



# **InterMed Cost Containment Services, Inc.**

## **California Utilization Review Plan**

### **Revision April 1, 2026**

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# InterMed Cost Containment Services, Inc.

## California Workers' Compensation

### Utilization Review Plan

Revised

#### I. InterMed Utilization Review Plan Overview

To comply with the requirements set forth in California Labor Code section 4610 and the Utilization Review regulations contained in Title 8, California Code of Regulations sections 9792.6 et seq., InterMed Cost Containment Services (ICCS) maintains a Utilization Review (UR) Plan describing the process used to review requests for authorization of medical treatment for injured workers.

InterMed originally filed its Utilization Review Plan with the Administrative Director of the Division of Workers' Compensation (DWC) on February 10, 2004, with subsequent revisions filed periodically to ensure continued compliance with applicable statutory and regulatory requirements. InterMed is submitting this revised Utilization Review Plan to ensure compliance with the current utilization review regulations effective April 1, 2026.

Any material modification to the Utilization Review Plan, including but not limited to changes to the medical director, organizational structure, company name, operational address, or corporate structure, will be submitted to the Administrative Director in accordance with 8 CCR §9792.7 and §9792.7.1, utilizing the required CA UR-01 (Effective April 1, 2026) within 30 calendar days of the change, as required by regulation.

**NEW ► April 1, 2026 Update** Effective April 1, 2026: The definition of "material modification" has been expanded per CCR §9792.6.1(n) to expressly include changes in corporate structure in addition to medical director, address, company name, and organizational structure. Material modifications must be filed using CA UR-01 (Effective April 1, 2026) within 30 calendar days of the change. Failure to file within 30 days may result in mandatory penalties.

Upon request by the public, InterMed will make available the complete Utilization Review Plan through electronic means or hard copy, consistent with applicable regulations governing public access to utilization review plans. Any applicable copy charges will not exceed \$0.25 per page plus actual postage costs.

InterMed performs utilization review for requests for authorization (RFA) for medical treatment in accordance with Labor Code §4610 and the applicable regulations contained in Title 8 CCR §§9792.6 through 9792.15. Utilization review applies to treatment requested for injured workers under the California workers' compensation system, regardless of the date of injury.

A determination will be made for every Request for Authorization (RFA) received by InterMed acting on behalf of a claims administrator. All utilization review determinations will be conducted in accordance with the timelines, procedural requirements, and medical necessity standards established in Labor Code §4610 and the applicable provisions of Title 8 CCR §9792.6 et seq.

#### UR Plan Approval, Probation, Suspension, and Revocation (CCR §9792.7 – Effective April 1, 2026)

**NEW ► April 1, 2026 | New Enforcement Authority – CCR §9792.7(e) and (h)**  
Effective April 1, 2026, the Administrative Director has authority to approve, conditionally approve, deny, place on probation, suspend, or revoke a utilization review plan for non-compliance. Written notice of violations will be issued with a 14-day correction period. A revoked UR plan may not reapply for 12 months unless a shorter period is approved. Upon suspension or revocation, InterMed will promptly notify all claims administrators for which it performs utilization review. Violations established through the probation, suspension, and revocation process do not bar additional penalty assessment under CCR §9792.12.

## II. URAC Accreditation

InterMed was awarded URAC Workers' Compensation Utilization Management full accreditation on June 1, 2016, complying with the re-accreditation schedule every 3 years. InterMed remains compliant with all regulatory standards set forth by DWC and URAC for all utilization review services.

## III. InterMed Clients

InterMed Cost Containment Services (InterMed) contracts with Claims Administrators to perform or conduct utilization review activities on their behalf in accordance with California Labor Code section 4610 and the utilization review regulations set forth in Title 8, California Code of Regulations sections 9792.6 et seq.

A list of InterMed's current clients is maintained in **Addendum IV**.

Pursuant to 8 CCR §9792.6(b), Claims Administrator means a self-administered workers' compensation insurer of an insured employer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator, or other entity subject to Labor Code section 4610, the California Insurance Guarantee Association, and the Director of the Department of Industrial Relations acting as administrator for the Uninsured Employers Benefits Trust Fund (UEBTF).

The term Claims Administrator also includes any utilization review organization under contract to provide or conduct the claims administrator's utilization review responsibilities, including InterMed when acting on behalf of its clients.

*[Please see Addendum IV for Client List: InterMed Contracted to Perform Utilization Review]*

## IV. Utilization Review Clinical and Non-Clinical Team

### i. Medical Director

InterMed's Medical Director, Thomas A. Reaper, MD, is a physician licensed by the Medical Board of California with an unrestricted license to practice medicine in the State of California pursuant to Sections 2050 and 2450 of the California Business and Professions Code (License #G42719). Dr. Reaper is board-certified in Occupational Medicine by the American Board of Preventive Medicine.

As Medical Director, Dr. Reaper provides clinical oversight of InterMed's utilization review program and is responsible for ensuring that the utilization review process and all determinations comply with California Labor Code §4610 and Title 8, California Code of Regulations §§9792.6 et seq. This includes oversight of physician and non-physician reviewers and ensuring that utilization review determinations are made by appropriately licensed reviewers acting within their scope of practice and in accordance with the evidence-based medical treatment guidelines adopted by the Administrative Director.

InterMed's utilization review process evaluates Requests for Authorization (RFA) to approve, modify, delay, or deny requested medical treatment in accordance with applicable statutory and regulatory requirements. Determinations to modify or deny treatment requests are made by licensed physician reviewers or other licensed health care professionals acting within their scope of practice, consistent with Labor Code §4610 and the utilization review regulations.

The Medical Director and physician reviewers are available to discuss utilization review determinations with the requesting physician during normal business hours, 9:00 AM to 5:30 PM Pacific Time. A mutually agreeable time may be scheduled for discussion of a decision. If the original reviewer is unavailable, the requesting physician may discuss the written determination with another reviewer who is competent to evaluate the specific clinical issues involved in the requested medical treatment services.

Dr. Reaper may be contacted c/o InterMed Cost Containment Services, PO Box 21947, Eagan, MN 55121; toll-free phone 1-800-318-4050; fax 916-781-5595.

## ii. Medical Advisors / Physician Reviewers

InterMed utilizes the services of licensed physician reviewers and other licensed health care professionals to evaluate requests for authorization involving specific clinical issues related to medical treatment services. These reviewers may include medical doctors, doctors of osteopathy, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners, provided they hold a current and unrestricted license and the requested services fall within the reviewer's scope of practice.

Physician reviewers are competent to evaluate the specific clinical issues involved in the requested treatment and may issue determinations to approve, modify, or deny requests for authorization for medical treatment, consistent with the utilization review regulations and applicable evidence-based medical treatment guidelines.

InterMed contracts with Dane Street, LLC, an independent medical review organization, to provide specialty peer review services through a national network of appropriately licensed physician advisors and healthcare professionals with expertise across multiple specialties.

Physician reviewers are available during normal business hours, 9:00 AM to 5:30 PM Pacific Time, to discuss utilization review determinations with the requesting physician. A mutually agreeable time may be scheduled for discussion. If the original reviewer is unavailable, another reviewer who is competent to evaluate the clinical issues involved in the requested treatment may discuss the determination.

All physician reviewer communications may be directed through InterMed Cost Containment Services, PO Box 21947, Eagan, MN 55121; toll-free phone 1-800-318-4050; fax 916-781-5595.

## iii. Peer Review Physicians

InterMed maintains access to qualified physician reviewers with appropriate clinical expertise to conduct utilization review determinations in accordance with California Labor Code §4610 and Title 8, California Code of Regulations §§9792.6 through 9792.15.

- **Thomas A. Reaper, MD – Medical Director.** Dr. Reaper holds an unrestricted license to practice medicine in the State of California (#G42719) and is board-certified in Occupational Medicine by the American Board of Preventive Medicine.
- **Dane Street, LLC** – InterMed contracts with Dane Street, LLC to provide access to a national network of qualified physician reviewers and healthcare professionals to conduct specialty peer review services when required. Dane Street is accredited by URAC as an Independent Review Organization (IRO) and maintains a panel of board-certified physician advisors across multiple specialties. These reviewers perform peer review evaluations consistent with California workers' compensation utilization review requirements.

**NEW ► April 1, 2026 Update** Effective April 1, 2026: Per updated CCR §9792.6.1, an "expert reviewer" consultation must be specifically requested by the claims administrator or utilization review organization, must necessitate an extension of time, and must occur prior to the determination of medical necessity.

## iv. Non-Physician Reviewers

InterMed utilizes qualified non-physician reviewers to perform the initial review of Requests for Authorization (RFA) in accordance with Labor Code §4610 and Title 8 CCR §§9792.6 et seq.

Non-physician reviewers may include individuals with professional credentials such as:

- Registered Nurse (RN)
- Licensed Vocational Nurse (LVN)
- Certified Case Manager (CCM)

Non-physician reviewers may apply the evidence-based medical treatment guidelines adopted by the Administrative Director and approve requests for authorization that meet the applicable criteria.

Non-physician reviewers may not modify or deny requests for authorization. If a request cannot be approved based on the applicable treatment guidelines, the request is referred to a physician reviewer or other licensed health care professional acting within their scope of practice for a utilization review determination.

### V. InterMed Overview of the Utilization Review Process

InterMed has provided utilization review services to self-insured employers, third-party administrators, and insurance carriers since 1998 in compliance with applicable federal, state, and jurisdictional laws and regulations.

All Requests for Authorization (RFA) received by InterMed on behalf of a claims administrator are processed through the utilization review program in accordance with California Labor Code §4610 and Title 8, California Code of Regulations §§9792.6 through 9792.15.

**NEW ► April 1, 2026 Update** Effective April 1, 2026 – CCR §9785(h): A Request for Authorization may be submitted by either the primary treating physician (PTP) or a secondary treating physician.

An initial review of each request for authorization may be performed by a qualified non-physician reviewer, who applies the evidence-based medical treatment guidelines adopted by the Administrative Director.

If the request meets the applicable criteria, the non-physician reviewer may approve the request for authorization.

If the request cannot be approved based on the applicable treatment guidelines, the request is referred to a physician reviewer or other licensed health care professional acting within their scope of practice for further evaluation and determination.

A non-physician reviewer may communicate with the requesting physician to clarify the request or discuss the applicable treatment guidelines. The requesting physician may voluntarily withdraw or amend the request for authorization and submit a revised request, if appropriate.

If additional information is necessary to render a determination, the reviewer may request the information in accordance with the timeframes and procedures established in the utilization review regulations, including the requirements governing incomplete Requests for Authorization.

Physician reviewers may contact the requesting physician to discuss the requested treatment and, when appropriate, attempt to reach agreement regarding the requested care through modification of the treatment request.

Following review, the physician reviewer prepares a written utilization review determination including the applicable medical treatment guidelines and rationale supporting the decision to approve, modify, or deny the requested treatment.

The determination is communicated to the requesting physician, the injured worker, and other parties entitled to notice in accordance with the utilization review notice requirements and applicable regulatory timeframes.

### VI. Quality Assurance

InterMed maintains a Quality Management Program to monitor and evaluate the utilization review process and determinations to ensure compliance with Labor Code §4610 and Title 8, California Code of Regulations §§9792.6 et seq. This program ensures that utilization review determinations are consistent with standards of medical practice, evidence-based medical treatment guidelines, and applicable regulatory requirements.

#### i. Non-Physician Reviewer Role in Quality Assurance

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*InterMed's Utilization Review Plan has been revised for compliance with California DWC regulations effective April 1, 2026 (8 CCR §§9792.6 et seq.). Submitted per CA Form UR-01 (Effective 04/01/2026).*

InterMed leadership conducts monthly audits of a representative sample of determinations completed by non-physician reviewers. These audits include review of, but are not limited to:

- Documentation of the date of receipt of the RFA and the date of determination.
- Documentation of requests for additional information, when applicable.
- Timeliness of utilization review determinations in accordance with regulatory UR timeframes.
- Appropriate application of evidence-based medical treatment guidelines (e.g., MTUS, ACOEM, ODG).
- Timely notice to all required parties, with documentation of outcomes in accordance with California regulations.

Audit findings are summarized in monthly quality assurance reports, which are reviewed by InterMed leadership to identify key areas needing improvement. When issues or gaps are identified, corrective actions are implemented, and follow-up reviews are conducted to ensure that improvements are effective and sustained.

## ii. Medical Director Role in Quality Assurance

InterMed's Medical Director, Thomas A. Reaper, MD, provides oversight and review of utilization review determinations completed by physician reviewers. As part of this process, Dr. Reaper reviews adverse determinations on a quarterly basis to assess:

- Timeliness of the utilization review determination.
- Rationale and clinical reasoning supporting the determination.
- Appropriate use and documentation of evidence-based medical treatment guidelines, in accordance with 8 CCR §9792.8(a)(3).
- Clinical justification regarding medical necessity.

This review ensures that all physician determinations comply with California Labor Code §4610, applicable regulations, and evidence-based standards of medical practice.

## iii. Corrective Actions and Continuous Improvement

Any issues or concerns identified through the Quality Assurance process are addressed with the relevant reviewer. Appropriate corrective actions are implemented, and follow-up reviews are performed to ensure compliance and quality.

Ongoing reassessment of the utilization review program, processes, and reviewer performance is conducted by the Medical Director and InterMed's leadership team to identify opportunities for improvement. An action plan is developed and implemented to address identified areas, with progress monitored to ensure measurable improvement within the designated timeframe.

## VII. Prior Authorization Process

By DWC definition, prior authorization refers to the claims administrator's process for authorizing medical treatment, including situations where authorization is provided without submission of a Request for Authorization (as defined in Title 8, California Code of Regulations, §9792.6.1(a)). "Request for Authorization" is the term used in the regulations to describe a treating physician's written request for approval of medical treatment under the utilization review standards.

