California Independent Medical Review (IMR) Process: Legal Research Report on Maximus Federal Services Administration and Workers' Compensation Dispute Resolution

(PART-A INJURED WORKERS ANALYSIS)

February 26, 2026

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CALIFORNIA INDEPENDENT MEDICAL REVIEW (IMR) PROCESS: LEGAL FRAMEWORK, PROCEDURES, AND APPEALS FOR WORKERS' COMPENSATION MEDICAL TREATMENT DISPUTES

Date: February 27, 2026

Jurisdiction: California (Statewide, with emphasis on Northern California)

This report explains how the Independent Medical Review (IMR) process works in California's workers' compensation system. IMR is the process used to resolve disputes when your employer's insurance company denies or changes medical treatment your doctor has requested. The report covers the law behind the process, how to participate in it, and what to do if the IMR decision goes against you.

> ***Important: IMR decisions are very difficult to overturn. Approximately 9 out of 10 treatment denials by an employer's insurance are upheld by the IMR reviewer. You should understand this reality before deciding how to proceed.***

Part 1: What Is the IMR Process and Where Does It Come From?

Overview of the IMR System

California's Independent Medical Review (IMR) process is the required method for resolving disputes about whether medical treatment is "medically necessary" in workers' compensation cases. "Medically necessary" means the treatment is needed to cure or relieve the effects of your work injury.

The IMR process began on January 1, 2013, after the California Legislature passed Senate Bill 863 (SB 863) in 2012. Before SB 863, judges at the Workers' Compensation Appeals Board (WCAB) — the court system that handles workers' comp disputes — decided whether treatment was medically necessary. SB 863 moved that decision away from judges and gave it to independent doctors hired through a private company called Maximus Federal Services, Inc. (https://maximus.com/certifications).

The goal of this change was to have medical questions decided by medical professionals, not lawyers or judges. However, this also means you have limited ability to challenge an IMR decision in court.

Key Statutes That Create the IMR Process

The IMR process is created by two main sections of the California Labor Code — the set of laws governing work and employment in California:

- Cal. Lab. Code § 4610.5 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/) — This section defines "disputed medical treatment" as treatment your doctor requested that the insurance company denied or changed based on medical necessity. It requires that insurance company decisions follow the Medical Treatment Utilization Schedule (MTUS), which is a set of evidence-based medical guidelines the state has adopted.
- Cal. Lab. Code § 4610.6 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-6/) — This section creates the IMR process itself. It says that if your treatment is denied based on medical necessity, you may request an independent medical review. It also sets out the five narrow reasons you can use to appeal an IMR decision.
- Cal. Lab. Code § 139.5 (https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139-5/) — This section sets rules for who can serve as an IMR reviewer, including requirements for medical credentials and rules against conflicts of interest.
- Cal. Lab. Code § 5307.27 (https://www.dir.ca.gov/dwc/mtus/mtus.html) — This section authorizes the Administrative Director of the Division of Workers' Compensation (DWC) to adopt the MTUS guidelines that IMR reviewers use to evaluate treatment requests.

Key Regulations

The California Code of Regulations (CCR), Title 8, contains the detailed rules for how IMR works day to day:

- 8 Cal. Code Regs. §§ 9792.10.1–9792.10.10 (https://www.dir.ca.gov/t8/9792104.html) — These sections cover eligibility criteria, document submission deadlines, reviewer assignment, decision timelines, and cost allocation.
- 8 Cal. Code Regs. § 10575 (https://www.dir.ca.gov/t8/10575.html) — This section governs how to file a petition to appeal an IMR decision before the WCAB, including filing deadlines and required grounds.
- 8 Cal. Code Regs. § 9792.12(c)(6) (https://www.dir.ca.gov/t8/9792_12.html) — This section establishes penalties against insurance companies that fail to submit your medical records to Maximus on time. Penalties can be $500 per day up to $5,000.

Part 2: Key Court Decisions Shaping the IMR Process

Overview

Several California court decisions have interpreted how the IMR process works and what rights injured workers have. These decisions are binding, meaning all courts and the WCAB must follow them.

The IMR Process Is Constitutional

In Stevens v. WCAB (Outspoken Enterprises), 241 Cal. App. 4th 1074 (1st Dist. 2015) (https://law.justia.com/cases/california/court-of-appeal/2015/a143043n.html), an injured worker argued that the IMR process violated the California Constitution because it took away judicial review of medical treatment decisions. The First District Court of Appeal rejected this argument. The court held that the California Legislature has broad authority over the workers' compensation system under California Constitution Article XIV, § 4, and the IMR process provides enough opportunity for workers to present evidence and be heard.

> ***Critical: Stevens established that the WCAB cannot re-weigh medical evidence or make its own decision about whether treatment is medically necessary. The WCAB can only review IMR decisions on narrow procedural and factual-error grounds.***

Late IMR Decisions Are Still Valid

In State Compensation Insurance Fund v. WCAB (Margaris), 248 Cal. App. 4th 349 (2d Dist. 2016) (https://law.justia.com/cases/california/court-of-appeal/2016/b269038m.html), the WCAB had ruled that an IMR decision issued 13 days past the 30-day deadline was invalid. The Second District Court of Appeal reversed, holding that the 30-day deadline is directory (a guideline) rather than mandatory (a strict requirement). This means even a late IMR decision is still valid and binding.

> ***Important: You cannot avoid the IMR process by arguing that Maximus took too long to issue its decision.***

IMR Reviewer Identity Is Confidential

In Zuniga v. WCAB, 19 Cal. App. 5th 98 (1st Dist. 2018) (https://law.justia.com/cases/california/court-of-appeal/2018/a143290.html), an injured worker tried to learn the name of the IMR reviewer to challenge potential bias. The court upheld the confidentiality requirement in Cal. Lab. Code § 4610.6(f) (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-6/), ruling that IMR reviewers are neutral decision-makers and that keeping their identity confidential does not violate due process.

This decision makes it very difficult in practice to prove that an IMR reviewer was biased, even though bias is one of the five grounds for appeal.

Successful Appeal Based on Factual Error

In Bowen v. County of San Bernardino, 2016 Cal. Wrk. Comp. P.D. LEXIS 15 (https://sdworkcompattorney.com/2019/04/26/imr-appeals/), a WCAB panel reversed an IMR determination because the reviewer stated there was "no documentation" of failed conservative treatment — but the treating physician's records clearly showed conservative treatment had been tried and failed. The panel held this was a "plainly erroneous mistake of fact" that could be identified from the medical records without needing expert opinion.

> ***Note: Bowen is a WCAB panel decision, not a published appellate court decision, so it is not binding precedent. However, it provides a useful roadmap for the most viable type of IMR appeal.***

No "Ongoing Treatment" Exception

In Illinois Midwest Insurance Agency LLC v. WCAB (Rodriguez), 2d Dist. Ct. App. (Nov. 10, 2025) (https://www.sullivanattorneys.com/blog/2nd-district-court-of-appeal-rejects-patterson-exception-to-ur/imr), the court rejected the argument that treatment a worker has been receiving for years cannot be stopped through UR/IMR. The court held that any dispute over a utilization review (UR) decision — the insurance company's initial decision to deny or modify treatment — must go through IMR. The WCAB has no separate authority to overrule a UR decision, even for ongoing treatment.

Part 3: How the IMR Process Works — Starting a Request

Step 1: Your Doctor Submits a Request for Authorization

The process begins when your treating physician submits a Request for Authorization (RFA) to the insurance company (called the claims administrator). The RFA is a form (DWC Form RFA) asking the claims administrator to approve specific medical treatment for your work injury. The claims administrator has 5 working days to issue a utilization review (UR) decision — either approving, modifying, or denying the treatment.

Step 2: The UR Decision

A UR decision is made by a doctor hired by the claims administrator. If the UR doctor denies or modifies your treatment based on medical necessity, the claims administrator must notify you, your treating doctor, and your attorney (if you have one). The notice must explain why the treatment was denied or changed and must inform you of your right to request IMR.

The UR doctor must base the decision on the Medical Treatment Utilization Schedule (MTUS) (https://www.dir.ca.gov/dwc/mtus/mtus.html), which incorporates guidelines from the American College of Occupational and Environmental Medicine (ACOEM). These guidelines are considered presumptively correct — meaning they are assumed to be right unless strong medical evidence shows otherwise.

Step 3: Filing the IMR Application

If UR denies or modifies your treatment, you must submit an IMR application to Maximus within 30 days of receiving the UR decision. You use the DWC Form IMR (https://www.dir.ca.gov/dwc/dwcpropregs/IMR/IMRFormApplication.pdf). Your application must include:

- Your name, address, and contact information
- The date of your work injury
- Your treating physician's name and specialty
- A description of the disputed treatment
- A copy of the UR decision that denied or modified treatment
- Your signature and consent to release medical records

Mail or fax the completed application to:

DWC-IMR, c/o Maximus Federal Services, Inc., PO Box 138009, Sacramento, CA 95813-8009

You must also send a copy to the claims administrator.

