorization (first date of knowledge.)

The UR nurse will document all attempts to obtain the information. If the required information is not received by the end of the 11th calendar day from the date of receipt of the original request, the RFA will be sent to a clinical peer reviewer to make a determination based on the information provided. A determination will be given no later than fourteen (14) calendar days for prospective or concurrent review, 72 hours for an expedited review or thirty (30) calendar days for retrospective review from the date of receipt of the RFA.

If an additional examination or test or specialized consultation by an expert reviewer is requested but not received within thirty (30) days from the date of the request for authorization, the clinical peer reviewer will deny the request with the stated condition that the request will be reconsidered upon receipt of the results of the examination or test or the specialized consultation.

If the request is denied due to lack of reasonable information, the requesting physician, injured worker and if represented, the injured worker's attorney will be notified of the denial and will be reconsidered once the request information or required results are received.

Second Level Review [8 CCR §9792.9.5]

Should requested medical treatment or service fail to meet treatment guidelines, a second level review is performed by a clinical peer reviewer consistent with URAC Standards:

Any decision to deny or modify a request for medical treatment will be conducted by a physician or psychologist, who is competent to evaluate the specific clinical issues involved in the medical treatment and where the requested services are within the scope of their practice.

M.D.s and D.O.s may review care recommended by any type of practitioner, but only M.D.s and D.O.s may review other M.D.s and D.O.s. For example, a psychiatrist may review a psychologist's plan of care (or another psychiatrist's). A psychologist may only review other psychologists.

The clinical peer reviewer assigned to the case reviews the documentation and attempts to contact the requesting physician in order to make a determination.

The clinical peer reviewer will attempt to contact the requesting physician to discuss the request at least two (2) times during the window of opportunity provided by the UR nurse. If contact is made, the clinical peer reviewer will notify the requesting provider of the determination or if contact is not successful, leave the determination with the office staff. All contact attempts will be documented on their report.

The CPR assigned to the case will review the documentation. Based upon the information provided by the requesting physician, either verbally or written, the clinical reviewer will make a determination in accordance with standards, treatment guidelines stated above, and/or based on medical necessity.

If the determination results in a certification of the service/treatment, the Clinical Peer Reviewer will notify the UR Nurse. The UR Nurse documents all the information in the treatment notes. A determination is completed within the specific timeframes for the prospective, concurrent, or retrospective review performed as provided in the "Timeframes for Decisions" section of this plan. A written notification is sent to the requesting physician with a copy delivered to the injured worker and/or their representative and the carrier.

For all decision types, prospective, concurrent, or expedited review, a decision to modify or deny shall be communicated to the requesting physician within twenty-four (24) hours of the decision and shall be communicated to the requesting physician initially by telephone, facsimile, or electronic mail. The UR nurse will send written notification via fax or letter to the affected parties within 24 hours for a concurrent review and within two (2) business days for a prospective review after the verbal notification has occurred.

If the review results in an adverse determination based on medical necessity and/or appropriateness, the principal reason for denial and the procedure to initiate an appeal will be included in the determination letter and sent to the required parties. The determination letter includes a toll-free number with which an injured worker, or injured worker representative and requesting provider may call to request a review of the determination or obtain further information regarding the right to appeal.

If the Clinical Peer Reviewer has issued an adverse determination and no peer-to-peer conversation has occurred. The requesting provider may contact StrataCare at the toll-free number within two (2) business days to discuss the adverse determination with the initial peer reviewer. If the initial peer reviewer is not available, another peer reviewer will be made available.

A utilization review decision to modify or deny a request for authorization of medical treatment shall remain effective for 12 months from the date of the decision without further action by the claim's administrator with regard to any further recommendation by the same physician for the same treatment, unless the further recommendation is supported by a documented change in the fact's material to the basis of the utilization review decision.

Internal Appeals Process [8 CCR §9792.9.5]

Carriers can choose to offer an internal clinical appeal review. The process is available to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. The decision to pursue the internal appeal process is voluntary and optional and neither triggers nor bars use of the dispute resolution procedures of Labor Code sections 4610.5 and 4610.6.

A voluntary internal appeal request should be submitted within ten (10) calendar days of the initial utilization review decision. Requests for an appeal can be submitted by calling, faxing, or mailing the request. A Clinical Peer Reviewer in the same discipline as the provider of record, who was not involved in the original adverse determination or is not a subordinate of the initial reviewer will review the rationale and information from the original decision, consider new information that has become available since the initial decision, and contact the attending physician. The clinical peer reviewer will then make a final determination.

All internal standard or expedited appeals will be completed within the state recommended timeframe, as provided in the "Timeframes for Decisions" section of this plan, from the date of receipt of the request.

When a request for an appeal is made, the UR nurse will:

- Document the name and phone number of the person making the appeal request.
- Document the stated reason for the appeal.
- Review the case information for any supporting information.
- Refer to a clinical peer reviewer not involved in the initial denial.

The clinical peer reviewer must respond to an appeal request by:

- Reviewing the rationale and information from the original decision, if necessary.
- Consider new information that has become available since the initial decision.
- Make reasonable attempts to contact the requesting physician.
- Make a final determination per regulatory requirements.

If the clinical peer reviewer agrees with the initial denial, he will notify the requesting physician by telephone. The clinical peer reviewer notifies the UR nurse of the determination and rationale for upholding the denial. The UR nurse will send the letter "CA UR Appeal Upheld" and the peer reviewers report within 24 hours to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney. A new IMR form is not included; however, the injured worker will still have thirty (30) days from the date of receipt of the initial denial/modification to request an IMR, if they have not already done so.

If the clinical peer reviewer modifies the initial denial, he will notify the UR nurse with the determination and rationale for the modification. The UR nurse will immediately notify the provider, if the advisor has not verbally notified the requesting physician, that the appeal request has been modified and proceed with the partial certification of the requested procedure and send written notice of the modification to the physician, the provider of goods, if any, the injured workers, and if the injured worker is represented by counsel, the injured worker's attorney. The written notification will include a new IMR form that indicates that the decision is a modification after appeal and the 30-day time period for requesting an IMR will begin anew.

If the clinical peer reviewer overturns the denial, he will provide the UR nurse with the determination and the rationale for reversing the denial. The UR nurse immediately notifies the provider, if the advisor has not verbally notified the requesting physician, that the determination was overturned and proceeds with certification of the requested procedure and sends written notice of the approval to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.

If a request for IMR has been sent by the injured worker and the denial is overturned, the UR nurse will also notify the claims adjuster to notify the IMRO that there is no further need for the IMR review.

Dispute Process [8 CCR § 9792.10.1]

An adverse treatment request decision may be disputed by the requesting physician, the injured worker and if the injured worker is represented by counsel, the injured worker's attorney, through the Division of Workers' Compensation dispute resolution process. The dispute may be for any health care service.

The exact dispute language can be found in the next section of this document, "Contents of Written Notifications," as well as in the letters themselves which can be found in the section entitled "Letters."

Timeframes for Decisions [8 CCR §9792.9.3]

The first day in counting any timeframe requirement is the first normal business or working day after receipt of the completed or accepted as complete request for authorization except when the timeline is measured in hours. Whenever the timeframe requirement is stated in hours, the time for compliance is counted in hours from the time of receipt of the request for authorization.

Unless state law dictates otherwise, StrataCare follows URAC timeframes. The following timeframes are used specifically for California:

Initial Reviews	
Non-urgent Prospective	Determination is issued within five (5) business days of the completed RFA Within twenty-four (24) hours after a decision is made it will be communicated to the requesting provider by phone or fax or electronic mail. The verbal decision is followed by written documentation to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within two (2) business days of the decision.
Expedited Prospective	Determination is issued within seventy-two (72) hours of receipt of the necessary information. Notification of the decision will be given to the requesting physician within twenty-four (24) hours by phone or fax or electronic mail.
Concurrent	Determination is issued within five (5) business days of receipt of the completed RFA. Within twenty-four (24) hours after a decision is made it will be communicated to the requesting provider by phone or fax or electronic mail. The verbal decision is followed by written documentation to the physician, the provider of goods, if any, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney within twenty-four (24) hours of the decision.
Expedited Concurrent	Determination is issued within seventy-two (72) hours of receipt of the necessary information. Notification of the decision will be given to the requesting physician within twenty-four (24) hours by phone or fax or electronic mail.
Retrospective	Determination is issued within 30 calendar days of the request.
Appeals	
Standard	Completed within thirty (30) calendar days of the initiation of the appeal process. The UR nurse will send the letter "CA UR Appeal Upheld" and the peer reviewer's report within 24 hours to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney..
Expedited	Completed within seventy-two 72 hours of the initiation of the appeal process

Contents of Written Notifications [8 CCR §9792.9.4], [8 CCR **§9792.9.5]**

All written notifications approving, modifying or denying treatment certification will be provided to the physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney and shall contain the following information:

- The date on which the RFA was first received;
- A description of the specific course of proposed medical treatment for which

certification was requested; date of requested service, and treatment identification number.

- Name of provider or facility
- The claimant's name
- The claimant's address
- The claimant's claim number
- The claimant's date of injury
- An RFA number that is a unique identifier for each request for certification
- The date the decision was made.
- A specific description of the medical treatment service approved, if any.
- The guidelines/criteria used for the determination.
- A clear, concise, and appropriate explanation of the reasons for the utilization review decision including the clinical reasons regarding medical necessity and a description of the medical criteria or guidelines used (if due to incomplete or insufficient info, must specify the reason and specific info needed).
- For approvals of a request for authorization of a drug where the request for authorization did not indicate "Do Not Substitute" or "Dispense as Written," the written decision approving the request in generic form shall indicate, "generic substitute authorized" or words to that effect and meaning.
- For approvals of a request for authorization of a drug that is exempt on the Drug Formulary, the written decision approving the request shall indicate, "Exempt per MTUS Drug Formulary" or words to that effect and meaning.
- For approvals of a request for authorization of non-drug treatment that are exempt under section 9792.9.7 (i.e., the 30-day exemption), the written decision approving the request shall identify the exempt treatment as, "30-day exemption" or words to that effect and meaning.
- If applicable, the date the request for information, exam, or consultation was requested, and the date the information was received.
- If the timeframe for decision was extended,
    - a specific description of the information needed to make a medical necessity determination;
    - the date(s) and time(s) the request(s) for information, exam, or consultation were requested;
    - the manner in which the requests were made; and
    - the date the information was first received.
- Identification of the URAC accredited entity, approved by the Division of Workers' Compensation, that is liable for the utilization review decision.

For Denials and Modifications will include all the above information in addition to the following:

- The name, signature and specialty of the physician reviewer, and a telephone number by which a discussion can be scheduled with the reviewer, expert reviewer or medical director. The UR nurse will coordinate the conversation and all physician reviewers will be available for at least four (4) hours per week during business hours (8:00 a.m. to 5:30 p.m., Pacific Time.)
- A list of all medical records reviewed;
- 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.
- The procedures to initiate an appeal of the determination and a toll-free telephone number.
- The timeframe to file an appeal for consideration.
- A clear statement advising the injured worker that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and that an objection to the utilization review decision must be communicated by the injured worker, the injured worker's representative, or the injured worker's attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR within the timeframe indicated on the last page of the application
- The 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 [claims adjuster's name] at [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."
- 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 section 4610.5 and 4610.6, but may be pursued on an optional basis.