Authorization means assurance that appropriate reimbursement will be made for an approved specific course of medical treatment to cure or relieve the effects of the industrial injury pursuant to Labor Code §4600, subject to the provisions of Labor Code §5402, and in accordance with the timeframes, procedures, and notice requirements set forth in Title 8 CCR §§9792.9.1 et seq.

The claims administrator may notify clinics, medical providers, or medical providers within the employer's Medical Provider Network (MPN) that the following treatments may be authorized without the submission of a Request for Authorization:

- Plain x-rays for all orthopedic injuries
- MRI/CT after major trauma or with documentation of neurological deficit
- Initial diagnostics (MRI, CT, EMG/NCV, etc.) that the provider deems necessary for treatment planning; repeat diagnostics require a Request for Authorization
- Initial and routine durable medical equipment (DME) under \$250: splints, crutches, non-custom braces, slings, basic ice/gel/non-moist heating packs, manual wheelchairs for a 30-day rental
- Ankle/Knee Brace, Wrist Splint, Shoulder Sling, Cane, Crutches
- Wound culture based on objective findings of infection (including a possible MRSA diagnosis)
- Antibiotics pre/post-operatively and for post-traumatic open injury
- Physical or occupational therapy up to 12 visits pre-operatively and up to 24 visits post-operatively
- Chiropractic treatment up to 6 visits for lumbar spine or cervical spine without radiculopathy (frequency not to exceed 3 times per week)

The regulation allows the employer flexibility to tailor the prior authorization process to meet operational needs. Notification of the prior authorization list is provided to preferred clinics, medical providers, or physicians via email, mail, or fax. InterMed's Medical Director, Thomas A. Reaper, MD, oversees and approves the prior authorization process and ensures that InterMed's utilization review plan is consistent with applicable statutory and regulatory requirements.

*[Please see Addendum II for County of Orange Specific Prior Authorization Plan]*

### **Compliance with Labor Code §4610 and CCR §9792.9.7 – 30-Day Treatment Exemption**

Under Labor Code §4610(b), for dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment for a compensable body part rendered by a provider within an MPN, health care organization, or pre-designated physician within the first 30 days following the initial date of injury shall be authorized without prospective utilization review when consistent with the Medical Treatment Utilization Schedule (MTUS). In the event the injured worker is not subject to treatment by an MPN, health care organization, or pre-designated physician, the employee shall be eligible for treatment under this section if the services are rendered by an employer-selected physician or facility. For treatment rendered by these providers, the report required under Labor Code §6409 and a complete Request for Authorization must be submitted by the physician within five days of the initial date of injury and evaluation.

#### **NEW ► April 1, 2026 | New CCR §9792.9.7 – Codification of 30-Day Treatment Exemption (Effective April 1, 2026)**

New CCR §9792.9.7 formally codifies the 30-day treatment exemption established under LC §4610(b). To qualify, treatment must: (1) be for a body part or condition accepted as compensable; (2) be consistent with the MTUS; and (3) require the physician to concurrently submit a Doctor's First Report (DFR) and a Request for Authorization. Written decisions approving non-drug treatment under the 30-day exemption must identify the exempt treatment as '30-day exemption' or words to that effect, per CCR §9792.9.7.

Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services provided within the first 30 days after injury are subject to prospective utilization review under Labor Code §4610(c):

- Pharmaceuticals not exempted from prospective review or not authorized by the drug formulary adopted under Section 5307.27
- Non-emergency inpatient and outpatient surgery, including pre- and post-surgical services
- Psychological treatment services

- Home health care services
- Imaging and radiology services, excluding x-rays
- Durable medical equipment with a combined total value over \$250 per the Official Medical Fee Schedule
- Electrodiagnostic medicine, including electromyography and nerve conduction studies
- Spinal injections ◀ *NEW – Added effective April 1, 2026 (CCR §9792.9.7)*
- Other services as designated by rules adopted by the Administrative Director

## VIII. Specific Treatment Criteria

InterMed follows the medical treatment guidelines set forth in the Medical Treatment Utilization Schedule (MTUS, 8 CCR §§9792.20 – 9792.23) as part of the utilization review process. This includes guidelines such as:

- American College of Occupational & Environmental Medicine (ACOEM) Occupational Medicine Practice Guidelines
- Acupuncture Medical Treatment Guidelines
- Chronic pain guidelines
- Postsurgical physical medicine treatment guidelines

Requests for treatment will not be denied solely because the condition or injury is not addressed in the MTUS. Approval may be provided if the requested treatment aligns with other scientifically valid, evidence-based, peer-reviewed medical treatment guidelines that are nationally recognized within the medical community.

The relevant portions of the criteria or guidelines used as the basis for any utilization review determination will be quoted or referenced in the written physician peer review report. In addition to the MTUS, InterMed may reference other nationally recognized evidence-based guidelines, including but not limited to:

- Reed Group Guidelines
- Official Disability Guidelines (ODG)
- MCG Guidelines
- National Guideline Clearinghouse

For conditions or injuries not addressed by the above guidelines, InterMed physician reviewers will apply ACOEM's strength-of-evidence methodology as defined in 8 CCR §9792.22.

### Collaboration with Claims Administrator

InterMed collaborates with the claims examiner in the utilization review process. The claims administrator may choose to approve certain requests in accordance with agreed-upon client criteria, developed jointly with the client, InterMed leadership team, and the Medical Director. The client retains discretion to approve treatments outside established criteria and is responsible for payment for any such approved services. These criteria are reviewed annually or more frequently as needed.

A non-physician reviewer may approve requests for authorization when consistent with established criteria and evidence-based guidelines. However, any decision to modify or deny a physician's request must be made by a physician reviewer competent to evaluate the specific clinical issues involved and within the reviewer's scope of practice, consistent with 8 CCR §9792.6 et seq.

### Claims Adjuster Recommendation – UR Referral Guide

The following reflects InterMed's general guidance on when claims adjusters should refer to UR vs. authorize directly. This list is not exhaustive and is subject to revision:

#### Diagnostic Testing

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**Adjuster may authorize without UR Clinical referral:**

- MRI/CT after major trauma or with documentation of neurologic deficit
- Plain x-rays for all orthopedic injuries
- EMG/NCS after 4 weeks of conservative treatment (CTS/Cubital tunnel, cervical/lumbar radiculopathy), or <4 weeks with documented neurologic deficit
- Routine pre-op testing by surgeon (CBC, chem panel, urinalysis, chest x-ray, EKG)

**Recommend UR Clinical referral:**

- MRI/CT prior to 4 weeks of conservative treatment for routine injuries
- Repeat MRI < one-year-old; Positional MRI or Functional MRI
- EMG/NCS prior to 4 weeks of conservative treatment & surface EMGs
- CT/discogram & CT/myelogram; Diagnostic ultrasound (orthopedic cases)

**Home Health / DME****Adjuster may authorize:**

- Simple braces (wrist, ankle, etc.)

**Recommend UR referral:**

- Home health; CPM machines (other than Total Knee Replacement, ACL repair, RC repair up to 21 days)
- Rigid, custom braces (knee/back); Cold therapy/vasopneumatic devices; Spinal unloading devices
- 30-day trial of TENS unit, E-stim units, H-wave, IF units (other than simple TENS)

**Physical Medicine****Adjuster may authorize:**

- Chiropractic/PT/OT/Acupuncture up to a combined total of 12-24 visits for initial injury

**Recommend UR referral:**

- > 12-24 combined visits; Manipulation under anesthesia (by DC); Massage & Pool Therapy
- Biofeedback; Computerized strength/ROM testing; FCE (unless part of P&S determination)
- Gym programs/membership; Post-Op PT exceeding ACOEM/MTUS guidelines

**Therapeutic Interventions****Adjuster may authorize:**

- Initial Consult/Eval, especially with MPN provider
- Epidural injection x1 with MRI evidence of nerve root compression & symptoms of radiculopathy

**Recommend UR referral:**

- Any surgery requests; Any percutaneous disc procedure (IDET, nucleoplasty, laser discectomy)
- Epidural injections (>1 and/or with no nerve root compression on MRI)
- Sympathetic & bioelectric nerve blocks; Botox & Trigger point injections; Prolotherapy
- Facet injections; Selective nerve root blocks; Any Radio Frequency (RF) procedure
- Chronic use of narcotics/unusual medication requests (e.g., Actiq, Fentora, Oxycontin, Opana, Butrans)
- Chronic pain management & drug detox programs; Compounded topical medications
- Dorsal column stimulators; Implantable pain pumps; Vax-D (or similar) pneumatic traction
- ECSWT; Laser & Magnet therapy; PENS or PNT treatment
- Shockwave Therapy (see shockwave-specific criteria in medical guidelines for applicable diagnoses)

- Non-exempt drugs on MTUS Drug Formulary

A non-physician reviewer is used to initially apply specified criteria to requests for authorization of medical services. The non-physician reviewer may approve requests for authorization when the request meets the applicable criteria and evidence-based medical treatment guidelines.

If a requested treatment appears inconsistent with the criteria, the non-physician reviewer may discuss the applicable guidelines with the requesting physician. In such cases, the requesting physician may voluntarily withdraw a portion or all of the treatment in question and submit a revised request. The non-physician reviewer may then approve the revised request in accordance with applicable criteria.

A non-physician reviewer may reasonably request additional information necessary to render a determination, provided that all requests and responses comply with the time limitations established under 8 CCR §9792.9.3.

InterMed maintains a toll-free telephone line (800-318-4050) with access to staff during normal business hours, 8:00 AM – 5:30 PM Pacific Time, and a voicemail system available 24 hours per day, 365 days per year. All messages are responded to within 24 hours. The fax line (916-781-5595) is available 24 hours a day.

## IX. MTUS Drug Formulary

InterMed follows DWC MTUS Drug Formulary in accordance with Title 8, California Code of Regulations sections 9792.27.1 – 9792.27.23. All medication requests for both exempt and non-exempt medications require a Request for Authorization (RFA) as all requests are subject to the utilization review process. Formulary requirements include:

### a. No prospective UR for drugs which are:

- Exempt per MTUS Drug List (regulation section 9792.27.10)
- Special fill (9792.27.12)
- Perioperative fill (9792.27.13)
- Physician-Dispensed Medications that fall within the regulation (9792.27.8)

### b. Prospective Utilization Review is required for:

- Non-exempt drugs identified on the most current MTUS Drug Formulary List
- Unlisted drugs
- Compounded drugs

### **NEW ► April 1, 2026 | Updated Drug Formulary UR Timeframes (Effective April 1, 2026)**

Non-exempt drugs identified on the MTUS Drug List: UR determination within 5 business days of receipt of the completed RFA. Unlisted drugs (not appearing on the MTUS Drug List): UR determination within 14 calendar days of receipt of the RFA. Consistent with LC §4610.5(h)(1), disputes involving only a drug on the MTUS Drug List have a shortened IMR filing deadline of 10 days (vs. 30 days for other treatment disputes).

### **Section 9792.27.2. MTUS Drug Formulary; MTUS Drug List; Scope of Coverage; Effective Date 1/1/2018.**

Drugs prescribed or dispensed to treat a work related injury or illness fall within Labor Code section 4600's definition of "medical treatment" and are subject to the relevant provisions of the MTUS, including the MTUS Treatment Guidelines, provisions relating to the presumption of correctness, and the methods for rebutting the presumption and for substantiating medical necessity where the MTUS Treatment Guidelines do not address the condition or injury.

Except for continuing drug treatment subject to section 9792.27.3, subdivision (b), a drug dispensed on or after January 1, 2018 for outpatient use shall be subject to the MTUS Drug Formulary, regardless of the date of injury.

- A drug is for “outpatient use” if it is dispensed to be taken, applied, or self-administered by the patient at home or outside of a clinical setting, including “take home” drugs dispensed at the time of discharge from a facility.
- The MTUS Drug Formulary does not apply to drugs administered to the patient by a physician; however, physician-administered drug treatment is subject to relevant MTUS provisions.

**Section 9792.27.10. MTUS Drug List; Exempt Drugs, Non-Exempt Drugs, Unlisted Drugs, Prospective Review.**

The MTUS Drug List is set forth by active drug ingredient(s). A drug identified as “Exempt” may be dispensed without obtaining authorization through prospective review if the drug treatment is in accordance with the MTUS Treatment Guidelines, except: (1) Brand name drugs are subject to section 9792.27.7; (2) Physician-dispensed drugs are subject to section 9792.27.8; (3) Compounded drugs are subject to section 9792.27.9.

For a drug identified as “Non-Exempt,” authorization through prospective review must be obtained prior to the time the drug is dispensed. Expedited review should be conducted where warranted by the injured worker’s condition.

For an unlisted drug, authorization through prospective review must be obtained prior to dispensing. A combination drug not on the MTUS Drug List is an unlisted drug even if the individual active ingredients are on the list.

InterMed can conduct a retrospective review on an exempt drug without a formal request for authorization for the purpose of determining compliance with MTUS. Upon a retrospective UR finding that an exempt drug was inconsistent with MTUS, this may be the basis for determining a “pattern and practice” and serve notice to the provider that future requests for exempt drugs will go through the prospective utilization review process and/or be removed from the Medical Provider Network (MPN).

**X. Utilization Review Workflow**

The DWC Form RFA shall be deemed to have been received by the claims administrator or its utilization review organization by facsimile or by electronic mail on the date the form was received if the receiving facsimile or electronic mail address electronically date stamps the transmission when received. If there is no electronically stamped date recorded, then the date the form was transmitted shall be deemed to be the date the form was received by the claims administrator or the claims administrator’s utilization review organization.

A DWC Form RFA transmitted by facsimile after 5:30 PM Pacific Time shall be deemed to have been received by the claims administrator on the following business day, except in the case of an expedited or concurrent review.