> ***Critical: If you miss the 30-day deadline, your application will be rejected. This deadline cannot be extended, even if the claims administrator failed to notify you properly.***

Step 4: Eligibility Screening

The DWC reviews your application to determine if it is eligible for IMR. The DWC checks whether your form is timely, complete, and signed; whether a prior IMR has already been requested for the same treatment; and whether there is a separate dispute about whether your injury is covered at all (a liability dispute). If your application is eligible, the DWC forwards it to Maximus for review.

Part 4: How the IMR Process Works — Review and Decision

The Notice of Assignment (NOARFI)

After the DWC determines your application is eligible, Maximus sends a Notice of Assignment and Request for Information (NOARFI) to all parties. The NOARFI tells you whether your case will receive a regular review or an expedited review (used only when your doctor certifies you face a serious and immediate health threat).

For a regular review, the claims administrator must send all required medical records to Maximus within 15 calendar days (or 12 days if notified electronically). You and your treating physician also have this time to submit additional supporting documents. For an expedited review, the deadline is only 24 hours.

What Documents Go to the IMR Reviewer?

The claims administrator must provide:

- All treating physician reports from the past six months
- The complete UR decision
- All medical records and reports identified in the RFA or UR decision
- Any materials the UR doctor used in making the denial

You or your doctor may submit additional documents supporting the medical necessity of the treatment, including a letter from your treating physician explaining why the treatment is needed.

> ***Important: The six-month lookback period means older records may not be available to the IMR reviewer. If important treatment history falls outside this window, ask your treating physician to summarize it in a current letter.***

How the IMR Reviewer Decides

The IMR reviewer is an independent physician who holds an M.D. or D.O. degree with board certification in an area related to your condition. Under Cal. Lab. Code § 139.5 (https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139-5/), the reviewer must have no conflicts of interest — no financial, professional, or family connections to the insurance company, your employer, or your treating doctor.

The reviewer conducts a documents-only review. There is no physical examination of you, no phone call, and no hearing. The reviewer applies the MTUS guidelines. If the MTUS does not address the specific treatment, the reviewer uses other nationally recognized, evidence-based medical guidelines.

Decision Timeline and the IMR Determination Letter

For regular reviews, Maximus must issue a decision within 30 days of receiving the application and all documents. For expedited reviews where treatment has not yet been provided, the deadline is 3 days. The IMR determination letter must:

- Be written in clear language
- Identify what treatment was requested and what the UR decision was
- Explain the reasons for the IMR decision
- Reference the specific medical guidelines used
- Describe the reviewer's qualifications (but not the reviewer's name)

Maximus sends the decision to you, your doctor, the claims administrator, and the Administrative Director.

Part 5: IMR Decision Patterns and Recent Developments

2024 IMR Data: What the Numbers Show

Understanding IMR statistics helps you set realistic expectations. According to the 2025 IMR Annual Report (analyzing 2024 data) (https://www.dir.ca.gov/dwc/IMR/reports/IMR-Annual-Report.pdf):

- Maximus received 199,651 IMR applications in 2024, a 14% increase from 2023
- After removing duplicates and ineligible applications, 148,106 eligible cases were processed
- The overall overturn rate — the percentage of UR denials reversed by IMR — was 12.7%
- This means roughly 87 out of 100 UR denials were upheld by IMR

Overturn rates vary by treatment type. Based on CWCI data and the 2025 IMR Report (https://www.cwci.org/press_release.html?id=1067):

Treatment Type	Approximate Overturn Rate
Evaluation and Management Services	23.1%
Functional Restoration Programs	22.2%
Behavioral/Mental Health Services	20.1%
Opioid Medications	18.6%
Analgesic Medications	17.4%
Physical Therapy	15–18% (estimated)
Injections	12–15% (estimated)
DME, Prosthetics, Orthotics	9.7%
Acupuncture	~7%

Recent Guideline Updates

The MTUS guidelines that IMR reviewers apply are updated periodically:

- A Traumatic Brain Injury guideline was added effective January 2, 2026 (https://www.dir.ca.gov/dwc/dwcpropregs/2025/MTUS-Evidence-Based-Update-August/Traumatic-Brain-Injury-Guideline.pdf)
- The Chronic Pain guideline was updated effective June 1, 2025 (https://www.dir.ca.gov/dwc/mtus/mtus.html)
- The Opioid Guidelines were updated effective March 27, 2024 (https://www.dir.ca.gov/dwc/mtus/mtus.html)

These updates matter because IMR reviewers apply the current version of the guidelines when evaluating your treatment request.

Enforcement Against Late Record Submission

The DWC actively penalizes claims administrators who fail to provide medical records to Maximus on time. Under 8 Cal. Code Regs. § 9792.12(c)(6) (https://www.dir.ca.gov/t8/9792_12.html), penalties can reach $500 per day up to $5,000 per violation. The DWC has sought approximately $8.25 million in total penalties (https://www.dir.ca.gov/dwc/imr.htm) against insurers for late submissions. If the claims administrator failed to send your records on time, this may support an argument that the IMR process was procedurally defective.

Part 6: Preparing Strong Medical Documentation for IMR

Why Documentation Matters

Because the IMR reviewer only sees documents — no examination, no hearing — the quality of your medical records is the single most important factor in whether IMR overturns a UR denial. Your treating physician's records must clearly explain why the treatment is medically necessary.

Key Documentation Elements

Your treating physician's records should address these areas:

- Specific diagnosis with clinical findings (imaging results, physical exam findings, test results)
- Prior treatment attempts and results — what treatments have already been tried and why they were not enough
- Functional limitations — how the injury limits your daily life and ability to work (for example, "unable to lift more than 10 pounds" or "cannot sit for more than 30 minutes")
- Alignment with MTUS guidelines — how the requested treatment matches what the MTUS (https://www.dir.ca.gov/dwc/mtus/mtus.html) recommends for your condition
- Expected outcome — what functional improvement is expected from the treatment

Documentation for Specific Treatment Types

Physical therapy: Document the specific condition being treated, the goals of therapy, objective functional limitations, and why prior therapy was not sufficient.

Injections (epidural, joint): Document imaging-confirmed pathology (such as a herniated disc), failed conservative treatment, objective neurological findings, and that the injection will be performed under imaging guidance by a qualified specialist.

Surgery: Document the specific surgically-correctable problem confirmed by imaging, that conservative treatment per MTUS guidelines has been tried and failed, and that a qualified surgeon will perform the procedure.

Medications: Document that the medication is appropriate per the MTUS Drug Formulary (https://www.dir.ca.gov/dwc/mtus/mtus.html), the dose is reasonable, prior medications were tried, and (for opioids) that screening and monitoring protocols are in place.

The Treating Physician Letter

One of the most effective documents you can submit is a detailed letter from your treating physician specifically written for the IMR reviewer. This letter should:

- Address the specific reasons the UR doctor gave for denying treatment
- Reference your clinical findings by date and document
- Explain how the requested treatment aligns with MTUS or other evidence-based guidelines
- Describe what functional improvement the treatment is expected to produce

> ***Important: Generic or brief RFAs are a common reason for IMR denials. A detailed, specific treating physician letter significantly improves your chances.***

Part 7: Arguments For and Against Treatment Authorization

Arguments Supporting Your Treatment Request

The strongest arguments for getting treatment authorized during IMR include:

- The treatment matches MTUS guidelines. If the MTUS specifically recommends the treatment for your diagnosis and situation, this creates a presumption that the treatment is medically necessary. The burden shifts to the UR/IMR reviewer to explain why it is not appropriate for you specifically.
- You have objective clinical evidence. Records showing measurable physical findings — limited range of motion, positive imaging results, strength deficits — that support the need for treatment are more persuasive than subjective pain complaints alone.
- Conservative treatment has failed. For more invasive treatments like injections or surgery, clear documentation that you tried less invasive options first (such as physical therapy and medication) and they did not work is often required. The Bowen case succeeded partly because the records clearly showed failed conservative treatment.
- Focus on function, not just pain. Modern IMR review emphasizes functional outcomes — your ability to work, perform daily activities, and meet specific physical demands. Frame your treatment request in terms of restoring function, not just reducing pain.

Arguments Used to Deny Treatment

Claims administrators and UR doctors commonly argue:

- The treatment does not match MTUS guidelines for your diagnosis or clinical presentation
- The medical records do not provide enough detail to justify the treatment
- You have reached a functional plateau — the same treatment has been provided before without documented improvement
- Less invasive alternatives exist that have not been tried yet

Realistic Expectations

Based on 2024 data, your overall probability of IMR overturning a UR denial is about 12.7%. Your odds are somewhat better for evaluation and management services (23.1%) or mental health treatment (20.1%), and lower for acupuncture (~7%) or durable medical equipment (9.7%). These statistics should inform your decisions about whether to pursue IMR and how much to invest in the process.

Part 8: Appealing an IMR Decision to the WCAB

Overview of the Appeal Process

If the IMR decision goes against you, you have the right to appeal to the Workers' Compensation Appeals Board (WCAB). However, this is not a new trial or a fresh review of your medical evidence. The WCAB can overturn an IMR decision only if you prove, by clear and convincing evidence — a very high standard of proof — that one of five specific problems exists.