- Included with the written decision, an IMR application with all fields completed except the injured worker's signature and an addressed envelope to the Administrative Director or his designee (the IMR application and envelope. will be sent only to the injured worker and to the attorney and only on the initial adverse determination – not with an appeal determination letter unless the determination is a modification of the initial determination).

Non-physician providers of goods identified in the request for authorization, and for whom contact information has been included, shall also be notified in writing.

The contents of the written communication are written in plain language.

Please see Exhibit 1 for examples of the written notifications.

Personnel Qualifications and Type [8 CCR §9792.7] [8 CCR 9792.6.1(o)]

National Medical Director

Dorian Kenleigh, MD, MPH, FACOEM, FIAIME serves as our National Medical Director. He received a BA in Asian Literature and Languages (Japanese), a BS in Bioengineering and a MS in Bioengineering from the University of Pittsburgh. He received an MD from University of Iowa and a Master of Public Health from the University of Washington.

From 2015 to 2020 he contributed to health initiatives with International Medical Relief and The Project to End Human Trafficking in Uganda where he assembled medical staff and materiel capacity leading to the construction of surgical/obstetrical centers. He also provided emergency medical services, and medical staff training.

Dr. Kenleigh also served as a physician and director at Signify Health from 2015 to 2020. He led development of in-home EMR systems and furthered development of the in-home assessment model for optimization of Medicare and Medicare Advantage reimbursement. . He also directed home health teams and care management across Indiana as a treating physician.

He served as a hospitalist at the University of Washington Medical Center (2021 -2022) during the COVID pandemic while completing fellowship training in Occupational and Environmental Medicine (2020 – 2022) at the University of Washington. He then served as an attending physician in occupational medicine at Banner Health in Phoenix, Arizona. He was also a locums occupational medicine physician with Medicine for Business and Industry (MBI) in Arizona.

Currently, Dr. Kenleigh is the physician owner of Desert Occupational Medicine in Phoenix, Arizona. His practice provides occupational health consultation, particularly for occupational toxicology, as well as independent medical examination, disability examination, medical case and claim forensic review, and expert witness services. He is also a contracted Independent Medical Examiner and a Utilization Review Physician Reviewer with Dane Street.

Dr. Kenleigh serves on the board of the Western Occupational and Environmental Medical Association (WOEMA) and provides section leadership for the medical informatics and environmental health sections of the American College of Occupational and Environmental Medicine (ACOEM). He is a panel expert for the Industrial Commission of Arizona and an expert reviewer for the Arizona Medical Board.

Dr. Kenleigh is responsible for reviewing all commercial criteria used during the utilization review process (ODG and ACOEM) as well as oversight of our national utilization management program at StrataCare. He assists in ensuring that the processes by which StrataCare reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, are in accordance with URAC standards and state requirements. Dr. Kenleigh is responsible for all decisions in the utilization review process. He is available to clinical staff by phone or email during normal business hours.

Dorian Kenleigh, MD, MPH, FACOEM, FIAIME

402 S Kentucky Ave, #390 | Lakeland, FL 33801
P.O. Box 14245 | Lexington, KY 40512
(p) (888) 853-4735 (f) (863) 668-9553
Email: dkenleigh@medrisknet.com

Licensure:

AZ	58925	EXP 05/02/2028
CA	C167244	EXP 12/31/2027
CT	83116	EXP 01/31/2027
IN	01076045A	EXP 10/31/2027
OK	46862	EXP 11/01/2026
UT	141307703-1205	EXP 01/31/2028

Certifications:

Preventive Medicine, American Board of Preventive Medicine
Occupational and Environmental Medicine, American Board of Preventive Medicine
Certified Independent Medical Examiner (CIME), American Board of Independent Medical Examiners
Certified MedicoLegal Evaluator (CMLE), International Association of Independent Medical Evaluators
Fellow, American College of Occupational and Environmental Medicine (FACOEM)
Fellow, International Association of Independent Medical Evaluators (FIAIME)
Medical Review Officer Certification, Certification Council - Registry #22-233768
NIOSH Spirometry Certification, Council
Level 2 Certification in Military Environmental Medicine, Military, VA
Level 1 Certification in Military Environmental Exposures, Military, VA
Medical Acupuncture, Helms Institute - 500-hour clinical course. Board eligible in medical acupuncture.

Nursing Staff

StrataCare nurses have current, unrestricted professional licenses and are RNs or LPN/LVNs. The nurses possess clinical nursing experience and are knowledgeable in the utilization review process in workers' compensation.

StrataCare performs primary source verification of an nurse's licensure, education, and certification(s) upon hire and before expiration. StrataCare will continually ensure that the licensure/certification(s) meets the requirements of the job description. Any nurse who does not hold a required license, whose license has been suspended or revoked, or whose education and/or certification status cannot be verified will not be considered for employment.

Their personnel records are updated upon each anniversary of their licensure and copies of their current license verification and any certifications are kept in their personnel file.

Based on their role, new nursing staff will have an individualized orientation plan developed using telephonic, e-learning platform, one-on-one discussions, and independent study. Nurses are required to participate in ongoing training to maintain current job knowledge.

Clinical Peer Review

StrataCare uses only URAC accredited vendors for our Clinical Peer Reviewer services. All Clinical Peer Reviewers hold active, unrestricted licenses or certifications to practice medicine or a health profession and hold professional qualifications, certifications, and fellowship

training in the same licensure category as the ordering provider; or, as a Doctor of Medicine or Doctor of Osteopathic Medicine.

All clinical peer reviewers hold current, unrestricted professional licenses by any state or the District of Columbia, hold board certification in their specialty and are in active practice. They are also competent to evaluate the specific clinical issues involved in the medical treatment services that are the subject of the request for authorization pursuant to 8 C.C.R. §9792.6.1(v) .

M.D.s and D.O.s may review care recommended by any type of practitioner, but only M.D.s and D.O.s may review other M.D.s and D.O.s. For example, a psychiatrist may review a psychologist's plan of care (or another psychiatrist's). A psychologist may only review other psychologists.

StrataCare contracts with URAC-accredited peer review organizations for clinical peer reviews. Licensing and credentialing functions are delegated to the peer review organization, ensuring that all URAC and jurisdictional requirements are met through primary source verification of licensure and board certifications. The vendors used are:

Ethos (Formerly Claims Eval, Inc.) 4980 Rocklin Road Rocklin, California 95677 Independent Review Organization: Comprehensive Review (Internal & External) 5.2 Workers' Compensation Utilization Management 8.1 Accreditation Status: Full Accreditation Accredited Since: 2008 Expiration Date: 10/01/2026 Expiration Date: 11/01/2027 (p) 916-797-9997 (f) 480-393-5620	**Physician Based Medical Management (PBMM)** 16255 Ventura BLVD., Suite 830 Encino, California 91436 Independent Review Organization 6.0: Internal Review Accreditation Status: Full Accreditation Accredited Since: 2012 Expiration Date: 11/01/2027 (p) 888-885-1131 (f) 800-986-0436
Network Medical Review Co. Ltd. 4960 E. State Street Rockford, Illinois 61108 Independent Review Organization 6.0: Comprehensive Review Accreditation Status: Full Accreditation Accredited Since: 2000 Expiration Date: 09/01/2028 (p) 815-964-6334 (f) 815-964-1162	**Broadspire Services, Inc.** 1391 NW 136th Ave Sunrise, FL 33323 Independent Review Organization 6.0: Internal Review Opioid Stewardship Designation Workers' Compensation Utilization Management 8.1 Accreditation Status: Full Accreditation Expiration Date: 05/01/2028 (p) 954-452-4000

Quality Assurance

StrataCare ensures the quality of decisions and outcomes through a comprehensive Quality Management Program (QMP) administered by the Quality Assurance Manager under the oversight of the National Medical Director. The QMP evaluates performance across the Utilization Management (UM) process through defined standards, structured audits, and continuous improvement activities.

Performance Standards and Monitoring

Quality is screened through measurable benchmarks, including:

- 98% compliance with state or URAC timelines for Prospective Review determinations.
- Nurse Utilization Review scores of 95% or higher.

- Clinical Peer Reviewer (CPR) vendor scores of 95% or higher.
- Completion of annual vendor risk assessments and timely risk mitigation.
- 100% of denied/modified determinations closed with an identified Peer Reviewer (with state-specific exceptions).

Performance data is reported to the Quality Management Committee and Quality Oversight Body for review and remediation planning.

Audit of Nurse Decisions

The QMP conducts detailed audits of Utilization Review Nurse (URN) work to assess both compliance and documentation quality.

- Regulatory compliance audits examine whether nurses applied the correct review type, used appropriate guidelines, met required timelines, created accurate determination letters, and followed both client-specific and state-specific protocols.
- Documentation quality audits ensure accurate capture of diagnosis codes, service dates, clinical findings, compensability status, and reviewer types, as well as completeness and clarity of UR notes. These audits generate a total quality score and drive individual performance feedback.

Evaluation of Clinical Peer Reviewers

The Medical Director audits CPR work for reviewer appropriateness, clarity of issue identification and recommendations, adequacy of clinical summaries and rationales, and correct application of treatment guidelines and citations. Vendor performance below required thresholds results in performance improvement plans. [Quality Assurance | Word]

Oversight of Determination Closures

UM Supervisors review all denied or modified determinations to verify proper Peer Reviewer involvement and adherence to closure standards. Exceptions are reviewed with responsible nurses, and trends are incorporated into quarterly quality reviews.

Continuous Quality Improvement

The organization conducts Quality Improvement Projects (QIPs) that analyze internal data to identify baseline performance, detect trends, and implement targeted improvements. These projects are designed to enhance processes while safeguarding personal information by limiting data to minimum necessary elements.

Accessibility [8 CCR §9792.7]

StrataCare operates during normal business hours Monday through Friday, 8:00 a.m. to 5:30 p.m. across all time zones.

The UR Nurses are accessible via a toll-free telephone number, 1-888-853-4735, between the hours of 8:00 a.m. to 5:30 p.m. Pacific Time, Monday through Friday, excluding holidays. All Nurses have voicemail and will return all incoming telephone calls within one business day.

Toll-free phones, fax numbers and emails are available 24 hours/day, 7 days/week. Staff are required to check their voicemail at intervals during business hours and return calls within one (1) business day. The fax number is 863-668-9553.

StrataCare has an after-hours call recording system to address utilization review concerns of injured workers and employers, and receive provider requests Monday through Thursday from 5:30 p.m. to 8 a.m. and Friday from 5:30 p.m. to Monday 8 a.m. The voice mail greeting identifies the organization and provides the caller an opportunity to leave a message, which staff will respond to on the next business day.

A request for authorization transmitted by facsimile after 5:30 p.m. Pacific Time shall be deemed to have been received by the claim's administrator on the following business day.