If the DWC Form RFA is sent by mail, the form, absent documentation of receipt, shall be deemed to have been received by the claims administrator five (5) business days after the deposit in the mail at a facility regularly maintained by the United States Postal Service.

If the DWC Form RFA is delivered via certified mail with return receipt, the form shall be deemed to have been received on the receipt date entered on the return receipt.

In the absence of documentation of receipt, evidence of mailing, or a dated return receipt, the DWC Form RFA shall be deemed to have been received by the claims administrator five days after the latest date the sender wrote on the document.

Utilization review of a medical treatment request made on the DWC Form RFA 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.

If the claims administrator disputes its liability for the requested medical treatment under this subdivision, it may, no later than five (5) business days from receipt of the request for authorization, issue a written decision deferring utilization review, unless the requesting physician has been previously notified of a dispute over

liability and an explanation for the deferral. The written decision must be sent to the requesting physician, the injured worker, and if the injured worker is represented by counsel, the injured worker's attorney.

The written deferral decision shall contain only the following information:

- The date on which the request for authorization was first received.
- A description of the specific course of proposed medical treatment for which authorization was requested.
- A clear, concise, and appropriate explanation of the reason for the claims administrator's dispute of liability.
- A plain language statement advising the injured employee that any dispute shall be resolved either by agreement of the parties or through the WCAB dispute resolution process.
- Mandatory advisory: "You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call me [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](http://www.dwc.ca.gov) or contact an information and assistance (I&A) officer of the DWC. For recorded information, call toll-free 1-800-736-7401."

#### **i. Definitions (per §9792.6.1)**

- **Concurrent review:** Utilization review conducted during an inpatient stay.
- **Denial:** A decision by a physician reviewer that the requested treatment or service is not authorized.
- **Expedited review:** Utilization review conducted when the injured worker's condition is such that the injured worker faces an imminent and serious threat to his or her health, including 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.
- **Modification:** A decision by a physician reviewer that part of the requested treatment or service is not medically necessary.
- **Prospective review:** Any utilization review conducted, except for utilization review conducted during an inpatient stay, prior to the delivery of the requested medical services.
- **Retrospective review:** Utilization review conducted after medical services have been provided and for which approval has not already been given.

#### **ii. Timeframe Requirements**

The first day in counting any timeframe requirement is the day after the receipt of the DWC Form RFA, 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 DWC Form RFA.

If the DWC Form RFA does not identify the employee or provider, does not identify a recommended treatment, is not accompanied by documentation substantiating the medical necessity, or is not signed by the requesting physician, the reviewer must either regard the request as complete and comply with the timeframes for decision OR return it to the requesting physician marked "not complete," specifying reasons, no later than five (5) business days from receipt. The timeframe for a decision on a returned request shall begin anew upon receipt of a completed DWC Form RFA.

Prospective or concurrent decisions to approve, modify, or deny shall be made not to exceed five (5) business days from the date of receipt of the completed DWC Form RFA, but in no event more than 14 calendar days from initial receipt of the complete DWC Form RFA.

Prospective or concurrent decisions related to expedited review shall be made not to exceed 72 hours after the receipt of the written information reasonably necessary to make the determination.

Retrospective decisions shall be made within 30 days of receipt of the request for authorization and medical information that is reasonably necessary to make a determination.

### iii. Decisions to Approve

All decisions to approve a request for authorization shall specify the date the complete request for authorization was received, the specific medical treatment service approved, and the date of the decision.

- **Prospective, concurrent, or expedited review:** Approvals shall be communicated to the requesting physician within 24 hours of the decision, initially by telephone, facsimile, or electronic mail. Telephone communication shall be followed by written notice to the requesting physician within 24 hours for concurrent review and within two (2) business days for prospective review.
- **Retrospective review:** A written decision to approve shall be communicated to the requesting physician who provided the medical services and to the individual who received the medical services, and his or her attorney/designee, if applicable.

**NEW ► April 1, 2026 Update** Per CCR §9792.9.7 (effective April 1, 2026): Written decisions approving non-drug treatment under the 30-day exemption must identify the exempt treatment as '30-day exemption' or words to that effect and meaning.

### iv. Decisions to Modify, Extend the Time, or Deny

The review and decision to deny, extend the time, or modify a request for medical treatment must be conducted by a reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the individual's practice.

For prospective, concurrent, or expedited review, a decision to modify, request a time extension, or deny shall be communicated to the requesting physician within 24 hours of the decision, initially by telephone, facsimile, or electronic mail. Written notice shall follow within 24 hours for concurrent review, within two (2) business days for prospective review, and within 72 hours for expedited review.

For retrospective review, a written decision to deny part or all of the requested medical treatment shall be communicated within 30 days of receipt of the request and medical information reasonably necessary to make a determination.

The written decision modifying, extending the time, or denying treatment authorization shall contain only the following information:

- The date on which the DWC Form RFA was first received.
- The date on which the decision is made.
- A description of the specific course of proposed medical treatment for which authorization was requested.
- A list of all medical records reviewed.
- A specific description of the medical treatment service approved, if any.
- A clear, concise, and appropriate explanation of the reasons for the reviewing physician's decision, including clinical reasons regarding medical necessity and a description of the relevant medical criteria or guidelines used, pursuant to section 9792.8.
- If the decision is due to incomplete or insufficient information, the decision shall specify the reason and the information that is needed.
- The completed DWC Form IMR (Application for Independent Medical Review), with all fields except the employee's signature completed by the claims administrator, and an addressed envelope for mailing to the Administrative Director or designee.
- A clear statement advising the injured employee that any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code sections 4610.5 and 4610.6, and that an objection

must be communicated on the enclosed DWC Form IMR within 10 calendar days for formulary disputes, and 30 calendar days for all other medical treatment disputes.

- Mandatory advisory: "You have a right to disagree with decisions affecting your claim..." [see full mandatory language per §9792.9.1].
- Name and specialty of the reviewer and telephone number in the United States.
- Hours of availability of the reviewer or medical director for treating physician discussion, at a minimum four (4) hours per week during normal business hours, 9:00 AM to 5:30 PM Pacific Time, or an agreed upon scheduled time.

Prior to a concurrent review decision to deny authorization: Medical care shall not be discontinued until the requesting physician has been notified of the decision and a care plan has been agreed upon by the requesting physician that is appropriate for the medical needs of the employee.

#### **v. Requesting Additional Information or Time Extension**

The timeframe for decisions may only be extended under one or more of the following circumstances:

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

If the information is not received within 14 days from receipt of the completed request for authorization for prospective or concurrent review, or within 30 days for retrospective review, the reviewer shall deny the request with the stated condition that the request will be reconsidered upon receipt of the information.

Upon receipt of the requested information, for prospective or concurrent review, the decision shall be made within 5 business days. For expedited review, within 72 hours. For retrospective review, within 30 calendar days.

**Note:** *InterMed will attempt to reach the provider to request information needed to meet evidence-based standards. If the requesting provider is unresponsive within the applicable timeframe, InterMed will escalate the request to a physician reviewer to approve, deny, or modify the request based on the clinical record available, following normal peer review protocol for any adverse decision.*

A utilization review decision to modify, extend the time, or deny a request for authorization 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 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.

#### **vi. New CCR §9792.9.2 – LC 4610(k) 12-Month UR Denial Deferral Notice**

##### **NEW ► April 1, 2026 | New Section CCR §9792.9.2 (Effective April 1, 2026)**

When a claims administrator determines that Labor Code §4610(k) applies — meaning the same treating physician is requesting the same treatment that was denied by a UR decision within the preceding 12 months — the claims administrator must issue a written UR Deferral Notice to the requesting physician, the injured worker, and if represented, the injured worker's attorney (per CCR §9792.9.2(a)(2)).

##### **Exception – when deferral is NOT permitted:**

The 12-month deferral under LC §4610(k) is NOT applicable, and the request must be processed through the standard UR process, when:

- The requesting physician expressly and unequivocally indicates in the RFA that there has been a change in the facts material to the basis of the prior UR denial; AND

- The physician includes supporting documentation of such factual change with the RFA.

In such cases, InterMed will process the request through the standard utilization review process in accordance with all applicable timeframes.

### **vii. Dispute Resolution**

InterMed does not have a voluntary internal appeals program.

If the request for authorization of medical treatment is not approved, or is approved in part, any dispute shall be resolved in accordance with Labor Code sections 4610.5 and 4610.6. A request for independent medical review must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director within 10 days of service of the written UR determination for formulary disputes, or 30 days for all other medical treatment disputes. The request must be made on the Application for Independent Medical Review, DWC Form IMR.

A party eligible to file a request for independent medical review includes:

- The employee or, if represented, the employee's attorney.
- An unrepresented employee may designate a parent, guardian, conservator, relative, or other designee as an agent to act on his or her behalf.
- The physician whose request for authorization was denied or modified may join with or otherwise assist the employee in seeking an independent medical review.
- A provider of emergency medical treatment when the employee faced an imminent and serious threat to health may submit an application for IMR within 30 days after service of the UR decision.

### **viii. Medical Records for Independent Medical Review**

Within 15 days of mailed notification (or 12 days if notification sent electronically, or 24 hours for expedited review) from the independent review organization, the claims administrator shall provide all required documents including: all relevant physician reports from the prior six months, the completed DWC Form IMR, all correspondence and materials submitted to the claims administrator in support of the request, any other relevant documents or information used in determining whether the disputed treatment should have been provided.

Any newly developed or discovered relevant medical records shall be forwarded immediately to the independent review organization. Confidentiality of medical records shall be maintained pursuant to applicable state and federal laws.

### **ix. Independent Medical Review – Standards & Timeframes**

The independent medical review process may be terminated at any time upon the claims administrator's written authorization of all disputed medical treatment.

Timeframes for IMR final determinations:

- Regular review: The IRO shall complete its review and make its final determination within 30 days of receipt of the Application for Independent Medical Review and supporting documentation.
- Expedited review: The IRO shall complete its review and make its final determination within 3 days of receipt of the Application and supporting documentation.
- Deadlines may be extended up to 3 days in extraordinary circumstances or for good cause, subject to Administrative Director approval.

The final determination issued by the independent review organization shall be deemed the determination of the Administrative Director and shall be binding on all parties.

**x. Utilization Review Determination Validity**

Utilization Review determinations do not have an expiration date and will be valid until treatment is rendered. InterMed clients have the right to opt in to providing a validity date range in the determination letters specific to their program.

**xi. Implementation of IMR Determination & Appeal**

Upon receiving the final determination of the Administrative Director that a disputed medical treatment is medically necessary, the claims administrator shall promptly implement the determination:

- In the case of reimbursement for services already rendered, the claims administrator shall reimburse within twenty (20) days after receipt of the final determination.
- In the case of services not yet rendered, the claims administrator shall authorize the services within five (5) working days of receipt of the final determination, or sooner if appropriate.

If the final determination is reversed by the Workers' Compensation Appeals Board, the dispute shall be remanded to the Administrative Director who shall submit the dispute to independent medical review by a different independent review organization, if available.

**xii. Payment for Independent Medical Review**

The costs of independent medical review and the administration of the IMR system shall be borne by claims administrators, per §9792.10.8, Independent Medical Review – Payment for Review.

**xiii. Penalty Schedule for Utilization Review & Independent Medical Review Violations**

A penalty shall be assessed for each failure to comply with the utilization review process required by Labor Code section 4610, the independent medical review process required by Labor Code sections 4610.5 and 4610.6, and sections 9792.6.1 through 9792.12 of Title 8 of the California Code of Regulations, per §9792.12.

**NEW ► April 1, 2026 | Overhauled Penalty Framework (Effective April 1, 2026)**

Effective April 1, 2026, the DWC's UR investigation and penalty system has been substantially overhauled. The previous "performance rating" system — which permitted penalty waivers for UR organizations that achieved an 85% or higher performance score on UR investigations — has been eliminated. Under the new framework, there is no performance score and no waiver mechanism, although mitigation of penalties remains available on a case-by-case basis. Penalties will be assessed per violation in accordance with CCR §9792.12. Additionally, per CCR §9792.7(e) and (h), violations established through the UR plan probation, suspension, and revocation process do not bar the assessment of additional penalties.

**XI. Confidentiality and Information Security**

InterMed is strongly committed to maintaining the confidentiality of individually identifiable health information of all parties associated with our organization including the injured workers, providers, our employees, and our service partners. Adherence with security protocols established is a required standard within our organization and our service partners. Periodic audits are performed to ensure compliance. InterMed provides mandatory trainings on security and confidentiality to all employees regularly.

Individually-identifiable health information will be used only to access health information of individuals who are injured on the job or who have a work-related illness to process or adjudicate claims, or to coordinate care, or payment purposes under workers' compensation systems. Minimum necessary information may be transmitted electronically or on paper.

All InterMed employees including committee members and board members within the InterMed organization and our parent company AvonRisk, are responsible for preserving confidentiality and securing information. All employees are required to sign a confidentiality agreement, a copy of which is maintained in their personnel file.

All employees, committee members, and board members within the AvonRisk/InterMed community are responsible and are committed to reporting information breaches and upholding AvonRisk privacy policies and

practices. InterMed has an established Confidentiality Policy that restricts employees, committee members, and board members from sharing proprietary information with any outside parties.

### Information Security

InterMed's internal controls have been designed assuming certain controls would be implemented by users in order to achieve the stated control objectives. For InterMed, any breach of private information has the potential to result in losses to the company and the clients we serve. Security incidents could arise in a myriad of contexts relating to paper documents and electronically stored and transmitted information such as theft, misuse of data, and computer- or technology-based violations. Because of these potential harms, AvonRisk places a high priority on the security of its information. It is InterMed's intention to investigate and respond appropriately to each information breach, depending upon the level of potential consequential harm and legal obligations related to each particular situation.

## XII. Financial Incentive Policy

InterMed does not have a system for reimbursement, bonuses or incentives to staff or health care providers based directly on consumer utilization of health care services.