The Five Grounds for Appeal

Under Cal. Lab. Code § 4610.6(h) (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-6/), you may appeal an IMR decision only on these grounds:

1. The Administrative Director acted without or beyond authority — Rarely successful because the IMR decision is legally treated as the AD's own determination.
2. The decision was obtained through fraud — Requires proving the reviewer deliberately lied or concealed information. Very difficult without knowing the reviewer's identity.
3. The reviewer had a material conflict of interest violating Cal. Lab. Code § 139.5 (https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139-5/) — Requires proving a financial, professional, or family connection between the reviewer and a party. Extremely difficult because the reviewer's identity is confidential under Zuniga.
4. The decision resulted from bias based on race, national origin, religion, age, sex, sexual orientation, color, or disability — Nearly impossible to prove without knowing the reviewer's identity.
5. The decision contained a plainly erroneous mistake of fact that is obvious from the submitted records and does not require expert medical opinion to identify — This is the most viable ground for appeal, as demonstrated in Bowen.

How to File an Appeal

Your appeal must comply with 8 Cal. Code Regs. § 10575 (https://www.dir.ca.gov/t8/10575.html):

1. File a Petition Appealing Administrative Director's Independent Medical Review Determination within 30 days of receiving the IMR decision (35 days if served by mail)
2. Caption the petition with both the ADJ case number and the IMR case number
3. Include all factual and legal grounds for your appeal — you cannot raise new grounds later
4. Serve the petition on the IMR Unit within the DWC, with proof of service filed with the WCAB
5. File a Declaration of Readiness to Proceed (DOR) to get the case placed on the WCAB calendar for a hearing

> ***Critical: If you miss the 30-day (or 35-day) deadline, you permanently lose the right to appeal. The IMR decision becomes final.***

Building a Successful "Plainly Erroneous Fact" Appeal

Based on the Bowen decision, a successful appeal on factual-error grounds requires you to:

- Identify a specific factual misstatement in the IMR decision that is contradicted by the submitted medical records
- Show the error is obvious — anyone reading the records can see it without medical expertise
- Show the error mattered — it likely affected the outcome of the IMR decision

For example, if the IMR decision says "no documentation of prior physical therapy" but your records clearly show six weeks of physical therapy with progress notes, that is a plainly erroneous factual error identifiable from the record itself.

Strategic Decision: Should You Appeal?

Given the low probability of success, carefully consider whether an appeal is worthwhile. Factors to weigh:

- Is there a clear, obvious factual error in the determination?
- How urgent is the treatment? Will a 60–90 day appeal delay harm you?
- Would alternative strategies — private payment, a different treatment, or waiting for changed circumstances — be more practical?

Part 9: Alternative Strategies When IMR Denies Treatment

Overview

Because IMR decisions are very difficult to overturn, you should understand your other options if treatment is denied.

Wait and Resubmit After Changed Circumstances

If IMR denies your treatment, you generally cannot request the same treatment again for one year. However, if your condition materially changes during that year — your injury worsens, conservative treatment fails, or new clinical findings emerge — your doctor can submit a new RFA documenting the changed circumstances. Keep attending medical appointments and documenting any changes.

Request a Different Treatment

Your doctor can request a different treatment for the same condition. For example, if IMR denies an epidural injection, your doctor might request a different pain medication, a different type of physical therapy, or a diagnostic study. The new treatment request has not been through IMR and may be authorized.

Private Payment or Health Insurance

You may choose to pay for the denied treatment yourself or use private health insurance. This can be important for time-sensitive treatments like surgery. However, you bear the cost, and reimbursement from workers' compensation is not guaranteed.

Lien-Based Treatment

Some medical providers will treat you on a lien basis, meaning they provide treatment now and seek payment later if your workers' compensation case resolves favorably. This is common in California workers' compensation practice but carries risk — if the case does not resolve in your favor, the provider may seek payment from you directly.

Settlement of the Workers' Compensation Case

In some situations, settling the entire workers' compensation case may be preferable to continued disputes over individual treatment requests. A settlement can provide a lump sum that you use to obtain treatment on your own. Discuss this option with your attorney.

Part 10: Northern California and San Francisco Procedures

San Francisco WCAB Filing

If your work injury occurred in San Francisco Bay Area counties (San Francisco, Alameda, Contra Costa, Marin, San Mateo), your IMR appeal is filed with the San Francisco WCAB office:

San Francisco Workers' Compensation Appeals Board

630 Sansome Street, 4th Floor, Room 475

San Francisco, CA 94111

You may also file electronically through the EAMS (Electronic Adjudication Management System). Electronic filing is preferred because it creates a timestamped record of your filing. A satellite hearing location serves Contra Costa County at 1855 Gateway Blvd., Suite 850, Concord, CA 94520.

Timing and Hearing Procedures

After filing your appeal petition and DOR, expect the WCAB to schedule a conference within 30–60 days. The first conference typically focuses on settlement discussions. If the case is not resolved, the WCAB may schedule an expedited hearing for substantive argument.

Under 8 Cal. Code Regs. § 10575(h)(2) (https://www.dir.ca.gov/t8/10575.html), if the claims administrator is separately disputing whether your injury is covered (a liability dispute), the WCAB will defer your IMR appeal until the liability dispute is resolved.

Common Disputes in Northern California

Northern California has a high volume of workers' compensation cases in manufacturing, construction, and healthcare. Common IMR disputes involve durable medical equipment, orthopedic procedures, and pain management medications. If your case involves pain medication, be familiar with the MTUS Opioid Guidelines (https://www.dir.ca.gov/dwc/mtus/mtus.html), which impose specific requirements for opioid authorization including functional restoration attempts and monitoring protocols.

Part 11: Risk Warnings and Important Considerations

Limitations You Should Understand

- The burden of proof is very high. "Clear and convincing evidence" is one of the hardest standards to meet in civil cases. Most IMR appeals fail.
- Appeal grounds are extremely narrow. Four of the five grounds (fraud, conflict of interest, bias, and exceeding authority) are nearly impossible to prove, especially because the reviewer's identity is confidential.
- IMR decisions are final. If your WCAB appeal fails, there is no further court review available.
- The one-year bar is strict. If IMR upholds a denial, the same treatment cannot be requested again for one year without documented changed circumstances.

Deadlines You Cannot Miss

- 30 days to file your IMR application after receiving the UR denial
- 15 calendar days (regular review) or 24 hours (expedited review) to submit documents to Maximus after the NOARFI
- 30 days (35 days if served by mail) to file an appeal petition with the WCAB after receiving the IMR decision

> ***Critical: Missing any of these deadlines results in permanent loss of the related right. There are no extensions.***

When You Need Expert Advice

Certain issues require consultation with professionals beyond the scope of this report:

- Medical questions — Whether a specific treatment is right for your condition requires consultation with your treating physician
- Tax implications — If you pay for treatment yourself and later seek reimbursement, consult a tax professional
- Health insurance coordination — If you have private health insurance and workers' compensation coverage, consult a benefits advisor about coordination

Ethical Obligations of Your Attorney

If you have an attorney, they must give you an honest assessment of your chances of success on an IMR appeal. Under California Rules of Professional Conduct Rule 1.1 (https://www.calbar.ca.gov/), your attorney must be competent in workers' compensation IMR law. Under Rule 1.4, they must keep you informed and explain your options clearly so you can make informed decisions.

References

1. Cal. Lab. Code § 4610.5 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/) — Utilization review standards and IMR procedures for medical treatment disputes.
2. Cal. Lab. Code § 4610.6 (https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-6/) — Independent medical review determination procedures, appeal grounds, and WCAB review standards.
3. Cal. Lab. Code § 139.5 (https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139-5/) — Qualification requirements and conflict-of-interest restrictions for IMR organizations and reviewers.

4. Cal. Lab. Code § 5307.27 (https://www.dir.ca.gov/dwc/mtus/mtus.html) — Authority for the Administrative Director to adopt the Medical Treatment Utilization Schedule (MTUS).

5. 8 Cal. Code Regs. §§ 9792.10.1–9792.10.10 (https://www.dir.ca.gov/t8/9792104.html) — IMR program general provisions, eligibility, assignment, document submission, reviewer selection, and decision requirements.

6. 8 Cal. Code Regs. § 10575 (https://www.dir.ca.gov/t8/10575.html) — Petition appealing Independent Medical Review determination; filing requirements, grounds, and WCAB procedures.

7. 8 Cal. Code Regs. § 9792.12(c)(6) (https://www.dir.ca.gov/t8/9792_12.html) — Administrative penalties for failure to timely submit records to Maximus.

8. 8 Cal. Code Regs. § 10615 (https://www.dir.ca.gov/t8/10615.html) — Filing of documents with the WCAB.

9. 8 Cal. Code Regs. § 10632 (https://www.dir.ca.gov/t8/10632.html) — Service of documents.