Confidentiality [8 CCR §9792.7]

All materials obtained during the utilization review process will be kept in strictest confidence in accordance with any applicable state and federal laws and used only in the delivery of our services. This includes medical records received from providers, triage notes, case management and/or utilization notes and other internal case notes or studies which contain individually identifiable health information. StrataCare will not disclose or publish any individual medical records, personal information, or other confidential information about an injured worker without the prior consent of the injured worker or as otherwise required by state and federal law. All medical information received will be used only for the purpose of utilization management, evaluation of performance and quality review (includes external and internal audits), for questionable bills, and quality improvement activities. This information will be utilized only by authorized personnel, on a need-to-know basis, and will be shared only with confirmed parties to the claim.

StrataCare is primarily paperless. Medical Records are scanned into our secure computer application. Hard copy medical records are secured in locked bins until shredded. No one other than designated staff have access to the secured bins. Computer access is limited to UR personnel only.

Voice mail on phone systems is password protected to prevent unauthorized access. E-mail access is password protected and all outgoing emails include a confidentiality disclaimer as described in our Web-Based and Mobile Technologies policy. All external emails which include personal identifiable health information are encrypted. Cellular phones are only used only on an account-specific basis and are secure. Outgoing faxes have a facsimile cover sheet with a privileged and confidential statement included.

Information generated and obtained for UR review shall be kept for at least three (3) years following either:

1. The most recent utilization review decision for each injured employee, or
2. The date on which any appeal from the assessment of penalties for violations of Labor Code section 4610 or sections 9792.6 through 9792.12 is final, whichever date is later.

As part of initial and ongoing training, StrataCare educates staff on their responsibilities regarding privacy and security of patient information.

Complaints [8 CCR § 9792.11]

Any party may file a complaint by telephone, e-mail, or in writing via mail.

Complaints are assigned to the appropriate responder for each type of complaint. The responder is responsible for gathering additional information, updating the complaint ticket with full details and any attachments received, logging the resolution, as well as sending any required letters (acknowledgement and resolution letters.)

StrataCare will take immediate corrective action and attempt to resolve the complaint within thirty (30) business days from receipt or according to statutory requirements.

Complaints concerning utilization review procedures may also be submitted with any supporting documentation to the Division of Workers' Compensation.

Request for CA URA Plan [8 CCR §9792.7]

StrataCare has filed our utilization review plan with the California Division of Workers' Compensation. Upon request by the public, StrataCare will make available the complete utilization review plan through electronic means. If a member of the public requests a hard copy of the utilization review plan, StrataCare may charge reasonable copying and postage expenses related to disclosing the complete utilization review plan. Such charge shall not exceed $0.25 per page plus actual postage costs.

Material Modification [8 CCR §9792.7]

A material modification will be filed with the DWC Administrative Director within 30 days of the material modification. Changes that initiate a material modification include changes to utilization review vendor(s);~~,~~ changes to the utilization review standards or changes to the medical director, address, company name or corporate structure.

The material modification will include a DWC Form UR-01, completed as applicable with an original signature by the applicant's medical director, and an attached statement certifying that the utilization review plan, as modified, continues to be in compliance with the rules governing utilization review.

Financial Incentives

StrataCare does not have a system for incentives, bonuses, or reimbursement to staff, vendors, or health care providers based directly on consumer utilization of health care services. This policy statement andthe Conflict-of-Interest Policy support that we do not wish to negatively influence the provision of health care services by offering incentives based on utilization of services.

Client List [8 CCR §9792.7]

StrataCare has been contracted by the following clients to perform utilization management services in the State of California.

Account	Account
The American Equity Underwriters (AEU)	Novare – Ethos Risk Services
Crum & Forster	Randstad
Employers (EIG)	Ryder System, Inc.
Equian - Optum	Salvation Army
	Spherion ESIS

Exhibit 1 – Written Notifications

Exhibit 1a – List of Written Notifications

- Notice of Administrative Certification
- Notice of Approval Program Certification
- Notice of Denial Determination
- Notice of Modified Determination
- Notice of Certification Determination [nurse]
- Notice of Certification Determination [physician]
- Notice of Untimely Appeal
- Notice of Appeal - Upheld Determination
- Notice of Appeal - Modified Determination
- Notice of Appeal - Overturned Determination
- Fax Notification in Lieu of Verbal
- Non-Exempt Rx Notice
- Request for Information
- Request to Withdraw or Modify
- Notice of Duplicate Request (Uphold to Denial)
- Notice of Extension Amended Certified - Non-Drug formulary
- Notice of "Not Complete" Request for Authorization (RFA)
- Notice of Denial Due to Lack of Information

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P.O. Box 14245 |Lexington, KY 40512
Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Notice of Administrative Certification

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», the claims administrator has instructed StrataCare Solutions to issue an administrative certification for the services/treatments listed below.

Diagnosis: «ICD10» «ICD10 Desc»

Treatment ID	Treatment(s)/Service(s)	Qty.	Start Date End Date
«Treatment ID»	«Item/Service»	00	00/00/000000/00/0000

Date of Determination: [INSERT DATE]

The Administrative Director of the State of California Division of Workers' Compensation has adopted regulations setting forth utilization review (UR) standards applicable to workers' compensation insurers and self-insured employers. Insurers and self-insured employers may engage in a case-by-case review of the medical treatment provided injured workers in order to improve care and manage costs.

California Medical Provider Network

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at https://www.dir.ca.gov/dwc/mpn/DWC_MPN_Main.html.

This administrative certification is valid for sixty (60) days. Extension or changes in the treatment plan will require additional certifications.

Questions can be directed to either the claims adjuster at «Adjuster Phone» or StrataCare Solutions Utilization Review at 888-853-4735 between the hours of 8:00 a.m. to 5:30 p.m. PT.

Sincerely,

«Nurse Signature»

Enclosure (1): Clinical Peer Review Report

Copy to: «Patient Name» *(mailed)*
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Adjuster Name», Claims Adjuster *(sent electronically)*

«Attorney Name», Attorney *(mailed)*
« Address Line»
« City», « State» « Zip»

«Attorney Name», Attorney *(mailed)*
« Address Line»
« City», « State» « Zip»

CA UR Administrative Certification REV 02/19/2026

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Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Notice of Approval Program Certification

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», StrataCare Solutions has been asked to review the treatment request listed below for medical necessity and appropriateness.

This notification is limited to this specific treatment and/or procedure requested and does not require utilization review pursuant to the «Account Name» Approval Program and only pertains to accepted body parts.

Diagnosis: «ICD10» «ICD10 Desc»

Treatment ID	Treatment(s)/Service(s)	Qty
«Treatment ID»	«Item/Service»	00

Date of Determination: [INSERT DATE]

California Medical Provider Network

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at https://www.dir.ca.gov/dwc/mpn/DWC_MPN_Main.html.

Questions can be directed to either the claims adjuster at «Adjuster Phone» or StrataCare Solutions Utilization Review at 888-853-4735 between the hours of 8:00 a.m. to 5:30 p.m. PT.

Sincerely,

«Nurse Signature»

Copy to: «Patient Name» (mailed)
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Adjuster Name», Claims Adjuster (sent electronically)

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

CA UR Approval Program Certification REV 02/19/2026

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P.O. Box 14245 | Lexington, KY 40512
Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

««Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Notice of Denial Determination

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», StrataCare Solutions has been asked to review the following treatment(s)/procedure(s) for medical necessity and appropriateness.

Diagnosis: «ICD10» «ICD10 Desc»

Treatment(s)/Service(s) Requested:
«Treatment ID» «Item/Service»

After review of this request, based on the medical information submitted at this time, the clinical peer reviewer determined that the services or treatments described below are **not certified.** This means the services or treatments are **not approved.**

Treatment ID	Treatment(s)/Service(s)	Determination Date	Date of Verbal
«Treatment ID»	«Item/Service»	00/00/0000	00/00/0000

Screening criteria and treatment guidelines used: See enclosed Clinical Peer Review report.

Date of Determination: [INSERT DATE]

Date Additional Information Requested: [INSERTED BY NURSE]

Information, exam or consultation requested: [INSERTED BY NURSE]

Manner Information Request was made: [INSERTED BY NURSE]

Date Information Received: [INSERTED BY NURSE]

Physician/practitioner who made the decision:

[insert provider]	[insert specialty]	[insert state]	[insert license]
Peer Reviewer Name	Specialty	License State	License No.

California Medical Provider Network

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at https://www.dir.ca.gov/dwc/mpn/DWC_MPN_Main.html.

StrataCare Internal Clinical Appeal Process

CA UR Notice of Denial REV 03/19/2026

medrisk | StrataCare urac ACCREDITED Workers' Compensation Utilization Management

P.O. Box 14245 | Lexington, KY 40512
Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

The internal appeals process is a voluntary process that neither triggers nor bars the use of dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis. Decisions are based upon medical necessity. If your provider disagrees with the decision, he/she can initiate an appeal by contacting StrataCare Solutions UR Team who can provide information on the steps to request an appeal.

All voluntary internal appeal requests must be received StrataCare Solutions within ten (10) calendar days of receipt of this written notification. Appeals can be submitted by calling, faxing or emailing the request. You must be prepared to present pertinent clinical information in support of your request. The appeal review will be conducted by a clinical peer reviewer other than the one involved in the initial determination. All internal appeals will be completed within thirty (30) days for a standard appeal or seventy-two (72) hours for an expedited appeal from the date of receipt of the request.

Division of Workers' Compensation Dispute Process for Injured Workers

All disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and 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.

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 «Adjuster Name» at «Adjuster Phone». However, if you are represented by an attorney, please contact your attorney instead.

A decision to modify, or deny a request for authorization will remain in effect for twelve (12) months from the date of the decision without further action by the claims administrator or utilization review agent with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

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.

StrataCare's utilization review findings are intended solely as clinical opinions to determine whether the proposed services or treatment is medically reasonable and necessary.

This determination letter is provided to the requesting provider, the adjuster, the injured worker and the injured worker's representative, if applicable.

This does not guarantee payment, acceptance of additional body parts or injuries into this claim. All payment decisions will be handled by the claims representative.

If a peer-to-peer discussion has not occurred, the requesting provider may contact StrataCare Solutions Utilization Review at « Toll Free Number» within two (2) business days to discuss the adverse determination. We will respond within one (1) business day. The reviewer, expert reviewer or the medical director's availability for discussion will be Monday through Friday from 9:00 am to 5:30 pm Pacific Time. In the event the physician reviewer is unavailable, the requesting physician may discuss the written decision with another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Questions can be directed to either the claims adjuster at «Adjuster Phone» or StrataCare Solutions Utilization Review at 888-853-4735 between the hours of 8:00 a.m. to 5:30 p.m. PT.