### Financial Disclosure Per Labor Code 4610(g)(3)(B)(i-ii)

Each employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

- **(i)** The employer, or any entity conducting utilization review on behalf of the employer, shall neither offer nor provide any financial incentive or consideration to a physician based on the number of modifications or denials made by the physician under this section.
- **(ii)** An insurer or third-party administrator shall not refer utilization review services conducted on behalf of an employer under this section to an entity in which the insurer or third-party administrator has a financial interest as defined under Section 139.32, unless prior written disclosure is provided to the employer and Administrative Director identifying both the entity conducting UR services and the financial interest.

## XIII. Patient Safety Policy

InterMed has implemented a mechanism to address potential safety issues identified during prospective review through to resolution. When reviewing each medical report or interviewing patients and providers, the Nurse will identify if safety was compromised and alert the management team.

Examples of potential safety issues during prospective review include, but are not limited to:

- Contraindicated treatment
- Conservative treatment not addressed or ruled out
- Adverse drug interactions
- Inappropriate treatment / over-utilization

During the initial utilization review process, known or potential safety issues may be identified. The possible decision points and next or final steps include:

1. A potential safety issue may be referred to another entity or authority in order to determine if it is a safety issue.
2. A potential safety issue may be researched by InterMed in order to determine if it is a safety issue.
3. A known safety issue may be referred to another entity or authority for further action.
4. A known safety issue may be referred internally within InterMed for further action.

5. If found, documentation of the patient's safety issues and any related action(s) leading to resolution/final step in the process will be completed.
6. Claims examiner and primary treating provider would be notified of findings.
7. May recommend assignment of a Nurse Case Manager to claim file to continue follow up on any related potential safety issues.

## Addendum I: Utilization Review Determination Letters – Authorization Letter



«UserAddress»  
«UserCity», «UserState» «UserZip»  
«UserPhone» fax «UserFax»  
Toll Free 800-318-4050  
**Confidential**

Date of Decision: «DecisionDate»

«ProviderFirstName» «ProviderLastName»  
«ProviderAddress»  
«ProviderCity», «ProviderState» «ProviderZip»  
**Faxed to:** «ProviderFax»

Claimant Name: «ClaimantName»  
Claim #: «ClaimNumber»  
DOI: «DateOfInjury»  
Employer: «EmployerName»  
Client: «ClaimAdminName»

### Utilization Review Authorization of Medical Necessity

At the request of your claims examiner, InterMed Cost Containment Services Inc. has completed utilization review regarding your request for authorization to determine the medical necessity of the recommended treatment in accordance with the statutory standards for UR (i.e. whether the treatment requested is consistent with the Medical Treatment Utilization Schedule (MTUS), ACOEM or other evidence-based medicine protocols).

Date of Receipt of RFA:	«AcknowledgeDate»
Procedure or Service Requested:	«TableStart:Treatment» • «TreatmentDescription» «CptCode» x «Units» units «TableEnd:Treatment»
Procedure or Service <b>Approved:</b>	«TableStart:TreatmentApproved» «TreatmentDescription» x «Units» units «UrServiceDecision» «TableEnd:TreatmentApproved»
UR ID#	«CaseNumber»

This is a certification for medical necessity. Per CA Code of Regulations Section 9792.6.1(a), appropriate reimbursement will be made for the specific services listed. Contact the claims adjuster for an explanation of coverage.

Sincerely,

«UserSignatureName»  
«UserTitle»

Hours of Availability: Monday through Friday 8:00 am-5:30 pm, Pacific Standard Time

Mailed to: Claim File: «ClaimNumber»

Injured Worker: «ClaimantName», «ClaimantAddress», «ClaimantCity», «ClaimantState» «ClaimantZip»  
Applicant Attorney: «AttorneyName», «AttorneyAddress», «AttorneyCity», «AttorneyState» «AttorneyZip»  
Defense Attorney: «DefAttorneyName», «DefAttorneyAddress», «DefAttorneyCity», «DefAttorneyState» «DefAttorneyZip»

# Addendum I: Utilization Review Determination Letters – Authorization Letter Santa Ana USD



«UserAddress»  
«UserCity», «UserState» «UserZip»  
«UserPhone» fax «UserFax»  
Toll Free 800-318-4050  
**Confidential**

Date of Decision: «DecisionDate»

«ProviderFirstName» «ProviderLastName»  
«ProviderAddress»  
«ProviderCity», «ProviderState» «ProviderZip»  
**Faxed to:** «ProviderFax»

Claimant Name: «ClaimantName»  
Claim #: «ClaimNumber»  
DOI: «DateOfInjury»  
Employer: «EmployerName»  
Client: «ClaimAdminName»

### Utilization Review Authorization of Medical Necessity

At the request of your claims examiner, InterMed Cost Containment Services Inc. has completed utilization review regarding your request for authorization to determine the medical necessity of the recommended treatment in accordance with the statutory standards for UR (i.e. whether the treatment requested is consistent with the Medical Treatment Utilization Schedule (MTUS), ACOEM or other evidence-based medicine protocols).

**This letter will confirm authorization of your request for the following treatment(s):**

Date of Receipt of RFA:	«AcknowledgeDate»
Procedure or Service Requested:	«TableStart:Treatment» - «TreatmentDescription» «CptCode» x «Units» units«TableEnd:Treatment»
Procedure or Service <b>Approved:</b>	«TableStart:TreatmentApproved» - «TreatmentDescription» x «Units» units «UrServiceDecision» «TableEnd:TreatmentApproved»
UR ID#	«CaseNumber»

This is a certification for medical necessity. Per CA Code of Regulations Section 9792.6.1(a), appropriate reimbursement will be made for the specific services listed. Contact the claims adjuster for an explanation of coverage.

**Services approved is valid for 4 months from the date of decision. If service is not rendered within the 4 months of the decision date, a new request for authorization will be required to be submitted through formal utilization review.**

Sincerely, \_\_  
«UserSignatureName»  
«UserTitle»

Hours of Availability: Monday through Friday 8:00 am-5:30 pm, Pacific Standard Time

Mailed to: Claim File: «ClaimNumber»  
Injured Worker: «ClaimantName», «ClaimantAddress», «ClaimantCity», «ClaimantState» «ClaimantZip»  
Applicant Attorney: «AttorneyName», «AttorneyAddress», «AttorneyCity», «AttorneyState» «AttorneyZip»  
Defense Attorney: «DefAttorneyName», «DefAttorneyAddress», «DefAttorneyCity», «DefAttorneyState» «DefAttorneyZip»

### Addendum I: Utilization Review Determination Letters – Authorization Letter CDSS



«UserAddress»  
«UserCity», «UserState» «UserZip»  
«UserPhone» fax «UserFax»  
Toll Free 800-318-4050  
**Confidential**

Decision Date: «DecisionDate»

«ProviderFirstName» «ProviderLastName»  
«ProviderAddress»  
«ProviderCity», «ProviderState» «ProviderZip»  
**Faxed to:** «ProviderFax»

Claimant Name: «ClaimantName»  
Claim #: «ClaimNumber»  
DOI: «DateOfInjury»  
Employer: «EmployerName»  
Client: «ClaimAdminName»

#### Utilization Review Authorization of Medical Necessity

At the request of your claims examiner, InterMed Cost Containment Services Inc. has completed utilization review regarding your request for authorization to determine the medical necessity of the recommended treatment in accordance with the statutory standards for UR (i.e. whether the treatment requested is consistent with the Medical Treatment Utilization Schedule (MTUS), ACOEM or other evidence-based medicine protocols).

Date of Receipt of RFA:	«AcknowledgeDate»
Procedure or Service Requested:	«TableStart:TreatmentApproved»«RequestedTreatmentDescription» x «RequestedUnits» units «TableEnd:TreatmentApproved»
Procedure or Service <b>Approved:</b>	«TableStart:TreatmentApproved»«TreatmentDescription» x «Units» units «UrServiceDecision» «TableEnd:TreatmentApproved»
UR ID#	«CaseNumber»

This is a certification for medical necessity. Per CA Code of Regulations Section 9792.6.1(a), appropriate reimbursement will be made for the specific services listed. Contact the claims adjuster for an explanation of coverage.

Sincerely,  
«AssignToUserName»  
Utilization Review Nurse  
Hours of Availability: Monday through Friday 8:00 am-5:30 pm, Pacific Standard Time

Supervising Quality Assurance  
Medical Director

Thomas A. Reaper, MD, MPH  
Board Certified in Occupational Medicine  
CA Lic. #G-042719  
ICCS Medical Director

If you have any questions regarding the above determination, you may correspond to the above address. If you wish to discuss the case, you may leave a message at the above number and a peer to peer conversation will be arranged.\*

Mailed to: Claim File: «ClaimNumber»  
Injured Worker: «ClaimantName», «ClaimantAddress», «ClaimantCity», «ClaimantState» «ClaimantZip»  
Applicant Attorney: «AttorneyName», «AttorneyAddress», «AttorneyCity», «AttorneyState» «AttorneyZip»  
Defense Attorney: «DefAttorneyName», «DefAttorneyAddress», «DefAttorneyCity», «DefAttorneyState» «DefAttorneyZip»

# Addendum I: Utilization Review Determination Letters – Adjuster Level UR Approval



«ExaminerAddress»  
«ExaminerCity», «ExaminerState» «ExaminerZip»  
Toll Free «ExaminerTollFree»  
Telephone «ExaminerPhone»  
Fax «ExaminerFax»  
E-Fax «ExaminerEFax»

**Confidential**

## **Adjuster Approval Letter**

«CurrentDate»

«ProviderFirstName» «ProviderLastName»  
«ProviderName»  
«ProviderAddress»  
«ProviderCity», «ProviderState» «ProviderZip»  
<<Provider fax number>>

Claimant Name: «ClaimantFirstName» «ClaimantLastName»  
Claim #: «ClaimNumber»  
DOI: «DateOfInjury»  
Diagnosis: «DxDescription1»  
Body Part: «BodyPart»  
Authorization #: «AuthNum»

Dear Dr. «ProviderLastName»,

You have requested medical services for the above referenced claimant. The request was received on «AcknowledgeDate».

**This letter will confirm authorization of your request for:**

«TableStart:Treatment»- «TreatmentDescription» «CptCode» = «Units» units.«TableEnd:Treatment»

Type of Review: «ReviewType»

This is a certification for medical necessity. Per CA Code of Regulations Section 9792.6.1(a), appropriate reimbursement will be made for the specific service listed.

Sincerely,

«ExaminerName»  
Claims Adjuster

Mailed To: <<Claim Number>>

Claimant Name: «ClaimantFirstName» «ClaimantLastName», «ClaimantAddress», «ClaimantCity», «ClaimantState»  
«ClaimantZip»  
Applicant Attorney: «AttorneyName», «AttorneyAddress1», «AttorneyAddress2», «AttorneyCity», «AttorneyState»  
«AttorneyZip»  
Defense Attorney: «DefAttorneyName», «DefAttorneyAddress1», «DefAttorneyAddress2», «DefAttorneyCity»,  
«DefAttorneyState» «DefAttorneyZip»

## Addendum I: Utilization Review Determination Letters – Adjuster Level UR Approval on Behalf of Sedgwick for County of Orange UR Program Only



P.O. Box 14442  
Lexington, KY 40512-4497  
Toll Free (800) 854-6188  
Fax (833) 875-6679

**Confidential**

### Adjuster Utilization Review Approval Letter

«CurrentDate»

«ProviderFirstLastOrPracticeName»

«ProviderAddress1»

«ProviderCity», «ProviderState» «ProviderZip»

«ProviderRespondToFax»

Claimant Name: «ClaimantName»

Claim #: «ClaimNumber»

DOI: «DateOfInjury»

Body Part: «BodyPart»

Authorization #: «AuthNum»

Diagnosis:

«Diagnosis»

Dear Dr. «ProviderLastName»

You have requested medical services for the above referenced claimant. The request was received on «AcknowledgeDate».

**This letter will confirm authorization of your request for:**

«TableStart:Treatment»- «FullTreatmentDescription» «TableEnd:Treatment»

Radiology, EMG, Physical Therapy, Occupational Therapy, Acupuncture, Chiropractic, DME and Home Health services must be scheduled, tracked and billed through PayersDirect only.

Phone: (310) 954-9543, Fax: (310) 906-4942, [support@payersdirect.com](mailto:support@payersdirect.com),

PO Box 491609, Los Angeles, CA 90049.

Type of Review: «ReviewType»

This is a certification for medical necessity. Per CA Code of Regulations Section 9792.6(b), appropriate reimbursement will be made for the specific service listed.

Sincerely,

«ExaminerName»

Claims Adjuster

Mailed To: «ClaimNumber»

Claimant Name: «ClaimantFirstName» «ClaimantLastName» «ClaimantAddress» «ClaimantCity», «ClaimantState» «ClaimantZip»

Applicant Attorney: «AttorneyFullInfo»

Defense Attorney: «DefAttorneyFullInfo»

## Addendum I: Utilization Review Determination Letters – Concurrent Approval Letter



«UserAddress»  
«UserCity», CA «UserZip»  
«UserPhone» fax «UserFax»  
Toll Free 800-318-4050  
**Confidential**

Decision Date: «DecisionDate»

«ProviderFirstName» «ProviderLastName»  
«ProviderAddress»  
«ProviderCity», «ProviderState» «ProviderZip»  
**Faxed to:** «ProviderFax»

Claimant Name: «ClaimantName»  
Claim #: «ClaimNumber»  
DOI: «DateOfInjury»  
Employer: «EmployerName»  
Client: «ClaimAdminName»

### Concurrent Utilization Review Authorization of Medical Necessity

At the request of your claims examiner, InterMed Cost Containment Services Inc. has completed utilization review regarding your concurrent request for authorization to determine the medical necessity of the recommended treatment in accordance with the statutory standards for UR (i.e. whether the treatment requested is consistent with the Medical Treatment Utilization Schedule (MTUS), ACOEM or other evidence-based medicine protocols).