10. Stevens v. WCAB (Outspoken Enterprises), 241 Cal. App. 4th 1074 (1st Dist. 2015) (https://law.justia.com/cases/california/court-of-appeal/2015/a143043n.html) — Upheld constitutionality of IMR statute; WCAB may not re-weigh medical evidence on IMR appeal.

11. State Compensation Insurance Fund v. WCAB (Margaris), 248 Cal. App. 4th 349 (2d Dist. 2016) (https://law.justia.com/cases/california/court-of-appeal/2016/b269038m.html) — The 30-day IMR deadline is directory, not mandatory; untimely IMR determinations remain valid.

12. Zuniga v. WCAB, 19 Cal. App. 5th 98 (1st Dist. 2018) (https://law.justia.com/cases/california/court-of-appeal/2018/a143290.html) — IMR reviewer confidentiality is constitutionally permissible; no right to identify or depose the reviewer.

13. Bowen v. County of San Bernardino, 2016 Cal. Wrk. Comp. P.D. LEXIS 15 (WCAB panel decision) (https://sdworkcompattorney.com/2019/04/26/imr-appeals/) — Successful reversal of IMR based on plainly erroneous factual error apparent from the record.

14. Illinois Midwest Insurance Agency LLC v. WCAB (Rodriguez), 2d Dist. Ct. App. (Nov. 10, 2025) (https://www.sullivanattorneys.com/blog/2nd-district-court-of-appeal-rejects-patterson-exception-to-ur/imr) — Rejected "ongoing treatment" exception; IMR is the exclusive mechanism for all UR disputes.

15. DWC Independent Medical Review (IMR) Program — Official Home Page (https://www.dir.ca.gov/dwc/imr.htm) — California Department of Industrial Relations.

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California Independent Medical Review (IMR) Process: Legal Research Report on Maximus Federal Services Administration and Workers' Compensation Dispute Resolution

(PART-B LEGAL ANALYSIS)

Generated by: Legal AI Assistant

Facilitated by: The Law Offices of Fernando Hidalgo, Inc.

February 26, 2026

California Independent Medical Review (IMR) Process: Comprehensive Legal Research Report on Maximus Federal Services Administration and Workers' Compensation Dispute Resolution

COVER PAGE

Title: California Independent Medical Review (IMR) Process: Legal Framework, Procedural Requirements, Strategic Considerations, and Appeals Practice for Workers' Compensation Medical Treatment Disputes

Generated by: Legal AI Assistant Facilitated by: The Law Offices of Fernando Hidalgo, Inc. Date: February 27, 2026 Jurisdiction: California (Statewide, with emphasis on Northern California administrative practices)

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I. EXECUTIVE SUMMARY

California's Independent Medical Review (IMR) process represents a fundamental shift in how medical treatment disputes are resolved within the workers' compensation system, removing medical necessity determinations from judicial consideration and placing them entirely within the domain of independent medical professionals contracted through Maximus Federal Services, Inc.[1] Since implementation on January 1, 2013, following Senate Bill 863, the IMR process has become the exclusive, non-appealable mechanism for resolving disputes when an employer's utilization review (UR) decision denies, delays, or modifies a treating physician's request for medical treatment based on medical necessity.[2][3] The current legal landscape reflects a system substantially protective of IMR finality, with the Workers' Compensation Appeals Board (WCAB) confined to reviewing IMR determinations only on five narrowly defined statutory grounds requiring clear and convincing evidence, and with no authority to override an IMR determination on the substantive issue of medical necessity itself.[4][5]

This report provides comprehensive analysis of the IMR process, including statutory foundations, regulatory requirements, procedural timelines, substantive medical necessity standards, appeal mechanisms, and strategic considerations for practitioners representing injured workers, claims administrators, or treating physicians. The research reflects current law as of February 2026, incorporates recent administrative data on IMR decision patterns, and addresses Northern California-specific procedural practices before the San Francisco Workers' Compensation Appeals Board. The report addresses key findings that IMR determinations are issued within statutory timeframes in the vast majority of cases, with Maximus maintaining an uphold rate on UR denials of approximately 87-88% (meaning IMR agrees with UR denial approximately 9 out of 10 times), and that successful appellate challenge to IMR determinations remains exceptionally rare and limited to demonstrable factual errors or procedural defects.[6][7]

For practitioners, the critical takeaway is that the IMR process is designed to achieve finality on medical treatment disputes and functions as a hard ceiling on injured workers' rights to judicial review of medical necessity determinations. Strategic considerations must therefore focus on either (1) maximizing the presentation of evidence during the initial IMR process itself, or (2) identifying one of the five narrow grounds for WCAB appeal, with successful appellate challenge to factual errors representing the most viable pathway (though still statistically uncommon). Risk assessment must account for the reality that denial of requested treatment through IMR generally stands for one year absent demonstration of changed circumstances, potentially subjecting injured workers and medical providers to extended uncertainty regarding treatment authorization.[6]

II. LEGAL FRAMEWORK AND STATUTORY AUTHORITY

A. Statutory Foundation: Senate Bill 863 and Labor Code SectionSection 4610.5 and 4610.6

The IMR process derives its authority from [California Labor Code Section 4610.5][https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/], which establishes utilization review standards and procedures, and [California Labor Code Section 4610.6][https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139-5/], which creates the independent medical review mechanism itself.[8][9] These provisions were enacted as part of Senate Bill 863, signed into law on September 18, 2012, and effective January 1, 2013.[10] The legislative purpose behind Senate Bill 863, according to contemporaneous legislative materials, was to streamline workers' compensation dispute resolution, reduce frictional costs, expedite medical treatment delivery, and ensure that medical necessity determinations were made by independent physicians rather than administrative law judges or courts.[11][6]

Labor Code Section 4610.5 defines "disputed medical treatment" as medical treatment that has been modified or denied by a utilization review decision on the basis of medical necessity.[12] The statute requires that utilization review decisions be based on the Medical Treatment Utilization Schedule (MTUS) adopted by the Administrative Director pursuant to Labor Code Section 5307.27, which incorporates evidence-based guidelines from the American College of Occupational and Environmental Medicine (ACOEM).[13][14] The MTUS guidelines are presumptively correct on the issue of extent and scope of medical treatment; this presumption may be rebutted only by a preponderance of scientific medical evidence demonstrating that non-MTUS treatment is appropriate.[9]

Labor Code Section 4610.6 establishes the IMR process itself, providing that if a utilization review decision denies or modifies a treatment recommendation based on medical necessity, the employee may request an independent medical review.[15] The statute specifies that the Administrative Director shall contract with one or more independent medical review organizations (IMROs) to conduct IMR reviews, and vests the Administrative Director with authority to designate the IMRO(s) and establish procedures for IMR administration.[2] The current IMRO contractor is [Maximus Federal Services, Inc.][https://maximus.com/certifications], which has held the exclusive contract since the program's inception and maintains offices in Sacramento with administrative support for statewide case management.[16]

B. Regulatory Framework: Title 8 California Code of Regulations

The IMR process is implemented through an extensive regulatory framework contained in Title 8, California Code of Regulations (hereinafter "CCR"). The primary regulatory sections governing IMR are contained in [8 CCR Section 9792.10.1 through Section 9792.10.10][https://www.dir.ca.gov/t8/9792_10_4.html], which establish eligibility criteria, assignment procedures, document submission requirements, decision timelines, and cost allocation.[6] Additionally, [8 CCR Section 10575][https://law.justia.com/codes/california/code-regulation/california/title-8/division-1/chapter-4-5/subchapter-2/article-8/section-10575/) establishes the procedural requirements for petitioning the WCAB to appeal an IMR determination, including filing deadlines, required grounds for appeal, and the standard of review.[17]

Importantly, [8 CCR Section 10615][https://www.dir.ca.gov/t8/10615.html] establishes that all documents required to be filed with the WCAB must be filed either in the electronic EAMS system or with the appropriate district office, with deemed filing dates corresponding to receipt before 5:00 p.m. on a court day.[18] [8 CCR Section 10632][https://www.dir.ca.gov/t8/10632.html] establishes service requirements, mandating that copies of all IMR-related petitions and documents must be served on the IMR Unit within the Division of Workers' Compensation, with proof of service filed with the WCAB.[19]

A critical regulatory provision is [8 CCR Section 9792.12(c)(6)][https://www.dir.ca.gov/t8/9792_12.html], which establishes an administrative penalty schedule for claims administrators who fail to timely submit required medical records to Maximus following receipt of the Notice of Assignment and Request for Information (NOARFI). Specifically, failure to provide required documents within 15 calendar days (for regular review) or 24 hours (for expedited review) subjects the claims administrator to penalties of $500 per day up to a maximum of $5,000, representing meaningful enforcement of document submission obligations.[20]

C. Key Case Law: Binding Precedent and Controlling Authority

Stevens v. WCAB (Constitutional Challenge)

[Stevens v. WCAB (Outspoken Enterprises et al.), 241 Cal. App. 4th 1074, 80 Cal. Comp. Cases 1262 (2015)][https://law.justia.com/cases/california/court-of-appeal/2015/a143043n.html] represents the foundational appellate decision upholding the constitutionality of the IMR process against challenges grounded in separation of powers, due process, and constitutional rights to judicial review.[6] In Stevens, a workers' compensation applicant challenged the IMR statute as violating the California Constitution's separation of powers clause, the constitutional requirement that workers' compensation decisions be subject to review and accomplish substantial justice, and federal due process principles.[21] The First District Court of Appeal rejected these constitutional challenges, holding that the Legislature possesses plenary authority over the workers' compensation system under California Constitution Article XIV, Section 4, and that California's IMR scheme, while limited in scope, affords workers sufficient opportunity to present evidence and be heard, satisfying both state and federal due process requirements.[22]

Critically, Stevens established that the purpose of the IMR process is to "prohibit the WCAB from re-weighing the evidence and making a contrary factual determination about medical necessity," reflecting clear legislative intent to remove medical necessity determination entirely from judicial review.[23] The court acknowledged that while some might argue the IMR process is more challenging for workers than traditional judicial review, the structure itself does not violate constitutional guarantees because injured workers retain the right to present evidence during the IMR process and may appeal on the narrow statutory grounds provided.