Sincerely,

«Nurse Signature»

Enclosures (3): Clinical Peer Reviewer Report (sent to all parties)

Application for Independent Medical Review, DWC form IMR (sent to IW and Attorney if applicable)
Pre-Addressed Envelope (sent to IW)

Copy to: «Patient Name» (mailed)
«Patient Address Line»

«Attorney Name», Attorney (mailed)
« Address Line»

CA UR Notice of Denial REV 03/19/2026

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P.O. Box 14245 | Lexington, KY 40512
Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

«Patient City», «Patient State» «Patient Zip»

« City», « State» « Zip»

«Adjuster Name», Claims Adjuster (sent electronically)

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

CA UR Notice of Denial

REV 03/19/2026

Clinical Peer Review Report

SECTION 1 - CASE INFORMATION

DATE REFERRED TO REVIEWER	DATE OF DETERMINATION	DATE OF VERBAL NOTIFICATION	DATE REPORT COMPLETE

INJURED WORKER NAME	CLAIM #	RFA ID	DOI

ACCOUNT NAME	WORK STATUS	JURIS STATE

REQUESTING PROVIDER NAME	DEGREE	SPECIALITY	PROVIDER PHONE

SECTION 2 – DOCUMENTS REVIEWED

SECTION 3 – CLINICAL SUMMARY

Section 4 - Requested Treatment, Determination and Rationale

Medical Treatment(s) Requested

1.

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):
	Prospective		Reconsideration	Certify/Approved
	Concurrent		1st Level Appeal	Non-Certify/Denied
	Retrospective		2nd Level Appeal	Modify
	Expedited			Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medical Treatment(s) Requested

2.

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):
	Prospective		Reconsideration	Certify/Approved
	Concurrent		1st Level Appeal	Non-Certify/Denied
	Retrospective		2nd Level Appeal	Modify
	Expedited			Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medical Treatment(s) Requested

3.

REV 09/2024

Clinical Peer Review Report

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
☐	Prospective	☐	Reconsideration	☐	Certify/Approved
☐	Concurrent	☐	1st Level Appeal	☐	Non-Certify/Denied
☐	Retrospective	☐	2nd Level Appeal	☐	Modify
☐	Expedited			☐	Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medication Non-certification/Denial does not imply abrupt cessation for a patient who may be at risk for withdrawal symptoms. Should the missing criteria necessary to support the medical necessity of this request remain unavailable, discontinuance should include a tapering by the patient's treating physician prior to discontinuing avoiding withdrawal symptoms.

Section 5 - Contacts/Outcomes

No.	Date	Time	Full Name of Contact	Outcome	Verbal Notification Given?	Appeal Information Given?
1.						
2.						
3.						

SECTION 6 - ATTESTATION

I hereby attest that I that have personally reviewed the list of medical information used to make the determination. To the best of my knowledge, I was not previously involved in reviewing this episode of care and do not have a material personal, professional, or financial conflict of interest with the patient, health care providers, insurer/payer, referring party, or the recommended treatment. I have not accepted compensation that is dependent in any way on the specific outcome of the case. I have a scope of licensure that typically manages the medical condition, procedure, treatment or issue under review for this specific case and have current, relevant experience and/or knowledge to render a determination for this case.

REVIEWER SIGNATURE

REVIEWER NAME	BOARD CERTIFICATION(S)
LICENSE NUMBER(S)	STATE(S)

REV 09/2024

DWC DIVISION OF WORKERS' COMPENSATION

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 Formulary Drug List ☐ | Retrospective for Exempt Treatment (Non-Drug) ☐ | Retrospective for Exempt Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

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:

DWC Form IMR – Effective 4/1/26 - Page 1

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.

1.

2.

3.

DWC Form IMR – Effective 4/1/26 - Page 2

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 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)

DWC Form IMR – Effective 4/1/26 - Page 3

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

DWC Form IMR – Effective 4/1/26 - Page 4

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.

DWC Form IMR – Effective 4/1/26 - Page 5

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URAC ACCREDITED Workers' Compensation Utilization Management

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Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Notice of Modified Determination

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», StrataCare Solutions has been asked to review the following treatment(s)/procedure(s) for medical necessity and appropriateness.

Diagnosis: «ICD10» «ICD10 Desc»

Treatment(s)/Service(s) Requested:
«Treatment ID» «Item/Service»

After review of this request, based on the medical information submitted at this time, the clinical peer reviewer determined that the services or treatments described below are **modified.**

Determination	Treatment ID	Treatment(s)/Service(s)	Qty	Start Date	End Date
«Determination»	«Treatment ID»	«Item/Service»	00	00/00/0000	00/00/0000

Date of Determination: [INSERT DATE]

Date of Verbal Notification: [INSERT DATE]

Date Additional Information Requested: [INSERTED BY NURSE]

Information, exam or consultation requested: [INSERTED BY NURSE]

Manner Information Request was made: [INSERTED BY NURSE]

Date Information Received: [INSERTED BY NURSE]

Screening criteria and treatment guidelines used: See enclosed Clinical Peer Review report.

Physician/practitioner who made the decision:

[insert provider]	[insert specialty]	[insert state]	[insert license]
Peer Reviewer Name	Specialty	License State	License No.

California Medical Provider Network

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at https://www.dir.ca.gov/dwc/mpn/DWC_MPN_Main.html.

StrataCare Internal Clinical Appeal Process

CA UR Notice of Modification REV 02/19/2026

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P.O. Box 14245 |Lexington, KY 40512
Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

The internal appeals process is a voluntary process that neither triggers nor bars the use of dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis. Decisions are based upon medical necessity. If your provider disagrees with the decision, he/she can initiate an appeal by contacting StrataCare Solutions UR Team who can provide information on the steps to request an appeal.

All voluntary internal appeal requests must be received by StrataCare Solutions within ten (10) calendar days of receipt of this written notification. Appeals can be submitted by calling, faxing or emailing the request. You must be prepared to present pertinent clinical information in support of your request. The appeal review will be conducted by a clinical peer reviewer other than the one involved in the initial determination. All internal appeals will be completed within thirty (30) days for a standard appeal or seventy-two (72) hours for an expedited appeal from the date of receipt of the request.

Division of Workers' Compensation Dispute Process for Injured Workers

All disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and 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.

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 «Adjuster Name» at «Adjuster Phone». However, if you are represented by an attorney, please contact your attorney instead.

For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

StrataCare's utilization review findings are intended solely as clinical opinions to determine whether the proposed services or treatment is medically reasonable and necessary.

This determination letter is provided to the requesting provider, the adjuster, the injured worker and the injured worker's representative, if applicable.

A decision to modify, or deny a request for authorization will remain in effect for twelve (12) months from the date of the decision without further action by the claims administrator or utilization review agent with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

This does not guarantee payment, acceptance of additional body parts or injuries into this claim. All payment decisions will be handled by the claims representative.

If a peer-to-peer discussion has not occurred, the requesting provider may contact StrataCare Solutions Utilization Review at «Toll Free Number» within two (2) business days to discuss the adverse determination. We will respond within one (1) business day. The reviewer, expert reviewer or the medical director's availability for discussion will be Monday through Friday from 9:00 am to 5:30 pm Pacific Time. In the event the physician reviewer is unavailable, the requesting physician may discuss the written decision with another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Questions can be directed to either the claims adjuster at «Adjuster Phone» or StrataCare Solutions Utilization Review at 888-853-4735 between the hours of 8:00 a.m. to 5:30 p.m. PT.

Sincerely,

«Nurse Signature»

Enclosures (3): Clinical Peer Reviewer Report (sent to all parties)

Application for Independent Medical Review, DWC form IMR (sent to IW and Attorney if applicable)
Pre-Addressed Envelope (sent to IW)

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Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

Copy to: «Patient Name» (mailed)
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Adjuster Name», Claims Adjuster (sent electronically)

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

CA UR Notice of Modification REV 02/19/2026

Clinical Peer Review Report

SECTION 1 - CASE INFORMATION			
DATE REFERRED TO REVIEWER	DATE OF DETERMINATION	DATE OF VERBAL NOTIFICATION	DATE REPORT COMPLETE
INJURED WORKER NAME	CLAIM #	RFA ID	DOI
ACCOUNT NAME	WORK STATUS		JURIS STATE
REQUESTING PROVIDER NAME	DEGREE	SPECIALITY	PROVIDER PHONE

SECTION 2 – DOCUMENTS REVIEWED

SECTION 3 – CLINICAL SUMMARY

Section 4 - Requested Treatment, Determination and Rationale

Medical Treatment(s) Requested

1.

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
	Prospective		Reconsideration		Certify/Approved
	Concurrent		1st Level Appeal		Non-Certify/Denied
	Retrospective		2nd Level Appeal		Modify
	Expedited				Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medical Treatment(s) Requested

2.

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
	Prospective		Reconsideration		Certify/Approved
	Concurrent		1st Level Appeal		Non-Certify/Denied
	Retrospective		2nd Level Appeal		Modify
	Expedited				Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medical Treatment(s) Requested

3.

REV 09/2024

Clinical Peer Review Report

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):
☐	Prospective	☐	Reconsideration	☐ Certify/Approved
☐	Concurrent	☐	1st Level Appeal	☐ Non-Certify/Denied
☐	Retrospective	☐	2nd Level Appeal	☐ Modify
☐	Expedited			☐ Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medication Non-certification/Denial does not imply abrupt cessation for a patient who may be at risk for withdrawal symptoms. Should the missing criteria necessary to support the medical necessity of this request remain unavailable, discontinuance should include a tapering by the patient's treating physician prior to discontinuing avoiding withdrawal symptoms.

Section 5 - Contacts/Outcomes

No.	Date	Time	Full Name of Contact	Outcome	Verbal Notification Given?	Appeal Information Given?
1.						
2.						
3.						

SECTION 6 - ATTESTATION

I hereby attest that I that have personally reviewed the list of medical information used to make the determination. To the best of my knowledge, I was not previously involved in reviewing this episode of care and do not have a material personal, professional, or financial conflict of interest with the patient, health care providers, insurer/payer, referring party, or the recommended treatment. I have not accepted compensation that is dependent in any way on the specific outcome of the case. I have a scope of licensure that typically manages the medical condition, procedure, treatment or issue under review for this specific case and have current, relevant experience and/or knowledge to render a determination for this case.

REVIEWER SIGNATURE

REVIEWER NAME	BOARD CERTIFICATION(S)
LICENSE NUMBER(S)	STATE(S)

REV 09/2024

DWC DIVISION OF WORKERS' COMPENSATION

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 Formulary Drug List ☐ | Retrospective for Exempt Treatment (Non-Drug) ☐ | Retrospective for Exempt Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

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:

DWC Form IMR – Effective 4/1/26 - Page 1

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.

1.

2.

3.

DWC Form IMR – Effective 4/1/26 - Page 2

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 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)

DWC Form IMR – Effective 4/1/26 - Page 3

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

DWC Form IMR – Effective 4/1/26 - Page 4

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.

DWC Form IMR – Effective 4/1/26 - Page 5

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P.O. Box 14245 |Lexington, KY 40512
Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Notice of Certification Determination

Injured Worker	Carrier Case ID	RFA Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», StrataCare Solutions has been asked to review the treatment request listed below for medical necessity and appropriateness.

Diagnosis: «ICD10» «ICD10 Desc»

Treatment(s)/Service(s) Requested:
«Treatment ID» «Item/Service»

After review of this request, based on the medical information submitted at this time, it has determined that the services or treatments described below are **certified.** This means these services or treatments are **approved**.