Date of Receipt of RFA:	«AcknowledgeDate»
Procedure or Service Requested:	«TableStart:Treatment» • «TreatmentDescription» «CptCode» x «Units» units «TableEnd:Treatment»
Procedure or Service <b>Approved:</b>	«TableStart:TreatmentApproved» • «TreatmentDescription» x «Units» units «UrServiceDecision» «TableEnd:TreatmentApproved»
UR ID#	«CaseNumber»

<i>Number of Extended Days or Units of Service:</i>	
<i>Next Anticipated Review Point:</i>	
<i>New Total Number of Days or Units of Service Approved:</i>	
<i>Date of Admission or Onset of Services:</i>	

This is a certification for medical necessity. Per CA Code of Regulations Section 9792.6.1(a), appropriate reimbursement will be made for the specific services listed. Contact the claims adjuster for an explanation of coverage.

Sincerely, \_  
«UserSignatureName»  
«UserTitle»

Hours of Availability: Monday through Friday 8:00 am-5:30 pm, Pacific Standard Time

Mailed To: Claim Number: «ClaimNumber»  
Injured Worker: «ClaimantName», «ClaimantAddress», «ClaimantCity», «ClaimantState» «ClaimantZip»  
Applicant Attorney: «AttorneyName», «AttorneyAddress», «AttorneyCity», «AttorneyState» «AttorneyZip»  
Defense Attorney: «DefAttorneyName», «DefAttorneyAddress», «DefAttorneyCity», «DefAttorneyState» «DefAttorneyZip»

InterMed Cost Containment Services, Inc. | PO Box 21947, Eagan, MN 55121 | 1-800-318-4050 | F: 916-781-5595 | [www.intermedccs.com](http://www.intermedccs.com)

*InterMed's Utilization Review Plan has been revised for compliance with California DWC regulations effective April 1, 2026 (8 CCR §§9792.6 et seq.). Submitted per CA Form UR-01 (Effective 04/01/2026).*

## Addendum I: Utilization Review Determination Letters – Peer Review Report



«UserAddress»  
 «UserCity», «UserState» «UserZip»  
 «UserPhone» fax «UserFax»  
 Toll Free 800-318-4050  
**Confidential**

**Requesting Provider:**

«ProviderFirstName» «ProviderLastName»  
 «ProviderAddress»  
 «ProviderCity», «ProviderState» «ProviderZip»

**Faxed to:** «ProviderFax»

<b>Claimant Name:</b>	«ClaimantName»
Claim #:	«ClaimNumber»
DOI:	«DateOfInjury»
Employer:	«EmployerName»
Client:	«ClaimAdminName»
Referred by:	«ReviewerName»

### Peer Review Determination Report

**Peer Review Decision Date:** «DecisionDate»  
**Date RFA First Received:** «AcknowledgeDate»  
**Date Additional Information Requested (if applicable):** «RequestforAdditionalInfoDate»

InterMed has been requested by the claims adjuster to perform utilization review to evaluate and determine if the requested medical treatment services are medically necessary and appropriate for this claim in accordance to evidence based medicine. This determination regarding medical requests does not determine compensability on the part of the employer or their Third Party Administrator. This letter is to notify you of the utilization review determination regarding medical necessity only.

<b>Procedure / Service Requested:</b>	<b>Determination:</b>	<b>UR #:</b>
«TableStart:Treatment» • «FinalTreatmentDescription» «FinalCptCode» x «FinalUnits» units	«UrServiceDecision»	«CaseNumber»«TableEnd:Treatment»

Per CA Code of Regulations Section 9792.6.1(a), appropriate reimbursement will be made for the specific services listed as approved. Contact the claims adjuster for an explanation of coverage.

**Telephonic Communication:**

**Review of Records:**

**Clinical History:**

**Criteria / Guidelines Used:**

**Peer Reviewer’s Summary and Rationale:**

**Conflict of Interest Attestation:**

InterMed Cost Containment Services, Inc. | PO Box 21947, Eagan, MN 55121 | 1-800-318-4050 | F: 916-781-5595 | [www.intermedccs.com](http://www.intermedccs.com)

InterMed’s Utilization Review Plan has been revised for compliance with California DWC regulations effective April 1, 2026 (8 CCR §§9792.6 et seq.). Submitted per CA Form UR-01 (Effective 04/01/2026).

## InterMed Cost Containment Services, Inc.

California Workers' Compensation Utilization Review Plan | Revised: April 1, 2026

*I hereby attest, as the reviewer of this request, I have a scope of licensure that typically manages the medical condition, procedure, treatment or issue under review for this specific case. I have current, relevant experience and/or knowledge to render a determination for this case.*

Sincerely,

«ReviewPhysicianSignature»

«ReviewPhysicianName»

Hours of Availability: Monday through Friday 8:00 am-5:30 pm, Pacific Standard Time

Mailed to: Claim File: «ClaimNumber»

Injured Worker: «ClaimantName», «ClaimantAddress», «ClaimantCity», «ClaimantState» «ClaimantZip»

Applicant Attorney: «AttorneyName», «AttorneyAddress», «AttorneyCity», «AttorneyState» «AttorneyZip»

Defense Attorney: «DefAttorneyName», «DefAttorneyAddress», «DefAttorneyCity», «DefAttorneyState» «DefAttorneyZip»

Enc: Independent Medical Review, DWC Form IMR (effective 2/2014), Addressed Envelope

### **Peer Review Decision Valid for 12 Months**

Per 9792.9.5(g), 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 claims 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 facts material to the basis of the utilization review decision. At which point, the requesting provider may submit additional documents supporting the request.

### **Peer to Peer**

A peer-to-peer discussion can be arranged within one business day, or within a specified time and date agreed upon by the physician reviewer and the requesting physician. The requesting physician may contact InterMed at «UserPhone» or toll free 800-281-8186. All InterMed physician reviewers are available for a minimum of four hours per week during normal business days from 9:00 A.M. to 5:30 P.M. Pacific. If the physician reviewer is unavailable, a peer to peer discussion will be arranged with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services. A peer-to-peer discussion is not considered an appeal. As of January 01, 2013, all appeals must be submitted through the Independent Medical Review Process according to Labor Code section 4610.5 and 4610.6.

### **Additional Medical Guideline Information:**

InterMed follows the medical treatment guidelines set forth in the Medical Treatment Utilization Schedule (Section 9792.20 – Section 9792.23) in the utilization review process. This includes The American College of Occupational & Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM), and the Acupuncture Medical Treatment Guidelines. Requests for treatment will not be denied on the sole basis that the condition or injury is not addressed in the Medical Treatment Utilization Schedule. Authorization will be provided if such treatment is in accordance with other scientifically and evidence-based, peer-reviewed, medical treatment guidelines that are nationally recognized by the medical community, in accordance with subdivisions (b) and (c) of section 9792.22, and pursuant to the Utilization Review Standards found in Section 9792.6.1 through Section 9792.10. In addition to the Medical Treatment Utilization Schedule, InterMed utilization review decisions may also be based upon other scientifically and evidence-based medical treatment guidelines generally recognized by the national medical community. These may include but are not limited to: ODG, Milliman Care Guidelines, Blue Cross, Aetna, CIGNA, MEDLINE, National Guideline Clearinghouse, State of Colorado Medical Treatment Guidelines, etc.

### **Appeals Process:**

InterMed does not have an internal appeals process. You may apply for an Independent Medical Review through Maximus by completing the enclosed IMR form within 30 days of service of the written utilization review determination.

§9792.10.1. Utilization Review Standards - Dispute Resolution - On or After January 1, 2013.

A request for independent medical review must be filed by an eligible party by mail, facsimile, or electronic transmission with the Administrative Director, or the Administrative Director's designee, within 10 calendar days after the utilization review decision to the employee for formulary disputes, and 30 calendar days after the utilization review decision for all other medical treatment disputes issued by the claims administrator. The request must be made on the Application for Independent Medical Review, DWC Form IMR, and submitted with a copy of the written decision denying, or modifying the request for authorization of medical treatment. At the time of filing, the employee shall concurrently provide a copy of the signed DWC Form IMR, without a copy of the written decision denying, or modifying the request for authorization of medical treatment, to the claims administrator.

## **INJURED WORKER**

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call your claims administrator at the phone number below. However, if you are represented by an attorney, please contact your attorney instead of the claims adjuster.

InterMed Cost Containment Services, Inc. | PO Box 21947, Eagan, MN 55121 | 1-800-318-4050 | F: 916-781-5595 | [www.intermedccs.com](http://www.intermedccs.com)

*InterMed's Utilization Review Plan has been revised for compliance with California DWC regulations effective April 1, 2026 (8 CCR §§9792.6 et seq.). Submitted per CA Form UR-01 (Effective 04/01/2026).*

## InterMed Cost Containment Services, Inc.

California Workers' Compensation Utilization Review Plan | Revised: April 1, 2026

<b>Adjuster Name:</b>	«ExaminerName»
<b>Phone Number:</b>	«ExaminerPhone»

For information about the workers' compensation claims process and your rights and obligations, go to [www.dwc.ca.gov](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.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. 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 (effective 2/2014), within 30 calendar after the service of the utilization review decision to the employee. As of 1/1/2018, Sec 5, 4610.5 of the labor code was amended based on SB1160, to change the timeframe for submission to 10 calendar days for formulary disputes, whereas all others remain the same.

# Addendum I: Utilization Review Determination Letters – Peer Review Report with ADR Program – County of Santa Barbara



«UserAddress»  
«UserCity», «UserState» «UserZip»  
«UserPhone» fax «UserFax»  
Toll Free 800-318-4050  
**Confidential**

**Requesting Provider:**

«ProviderFirstName» «ProviderLastName»  
«ProviderAddress»  
«ProviderCity», «ProviderState» «ProviderZip»

**Faxed to:** «ProviderFax»

<b>Claimant Name:</b>	«ClaimantName»
Claim #:	«ClaimNumber»
DOI:	«DateOfInjury»
Employer:	«EmployerName»
Client:	«ClaimAdminName»
Referred by:	«ReviewerName»

## Peer Review Determination Report with Alternative Dispute Resolution (ADR) Program

**Peer Review Decision Date:** «DecisionDate»  
**Date RFA First Received:** «AcknowledgeDate»

InterMed has been requested by the claims adjuster to perform utilization review to evaluate and determine if the requested medical treatment services are medically necessary and appropriate for this claim in accordance to evidence based medicine. This determination regarding medical requests does not determine compensability on the part of the employer or their Third Party Administrator. This letter is to notify you of the utilization review determination regarding medical necessity only.

<b><u>Procedure / Service Requested:</u></b>	<b><u>Determination:</u></b>	<b><u>UR #:</u></b>
«TableStart:Treatment» • «FinalTreatmentDescription» «FinalCptCode» x «FinalUnits» units	«UrServiceDecisi on»	«CaseNumber»«TableE nd:Treatment»

*Per CA Code of Regulations Section 9792.6.1(a), appropriate reimbursement will be made for the specific services listed as approved. Contact the claims adjuster for an explanation of coverage.*

**Telephonic Communication:**

**Review of Records:**

**Clinical History:**

**Criteria / Guidelines Used:**

**Peer Reviewer's Summary and Rationale:**

**Conflict of Interest Attestation:**

*I hereby attest, as the reviewer of this request, I have a scope of licensure that typically manages the medical condition, procedure, treatment or issue under review for this specific case. I have current, relevant experience and/or knowledge to render a determination for this case.*

Sincerely,

«ReviewPhysicianName»

Hours of Availability: Monday through Friday 8:00 am-5:30 pm, Pacific Standard Time

Mailed to: Claim File: «ClaimNumber»

Injured Worker: «ClaimantName», «ClaimantAddress», «ClaimantCity», «ClaimantState» «ClaimantZip»

Applicant Attorney: «AttorneyName», «AttorneyAddress», «AttorneyCity», «AttorneyState» «AttorneyZip»

Defense Attorney: «DefAttorneyName», «DefAttorneyAddress», «DefAttorneyCity», «DefAttorneyState» «DefAttorneyZip»

**Peer to Peer**

A peer-to-peer discussion can be arranged within one business day, or within a specified time and date agreed upon by the physician reviewer and the requesting physician. The requesting physician may contact InterMed at «UserPhone» or toll free 800-281-8186. All InterMed physician reviewers are available for a minimum of four hours per week during normal business days from 9:00 A.M. to 5:30 P.M. Pacific. If the physician reviewer is unavailable, a peer to peer discussion will be arranged with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services. A peer-to-peer discussion is not considered an appeal. All appeals must be submitted through the Alternative Dispute Resolution (ADR) Program.

**Additional Medical Guideline Information:**

InterMed follows the medical treatment guidelines set forth in the Medical Treatment Utilization Schedule (Section 9792.20 – Section 9792.23) in the utilization review process. This includes The American College of Occupational & Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM), and the Acupuncture Medical Treatment Guidelines. Requests for treatment will not be denied on the sole basis that the condition or injury is not addressed in the Medical Treatment Utilization Schedule. Authorization will be provided if such treatment is in accordance with other scientifically and evidence-based, peer-reviewed, medical treatment guidelines that are nationally recognized by the medical community, in accordance with subdivisions (b) and (c) of section 9792.22, and pursuant to the Utilization Review Standards found in Section 9792.6.1 through Section 9792.10. In addition to the Medical Treatment Utilization Schedule, InterMed utilization review decisions may also be based upon other scientifically and evidence-based medical treatment guidelines generally recognized by the national medical community. These may include but are not limited to: ODG, Milliman Care Guidelines, Blue Cross, Aetna, CIGNA, MEDLINE, National Guideline Clearinghouse, State of Colorado Medical Treatment Guidelines, etc.