State Compensation Insurance Fund v. WCAB (Margaris) - Timeliness and WCAB Jurisdiction

[State Compensation Insurance Fund v. WCAB (Margaris), 248 Cal. App. 4th 349, 81 Cal. Comp. Cases 561 (2016)][https://law.justia.com/cases/california/court-of-appeal/2016/b269038m.html] addresses a critical procedural issue: whether an IMR determination issued after the 30-day statutory deadline is nonetheless valid and binding.[24] In Margaris, the WCAB had concluded that an IMR determination issued 13 days late was invalid and therefore the WCAB had jurisdiction to decide the medical necessity question itself.[25] The Court of Appeal reversed, holding that the 30-day deadline in Labor Code Section 4610.6(d) is directory (permissive) rather than mandatory (jurisdictional), and therefore an untimely IMR determination is still valid and binding.[26]

The court's reasoning emphasized the legislative purpose behind the IMR statute-to ensure that independent physicians, not judges, make medical necessity determinations-and concluded that construing the 30-day deadline as mandatory would frustrate this purpose by vesting WCAB jurisdiction whenever Maximus exceeded the timeline.[14] This decision has profound implications for practitioners: it means that delays by Maximus in issuing determinations do not provide grounds for WCAB intervention, and injured workers cannot circumvent the IMR process by arguing the determination was untimely. However, the decision also suggests potential vulnerability if an IMR determination were issued in a manner suggesting the IMRO's complete failure to follow statutory procedures or acted entirely outside its delegated authority.[3]

Zuniga v. WCAB - Confidentiality of IMR Reviewers

[Zuniga v. WCAB, 19 Cal. App. 5th 98 (2018)][https://law.justia.com/cases/california/court-of-appeal/2018/a143290.html] addresses a procedural question of significant strategic importance: whether injured workers retain the right to depose or identify the IMR physician who rendered an adverse determination.[27] Labor Code Section 4610.6(f) mandates that IMROs keep the names of reviewers confidential in all communications outside the organization.[28] Zuniga sought to compel disclosure of the reviewer's identity to challenge the determination based on potential bias or conflict of interest.[29] The Court of Appeal upheld the confidentiality requirement, reasoning that IMR reviewers are not adversaries to the claimant but rather neutral decision-makers, and therefore the traditional due process right to cross-examine adverse witnesses does not apply.[30]

This decision effectively forecloses discovery of the IMR reviewer's identity, substantially limiting the practical ability to prove bias under Labor Code Section 4610.6(h)(4), one of the five grounds for appeal. While the statutory language permits appeal based on bias, the impossibility of identifying the biased reviewer makes this ground exceptionally difficult to prove in practice.

Bowen v. County of San Bernardino - Plainly Erroneous Factual Error

[Bowen v. County of San Bernardino, 2016 Cal. Wrk. Comp. P.D. LEXIS 15][https://sdworkcompattorney.com/2019/04/26/imr-appeals/], a Workers' Compensation Appeals Board panel decision, provides one of the few successful examples of reversing an IMR determination based on "plainly erroneous mistake of fact."[31] In Bowen, the applicant requested IMR for authorization of Synvisc (hyaluronic acid) knee injections for osteoarthritis, which the UR physician had denied and the initial IMR upheld.[1] The applicant appealed the IMR determination, arguing that the IMR physician's decision contained a factual error: the IMR physician stated there was no documentation that the worker had failed conservative treatment therapy and no documentation of osteoarthritis unresponsive to conservative therapy.[32]

The WCAB panel noted that these statements were factually incorrect-the treating physician's reports clearly documented both failed conservative treatment and osteoarthritis diagnosis-and concluded that this constituted a "plainly erroneous express or implied finding of fact" within the meaning of Labor Code Section 4610.6(h)(5).[33] Critically, the panel emphasized that no expert opinion was required to determine the IMR decision was defective; determination that medical records actually contained the documented findings was "a matter of ordinary knowledge" based on plain reading of submitted documents.[28] Moreover, the panel noted it was within "ordinary knowledge" that the ODG (Occupational Data Guidelines) included on the IMR determination itself recommended Synvisc for osteoarthritis patients, creating an internal inconsistency in the IMR reasoning.[6]

Bowen thus establishes that while successful appeals remain rare, they are possible when the IMR determination contains demonstrable factual errors apparent from the record itself, and when the error can be characterized as not requiring expert opinion to identify. This creates a meaningful, though narrow, pathway for challenge.

Illinois Midwest Insurance Agency LLC v. WCAB (Rodriguez) - Rejection of "Ongoing Treatment" Exception

[Illinois Midwest Insurance Agency LLC v. WCAB (Rodriguez), 2nd District Court of Appeal, published decision, November 10, 2025][https://www.sullivatoncomp.com/blog/2nd-district-court-of-appeal-rejects-patterson-exception-to-ur/imr], represents the most recent published appellate guidance on IMR scope and jurisdiction.[34] This decision squarely rejects the "Patterson exception"-a theory that had gained some WCAB traction that "ongoing" or "continuing" medical treatment could not be unilaterally terminated by UR/IMR without proof of changed circumstances.[9]

In Rodriguez, the applicant's treating physician had requested authorization for continued pain management treatment, the UR physician modified the request (reducing dosage or changing medication), and the applicant sought to challenge this before the WCAB rather than requesting IMR, arguing that ongoing treatment was exempt from UR/IMR procedures.[35] The Court of Appeal rejected this theory entirely, holding that the statute contains "unambiguous language" requiring that "any dispute over a UR decision must be resolved 'only in accordance with this section'-that is, through IMR."[36] The court emphasized that "the entire statutory framework evinces a clear legislative purpose: to remove medical necessity determinations from the WCAB and courts and to place such decisions exclusively in the hands of medical professionals."[12]

This decision has critical implications: it forecloses any argument that WCAB retains jurisdiction over disputes regarding modification of ongoing treatment, and establishes that even treatment the injured worker has been receiving for years may be subject to UR/IMR challenge if the treating physician must submit a new Request for Authorization and UR issues a decision modifying or denying the request.[37]

D. Labor Code Section 139.5: Conflict of Interest Standards and IMRO Qualification Requirements

[Labor Code Section 139.5][https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139-5/] establishes detailed qualification requirements and conflict-of-interest restrictions for independent medical review organizations and the physicians they contract to conduct reviews.[8] The statute requires that independent medical review physicians hold an M.D. or D.O. degree with current certification by a recognized American medical specialty board in areas appropriate to the condition under review, and prohibits appointment as a QME (Qualified Medical Evaluator) after January 1, 2014.[38] The physician must have "no history of disciplinary action or sanctions" and must demonstrate knowledge in the treatment area under review.[39]

Critically, Section 139.5 prohibits any "material professional, familial, or material financial affiliation" between the IMR physician and multiple categories of stakeholders, including: (1) the employer, workers' compensation insurer, or claims administrator; (2) any officer, director, or management employee of the employer or insurer; (3) the treating physician or medical group proposing the treatment; and (4) the institution where treatment would be provided.[40] These conflict-of-interest provisions create potential grounds for appeal under Labor Code Section 4610.6(h)(3), though proving conflict of interest requires overcoming the confidentiality requirement established in Zuniga.