Treatment ID	Treatment(s)/Service(s)	Qty	Start Date	End Date
«Treatment ID»	«Item/Service»	00	00/00/0000	00/00/0000

Date of Determination: [INSERT DATE]

Date Additional Information Requested: [INSERTED BY NURSE]

Information, exam or consultation requested: [INSERTED BY NURSE]

Manner Information Request was made: [INSERTED BY NURSE]

Date Information Received: [INSERTED BY NURSE]

Explanation of Determination: [INSERTED BY NURSE]

Screening criteria and treatment guidelines used: «Treatment Guidelines»

California Medical Provider Network

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at https://www.dir.ca.gov/dwc/mpn/DWC_MPN_Main.html.

StrataCare's utilization review findings are intended solely as clinical opinions to determine whether the proposed services or treatment is medically reasonable and necessary.

This does not guarantee payment, acceptance of additional body parts or injuries into this claim. All payment decisions will be handled by the claims representative.

Questions can be directed to either the claims adjuster at «Adjuster Phone» or StrataCare Solutions Utilization Review at 888-853-4735 between the hours of 8:00 a.m. to 5:30 p.m. PT.

Sincerely,

UR Nurse Approved-Certified Determination REV 02/19/2026

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Tel: (888) 853-4735 | Fax: (863) 668-9553
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«Nurse Signature»

Copy to: «Patient Name» *(mailed)*
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Attorney Name», Attorney *(mailed)*
« Address Line»
« City», « State» « Zip»

«Adjuster Name», Claims Adjuster *(sent electronically)*

«Attorney Name», Attorney *(mailed)*
« Address Line»
« City», « State» « Zip»

UR Nurse Approved-Certified Determination REV 02/19/2026

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Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

««Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Notice of Certification Determination

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», StrataCare Solutions has been asked to review the treatment request listed below for medical necessity and appropriateness.

Diagnosis: «ICD10» «ICD10 Desc»

Treatment(s)/Service(s) Requested:
«Treatment ID» «Item/Service»

After review of this request, based on the medical information submitted at this time, the clinical peer reviewer determined that the services or treatments described below are **certified.** This means these services or treatments are **approved**.

Treatment ID	Treatment(s)/Service(s)	Qty	Start Date	End Date
«Treatment ID»	«Item/Service»	00	00/00/0000	00/00/0000

Date of Determination: [INSERT DATE]

Date Additional Information Requested: [INSERTED BY NURSE]

Information, exam or consultation requested: [INSERTED BY NURSE]

Manner Information Request was made: [INSERTED BY NURSE]

Date Information Received: [INSERTED BY NURSE]

Screening criteria and treatment guidelines used: See enclosed Clinical Peer Review report.

Physician/practitioner who made the decision:

[insert provider]	[insert specialty]	[insert state]	[insert license]
Peer Reviewer Name	Specialty	License State	License No.

California Medical Provider Network

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at https://www.dir.ca.gov/dwc/mpn/DWC_MPN_Main.html.

StrataCare's utilization review findings are intended solely as clinical opinions to determine whether the proposed services or treatment is medically reasonable and necessary.

CA UR Physician Approved-Certified Determination REV 02/19/2026

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Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

This does not guarantee payment, acceptance of additional body parts or injuries into this claim. All payment decisions will be handled by the claims representative.

Questions can be directed to either the claims adjuster at «Adjuster Phone» or StrataCare Solutions Utilization Review at 888-853-4735 between the hours of 8:00 a.m. to 5:30 p.m. PT.

Sincerely,

«Nurse Signature»

Enclosures (13): Clinical Peer Reviewer Report (sent to all parties)

Copy to: «Patient Name» *(mailed)*
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Adjuster Name», Claims Adjuster *(sent electronically)*

«Attorney Name», Attorney *(mailed)*
« Address Line»
« City», « State» « Zip»

«Attorney Name», Attorney *(mailed)*
« Address Line»
« City», « State» « Zip»

CA UR Physician Approved-Certified Determination REV 02/19/2026

Clinical Peer Review Report

SECTION 1 - CASE INFORMATION			
DATE REFERRED TO REVIEWER	DATE OF DETERMINATION	DATE OF VERBAL NOTIFICATION	DATE REPORT COMPLETE
INJURED WORKER NAME	CLAIM #	RFA ID	DOI
ACCOUNT NAME	WORK STATUS		JURIS STATE
REQUESTING PROVIDER NAME	DEGREE	SPECIALITY	PROVIDER PHONE

SECTION 2 – DOCUMENTS REVIEWED

SECTION 3 – CLINICAL SUMMARY

Section 4 - Requested Treatment, Determination and Rationale

Medical Treatment(s) Requested

1.

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
	Prospective		Reconsideration		Certify/Approved
	Concurrent		1st Level Appeal		Non-Certify/Denied
	Retrospective		2nd Level Appeal		Modify
	Expedited				Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medical Treatment(s) Requested

2.

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
	Prospective		Reconsideration		Certify/Approved
	Concurrent		1st Level Appeal		Non-Certify/Denied
	Retrospective		2nd Level Appeal		Modify
	Expedited				Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medical Treatment(s) Requested

3.

REV 09/2024

Clinical Peer Review Report

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
	Prospective		Reconsideration		Certify/Approved
	Concurrent		1st Level Appeal		Non-Certify/Denied
	Retrospective		2nd Level Appeal		Modify
	Expedited				Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medication Non-certification/Denial does not imply abrupt cessation for a patient who may be at risk for withdrawal symptoms. Should the missing criteria necessary to support the medical necessity of this request remain unavailable, discontinuance should include a tapering by the patient's treating physician prior to discontinuing avoiding withdrawal symptoms.

Section 5 - Contacts/Outcomes

No.	Date	Time	Full Name of Contact	Outcome	Verbal Notification Given?	Appeal Information Given?
1.						
2.						
3.						

SECTION 6 - ATTESTATION

I hereby attest that I that have personally reviewed the list of medical information used to make the determination. To the best of my knowledge, I was not previously involved in reviewing this episode of care and do not have a material personal, professional, or financial conflict of interest with the patient, health care providers, insurer/payer, referring party, or the recommended treatment. I have not accepted compensation that is dependent in any way on the specific outcome of the case. I have a scope of licensure that typically manages the medical condition, procedure, treatment or issue under review for this specific case and have current, relevant experience and/or knowledge to render a determination for this case.

REVIEWER SIGNATURE

REVIEWER NAME	BOARD CERTIFICATION(S)
LICENSE NUMBER(S)	STATE(S)

REV 09/2024

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Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Notice of Untimely Appeal

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», StrataCare Solutions received an appeal request dated [ENTER DATE APPEAL RECEIVED]. Your request to appeal the decision did not meet the required timeframe during which you can request an appeal, therefore your request was not accepted.

Diagnosis: «IDC10» «IDC10 Desc»

Date of Determination: [INSERT DATE]

Date of Verbal Notification: [INSERT DATE]

Treatment(s)/Service(s) Requested:

«Treatment ID»	«Item/Service»

Your request to appeal the decision did not meet the required timeframe of ten (10) days of your written determination receipt during which you can request an appeal. If you have not already done so, you may request an Independent Medical Review IMR, within the timeframe indicated on the last page of the application

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call [claims adjuster's name] at [telephone number]. However, if you are represented by an attorney, please contact your attorney instead.

For information about the workers' compensation claims process and your rights and obligations, go to http://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.

Please contact the StrataCare Solutions Utilization Review at 888-853-4735 between the hours of 8:00 a.m. and 5:30 p.m. PT., if we can be of further assistance.

Sincerely,

«Nurse Signature»

Copy to: «Patient Name» *(mailed)*
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Adjuster Name», Claims Adjuster *(sent electronically)*

«Attorney Name», Attorney *(mailed)*
« Address Line»
« City», « State» « Zip»

«Attorney Name», Attorney *(mailed)*
« Address Line»
« City», « State» « Zip»

CA UR Notice of Untimely Appeal REV 2/19/2026

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P.O. Box 14245 | Lexington, KY 40512
Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Notice of Appeal – Upheld Determination

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», StrataCare Solutions has been asked to review the appeal request dated [ENTER DATE APPEAL RECEIVED] to address the following treatment(s) or procedure(s) listed below.

Diagnosis: «ICD10» «ICD10 Desc»

Treatment(s)/Service(s) Requested:
«Treatment ID» «Item/Service»

After review of this appeal request, based on the medical information submitted at this time, the clinical peer reviewer has **upheld** the original adverse determination. This means these services or treatments are **not approved**.

Treatment ID	Treatment(s)/Service(s)	Determination Date	Date of Verbal
«Treatment ID»	«Item/Service»	00/00/0000	00/00/0000

Date of Determination: [INSERT DATE]

Date Additional Information Requested: [INSERTED BY NURSE]

Information, exam or consultation requested: [INSERTED BY NURSE]

Manner Information Request was made: [INSERTED BY NURSE]

Date Information Received: [INSERTED BY NURSE]

Screening criteria and treatment guidelines used: See enclosed Clinical Peer Review report.

Physician/practitioner who made the decision:

[insert provider]	[insert specialty]	[insert state]	[insert license]
Peer Reviewer Name	Specialty	License State	License No.

California Medical Provider Network

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at https://www.dir.ca.gov/dwc/mpn/DWC_MPN_Main.html.

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Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

Division of Workers' Compensation Dispute Process for Injured Workers

All disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and 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. This deadline must be adhered to even if the appeal process outlined above is used. Complete instructions are given on the second page of the form. We have enclosed a pre-addressed envelope for your convenience in returning the form.

A decision to modify or deny a request for authorization will remain in effect for twelve (12) months from the date of the decision without further action by the claim's administrator or utilization review agent with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

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 «Adjuster Name» at «Adjuster Phone». However, if you are represented by an attorney, please contact your attorney instead.

For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

StrataCare's utilization review findings are intended solely as clinical opinions to determine whether the proposed services or treatment is medically reasonable and necessary.

This determination letter is provided to the requesting provider, the adjuster, the injured worker and the injured worker's representative, if applicable.

If a peer-to-peer discussion has not occurred, the requesting provider may contact StrataCare Solutions Utilization Review at «Toll Free Number» within two (2) business days to discuss the adverse determination. We will respond within one (1) business day. The reviewer, expert reviewer or the medical director's availability for discussion will be Monday through Friday from 9:00 am to 5:30 pm Pacific Time. In the event the physician reviewer is unavailable, the requesting physician may discuss the written decision with another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Questions can be directed to either the claims adjuster at «Adjuster Phone» or StrataCare Solutions Utilization Review at 888-853-4735 between the hours of 8:00 a.m. to 5:30 p.m. PT.