**Appeals Process:**

InterMed does not have an internal appeals process. InterMed will follow the City of Chula Vista Alternative Dispute Resolution (ADR) Program.

**This Claim is Enrolled in Santa Barbara County Alternative Dispute Resolution (ADR) Program**

If you disagree with the Utilization Review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute by following the instructions in Alternative Dispute Resolution (ADR) Program description provided below. Disputes will be resolved in accordance with the Santa Barbara County's Alternative Dispute Resolution program.

The Santa Barbara County and your union established an Alternative Dispute Resolution (ADR) program. The ADR program has elected not to utilize the Independent Medical Review (IMR) process. All utilization review disputes will be handled by the ADR program's Independent Medical Evaluator (IME) panel of providers. The exclusive list of IMEs shall serve as the exclusive source of medical evaluations for all disputed medical issues arising from a claimed injury.

Please contact your member advocate, **Mariotto Resolutions at (415) 932-6770**, if you have any questions or would like to appeal this utilization review determination.

# Addendum I: Utilization Review Determination Letters – Peer Review Report with ADR Program – City of Chula Vista



«UserAddress»  
«UserCity», «UserState» «UserZip»  
«UserPhone» fax «UserFax»  
Toll Free 800-318-4050  
**Confidential**

**Requesting Provider:**

«ProviderFirstName» «ProviderLastName»  
«ProviderAddress»  
«ProviderCity», «ProviderState» «ProviderZip»

**Faxed to:** «ProviderFax»

<b>Claimant Name:</b>	«ClaimantName»
Claim #:	«ClaimNumber»
DOI:	«DateOfInjury»
Employer:	«EmployerName»
Client:	«ClaimAdminName»
Referred by:	«ReviewerName»

## Peer Review Determination Report with Alternative Dispute Resolution (ADR) Program

**Peer Review Decision Date:** «DecisionDate»  
**Date RFA First Received:** «AcknowledgeDate»

InterMed has been requested by the claims adjuster to perform utilization review to evaluate and determine if the requested medical treatment services are medically necessary and appropriate for this claim in accordance to evidence based medicine. This determination regarding medical requests does not determine compensability on the part of the employer or their Third Party Administrator. This letter is to notify you of the utilization review determination regarding medical necessity only.

<b><u>Procedure / Service Requested:</u></b>	<b><u>Determination:</u></b>	<b><u>UR #:</u></b>
«TableStart:Treatment» • «FinalTreatmentDescription» «FinalCptCode» x «FinalUnits» units	«UrServiceDecisi on»	«CaseNumber»«TableE nd:Treatment»

*Per CA Code of Regulations Section 9792.6.1(a), appropriate reimbursement will be made for the specific services listed as approved. Contact the claims adjuster for an explanation of coverage.*

**Telephonic Communication:**

**Review of Records:**

**Clinical History:**

**Criteria / Guidelines Used:**

**Peer Reviewer's Summary and Rationale:**

**Conflict of Interest Attestation:**

*I hereby attest, as the reviewer of this request, I have a scope of licensure that typically manages the medical condition, procedure, treatment or issue under review for this specific case. I have current, relevant experience and/or knowledge to render a determination for this case.*

Sincerely,

«ReviewPhysicianName»

Hours of Availability: Monday through Friday 8:00 am-5:30 pm, Pacific Standard Time

Mailed to: Claim File: «ClaimNumber»

Injured Worker: «ClaimantName», «ClaimantAddress», «ClaimantCity», «ClaimantState» «ClaimantZip»

Applicant Attorney: «AttorneyName», «AttorneyAddress», «AttorneyCity», «AttorneyState» «AttorneyZip»

Defense Attorney: «DefAttorneyName», «DefAttorneyAddress», «DefAttorneyCity», «DefAttorneyState» «DefAttorneyZip»

**Peer to Peer**

A peer-to-peer discussion can be arranged within one business day, or within a specified time and date agreed upon by the physician reviewer and the requesting physician. The requesting physician may contact InterMed at «UserPhone» or toll free 800-281-8186. All InterMed physician reviewers are available for a minimum of four hours per week during normal business days from 9:00 A.M. to 5:30 P.M. Pacific. If the physician reviewer is unavailable, a peer to peer discussion will be arranged with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services. A peer-to-peer discussion is not considered an appeal. All appeals must be submitted through the Alternative Dispute Resolution (ADR) Program.

**Additional Medical Guideline Information:**

InterMed follows the medical treatment guidelines set forth in the Medical Treatment Utilization Schedule (Section 9792.20 – Section 9792.23) in the utilization review process. This includes The American College of Occupational & Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM), and the Acupuncture Medical Treatment Guidelines. Requests for treatment will not be denied on the sole basis that the condition or injury is not addressed in the Medical Treatment Utilization Schedule. Authorization will be provided if such treatment is in accordance with other scientifically and evidence-based, peer-reviewed, medical treatment guidelines that are nationally recognized by the medical community, in accordance with subdivisions (b) and (c) of section 9792.22, and pursuant to the Utilization Review Standards found in Section 9792.6.1 through Section 9792.10. In addition to the Medical Treatment Utilization Schedule, InterMed utilization review decisions may also be based upon other scientifically and evidence-based medical treatment guidelines generally recognized by the national medical community. These may include but are not limited to: ODG, Milliman Care Guidelines, Blue Cross, Aetna, CIGNA, MEDLINE, National Guideline Clearinghouse, State of Colorado Medical Treatment Guidelines, etc.

**Appeals Process:**

InterMed does not have an internal appeals process. InterMed will follow the City of Chula Vista Alternative Dispute Resolution (ADR) Program.

**This Claim is enrolled in the City of Chula Vista Alternative Dispute Resolution (ADR) Program**

If you disagree with the Utilization Review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute by following the instructions in Alternative Dispute Resolution (ADR) Program description provided below. Disputes will be resolved in accordance with the City of Chula Vista's Alternative Dispute Resolution program.

The City of Chula Vista and your union established an Alternative Dispute Resolution (ADR) program. The ADR program has elected not to utilize the Independent Medical Review (IMR) process. All utilization review disputes will be handled by the ADR program's Independent Medical Evaluator (IME) panel of providers. The exclusive list of IMEs shall serve as the exclusive source of medical evaluations for all disputed medical issues arising from a claimed injury.

Please contact your Claims Adjuster at «ClaimAdminPhoneNumber» or your attorney if you are represented, if you would like to appeal this utilization review determination or if you have any questions.

# Addendum I: Utilization Review Determination Letters– Peer Review Report with ADR Program – Chino Valley Fire District



«UserAddress»  
«UserCity», «UserState» «UserZip»  
«UserPhone» fax «UserFax»  
Toll Free 800-318-4050  
**Confidential**

**Requesting Provider:**

«ProviderFirstName» «ProviderLastName»  
«ProviderAddress»  
«ProviderCity», «ProviderState» «ProviderZip»

**Faxed to:** «ProviderFax»

<b>Claimant Name:</b>	«ClaimantName»
Claim #:	«ClaimNumber»
DOI:	«DateOfInjury»
Employer:	Chino Valley Fire District
Client:	«ClaimAdminName»
Referred by:	«ReviewerName»

## Peer Review Determination Report with Alternative Dispute Resolution (ADR) Program

**Peer Review Decision Date:** «DecisionDate»  
**Date RFA First Received:** «AcknowledgeDate»

InterMed has been requested by the claims adjuster to perform utilization review to evaluate and determine if the requested medical treatment services are medically necessary and appropriate for this claim in accordance to evidence based medicine. This determination regarding medical requests does not determine compensability on the part of the employer or their Third Party Administrator. This letter is to notify you of the utilization review determination regarding medical necessity only.

<b><u>Procedure / Service Requested:</u></b>	<b><u>Determination:</u></b>	<b><u>UR #:</u></b>
«TableStart:Treatment» • «FinalTreatmentDescription» «FinalCptCode» x «FinalUnits» units	«UrServiceDecisi on»	«CaseNumber»«TableE nd:Treatment»

*Per CA Code of Regulations Section 9792.6.1(a), appropriate reimbursement will be made for the specific services listed as approved. Contact the claims adjuster for an explanation of coverage.*

**Telephonic Communication:**

**Review of Records:**

**Clinical History:**

**Criteria / Guidelines Used:**

**Peer Reviewer’s Summary and Rationale:**

**Conflict of Interest Attestation:**

*I hereby attest, as the reviewer of this request, I have a scope of licensure that typically manages the medical condition, procedure, treatment or issue under review for this specific case. I have current, relevant experience and/or knowledge to render a determination for this case.*

Sincerely,

«ReviewPhysicianName»

Hours of Availability: Monday through Friday 8:00 am-5:30 pm, Pacific Standard Time

Mailed to: Claim File: «ClaimNumber»

Injured Worker: «ClaimantName», «ClaimantAddress», «ClaimantCity», «ClaimantState» «ClaimantZip»

Applicant Attorney: «AttorneyName», «AttorneyAddress», «AttorneyCity», «AttorneyState» «AttorneyZip»

Defense Attorney: «DefAttorneyName», «DefAttorneyAddress», «DefAttorneyCity», «DefAttorneyState» «DefAttorneyZip»

**Peer to Peer**

A peer-to-peer discussion can be arranged within one business day, or within a specified time and date agreed upon by the physician reviewer and the requesting physician. The requesting physician may contact InterMed at «UserPhone» or toll free 800-281-8186. All InterMed physician reviewers are available for a minimum of four hours per week during normal business days from 9:00 A.M. to 5:30 P.M. Pacific. If the physician reviewer is unavailable, a peer to peer discussion will be arranged with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services. A peer-to-peer discussion is not considered an appeal. All appeals must be submitted through the Alternative Dispute Resolution (ADR) Program.

**Additional Medical Guideline Information:**

InterMed follows the medical treatment guidelines set forth in the Medical Treatment Utilization Schedule (Section 9792.20 – Section 9792.23) in the utilization review process. This includes The American College of Occupational & Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM), and the Acupuncture Medical Treatment Guidelines. Requests for treatment will not be denied on the sole basis that the condition or injury is not addressed in the Medical Treatment Utilization Schedule. Authorization will be provided if such treatment is in accordance with other scientifically and evidence-based, peer-reviewed, medical treatment guidelines that are nationally recognized by the medical community, in accordance with subdivisions (b) and (c) of section 9792.22, and pursuant to the Utilization Review Standards found in Section 9792.6 through Section 9792.10. In addition to the Medical Treatment Utilization Schedule, InterMed utilization review decisions may also be based upon other scientifically and evidence-based medical treatment guidelines generally recognized by the national medical community. These may include but are not limited to: ODG, Milliman Care Guidelines, Blue Cross, Aetna, CIGNA, MEDLINE, National Guideline Clearinghouse, State of Colorado Medical Treatment Guidelines, etc.

**Appeals Process:**

InterMed does not have an internal appeals process. InterMed will follow the City of Chula Vista Alternative Dispute Resolution (ADR) Program.

**This Claim is Enrolled in the Chino Valley Fire District Alternative Dispute Resolution (ADR) Program**

If you disagree with the Utilization Review decision and wish to dispute it, the injured worker, the injured worker's representative, or the injured worker's attorney must communicate this dispute by following the instructions in Alternative Dispute Resolution (ADR) Program description provided below. Disputes will be resolved in accordance with the District of Chino Valley Fire District and Chino Valley Professional Fire Fighters, Local 3522 "Alternative Dispute Resolution program".

The District of Chio Valley Fire District and your union established an Alternative Dispute Resolution (ADR) program. The ADR program has elected not to utilize the Independent Medical Review (IMR) process. All utilization review disputes will be handled by the ADR program's Independent Medical Evaluator (IME) panel of providers. The exclusive list of IMEs shall serve as the exclusive source of medical evaluations for all disputed medical issues arising from a claimed injury.

Please contact your Claims Adjuster at «ClaimAdminPhoneNumber» or your attorney (if you are represented), if you wish like to appeal this utilization review determination or if you have any questions.

InterMed Cost Containment Services, Inc. | PO Box 21947, Eagan, MN 55121 | 1-800-318-4050 | F: 916-781-5595 | [www.intermedccs.com](http://www.intermedccs.com)

*InterMed's Utilization Review Plan has been revised for compliance with California DWC regulations effective April 1, 2026 (8 CCR §§9792.6 et seq.). Submitted per CA Form UR-01 (Effective 04/01/2026).*

## Addendum I: Utilization Review Determination Letters– Peer Review Report with ADR Program – County of Orange



P.O. Box 21947  
Eagan, MN 55121  
Fax: «ReviewerFax»  
Toll Free 800-318-4050  
**Confidential**

«ProviderFirstLastOrPracticeName»  
«ProviderAddress»  
«ProviderCity», «ProviderState» «ProviderZip»  
**Faxed to:** «ProviderOtherFax»

Claimant Name: «ClaimantName»  
Claim #: «ClaimNumber»  
DOI: «DateOfInjury»  
Employer: «EmployerName»  
Client: «ClaimAdminName»  
Referred By: «ReviewerName»

### Peer Review Determination Report with Alternative Dispute Resolution (ADR) Program

**Peer Review Decision Date:** «DecisionDate»  
Date of Receipt of RFA: «AcknowledgeDate»

InterMed has been requested by the claims adjuster to perform utilization review to evaluate and determine if the requested medical treatment services are medically necessary and appropriate for this claim in accordance to evidence based medicine. This determination regarding medical requests does not determine compensability on the part of the employer or their Third Party Administrator. This letter is to notify you of the utilization review determination regarding medical necessity only.