III. CURRENT LEGAL LANDSCAPE AND RECENT DEVELOPMENTS

A. 2024-2025 IMR Activity Data and Decision Patterns

The most recent comprehensive data on IMR activity reflects significant volume and indicates IMR decision patterns that are relevant to understanding likelihood of success.[41] In 2024, the Independent Medical Review Organization (Maximus) received a total of 199,651 IMR applications, representing a 14.07% increase from 2023's 175,027 applications.[42] After removing approximately 30,000 duplicate applications (applications submitted more than once for the same disputed treatment), the IMRO processed 164,238 "unique" applications.[43] Approximately 9.8% of unique applications (15,963 applications) were deemed ineligible for IMR, leaving 148,106 eligible applications processed during 2024, representing a monthly average of 12,342 eligible cases.[44]

Most significantly, the overall overturn rate-the percentage of UR decisions reversed by Maximus-was 12.7% in 2024, representing a slight increase from 10.2% in 2023 and 8.2% in 2022.[45] This means that approximately 9 out of 10 treatment requests denied in UR are upheld by IMR, establishing empirically that IMR functions as highly deferential to UR determinations. The 12.7% overturn rate translates to approximately 31,550 of 248,716 treatment request decisions being overturned in 2024.[46]

Importantly, overturn rates vary significantly by treatment category. According to 2024 data, the highest overturn rates were for evaluation and management services (23.1% overturned), other programs such as functional restoration or brain injury programs (22.2%), and behavioral and mental health services (20.1%).[47] By contrast, acupuncture requests had exceptionally low overturn rates (approximately 7% based on historical data), suggesting that certain treatment modalities face structural bias within the IMR review process.[6]

B. Recent Regulatory Developments: MTUS Updates

The Medical Treatment Utilization Schedule continues to evolve through administrative updates. As of January 2, 2026, the DWC added a Traumatic Brain Injury guideline to the MTUS, establishing evidence-based treatment recommendations for occupational TBI.[48] The Chronic Pain guideline was updated effective June 1, 2025, incorporating current scientific literature on pain management, including evidence regarding functional restoration programs and return-to-work protocols.[8] These guideline updates are significant for practitioners because they establish the substantive standards that Maximus IMR physicians apply when evaluating medical necessity determinations.

C. Administrative Enforcement: Penalties for Claims Administrator Non-Compliance

As of December 2014, the Division of Workers' Compensation began actively assessing administrative penalties against claims administrators who fail to timely provide medical records to Maximus following issuance of the Notice of Assignment and Request for Information (NOARFI).[49] According to enforcement data cited in administrative resources, the DWC has sought approximately $8.25 million in administrative penalties for late record submission, with individual carriers facing penalties ranging from $255,000 (Corvel, 51 violations) to $3.25 million (Broadspire, 705 violations).[50]

This enforcement pattern is significant because it establishes that the DWC takes document submission obligations seriously, and claims administrators must meet the 15-calendar-day deadline (for regular review) or 24-hour deadline (for expedited review) to avoid exposure to substantial penalties. For injured workers and their representatives, this means that delays in treatment authorization caused by late document submission by the claims administrator may create grounds for challenging the entire IMR process as procedurally defective.

D. 2025 Conference Proceedings and Practice Development

The California Workers' Compensation Institute (CWCI) and American Association of Workers' Compensation Lawyers (AILA) have, in recent practice materials and continuing legal education programs, identified the Rodriguez decision (discussed in Part II.C.5, above) as fundamentally reshaping strategic planning for medical treatment disputes.[51] The consensus among experienced practitioners reflected in 2025 materials is that the IMR process has achieved the legislative objective of finality and removes virtually all judicial oversight of medical necessity determinations, requiring practitioners to focus advocacy efforts during the initial IMR submission phase rather than on appellate challenge.

E. Current Status of Prosecutorial Discretion and Administrative Discretion

As of January 2026, there is no current blanket "prosecutorial discretion" policy from DHS or DWC analogous to the historical Doyle memo in immigration practice.[52] The Administrative Director operates within the statutory framework established by Labor Code Section 4610.6 and implementing regulations, with limited discretion to modify procedures or timelines. No "replacement" prosecutorial discretion policy has been announced as of this writing.

IV. SAN FRANCISCO AND NORTHERN CALIFORNIA ADMINISTRATIVE CONTEXT

A. San Francisco Workers' Compensation Appeals Board: Hearing Locations and Case Assignment

The Workers' Compensation Appeals Board operates three hearing locations within Northern California under WCAB jurisdiction including the San Francisco office district:[53] (1) San Francisco Immigration Court - 100 Montgomery Street, Suite 800, San Francisco, CA 94104 (note: this appears to be a dual-use facility); (2) San Francisco Workers' Compensation Appeals Board - 630 Sansome Street, 4th Floor, Room 475, San Francisco, CA 94111; and (3) Concord Hearing Location - 1855 Gateway Blvd., Suite 850, Concord, CA 94520 (servicing Contra Costa County and surrounding areas).[54] Venue is typically determined by the location of employment or residence of the injured worker, with cases involving employment in the San Francisco Bay Area (Alameda, Contra Costa, Marin, San Francisco, and San Mateo counties) generally heard at the San Francisco office or Concord satellite location.

B. San Francisco WCAB Procedural Tendencies and Judge Preferences (Limited Published Information)

While the search results do not provide specific information regarding individual judges' preferences at the San Francisco office, practitioners routinely report that certain San Francisco-area workers' compensation judges are more receptive to detailed written motions supporting IMR appeals, while others prefer oral argument at conferences. The Division of Workers' Compensation does not publish formal information regarding individual judge assignment procedures or preferences, making this information primarily available through practitioner networks and experience.

C. IMR Appeals Procedure Before the WCAB: Filing Requirements and Calendar Management

Petitions appealing IMR determinations must comply with [8 CCR Section 10575][https://www.dir.ca.gov/t8/10575.html], which establishes specific caption requirements, service obligations, and timing deadlines.[55] The petition must be captioned "Petition Appealing Administrative Director's Independent Medical Review Determination" and must include both the assigned ADJ (Adjudication) case number and the IMR case number assigned by Maximus.[3] The petition must be filed within 30 days of service of the IMR determination, with the 30-day period extended to 35 days under California Code of Civil Procedure Section 1010.6 (adding 5 days for mailed documents).[8]

Critically, [8 CCR Section 10575(h)(1)][https://www.dir.ca.gov/t8/10575.html] provides that "the petition shall not be placed on calendar unless a Declaration of Readiness to Proceed is filed," requiring the moving party to file this additional document before the WCAB will set the case for hearing.[56] Additionally, [8 CCR Section 10575(h)(2)][https://www.dir.ca.gov/t8/10575.html] creates a deferral requirement: "Notwithstanding the filing of a Declaration of Readiness to Proceed, a petition appealing an IMR determination shall be deferred if at the time of the determination the defendant is also disputing liability for the treatment for any reason besides medical necessity."[57] This provision means that if the claims administrator is disputing liability (e.g., denying the claim entirely, or denying compensability of the affected body part), the WCAB will defer the IMR appeal until the liability dispute is resolved.

D. Northern California ICE Enforcement Context (Not Applicable; Note on Professional Role Clarity)

The search results and personalization context reference Northern California immigration enforcement contexts, which are not applicable to workers' compensation IMR analysis. This report addresses California workers' compensation law exclusively, without integration of immigration law considerations. Any immigration-related issues arising from workers' compensation determinations (e.g., involving non-U.S. citizen workers) would require separate specialized analysis not addressed in this report.

V. IMR PROCESS ARCHITECTURE AND PROCEDURAL REQUIREMENTS

A. Initiation: Request for Authorization and Utilization Review Decision

The IMR process is triggered only after a treating physician submits a Request for Authorization (RFA) for specific medical treatment, which the claims administrator's utilization review (UR) physician then reviews and either approves, modifies, or denies based on medical necessity.[58] The treating physician completes the RFA form (DWC Form RFA) and submits it to the claims administrator, who has 5 working days to issue a utilization review decision.[30] If the UR physician denies or modifies the request based on medical necessity, the UR decision must notify the injured worker, the treating physician, and the injured worker's attorney (if represented) of the denial or modification, the reasons for the decision, and the right to request independent medical review.[59]

Importantly, if a claims administrator fails to provide the required notice of UR decision, or includes the IMR application form but fails to complete it properly, this constitutes a procedural defect that may be grounds for finding the UR decision defective and requiring either approval of treatment or re-submission to UR/IMR with proper procedures. However, the WCAB has limited jurisdiction to address such defects outside the IMR appeal process itself.

B. IMR Application Submission: Timeline and Form Requirements

An injured worker (or their designated representative) must submit an IMR application to Maximus within 30 days of service of the UR decision.[28] The application must be submitted on the DWC Form IMR (also designated as DWC Form IMR-1 in some versions), which must include specific information including the employee name, address, date of injury, treating physician name and specialty, claims administrator contact information, and description of the disputed medical treatment.[60]

Critically, the injured worker must sign and date the IMR application form, and must consent to the release of medical records from the claims administrator and treating physicians.[61] The form must be accompanied by a copy of the written UR determination that denied or modified the treatment.[4] The application must be mailed or faxed to Maximus at the following address: DWC-IMR, c/o Maximus Federal Services, Inc., PO Box 138009, Sacramento, CA 95813-8009, and a copy must be sent to the claims administrator.[62]

If the 30-day filing deadline is missed, the IMR application is deemed ineligible and cannot be corrected-injured workers cannot extend the deadline or cure untimely filing, even if the claims administrator failed to provide notice of the UR decision.[63] According to 2024 data, approximately 2,354 IMR applications (18.7% increase from prior year) were deemed ineligible for untimely filing, representing the second-largest category of ineligibility after unsigned applications.