Sincerely,

«Nurse Signature»

Enclosures (3): Clinical Peer Reviewer Report (sent to all parties)
Application for Independent Medical Review, DWC form IMR (sent to IW and Attorney if applicable)
Pre-Addressed Envelope (sent to IW)

Copy to:
«Patient Name» (mailed)
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Adjuster Name», Claims Adjuster (sent electronically)

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

CA UR Appeal Notice –Upheld REV 02/19/2026

Clinical Peer Review Report

SECTION 1 - CASE INFORMATION			
DATE REFERRED TO REVIEWER	DATE OF DETERMINATION	DATE OF VERBAL NOTIFICATION	DATE REPORT COMPLETE
INJURED WORKER NAME	CLAIM #	RFA ID	DOI
ACCOUNT NAME	WORK STATUS		JURIS STATE
REQUESTING PROVIDER NAME	DEGREE	SPECIALITY	PROVIDER PHONE

SECTION 2 – DOCUMENTS REVIEWED

SECTION 3 – CLINICAL SUMMARY

Section 4 - Requested Treatment, Determination and Rationale

Medical Treatment(s) Requested

1.

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
	Prospective		Reconsideration		Certify/Approved
	Concurrent		1st Level Appeal		Non-Certify/Denied
	Retrospective		2nd Level Appeal		Modify
	Expedited				Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medical Treatment(s) Requested

2.

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
	Prospective		Reconsideration		Certify/Approved
	Concurrent		1st Level Appeal		Non-Certify/Denied
	Retrospective		2nd Level Appeal		Modify
	Expedited				Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medical Treatment(s) Requested

3.

REV 09/2024

Clinical Peer Review Report

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
	Prospective		Reconsideration		Certify/Approved
	Concurrent		1st Level Appeal		Non-Certify/Denied
	Retrospective		2nd Level Appeal		Modify
	Expedited				Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medication Non-certification/Denial does not imply abrupt cessation for a patient who may be at risk for withdrawal symptoms. Should the missing criteria necessary to support the medical necessity of this request remain unavailable, discontinuance should include a tapering by the patient's treating physician prior to discontinuing avoiding withdrawal symptoms.

Section 5 - Contacts/Outcomes

No.	Date	Time	Full Name of Contact	Outcome	Verbal Notification Given?	Appeal Information Given?
1.						
2.						
3.						

SECTION 6 - ATTESTATION

I hereby attest that I that have personally reviewed the list of medical information used to make the determination. To the best of my knowledge, I was not previously involved in reviewing this episode of care and do not have a material personal, professional, or financial conflict of interest with the patient, health care providers, insurer/payer, referring party, or the recommended treatment. I have not accepted compensation that is dependent in any way on the specific outcome of the case. I have a scope of licensure that typically manages the medical condition, procedure, treatment or issue under review for this specific case and have current, relevant experience and/or knowledge to render a determination for this case.

REVIEWER SIGNATURE

REVIEWER NAME	BOARD CERTIFICATION(S)
LICENSE NUMBER(S)	STATE(S)

REV 09/2024

DWC DIVISION OF WORKERS' COMPENSATION

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 Formulary Drug List ☐ | Retrospective for Exempt Treatment (Non-Drug) ☐ | Retrospective for Exempt Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

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:

DWC Form IMR – Effective 4/1/26 - Page 1

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.

1.

2.

3.

DWC Form IMR – Effective 4/1/26 - Page 2

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 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)

DWC Form IMR – Effective 4/1/26 - Page 3

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

DWC Form IMR – Effective 4/1/26 - Page 4

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.

DWC Form IMR – Effective 4/1/26 - Page 5

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«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Notice of Appeal - Modified Determination

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», StrataCare Solutions has been asked to review the appeal request dated [ENTER DATE APPEAL RECEIVED] to address the following treatment(s) or procedure(s) listed below.

Diagnosis: «ICD10» «ICD10 Desc»

Treatment(s)/Service(s) Requested:
«Treatment ID» «Item/Service»

After review of this appeal request, based on the medical information submitted at this time, the clinical peer reviewer recommends a **modification** of the original request to the following:

Determination	Treatment ID	Treatment(s)/Service(s)	Qty	Start Date	End Date
«Determination»	«Treatment ID»	«Item/Service»	00	00/00/0000	00/00/0000

Date of Determination: [INSERT DATE]

Date of Verbal Notification: [INSERT DATE]

Date Additional Information Requested: [INSERTED BY NURSE]

Information, exam or consultation requested: [INSERTED BY NURSE]

Manner Information Request was made: [INSERTED BY NURSE]

Date Information Received: [INSERTED BY NURSE]

Screening criteria and treatment guidelines used: See enclosed Clinical Peer Review report.

Physician/practitioner who made the decision:

[insert provider]	[insert specialty]	[insert state]	[insert license]
Peer Reviewer Name	Specialty	License State	License No.

California Medical Provider Network

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at https://www.dir.ca.gov/dwc/mpn/DWC_MPN_Main.html.

Division of Workers' Compensation Dispute Process for Injured Workers

CA UR Appeal Notice –Modified REV 02/19/2026

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All disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and 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. This deadline must be adhered to even if the appeal process outlined above is used. Complete instructions are given on the second page of the form. We have enclosed a pre-addressed envelope for your convenience in returning the form.

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 «Adjuster Name» at «Adjuster Phone». However, if you are represented by an attorney, please contact your attorney instead.

For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

A decision to modify or deny a request for authorization will remain in effect for twelve (12) months from the date of the decision without further action by the claim's administrator or utilization review agent with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

StrataCare's utilization review findings are intended solely as clinical opinions to determine whether the proposed services or treatment is medically reasonable and necessary.

This determination letter is provided to the requesting provider, the adjuster, the injured worker and the injured worker's representative, if applicable.

This does not guarantee payment, acceptance of additional body parts or injuries into this claim. All payment decisions will be handled by the claims representative.

If a peer-to-peer discussion has not occurred, the requesting provider may contact StrataCare Solutions Utilization Review at «Toll Free Number» within two (2) business days to discuss the adverse determination. We will respond within one (1) business day. The reviewer, expert reviewer or the medical director's availability for discussion will be Monday through Friday from 9:00 am to 5:30 pm Pacific Time. In the event the physician reviewer is unavailable, the requesting physician may discuss the written decision with another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Questions can be directed to either the claims adjuster at «Adjuster Phone» or StrataCare Solutions Utilization Review at 888-853-4735 between the hours of 8:00 a.m. to 5:30 p.m. PT.

Sincerely,

«Nurse Signature»

Enclosures (3): Clinical Peer Reviewer Report (sent to all parties)

Application for Independent Medical Review, DWC form IMR (sent to IW and Attorney if applicable)
Pre-Addressed Envelope (sent to IW)

Copy to: «Patient Name» (mailed)
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

«Adjuster Name», Claims Adjuster (sent electronically)

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

CA UR Appeal Notice –Modified REV 02/19/2026

Clinical Peer Review Report

SECTION 1 - CASE INFORMATION			
DATE REFERRED TO REVIEWER	DATE OF DETERMINATION	DATE OF VERBAL NOTIFICATION	DATE REPORT COMPLETE
INJURED WORKER NAME	CLAIM #	RFA ID	DOI
ACCOUNT NAME	WORK STATUS		JURIS STATE
REQUESTING PROVIDER NAME	DEGREE	SPECIALITY	PROVIDER PHONE

SECTION 2 – DOCUMENTS REVIEWED

SECTION 3 – CLINICAL SUMMARY

Section 4 - Requested Treatment, Determination and Rationale

Medical Treatment(s) Requested

1.

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
	Prospective		Reconsideration		Certify/Approved
	Concurrent		1st Level Appeal		Non-Certify/Denied
	Retrospective		2nd Level Appeal		Modify
	Expedited				Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medical Treatment(s) Requested

2.

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
	Prospective		Reconsideration		Certify/Approved
	Concurrent		1st Level Appeal		Non-Certify/Denied
	Retrospective		2nd Level Appeal		Modify
	Expedited				Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medical Treatment(s) Requested

3.

REV 09/2024

Clinical Peer Review Report

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
	Prospective		Reconsideration		Certify/Approved
	Concurrent		1st Level Appeal		Non-Certify/Denied
	Retrospective		2nd Level Appeal		Modify
	Expedited				Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medication Non-certification/Denial does not imply abrupt cessation for a patient who may be at risk for withdrawal symptoms. Should the missing criteria necessary to support the medical necessity of this request remain unavailable, discontinuance should include a tapering by the patient's treating physician prior to discontinuing avoiding withdrawal symptoms.

Section 5 - Contacts/Outcomes

No.	Date	Time	Full Name of Contact	Outcome	Verbal Notification Given?	Appeal Information Given?
1.						
2.						
3.						

SECTION 6 - ATTESTATION

I hereby attest that I that have personally reviewed the list of medical information used to make the determination. To the best of my knowledge, I was not previously involved in reviewing this episode of care and do not have a material personal, professional, or financial conflict of interest with the patient, health care providers, insurer/payer, referring party, or the recommended treatment. I have not accepted compensation that is dependent in any way on the specific outcome of the case. I have a scope of licensure that typically manages the medical condition, procedure, treatment or issue under review for this specific case and have current, relevant experience and/or knowledge to render a determination for this case.

REVIEWER SIGNATURE

REVIEWER NAME	BOARD CERTIFICATION(S)
LICENSE NUMBER(S)	STATE(S)

REV 09/2024

DWC DIVISION OF WORKERS' COMPENSATION

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 Formulary Drug List ☐ Retrospective for Exempt Treatment (Non-Drug) ☐ Retrospective for Exempt Treatment (Drug) ☐

Employee Information:

First Name: Middle Initial: Last Name:

Address: Number/Unit:

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:

DWC Form IMR – Effective 4/1/26 - Page 1

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.

1.

2.

3.

DWC Form IMR – Effective 4/1/26 - Page 2

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 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)

DWC Form IMR – Effective 4/1/26 - Page 3

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

DWC Form IMR – Effective 4/1/26 - Page 4

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.

DWC Form IMR – Effective 4/1/26 - Page 5

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«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Notice of Appeal - Overturned Determination

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», StrataCare Solutions has been asked to review the appeal request dated [ENTER DATE APPEAL RECEIVED] to address the following tredatment(s) or procedure(s) listed below.

Diagnosis: «IDC10» «IDC10 Desc»

Treatment(s)/Service(s) Requested:

«Treatment ID» «Item/Service»

After review of this appeal request, based on the medical information submitted at this time, the clinical peer reviewer determined to **overturn** the original request. This means these services or treatments are **approved.**

Treatment ID	Treatment(s)/Service(s)	Qty.	Start Date	End Date
«Treatment ID»	«Item/Service»	00	00/00/0000	00/00/0000

Date of Determination: [INSERT DATE]

Date of Verbal Notification: [INSERT DATE]

Date Additional Information Requested: [INSERTED BY NURSE]

Information, exam or consultation requested: [INSERTED BY NURSE]

Manner Information Request was made: [INSERTED BY NURSE]

Date Information Received: [INSERTED BY NURSE]

Screening criteria and treatment guidelines used: See enclosed Clinical Peer Review report.

Physician/practitioner who made the decision:

[insert provider]	[insert specialty]	[insert state]	[insert license]
Peer Reviewer Name	Specialty	License State	License No.

California Medical Provider Network

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at https://www.dir.ca.gov/dwc/mpn/DWC_MPN_Main.html.

CA UR Appeal Notice –Overturned REV 02/19/2026

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StrataCare's utilization review findings are intended solely as clinical opinions to determine whether the proposed services or treatment is medically reasonable and necessary.