**Procedure / Service Requested:**

«TableStart:TreatmentRequested» • «FullTreatmentDescription» «UrServiceDecision» «CaseNumber»  
«TableEnd:TreatmentRequested»

Radiology, EMG, Physical Therapy, Occupational Therapy, Acupuncture, Chiropractic, DME and Home Health services must be scheduled, tracked and billed through PayersDirect only.  
Phone: (310) 954-9543, Fax: (310) 906-4942, [support@payersdirect.com](mailto:support@payersdirect.com),  
PO Box 491609, Los Angeles, CA 90049.

Per CA Code of Regulations Section 9792.6(b), appropriate reimbursement will be made for the specific services listed as approved. Contact the claims adjuster for an explanation of coverage.

**Telephonic Communication:**

**Review of Records:**

**Clinical History:**

**Criteria / Guidelines Used:**

**Peer Reviewer's Summary and Rationale:**

**Conflict of Interest Attestation:**

*I hereby attest, as the reviewer of this request, I have a scope of licensure that typically manages the medical condition, procedure, treatment or issue under review for this specific case. I have current, relevant experience and/or knowledge to render a determination for this case.*

Sincerely,

«ReviewPhysicianName»

Hours of Availability: Monday through Friday 8:00 am-5:30 pm, Pacific Standard Time

Mailed to: Claim File: «ClaimNumber»

Injured Worker: «ClaimantName», «ClaimantAddress», «ClaimantCity», «ClaimantState» «ClaimantZip»

Applicant Attorney: «AttorneyFullInfo»

Defense Attorney: «DefAttorneyFullInfo»

**Peer to Peer**

A peer-to-peer discussion can be arranged within one business day, or within a specified time and date agreed upon by the physician reviewer and the requesting physician. The requesting physician may contact InterMed at «UserPhone» or toll free 800-281-8186. All InterMed physician reviewers are available for a minimum of four hours per week during normal business days from 9:00 A.M. to 5:30 P.M. Pacific. If the physician reviewer is unavailable, a peer to peer discussion will be arranged with another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services. A peer-to-peer discussion is not considered an appeal. All appeals must be submitted through the Alternative Dispute Resolution (ADR) Program.

**Medical Guideline Information**

InterMed follows the medical treatment guidelines set forth in the Medical Treatment Utilization Schedule (Section 9792.20 – Section 9792.23) in the utilization review process. This includes The American College of Occupational & Environmental Medicine's Occupational Medicine Practice Guidelines (ACOEM), and the Acupuncture Medical Treatment Guidelines. Requests for treatment will not be denied on the sole basis that the condition or injury is not addressed in the Medical Treatment Utilization Schedule. Authorization will be provided if such treatment is in accordance with other scientifically and evidence-based, peer-reviewed, medical treatment guidelines that are nationally recognized by the medical community, in accordance with subdivisions (b) and (c) of section 9792.22, and pursuant to the Utilization Review Standards found in Section 9792.6 through Section 9792.10. In addition to the Medical Treatment Utilization Schedule, InterMed utilization review decisions may also be based upon other scientifically and evidence-based medical treatment guidelines generally recognized by the national medical community. These may include but are not limited to: ODG, Milliman Care Guidelines, Blue Cross, Aetna, CIGNA, MEDLINE, National Guideline Clearinghouse, State of Colorado Medical Treatment Guidelines, etc.

**Appeals Process**

InterMed does not have an internal appeals process. InterMed will follow the County of Orange Alternative Dispute Resolution (ADR) Program.

**This Claim is Enrolled in the County of Orange Alternative Dispute Resolution (ADR) Program**

As required under the Alternative Dispute Resolution (ADR) Agreement (Agreement) between the County of Orange and the <insert agency name> and Labor Code Section 3201.7 (a)(3)(C), Workers' Compensation medical disputes are to be resolved by the use of a limited list of Independent Medical Evaluators (IME) and that is the exclusive source for all Medical Legal reports involving ADR claims. Both parties shall be bound by the opinion(s) and recommendation(s) of the IME selected in accordance with the terms of the Agreement subject to any legal challenges brought by the parties. This ADR dispute resolution process replaces the California state-administered Independent Medical Review (IMR) processes under Labor Code Sections 4060, 4061, 4062, 4062.1, 406.2.

## InterMed Cost Containment Services, Inc.

California Workers' Compensation Utilization Review Plan | Revised: April 1, 2026

You have the right to disagree with decisions affecting your claim. If you have any questions about the information in this notice, please call your claims adjuster, «ExaminerName» at «ExaminerPhone». 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](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.

## Addendum I: Utilization Review Determination Letters – Request for Additional Information



«UserAddress»  
«UserCity», CA «UserZip»  
«UserPhone» fax «UserFax»  
Toll Free: 800-318-4050  
*Confidential*

«CurrentDate»

«ProviderFirstName» «ProviderLastName»  
«ProviderAddress»  
«ProviderCity», «ProviderState» «ProviderZip»  
**Faxed to:** «ProviderFax»

Claimant Name:        **«ClaimantName»**  
Claim #:                **«ClaimNumber»**  
DOI:                    **«DateOfInjury»**  
Employer:             **«EmployerName»**  
Client:                 **«ClaimAdminName»**

### Request for Additional Information

InterMed Cost Containment Services Inc. has been requested by the claims examiner to perform utilization review to determine if the requested health care services are medically necessary and appropriate. This letter is to inform you that without documentation to provide rationale for the service(s) requested below, medical necessity cannot be established. We request you address the necessary information needed regarding your request(s) for:

Date of Receipt of RFA: «AcknowledgeDate»
Extension Date: «Extended Date»

«TableStart:Treatment» • «TreatmentDescription» «CptCode» x «Units» units«TableEnd:Treatment»
--

Please forward recent medical information to support your request which might include:

**Please fax additional information to my attention at: fax «UserFax»**

9792.9.6(c)(1) If the information reasonably necessary to make a determination under subdivision (a) (1)(A) that is requested by the reviewer or non-physician reviewer is not received within fourteen (14) days from receipt of the completed or accepted request for authorization for prospective or concurrent review, or within thirty (30) days of the request for retrospective review, a physician reviewer shall deny the request in accordance with applicable rules in section 9792.9.5(e).

Sincerely,

## InterMed Cost Containment Services, Inc.

California Workers' Compensation Utilization Review Plan | Revised: April 1, 2026

«UserSignatureName»

«UserTitle»

Hours of Availability: Monday through Friday 8:00 am-5:30 pm, Pacific Standard Time

Mailed to: Claim File: «ClaimNumber»

Injured Worker: «ClaimantName», «ClaimantAddress», «ClaimantCity», «ClaimantState» «ClaimantZip»

Applicant Attorney: «AttorneyName», «AttorneyAddress», «AttorneyCity», «AttorneyState» «AttorneyZip»

Defense Attorney: «DefAttorneyName», «DefAttorneyAddress», «DefAttorneyCity», «DefAttorneyState» «DefAttorneyZip»

## Addendum I: Utilization Review Determination Letters – 12-Month Duplicate Notice



«UserAddress»  
«UserCity», «UserState» «UserZip»  
«UserPhone» fax «UserFax»  
Toll Free 800-318-4050

**Confidential**

«CurrentDate»  
«ProviderFirstName» «ProviderLastName»  
«ProviderAddress»  
«ProviderCity», «ProviderState» «ProviderZip»  
**Faxed to:** «ProviderFax»

Claimant Name: «ClaimantName»  
Claim #: «ClaimNumber»  
DOI: «DateOfInjury»  
Employer: «EmployerName»  
Client: «ClaimAdminName»

### Notice of 12-Month Duplicate of Utilization Review Request

**InterMed Cost Containment Services Inc. received your request for authorization dated: «RequestedDate»**

The request treatment included the following:

«TableStart:Treatment» • «TreatmentDescription» «CptCode» x «Units»  
units«TableEnd:Treatment»

This same request for treatment service(s) was reviewed by peer review and the issued adverse determination was dated:

<<insert initial peer review determination date>>

**Per §9792.9.5(g) & LC 4610(k)**

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.

Your request for the same treatment will not be addressed at this time. Information must be provided that documents a change in the facts material to the basis of the previous utilization review decision. Please let me know if you have any questions.

Sincerely,

«UserSignatureName»

«UserTitle»

Hours of Availability: Monday through Friday -F 89:00 am-5:30 pm, Pacific Standard Time

Mailed To: Claim Number: «ClaimNumber»

Claimant Name: «ClaimantName», «ClaimantAddress», «ClaimantCity», «ClaimantState» «ClaimantZip»

Applicant Attorney: «AttorneyName», «AttorneyAddress1» «AttorneyAddress2», «AttorneyCity»,

«AttorneyState» «AttorneyZip»

Defense Attorney: «DefAttorneyName», «DefAttorneyAddress1» «DefAttorneyAddress2», «DefAttorneyCity»,

«DefAttorneyState» «DefAttorneyZip»

InterMed Cost Containment Services, Inc. | PO Box 21947, Eagan, MN 55121 | 1-800-318-4050 | F: 916-781-5595 | [www.intermedccs.com](http://www.intermedccs.com)

*InterMed's Utilization Review Plan has been revised for compliance with California DWC regulations effective April 1, 2026 (8 CCR §9792.6 et seq.). Submitted per CA Form UR-01 (Effective 04/01/2026).*

## Addendum I: Utilization Review Determination Letters – Deferred UR Request



«UserAddress»  
«UserCity», CA «UserZip»  
«UserPhone» fax «UserFax»  
Toll Free: 800-318-4050  
**Confidential**

«CurrentDate»

«ProviderFirstName» «ProviderLastName»  
«ProviderAddress»  
«ProviderCity», «ProviderState» «ProviderZip»  
**Faxed to:** «ProviderFax»

Claimant Name: «ClaimantName»  
Claim #: «ClaimNumber»  
DOI: «DateOfInjury»  
Employer: «EmployerName»  
Client: «ClaimAdminName»

### Deferred Utilization Review Request

InterMed Cost Containment Services Inc. received your request for treatment on: «RequestedDate»

The treatment request received include the following:

«TableStart:Treatment» • «TreatmentDescription» «CptCode» x «Units» units «TableEnd:Treatment»

**This same request was reviewed by InterMed UR and approved on: <<insert initial UR auth date>>**

Pursuant to Labor Code section 4610(k) and California Code of Regulations, title 8, section 9792.9.2, utilization review is being deferred because the current request is considered a duplicate request for treatment previously reviewed and authorized, and no material change in the facts supporting medical necessity was identified within the request submitted.

Accordingly, no new utilization review determination will be issued for this request at this time.

Upon written request submitted by fax to InterMed at 916-781-5595, a copy of the prior utilization review determination may be provided.

Any dispute regarding this decision may be resolved by agreement of the parties or through the dispute resolution process of the Workers' Compensation Appeals Board.

You have a right to disagree with decisions affecting your claim. If you have questions about the information in this notice, please call («AdjusterName») at («AdjusterPhone»). However, if you are represented by an attorney, please contact your attorney instead of me.

## InterMed Cost Containment Services, Inc.

California Workers' Compensation Utilization Review Plan | Revised: April 1, 2026

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

Sincerely, \_\_

«UserSignatureName»

«UserTitle»

Hours of Availability: M-F 8:00am-5:30pm Pacific Time

Mailed to: Claim File: «ClaimNumber»

Injured Worker: «ClaimantName», «ClaimantAddress», «ClaimantCity», «ClaimantState» «ClaimantZip»

Applicant Attorney: «AttorneyName», «AttorneyAddress», «AttorneyCity», «AttorneyState» «AttorneyZip»

Defense Attorney: «DefAttorneyName», «DefAttorneyAddress», «DefAttorneyCity», «DefAttorneyState» «DefAttorneyZip»

## Addendum I: Utilization Review Determination Letters – Incomplete UR Request



«UserAddress»  
«UserCity», CA «UserZip»  
«UserPhone» fax «UserFax»  
Toll Free 800-318-4050  
**Confidential**

Decision Date: «DecisionDate»

«ProviderFirstName» «ProviderLastName»  
«ProviderAddress»  
«ProviderCity», «ProviderState» «ProviderZip»  
**Faxed to:** «ProviderFax»

Claimant Name: «ClaimantName»  
Claim #: «ClaimNumber»  
DOI: «DateOfInjury»  
Employer: «EmployerName»  
Client: «ClaimAdminName»

### Incomplete Utilization Review Request

InterMed Cost Containment Services Inc. received the following Request for Authorization (RFA):

Date Documents Received:	«AcknowledgeDate»
Procedure or Service Requested:	«TableStart:Treatment» • «TreatmentDescription» «CptCode» x «Units» units«TableEnd:Treatment»
Utilization Review Response:	<b>Request for Authorization Returned as Incomplete</b>
Reason(s) for the Return of the Request:	

The submitted request does not contain sufficient information required under California Code of Regulations, title 8, section 9792.9.1(c)(2)(A), to process the request for utilization review. Because the request was incomplete, no medical necessity determination was made and no utilization review decision has been issued at this time.

Pursuant to California Code of Regulations, title 8, section 9792.9.1(c)(2)(A), the request is being returned to the requesting physician for completion. Please fax the missing information and/or supporting documentation to InterMed at (916) 781-5595.

The timeframe for utilization review begins anew upon receipt of a completed DWC Form RFA.