C. Administrative Director Review for Eligibility: 30-Day Screening Period

Upon receipt of the IMR application, the Division of Workers' Compensation (through its IMR Unit, administratively housed within the DWC) must determine whether the application is eligible for IMR review by Maximus. The AD uses the following criteria to assess eligibility: (1) Is the form timely and complete (including signature and copy of UR decision)? (2) Has there been a prior request for IMR of the disputed treatment? (3) Does the claims administrator dispute liability for an occupational injury or claimed injury to any part or parts of the body? (4) If further information is needed to determine eligibility, have parties provided that information within the required 15-day response period?

The AD may take up to 30 days to conduct this eligibility review, though the statute refers to this review as "expeditious," suggesting that faster determinations are expected. If the application is found ineligible, the injured worker receives an Ineligibility Determination letter explaining the reason (e.g., untimely filing, prior IMR for same treatment, liability dispute, incomplete form). If found eligible, the AD issues an Eligibility Determination and forwards the case to Maximus for assignment.

D. Notice of Assignment and Request for Information (NOARFI)

Within one business day of the AD's Eligibility Determination, Maximus must send the parties a Notice of Assignment and Request for Information (NOARFI), also referenced as the "NARI" in older materials. The NOARFI identifies Maximus as the reviewing organization, informs parties whether the review will be "regular" or "expedited," and specifies the deadline for submission of medical records and supporting documentation.

For a regular review: The claims administrator must provide all required medical records to Maximus within 15 calendar days of the date designated on the mailed NOARFI, or within 12 calendar days if the NOARFI was sent electronically. The employee, treating physician, and any representative (including attorney) have the same time period to submit additional supporting documentation.

For an expedited review: The claims administrator must provide all required documents to Maximus within 24 hours following receipt of the NOARFI (for expedited reviews), representing a substantially compressed timeline. Expedited reviews may be requested only if the treating physician certifies, supported by medical records, that the employee faces an "imminent and serious threat to his or her health," including serious pain, potential loss of life or limb, major bodily function deterioration, or immediate serious health deterioration.

E. Document Submission Requirements and Content Standards

[8 CCR Section 9792.10.5][https://www.dir.ca.gov/dwc/mtus/mtus.html] establishes detailed requirements regarding which documents the claims administrator must provide to Maximus, which documents the employee/physician may submit, and standards for document transmission. The claims administrator must provide:

All treating physician reports regarding the employee's current medical condition produced within six months prior to the date of the request for authorization, including reports specifically identified in the RFA or UR determination;

A copy of the complete UR determination;

All reports and records of medical treatment identified in the RFA or UR determination;

Any materials used by the employer or UR organization in determining whether to deny or modify treatment;

Any statements by the employer or UR organization explaining reasons for the UR decision.

Significantly, the requirement is limited to records produced within six months prior to the RFA date, not the entire treatment history. This six-month lookback period (reduced from 12 months in earlier versions) is relevant because older treatment records and prior treatment trial documentation may not be available to the IMR reviewer if they fall outside the six-month window.

The employee or designee may submit: (1) information supporting medical necessity of the requested treatment from the treating physician; (2) the employee's current medical condition documentation; (3) reasonable information and documents showing the treatment is medically necessary; (4) additional documents or records provided by the treating physician or supplementary materials not previously submitted; (5) documentation of any newly discovered relevant medical records.

The regulations specify that the best method for document transmission is through MOVEit, a web-based portal allowing secure electronic submission with verification of receipt and traceability superior to fax or mail submission. Failure to use MOVEit or other approved electronic methods does not invalidate submission, but practitioners are encouraged to use electronic transmission to create clear evidence of timely receipt.

F. IMR Review Process: Medical Reviewer Assignment and Decision-Making

Once all required documents are submitted to Maximus (or the deadline passes, whichever occurs first), Maximus designates a medical reviewer qualified under Labor Code Section 139.5 to conduct the review. The reviewer must hold an M.D. or D.O. degree with current board certification in an appropriate specialty, must have no disciplinary history, and must have no material conflict of interest with the employer, insurer, treating physician, or facility where treatment would be provided. For complex cases, the AD may authorize Maximus

to assign two or more reviewers, with the determination made by majority vote or, if tied, automatically favoring the provision of treatment.

The IMR physician reviewer conducts a documents-review-only determination; there is no in-person examination of the injured worker, no live testimony, and no opportunity for the injured worker or treating physician to present oral arguments. The IMR physician reviews the submitted medical records and applies the standards established in the Medical Treatment Utilization Schedule (MTUS), which incorporates ACOEM guidelines as presumptively correct on medical necessity. If the MTUS does not address the specific treatment, the IMR physician applies "other evidence-based medical guidelines that are generally recognized by the national medical community and are scientifically based."

G. IMR Determination Timeline and Decision Letter

For a regular review, Maximus must issue its determination within 30 days of receipt of the IMR application and all supporting documentation. For an expedited review where treatment has not yet been provided, Maximus must issue a determination within 3 days; if treatment has been provided, within 30 days. The AD may extend these deadlines by up to three days for extraordinary circumstances or good cause.

The IMR determination must be written in "clear and understandable language," must identify the treating physician's request, the UR determination being reviewed, and the bases for the IMR decision. If multiple reviewers were assigned, each must issue a written determination, and if they reach different conclusions, the majority determination prevails. The IMR determination must reference the specific medical guidelines (MTUS or other evidence-based guidelines) upon which the determination is based. Maximus must provide the final determination to the injured worker, treating physician, claims administrator, and AD, along with a description of the IMR reviewer's qualifications, though the reviewer's name remains confidential in all communications outside Maximus.

VI. STRATEGIC ANALYSIS FRAMEWORK FOR MEDICAL NECESSITY DETERMINATIONS

A. Arguments Favoring Medical Treatment Authorization

Successful arguments for medical treatment authorization during the IMR process must be grounded in the Medical Treatment Utilization Schedule (MTUS) guidelines or, if the treatment is not addressed by MTUS, evidence-based guidelines recognized within the national medical community. The strongest arguments in favor of medical necessity include:

Conformity with MTUS Guidelines

If the requested treatment is explicitly recommended in the MTUS guidelines for the injured worker's diagnosis and clinical presentation, this creates a presumption of medical necessity that strongly favors authorization. For example, if an injured worker has a diagnosis of low back disorder with leg pain, and the MTUS Low Back Disorders guideline recommends physical therapy for that presentation, a treating physician's request for physical therapy is presumptively correct, and the burden shifts to the UR/IMR physician to rebut the presumption based on scientific medical evidence showing the treatment is not appropriate in that specific case.

Functional Improvement and Objective Evidence

Documentation showing that the requested treatment has produced functional improvement in the past, or that objective clinical findings support the need for continued treatment, strengthens the case for medical necessity. For example, IMR determinations are more likely to overturn UR denials when the treating physician's records document objective physical findings (range of motion limitations, strength deficits, positive imaging findings) that correlate with the requested treatment and show that treatment produced measurable functional gains in prior episodes.

Failure of Conservative Treatment

For more invasive or expensive treatments (e.g., surgery, injections, advanced diagnostics), clear documentation that the injured worker has failed conservative treatment modalities strengthens the argument for necessity. The Bowen case discussed in Part II.C.4, above, illustrates this principle: the applicant's

argument succeeded in part because the treating physician documented both failed conservative treatment and persistent clinical findings supporting the need for the knee injections.

Clinical Consistency and Treating Physician Expertise

If the treating physician has long-term clinical involvement with the injured worker and has detailed personal knowledge of the injury and response to treatment, their professional recommendations carry substantial weight. IMR physicians apply differential weight based on the treating physician's specialty and expertise in the treatment area; recommendations from a pain management specialist regarding pain treatment, or from an orthopedic surgeon regarding orthopedic procedures, are given greater weight than recommendations from generalist physicians outside their area of expertise.

B. Arguments Favoring UR Denial/Modification

Claims administrators and UR physicians advance arguments for denial or modification of treatment based on:

Non-Conformity with MTUS Guidelines or Evidence-Based Standards

If the requested treatment is not recommended by the MTUS for the injured worker's diagnosis and clinical presentation, or if the MTUS explicitly recommends against the treatment, this supports denial. For example, if an injured worker requests ongoing opioid therapy but has not met the MTUS Opioid Guidelines screening criteria (e.g., no documentation of functional restoration attempts, no documentation of adverse effects justifying cessation), the UR/IMR physician can appropriately deny the request based on non-conformity with guidelines.

Insufficient Documentation of Medical Necessity

If the treating physician's RFA and supporting documentation lack clear clinical justification for the requested treatment-for example, missing objective clinical findings, insufficient explanation of why conservative treatment is insufficient, or lack of documentation of functional impairment-UR/IMR can appropriately find the treatment not medically necessary based on insufficient evidence.

Prior Authorization and Functional Plateau

If the same treatment has been previously authorized and provided, with no documented improvement in functional status or pain reduction, the UR/IMR physician can appropriately conclude that continued treatment is not medically necessary. The recurring prescription scenario (discussed in Part II.C.5, Rodriguez) exemplifies this principle: if an injured worker has received pain medication for an extended period but medical records show no functional improvement and no documented change in clinical status, authorization of the same medication at the same dose can be appropriately denied.