This does not guarantee payment, acceptance of additional body parts or injuries into this claim. All payment decisions will be handled by the claims representative.

Questions can be directed to either the claims adjuster at «Adjuster Phone» or StrataCare Solutions Utilization Review at 888-853-4735 between the hours of 8:00 a.m. to 5:30 p.m. PT.

Sincerely,

«Nurse Signature»

Enclosures (1): Clinical Peer Reviewer Report (sent to all parties)

Copy to:

«Patient Name» (mailed)
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Adjuster Name», Claims Adjuster (sent electronically)

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

CA UR Appeal Notice –Overturned REV 02/19/2026

Clinical Peer Review Report

SECTION 1 - CASE INFORMATION			
DATE REFERRED TO REVIEWER	DATE OF DETERMINATION	DATE OF VERBAL NOTIFICATION	DATE REPORT COMPLETE
INJURED WORKER NAME	CLAIM #	RFA ID	DOI
ACCOUNT NAME	WORK STATUS		JURIS STATE
REQUESTING PROVIDER NAME	DEGREE	SPECIALITY	PROVIDER PHONE

SECTION 2 – DOCUMENTS REVIEWED

SECTION 3 – CLINICAL SUMMARY

Section 4 - Requested Treatment, Determination and Rationale

Medical Treatment(s) Requested

1.

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
	Prospective		Reconsideration		Certify/Approved
	Concurrent		1st Level Appeal		Non-Certify/Denied
	Retrospective		2nd Level Appeal		Modify
	Expedited				Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medical Treatment(s) Requested

2.

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
	Prospective		Reconsideration		Certify/Approved
	Concurrent		1st Level Appeal		Non-Certify/Denied
	Retrospective		2nd Level Appeal		Modify
	Expedited				Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medical Treatment(s) Requested

3.

REV 09/2024

Clinical Peer Review Report

Type of Review (Check all that apply)				Clinical Peer Reviewer Recommendation (check one):	
☐	Prospective	☐	Reconsideration	☐	Certify/Approved
☐	Concurrent	☐	1st Level Appeal	☐	Non-Certify/Denied
☐	Retrospective	☐	2nd Level Appeal	☐	Modify
☐	Expedited			☐	Withdrawn

Guideline/Reference Used *(Cite State Required Guideline/Chapter/Section Used)*

Principal Reason and Clinical Rationale for Recommendation:

Medication Non-certification/Denial does not imply abrupt cessation for a patient who may be at risk for withdrawal symptoms. Should the missing criteria necessary to support the medical necessity of this request remain unavailable, discontinuance should include a tapering by the patient's treating physician prior to discontinuing avoiding withdrawal symptoms.

Section 5 - Contacts/Outcomes

No.	Date	Time	Full Name of Contact	Outcome	Verbal Notification Given?	Appeal Information Given?
1.						
2.						
3.						

SECTION 6 - ATTESTATION

I hereby attest that I that have personally reviewed the list of medical information used to make the determination. To the best of my knowledge, I was not previously involved in reviewing this episode of care and do not have a material personal, professional, or financial conflict of interest with the patient, health care providers, insurer/payer, referring party, or the recommended treatment. I have not accepted compensation that is dependent in any way on the specific outcome of the case. I have a scope of licensure that typically manages the medical condition, procedure, treatment or issue under review for this specific case and have current, relevant experience and/or knowledge to render a determination for this case.

REVIEWER SIGNATURE

REVIEWER NAME	BOARD CERTIFICATION(S)
LICENSE NUMBER(S)	STATE(S)

REV 09/2024

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www.StrataCare.com

«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Fax Notification in Lieu of Verbal

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

An attempt was made on [INSERT DATE] to call your office to provide the verbal determination on the treatment request noted below, dated [INSERT DATE]; however, your office was unavailable to receive a verbal notification.

Diagnosis: «IDC10» «IDC10 Desc»

Treatment(s)/Service(s)		
«Determination»	«Treatment ID»	«Item/Service»

This fax will serve as verbal notification of StrataCare Solutions' Workers' Compensation Utilization Review determination. A letter of determination will be faxed to your office shortly along with any available appeal process.

Sincerely,

«Nurse Signature»

CA UR Fax in Lieu of Verbal REV 02/19/2026

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P.O. Box 14245 | Lexington, KY 40512
Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Non-Exempt Rx Notice

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

StrataCare Solutions is the designated Utilization Review Agent for «Account Name». Our role is to perform medical necessity reviews on treatment requests from medical providers. I am the Nurse Case Manager responsible for coordinating medical treatment as well as facilitating the injured worker's return to work.

We are in receipt of a non-exempt medication [NURSE TO FILL IN] for «Patient Name». ***Per CA AB1124, effective January 1, 2018, the treating provider is required to submit the §9785 Progress Report (PR-2) and a Request for Authorization to address the ongoing drug treatment plan.***

- ***Treatment plan shall set forth a medically appropriate weaning, tapering or transitioning of the injured worker to a drug pursuant to the MTUS, or***
- ***Treatment plan shall provide supporting documentation to substantiate the continued medical necessity of the non-exempt drug, unlisted drug or compounded drug pursuant to the MTUS.***

Please submit a Request for Authorization for this medication and include supporting documentation as noted above. You may submit this documentation on a PR-2 or complete the following information and fax this letter back.

What is your plan to wean or transition «Patient Name» from the current medication/s to medication/s in accordance with MTUS as required in AB1124?

_____

_____

_____

_____

_____

_____

_____

Physician's Signature: _____ Date: _____

For your convenience, you may complete this document and fax it to «Bunch Fax Number».

If you have questions or require clarification on the requested information, please do not hesitate to contact me at 888-853-4735.

CA UR Non-Exempt Rx Notification REV 02/19/2020

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Tel: (888) 853-4735 | Fax: (863) 668-9553
www.StrataCare.com

Sincerely,

«Nurse Signature»

Copy to: «Patient Name» (mailed)
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Adjuster Name», Claims Adjuster (sent electronically)

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

CA UR Non-Exempt Rx Notification REV 02/19/2026

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«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Request for Information

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», StrataCare Solutions has received a request to review the following treatment(s)/procedure(s) for medical necessity and appropriateness of treatment:

Diagnosis: «ICD10» «ICD10 Desc»

Treatment(s)/Service(s) Requested:
«Treatment ID» «Item/Service»

Date Additional Information Requested: [INSERTED BY NURSE]

Manner Information Request was made: [INSERTED BY NURSE]

At this time, we are unable to make a medical necessity determination due to lack of sufficient medical documentation for the procedure(s). In order to continue this review, we will need the following information: [INSERT REQUIRE DOCUMENTATION].

Please fax the information to my attention at « Fax Number» by [INSERT DATE] so the process can be completed within fourteen (14) days of receipt of your original request and a decision rendered.

Questions can be directed to either the claims adjuster at «Adjuster Phone» or the StrataCare Solutions Utilization Review at 888-853-4735 between the hours of 8:00 a.m. to 5:30 p.m. PT.

Sincerely,

«Nurse Signature»

Copy to: «Patient Name» (mailed)
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Adjuster Name», Claims Adjuster (sent electronically)

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

CA UR Lack of Information REV 02/19/2026

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«Date»
Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Request to Withdraw or Modify

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

Per our conversation on «Date», this letter confirms the discussion whereby you have agreed to withdraw the following request:

Diagnosis: «IDC10» «IDC10 Desc»

Treatment ID	Treatment(s)/Services
«Treatment ID»	«Item/Service»

OR (if applicable)

I am submitting a new request for: _____

_____

_____

By completing and signing this letter, we will be able to process your new request for utilization review.

TO BE COMPLETED BY THE PHYSICIAN/MEDICAL PROVIDER

_____ _____
Signature *Date*

_____
Print Name

Sincerely,

«Nurse Signature»

Copy to:
«Patient Name» (mailed)
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Adjuster Name», Claims Adjuster (sent electronically)

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

CA UR Request to Withdraw or Modify REV 02/19/2026

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«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Notice of Duplicate Request (Uphold to Denial)

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», StrataCare Solutions has received a request to extend the service date for the following treatment(s)/procedure(s) for medical necessity and appropriateness of treatment:

On [INSERT DATE OF REQUEST], we received a RFA that appears to be a duplicate of a previously submitted and denied, delayed or modified RFA. According to 8 C.C.R. 9792.9.1(h), unless there is new documentation that shows there has been a material change in the case since the original request, we are not required to respond to this RFA.

Treatment ID	Treatment(s)/Service(s)	Qty
«Treatment ID»	«Item/Service»	00

Our records indicate that the same treating physician, [INSERT PHYSICIAN NAME], submitted a RFA and a determination was made on [INSERT DATE] for this same treatment/service.

California Medical Provider Network

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at https://www.dir.ca.gov/dwc/mpn/DWC_MPN_Main.html.

A decision to modify or deny a request for authorization will remain in effect for twelve (12) months from the date of the decision without further action by the claim's administrator or utilization review agent with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

Questions can be directed to either the claims adjuster at «Adjuster Phone» or StrataCare Solutions Utilization Review at 888-853-4735 between the hours of 8:00 a.m. to 5:30 p.m. PT.

Sincerely,

«Nurse Signature»

Copy to: «Patient Name» (mailed)
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Adjuster Name», Claims Adjuster (sent electronically)

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

CA UR Duplicate Request for Authorization REV 02/19/2026

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«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Notice of Extension of Certification

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», StrataCare Solutions has received a request to extend the service date for the following treatment(s)/procedure(s) for medical necessity and appropriateness of treatment:

Diagnosis: «ICD10» «ICD10 Desc»

Treatment ID	Treatment(s)/Service(s) Requested		No. of Visits/Services
«Treatment ID»	«Item/Service»		00
Original Begin Date	Original End Date	Extended Begin Date	Extended End Date
00/00/0000	00/00/0000	00/00/0000	00/00/0000

California Medical Provider Network

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at https://www.dir.ca.gov/dwc/mpn/DWC_MPN_Main.html.

StrataCare's utilization review findings are intended solely as clinical opinions to determine whether the proposed services or treatment is medically reasonable and necessary.

This does not guarantee payment, acceptance of additional body parts or injuries into this claim. All payment decisions will be handled by the claims representative.

Questions can be directed to either the claims adjuster at «Adjuster Phone» or the StrataCare Solutions Utilization Review at 888-853-4735 between the hours of 8:00 a.m. to 5:30 p.m. PT.

Sincerely,

«Nurse Signature»

Copy to: «Patient Name» (mailed)
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Adjuster Name», Claims Adjuster (sent electronically)

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

CA UR Extension Amended Certification REV 02/19/2026

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«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Notice of "Not Complete" Request for Authorization (RFA)

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», StrataCare Solutions has received a request to review the following treatment(s)/procedure(s) for medical necessity and appropriateness of treatment:

Treatment ID	Treatment(s)/Service(s) Requested
«Treatment ID»	«Item/Service»

On [INSERT DATE RFA WAS RECEIVED] we received a RFA that was **"NOT COMPLETE"** according to 8 C.C.R. 9792.9.1(a) (3)(b)

A request for authorization must:

- identify both the employee and the requesting provider;
- identify 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;
- 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.
- must be signed by the treating physician

A request for authorization ***shall*** be deemed completed following receipt of information, test results, or a specialized consultation requested under section 9792.9.6.