Sincerely,

«UserSignatureName»  
«UserTitle»  
Hours of Availability: Monday through Friday 8:00 am-5:30 pm, Pacific Standard Time

Mailed to: Claim File: «ClaimNumber»  
Injured Worker: «ClaimantName», «ClaimantAddress», «ClaimantCity», «ClaimantState» «ClaimantZip»  
Applicant Attorney: «AttorneyName», «AttorneyAddress», «AttorneyCity», «AttorneyState» «AttorneyZip»  
Defense Attorney: «DefAttorneyName», «DefAttorneyAddress», «DefAttorneyCity», «DefAttorneyState» «DefAttorneyZip»

## Addendum I: Utilization Review Determination Letters – Vendor Notification of UR



«UserAddress»  
«UserCity», «UserState» «UserZip»  
«UserPhone» fax «UserFax»  
Toll Free 800-318-4050  
**Confidential**

### Vendor Notification of Utilization Review Determination

**Date:**     «CurrentDate» \_\_\_\_\_

**To:** \_\_\_\_\_

**Vendor Name:** \_\_\_\_\_

**Fax #:** \_\_\_\_\_

Claimant Name:     **«ClaimantName»**  
Claim #:            «ClaimNumber»  
DOI:                «DateOfInjury»  
Employer:          «EmployerName»  
Client:             «ClaimAdminName»

**Service Requested** \_\_\_\_\_

**Requested By:** \_\_\_\_\_

### Outcome of Utilization Review:

- APPROVED
- NOT APPROVED
- DELAYED PENDING: \_\_\_\_\_
- MODIFIED:  
Modification includes:

### **Additional Comments:**

**From:**     «UserSignatureName»  
              «UserTitle»  
              «UserPhone»    fax «UserFax»



## Addendum II: County of Orange Specific Pre-Authorization Plan



### COUNTY OF ORANGE (COO) PRIOR AUTHORIZATION PLAN

The following is the customized Utilization Review (UR) Plan for County of Orange (COO) as administered by Sedgwick Claims Management Services, Inc. COO's prior authorization plan shall be effective 7/1/2024 and shall not be modified or discontinued without written notice and consent from COO. Any approved modifications to COO's Prior Authorization Plan shall be updated in InterMed Cost Containment Services' California Utilization Management Plan filed with the State.

#### I. Prior Authorization Criteria for Claim's Adjuster, Pharmacy Benefit Manager (PBM), Nurse Case Manager and Designated Provider/Clinic.

The County of Orange (COO) has customized the pre-authorization plan to include the Claims Administrator/Adjuster, Pharmacy Benefit Management, Nurse Case Manager, and designated providers/clinics (see list of providers/clinics below). Each shall have authority to approve requested treatment based upon the criteria below and refer to COO's specified vendor partner.

Prior authorization must not exceed statutory limits (unless permitted under the Prior Authorization Plan), must be for an accepted claim and body part, and must not involve a disputed body part.

All other requested treatment not listed below, must be included on a Request for Authorization (RFA) and be submitted to the Utilization Review (UR) division for a determination on prospective and concurrent utilization reviews. All regulated and applicable timelines will be adhered to.

Only the Utilization Review Organization (URO) Physician Advisor can modify or deny requested treatment on an RFA.

Appropriate reimbursement will be paid to providers for treatment authorized under the Prior Authorization Criteria described below.

Treatment Modalities	Treatment Criteria and Duration		Approved Providers
<b>Procedures or Services Requested</b>	<b>Pre-Authorized Treatment</b>	<b>Pre-Authorized Treatment Post-Surgical</b>	<b>Provider Must Be in the Network Below</b>
Acupuncture	Initial 12 visits.	Initial 12 visits	Payer's Direct
Chiropractic	30 visits	30 visits	Payer's Direct

## InterMed Cost Containment Services, Inc.

California Workers' Compensation Utilization Review Plan | Revised: April 1, 2026

Diagnosics and Radiology	All X-rays. 1st MRI, 1st CT Scan . 1st EMG/NCS. Bone Scans. Annual stress tests and echocardiograms on accepted cardiac claims	1 Post-Surgical MRI/CT Scan/X-ray.	Payer's Direct
Laboratory Tests	Blood/lab work. Urine drug screen 3 times annually when opioids are being dispensed.	Blood/lab work. Urine drug screen 3 times annually when opioids are being dispensed.	Payer's Direct
Durable Medical Equipment (DME)	DME items <\$750.	DME items <\$750	Payer's Director
Consultations/Second Opinions	Initial Consultations/Second Opinions/Rule Out Evals	Post-Surgical/Routine Follow- ups	County of Orange MPN
Physical Therapy, Occupational Therapy, Aquatic Therapy ( <i>UR required beyond 30 total visits</i> )	30 visits	30 visits	Payer's Direct
Injections	Initial trigger point/Cortisone injections	Initial trigger point/Cortisone injections	County of Orange MPN

## II. Prior Authorization Criteria for Designated Medical Providers, Industrial/Occupational Clinics and Treatment Centers

COO has implemented a Prior Authorization program for specific providers and clinics within the County of Orange MPN. Treatment received by injured employees under the Prior Authorization Criteria in Section I above at any of the industrial/occupational clinics listed below is authorized without the need for an RFA.

GROUP	ADDRESS	CITY	STATE	ZIP
Brea Urgent Care, Inc	395 W Central Ave	Brea	CA	92821
CEP America AUC PC	22855 Lake Forest Dr Ste A	Lake Forest	CA	92630
Cheshire Medical Corp	17122 Beach Blvd Ste 104	Huntington Beach	CA	92647
Concentra Medical Center	3100 W. Warner Ave	Santa Ana	CA	92704
Concentra Medical Center	1101 S Anaheim Blvd.	Anaheim	CA	92805
Concentra Medical Center	640 S Placentia Ave	Placentia	CA	92870

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InterMed's Utilization Review Plan has been revised for compliance with California DWC regulations effective April 1, 2026 (8 CCR §§9792.6 et seq.). Submitted per CA Form UR-01 (Effective 04/01/2026).

**InterMed Cost Containment Services, Inc.**

California Workers' Compensation Utilization Review Plan | Revised: April 1, 2026

Concentra Medical Center	40 Centerpoint Dr	La Palma	CA	90623
Graph Surgery Inc	10212 Westminster Ave Ste 102	Garden Grove	CA	92843
Healthpointe Medical Group	1717 E Lincoln Ave	Anaheim	CA	92805
Healthpointe Medical Group	16750 Valley View Ave	La Mirada	CA	90638
MD Medical Clinics	1300 N Kraemer Blvd	Anaheim	CA	92806
Kaiser On - The - Job Occupational Health	3460 E. La Palma Avenue	Anaheim	CA	92806
Kaiser Permanente Anaheim Medical Center	3440 E La Palma Ave	Anaheim	CA	92806
Kaiser Permanente Anaheim Medical Center	6670 Alton Pkwy	Irvine	CA	92618
Kaiser Permanente Garden Grove	3460 E La Palma Ave	Anaheim	CA	92806
Kaiser Permanente Orange County	3401 S Harbor Blvd	Santa Ana	CA	92704
Kaiser Permanente Yorba Linda Medical Offices	3460 E La Palma Ave Bldg 1	Anaheim	CA	92806
Newport Urgent Care	1000 Bristol St N Ste 1B	Newport Beach	CA	92660
Newport Urgent Care	1000 Bristol St N Ste 1B	Newport Beach	CA	92660
Vital Urgent Care	2507 Eastbluff Dr	Newport Beach	CA	92659
Edinger Urgent Care	1530 E Edinger Ave Ste 1	Santa Ana	CA	92705
Concentra Urgent Care	1619 E Edinger Ave	Santa Ana	CA	92705
Akeso Occupational Health	17232 Red Hill Ave	Irvine	CA	92614
Concentra Urgent Care	1045 North Tustin Ave	Orange	CA	92867
Concentra Urgent Care	2362 Morse Avenue	Irvine	CA	92614
Anaheim Urgent Care	831 S State College Blvd	Anaheim	CA	92806
Anaheim Urgent Care	2100 S Euclid St	Anaheim	CA	92802
Gateway Urgent Care Center	1006 W La Palma Ave	Anaheim	CA	92801
Healthpointe	7052 Orangewood Ave Ste 6	Garden Grove	CA	92841
Concentra Urgent Care	15751 Rockfield Blvd	Irvine	CA	92614
Healthpointe	16702 Valley View Ave	La Mirada	CA	90638
Akeso Occupational Health	17232 Red Hill Ave	Irvine	CA	92614
MemorialCare Medical Group Urgent Care	17762 Beach Blvd Ste 100	Huntington Beach	CA	92647
Healthpointe	16702 Valley View Ave	La Mirada	CA	90638
Immediate Medical Center	15330 Valley View Ave #1	La Mirada	CA	90638
Restore Orthopedics and Spine Center	1120 W La Veta Ave #300	Orange	CA	92868

**III. Prior Authorization Protocols for Authorized Treating Providers (listed above)**

The Prior Authorization listing in Section I applies to Authorized Treating Providers for COO as listed in Section II. Non-medical network providers, health care organizations, or predesignated providers not listed will continue to require pre-authorization on all treatment requests.

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*InterMed's Utilization Review Plan has been revised for compliance with California DWC regulations effective April 1, 2026 (8 CCR §§9792.6 et seq.). Submitted per CA Form UR-01 (Effective 04/01/2026).*

The Prior Authorization items are items/procedures that do not require a DWC FORM RFA (request for authorization form). The provider will still be required to provide all regulatory and applicable required reports (DFR, PR2's, narrative reports, work status forms, etc.) outlining pertinent items, including patient's diagnosis, treatment plan, outcomes achieved from the treatment provided, updated work status information, etc.

The following protocols are to be adhered to by the Authorized Treating Providers, COO, and Claims Administrator:

1. ALL WORK STATUS – Fax to Sedgwick AND the County of Orange Workers' Compensation representative at (714) 285-5598. Give employee a copy of status.
2. Fax ALL: DFR, PR2/PR4/Progress Notes, Intake forms ONLY to Sedgwick at (714) 922-6239.
3. Claim Administrator to email job description for each injured worker.
4. Provide First Fill form to patient at initial visit if written prescription provided.
5. Doctor's First Report (DFR) must describe mechanism of injury and address work relatedness AOE/COE.

#### **IV. Pharmacy Requests**

COO's pharmacy program is managed by Optum. All medication requests must be sent directly to the pharmacy. Medications are not to be included on an RFA. If UR is required for any pharmacy related requests, Optum will send them directly to Sedgwick for a determination.

#### **COO Approved Top 10 pharmacies**

1. CVS
2. Walgreens
3. Health Way Pharmacy
4. Savon Pharmacy
5. Vons Pharmacy
6. Walmart Pharmacy
7. Rite-Aid Pharmacy
8. Costco Pharmacy
9. Sam's Club Pharmacy
10. Ralph's Pharmacy

For all medical (non-pharmacy related) requests NOT listed in Section I above please fax the RFA to InterMed at (714) 795-6864

### **Addendum III: Alternative Dispute Resolution Program Description & Participating Clients**

If a dispute arises from a utilization review determination issued by InterMed on behalf of our clients who have an approved Alternative Dispute Resolution Program (ADR), InterMed will follow the clients ADR program protocols.

InterMed clients who have an approved ADR program have elected not to utilize the Independent Medical Review (IMR) process. All utilization review disputes will be handled by the ADR program's Independent Medical Evaluator (IME) panel of providers. The exclusive list of IMEs shall serve as the exclusive source of medical evaluations for all disputed medical issues arising from a claimed injury.

#### **InterMed Participating Clients with ADR Programs**

County of Santa Barbara
City of Chula Vista
Chino Valley Fire District
County of Orange
Los Angeles World Airport (LAWA)

## **Addendum IV: Client List - InterMed Contracted to Perform Utilization Review**

ACWA JPIA (Conflict Claims)  
AXA XL - AGG 1 PIC (AARIS)  
AXA XL - Agricultura PIC (AARIS)  
AXA XL - B-East  
AXA XL - Empire Films, Inc. (Run-off Program)  
AXA XL - Ganahl Lumber Company  
AXA XL - Reiter Affiliated Companies  
Berkeley Unified School District  
CA Agricultural Network SIG (CANSIG)  
California Department of Social Services (CDSS)  
California Fair Services Authority (Conflict Claims)  
California Farm Mgmt SIG (CFMSIG)  
California Healthcare Industry Program (CHIP)  
California Livestock Producers (CLPSIG)  
California Risk Management Authority (CRMA)  
Capital Insurance Group (CIG)  
City of Chula Vista  
City of Los Alamitos  
City of Napa  
City of Peoria  
City of Redwood City  
City of San Jose  
City of San Leandro  
City of San Rafael  
City of Santa Monica  
City of Santa Monica- Big Blue Bus  
City of South Pasadena  
City of South San Francisco  
Clarendon  
CNA  
Contra Costa County (Conflict Claims)  
County of Monterey  
County of Orange  
County of Sacramento  
County of San Luis Obispo (CSLO)  
County of San Joaquin  
County of Sonoma  
Intercare Holdings Insurance  
Lynwood Unified School District  
Los Angeles World Airport (LAWA)  
Marin Schools Insurance Authority (MSIA)  
Merced County Schools Ins. Group (MCSIG)  
Monterey Educational Risk Management Authority (MERMA)

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Municipal Pooling Authority (Conflict Claims)  
Orange County Transportation Authority (OCTA)  
Paramount  
PRISM PWC: Sacramento County Contracts Rancho Cordova Police Department  
PRISM PWC: Evergreen Unified School District  
PRISM PWC: Humboldt County  
PRISM PWC: Humboldt Transit  
PRISM PWC: Kings Waste  
PRISM PWC: Nevada County  
PRISM PWC: San Luis Obispo Regional Transit Joint Powers Authority  
PRISM PWC: Santa Barbara County  
PRISM PWC: Town of Colma  
Redlands Community Hospital (RCH)  
Riverside Transit Agency  
Sacramento Regional Transit District (SRTD)  
Safety National - Antelope Valley Hospital  
Safety National - California Agricultural Network LPT  
Safety National – Focus Plumbing  
Safety National - Glidewell  
Safety National – Yoshinoya (Run-Off Programs)  
San Jose Unified School District  
San Mateo County Schools Insurance Group (SMCSIG)  
Santa Ana Unified School District  
Sirius America- Formerly Oakwood  
Small Cities Organized Risk Effort (SCORE)  
The Pebble Beach Company  
Westlake