Upon receipt of a request for authorization that does not meet the definition of a complete request for authorization under section 9792.6.1(u), a claims administrator, non-physician reviewer as allowed by section 9792.7 or physician reviewer must either accept the request as a complete request for authorization and comply with the requirements in this article or mark it "not complete" and return it to the requesting physician, specifying the reasons for the return of the request, no later than five (5) business days from receipt. A request for authorization accepted as complete shall be subject to investigation under section 9792.11 and the assessment of administrative penalties under section 9792.12.

The following information was missing or incomplete: [INSERT INFORMATION]

Upon receipt of a completed DWC Form RFA, we will begin processing your request based upon the date of receipt of the completed form.

Sincerely,

«Nurse Signature»

Copy to: «Patient Name» (mailed)
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

CA UR RFA Not Complete REV 02/19/2026

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«Adjuster Name», Claims Adjuster (sent electronically)

«Attorney Name», Attorney (mailed)
« Address Line»
« City», « State» « Zip»

CA UR RFA Not Complete

REV 02/19/2026

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«Date»

Sent via Fax: «Provider Fax»
«Provider Name»
«Provider Address Line»
«Provider City», «Provider State» «Provider Zip»

Notice of Denial Due to Lack of Information

Injured Worker	Carrier Case ID	RFA First Received Date	RFA ID	Date of Injury
«Patient Name»	«Carrier Case ID»	«date received»	«RFA ID»	«DOI»

On behalf of «Account Name», StrataCare Solutions has been asked to review the request dated [Insert Date] to address the following treatment(s) or procedure(s) listed below.

Diagnosis: «ICD10» «ICD10 Desc»

Treatment(s)/Service(s) Requested:
«Treatment ID» «Item/Service»

Date of Determination: [INSERT DATE]

At this time, we are unable to make a medical necessity determination for the procedure(s) for the following reason(s):

[Insert Reason]

The clinical peer reviewer who reviewed the procedure(s) has requested [INSERT THE TEST OR EXAMINATION REQUESTED] on [INSERT DATE] via [fax, phone conversation, other] before making a decision on the medical necessity of the procedure.

The requested treatment will be reconsidered upon receipt of a new request for authorization containing the additional information, exam or test, or specialized consultation.

Pursuant to 8 CCR 9792.9.6

The timeframes for decisions specified in section 9792.9.3 may only be extended under one or more of the following circumstances:

(A) The claims administrator or reviewer does not have all of the information reasonably necessary to make a determination.

(B) The reviewer has asked that an additional examination or test that is reasonable and consistent with professionally recognized standards of medical practice.

(C) The reviewer needs a specialized consultation and review of medical information by an expert reviewer.

If the information reasonably necessary to make a determination under subdivision (A) is not received within fourteen (14) days from receipt of the completed or accepted request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, a physician reviewer shall deny the request

If the results of the additional examination or test required under (B), or the specialized consultation under (C), is not received within thirty (30) days from the date of the request for authorization, the reviewer shall deny the treating physician's request

Upon receipt of the information requested, the claims administrator or reviewer, for prospective or concurrent review, shall make the decision to approve, modify, or deny the request for authorization within five (5) business days of receipt of the information

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Upon receipt of the information requested, the claims administrator or reviewer, for prospective or concurrent decisions related to an expedited review, shall make the decision to approve, modify, or deny the request for authorization within 72 hours of receipt of the information.

Upon receipt of the information requested, the claims administrator or reviewer, for retrospective review, shall make the decision to approve, modify, or deny the request for authorization within thirty (30) calendar days of receipt of the information requested.

California Medical Provider Network

If this injured worker's employer is in a Medical Provider Network (MPN), medical treatment for the injured worker may be required to be provided by a MPN provider. For further information, you may contact the claims administrator or for additional information about Medical Provider Networks, contact the Division of Workers' Compensation website at https://www.dir.ca.gov/dwc/mpn/DWC_MPN_Main.html.

StrataCare Internal Clinical Appeal Process

The internal appeals process is a voluntary process that neither triggers nor bars the use of dispute resolution procedures of Labor Code section 4610.5 and 4610.6, but may be pursued on an optional basis. Decisions were based upon medical necessity. If your provider disagrees with the decision, he/she can initiate an appeal by contacting StrataCare Solutions UR Team who can provide information on the steps to request an appeal.

All appeal requests must be received by StrataCare Solutions within ten (10) calendar days of receipt of this written notification. Appeals can be submitted by calling, faxing or emailing the request. You must be prepared to present pertinent clinical information in support of your request. The appeal review will be conducted by a clinical peer reviewer other than the one involved in the initial determination. All internal appeals will be completed within thirty (30) days for a standard appeal or seventy-two (72) hours for an expedited appeal from the date of receipt of the request.

Division of Workers' Compensation Dispute Process for Injured Workers

All disputes will be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6, and 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) calendar days after the service of the utilization review decision for formulary disputes, or within the timeframe indicated on the last page of the application. We have enclosed a pre-addressed envelope for your convenience in returning the form.

A decision to modify or deny a request for authorization will remain in effect for twelve (12) months from the date of the decision without further action by the claim's administrator or utilization review agent with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

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 «Adjuster Name» at «Adjuster Phone». However, if you are represented by an attorney, please contact your attorney instead.

For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

If a peer-to-peer discussion has not occurred, the requesting provider may contact StrataCare Solutions Utilization Review at « Toll Free Number» within two (2) business days to discuss the adverse determination. We will respond within one (1) business day. The reviewer, expert reviewer or the medical director's availability for discussion will be Monday through Friday from 9:00 am to 5:30 pm Pacific Time. In the event the physician reviewer is unavailable, the requesting physician may discuss the written decision with another physician reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services.

Questions can be directed to either the claims adjuster at «Adjuster Phone» or the StrataCare Solutions Utilization Review at 888-853- 4735 between the hours of 8:00 a.m. to 5:30 p.m. PT.

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www.StrataCare.com

Sincerely,

«Nurse Signature»

Copy to: «Patient Name» *(mailed)*
«Patient Address Line»
«Patient City», «Patient State» «Patient Zip»

«Adjuster Name», Claims Adjuster *(sent electronically)*

«Attorney Name», Attorney *(mailed)*
« Address Line»
« City», « State» « Zip»

«Attorney Name», Attorney *(mailed)*
« Address Line»
« City», « State» « Zip»

CA UR Notice of Conditional Denial REV 02/19/2026

Exhibit 2 - URAC Certificate

8 CCR §9792.7.

StrataCare - URAC Certificate of Award

urac

CERTIFICATE OF AWARD

in recognition of

StrataCare Solutions, LLC
402 S. Kentucky Ave., Suite 390
Lakeland, Florida 33801

for compliance with

Workers' Compensation Utilization Management 8.1 Accreditation Program

is awarded

Full Accreditation

Effective from 04/01/2024 through 04/01/2027

Shawn Griffin MD

Shawn Griffin, MD
President & Chief Executive Officer

Certificate Number: WUM010014

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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.

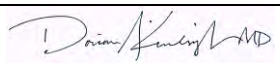
Utilization Review Plan Review and Approval Sign-Off Sheet

This sign-off sheet documents that the undersigned have reviewed and approved the Filing, Renewal or Material Modification, including any updates, changes, additions, or subtractions to this Plan, in accordance with all applicable federal and state regulatory requirements.

See the Revision History for a description of the changes made.

Reviewer Attestation

By signing below, each reviewer attests that they have read the Utilization Review Plan in its entirety, confirmed compliance with applicable clinical and regulatory standards, and approve implementation of the plan as documented.

Date	Printed Name	Title	Department	Signature
06/25/2026	*Malinda Wissen*	*Sr. Regulatory Compliance Analyst*	*Clinical Regulatory Compliance (CRC)*	Malinda Wissen
07/07/2026	*Dorian Kenleigh MD*	*National Medical Director*	*Executive/Operations*	

Record Retention

This approval record shall be retained in accordance with the organization's document retention policy and made available for regulatory review or audit upon request.

Revision History

Date	Revision	Staff Name
05/20/2023	Removal of client – Barnes - page 2 Update Dr. Natwa contact information and updated license expiration – page 12. Removal of peer review vendor – Dane Street – page 13	Marcia Allen
06/07/2023	Per CA State recommendations – Kristine Riggs UR nurse qualifications (RN or LVN/LPN). Added statement to Expedited Review - Notification of the decision will be given to the requesting physician within twenty-four (24) hours by phone or fax or electronic mail. Added to contents of written documents - a specific description of the medical treatment service approved, if any Added to Letter of Denial due to Lack of Information - For formulary disputes, 10 days after the service of the utilization review decision to the employee. Added Peer to peer paragraph to denial letter Added blank peer review report to all letters that has a physician review	Marcia Allen
10/05/2023	Add Dr. Natwa Tx license, remove license expirations date, correct vendor Exam Works to NMR, remove paragraph about the drug request timeframe.	Marcia Allen
04/03/2024	Updated sections to align with standardized template Rearranged order of sections for flow Rearranged contents of sections to remove redundant information Updated URAC seal and added URAC certificate	M. Wissen
07/23/2024	Replaced Conduent references with StrataCare Rearranged some information to other sections	M. Wissen
08/09/2024	Added tags to state rules and regulations	M. Wissen
09/10/2024	Updated plan with medrisk colors and new logos	M. Wissen
10/25/2024	Updated URAC certification	M. Wissen
11/08/2024	Updated plan based on state recommendations during material change	M. Wissen
11/11/2024	Updated revision date and date on cover page Updated table of contents	M. Wissen
11/18/2024	Updated plan to align with company branding	M. Wissen
12/03/204	Updated Address	M. Wissen
01/28/2025	Updated MD email address	M. Wissen
10/15/2025	Updated Medical Director Info	M. Wissen

	Updated Peer Reviewer info	
10/27/2025	Updated MD license expiration date Updated date on cover page	M. Wissen
02/27/2026	Update to : • Program Goals section • Overview to make it more concise • Prior Authorization Process Program to align with updated regulations • Prospective Review to align with updated regulations • Expedited Review to align with updated regulations • Treatment Guidelines and Medically Based Review Criteria to align with updated regulations • Initial Screening of RFA to align with updated regulations • First Level Review to align with updated regulations • Request for Information to align with updated regulations • Timeframe for Decisions to align with updated regulations • Contents of Written Notification to align with updated regulations • Confidentiality to align with updated regulations • Exhibit 1a to align with updated regulations Addition of Sections: • Medical Treatment – First 30 Days • MTUS – Drug Formulary • Material Modifications Updated CA UR Determination letters in Exhibit 1	M. Wissen
06-25-2026	Added Broadsprire to list of peer review vendors on page 23	M.Wissen
07-07-2026	Reviewed and Approved	D. Kenleigh MD

StrataCare Solutions, LLC
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