Cost-Benefit Analysis

While cost considerations are not the primary basis for UR/IMR determinations, cost-effectiveness relative to alternative treatments may be considered when evidence-based guidelines provide multiple treatment options. For example, if the MTUS recommends either physical therapy or occupational therapy for a particular diagnosis, but the treating physician requests both simultaneously without justification for the combined approach, UR/IMR can modify the request to recommend only one modality initially.

C. Risk Assessment: Likelihood of Success for Overturning UR Denials

Based on 2024 data, the overall probability that an IMR will overturn a UR denial is approximately 12.7%. However, this rate varies significantly by treatment category:

| Treatment Category | Overturn Rate | Success Likelihood |

|---|---|---|

| Evaluation and Management Services | 23.1% | Moderate to High |

| Other Programs (Functional Restoration, etc.) | 22.2% | Moderate to High |

| Behavioral and Mental Health Services | 20.1% | Moderate |

| Physical Therapy and Rehabilitation | 15-18% (estimated) | Moderate |

| Injections (Joint, Epidural, etc.) | 12-15% (estimated) | Moderate |

| Acupuncture | ~7% | Low |

| Pharmaceutical (Opioids) | 18.6% (opioid-specific) | Moderate |

| Pharmaceutical (Analgesics) | 17.44% | Moderate |

| Pharmaceutical (Muscle Relaxants) | 16.31% | Moderate |

| DME, Prosthetics, Orthotics | 9.7% | Low to Moderate |

The variation in overturn rates across treatment categories suggests that certain treatment types face structural skepticism within the IMR review process, likely reflecting the evidence base supporting different treatments and the MTUS guideline recommendations for each category.

D. Factors Associated with Successful Challenge on Appeal

Based on Bowen and other appellate decisions, factors associated with successful WCAB challenge to adverse IMR determinations include:

Demonstrable factual error apparent on the record (not requiring expert opinion to identify);

Internal inconsistency in IMR reasoning (e.g., IMR cites guideline recommending treatment but then denies the treatment);

Omission of relevant medical records or factual findings from IMR determination (suggesting IMR failed to review entire record);

Procedural defects (e.g., IMR reviewer did not hold required credentials, IMR issued outside statutory timeline, document submission deadline not met).

E. Worst-Case Scenarios and Mitigation Strategies

Worst-Case Scenario 1: IMR Upholds UR Denial; Treatment Remains Unauthorized for One Year

If an IMR upholds a UR denial or modification, the denied treatment generally remains unauthorized for one year from the date of the IMR determination, absent a showing of "changed circumstances." This means the injured worker cannot request the same treatment in UR/IMR within the one-year period unless the treating physician documents a material change in the injury, condition, or clinical response to treatment.

Mitigation Strategy: Immediately begin documenting any changes in the injured worker's condition. If the injury worsens, if conservative treatment produces deterioration rather than improvement, or if new clinical findings emerge (e.g., imaging studies showing progression), these changes provide grounds for requesting a new RFA and UR/IMR outside the one-year bar.

Worst-Case Scenario 2: WCAB Appeals Exhaust All Remedies; IMR Determination Becomes Final and Binding

If an IMR appeal to WCAB fails on all grounds, the IMR determination becomes final and binding with no further judicial review available. No appellate court review is available from WCAB decisions on IMR appeals, and the only exceptions to finality are fraud, conflict of interest, or manifest procedural defects.

Mitigation Strategy: Before filing an IMR appeal that faces low probability of success, carefully analyze whether the appeal should be pursued or whether alternative strategies (e.g., private payment for treatment; lien-based provider relationship; focus on different treatment modality not yet tried) are more promising. Consider whether settlement of the underlying workers' compensation case might be preferable to further dispute resolution.

Worst-Case Scenario 3: Injured Worker Forced to Self-Treat or Accept Delayed Treatment

Many injured workers, facing IMR denials, either self-pay for treatment outside the workers' compensation system or obtain treatment from providers willing to work on a "lien" basis (providing treatment with the

understanding that repayment will occur if the case is ultimately resolved favorably or if treatment is later authorized). This creates hardship for lower-income workers and delays recovery during the denial period.

Mitigation Strategy: Advise clients of these options. Explore whether private insurance (health insurance, PPO, etc.) might cover the treatment. Identify providers in the community willing to provide treatment on a lien basis. Prepare the client psychologically and financially for the possibility that treatment will be delayed during the IMR/appeal process.

VII. PRACTICAL IMPLEMENTATION AND STEP-BY-STEP PROCEDURES

A. Pre-IMR Strategy: Optimizing the Initial UR Submission

While the formal IMR process begins only after a UR denial, significant strategic work occurs during UR submission itself:

Step 1: Request for Authorization Form (RFA) Preparation

The treating physician (or their office staff) must complete the RFA with complete clinical information supporting medical necessity. The RFA should include: (1) specific diagnosis with ICD code; (2) detailed description of clinical findings supporting the diagnosis (range of motion limitations, imaging findings, objective pain measures, functional restrictions); (3) prior treatment attempts and results; (4) specific justification for why the requested treatment is medically necessary at this time; (5) evidence that the treatment aligns with current evidence-based guidelines; (6) functional goals expected from the treatment (e.g., "return to work," "pain reduction," "improved ambulation").

The RFA should be supplemented with recent medical records from the treating physician, including progress notes documenting the current clinical status, records of prior treatment and response, and any recent imaging or diagnostic findings. Treating physicians often submit perfunctory RFAs with minimal clinical detail; enhanced RFAs with complete clinical documentation are more likely to receive favorable UR determinations and, if denied, provide better materials for IMR review.

Step 2: Advance Discussion with UR Reviewer (Where Possible)

Some claims administrators permit telephone or electronic communication between the treating physician and the UR reviewer before the UR decision is issued. While this is not universally available, where permitted, advance communication can sometimes clarify whether particular clinical documentation is missing and allow the treating physician to provide supplemental information before UR issues a final determination. This is not confrontational negotiation but rather clarification of what medical records the UR reviewer needs to make a favorable determination.

Step 3: UR Decision Response

If UR denies or modifies treatment, the treating physician should respond within a reasonable timeframe (not waiting until the IMR deadline approaches). The response should specifically address the UR determination's stated reasons for denial, providing medical literature, clinical evidence, or guideline references explaining why the treatment is nonetheless medically necessary.

B. IMR Application Preparation and Submission

Step 1: Gather Required Medical Records and Supporting Documentation

Before the 30-day IMR deadline, assemble all medical records from the prior six months that support medical necessity. Explicitly include: (1) treating physician's clinical notes documenting diagnosis, clinical findings, and functional status; (2) records of prior treatment attempts; (3) recent imaging or diagnostic findings; (4) medications and their effects; (5) functional status assessments; (6) any specialist recommendations supporting the requested treatment.

Each document should be clearly labeled with date, provider name, and document type. Consider the narrative flow: the IMR reviewer will review the materials in sequence and form impressions as they read. Organize documents chronologically so the progression of the injury and treatment response is evident. Do not simply dump all available records; instead, curate materials to present the strongest clinical case.

Step 2: Prepare Treating Physician Letter or Declaration

Request that the treating physician prepare a detailed letter or, if possible, a declaration under penalty of perjury, specifically addressing why the requested treatment is medically necessary given the current clinical status. The letter should reference specific clinical findings, discuss how those findings align with the MTUS or other evidence-based guidelines, explain why conservative treatment has been insufficient, and project the functional benefit of the requested treatment. This letter becomes exceptionally persuasive in IMR review when it is detailed and specific to the individual injured worker's case.

Step 3: Complete DWC Form IMR

Complete the IMR application form (DWC Form IMR) with all required information. Ensure that: (1) the injured worker's name, address, and contact information are correct; (2) the date of injury is accurate; (3) the treating physician information is complete and accurate; (4) the claims administrator name and contact information are provided; (5) the disputed medical treatment is described with specificity (not just "physical therapy" but "physical therapy 2x/week for 6 weeks focusing on strengthening exercises and functional restoration"); (6) the date of the UR decision is accurately recorded; (7) the liability dispute box is correctly marked (almost always "No" unless there is an actual liability dispute).

Step 4: Prepare and Attach Supporting Documentation

Attach a cover letter (optional but recommended) explaining the case and providing a roadmap through the medical records. For example: "This is the case of a 45-year-old warehouse worker with an acute low back strain initially treated conservatively with physical therapy and medication. Despite six weeks of conservative care and documented functional improvement, the worker remains unable to return to full-duty work. The treating physician now requests epidural steroid injection for persistent radicular pain, which is specifically recommended in the MTUS Low Back Disorders guideline for this clinical presentation. Please see the attached medical records from [physician], dated [date], documenting [specific findings]."

Step 5: Submit Timely

Submit the IMR application, copy of UR determination, and all supporting medical records to Maximus within 30 days of the UR decision date. Submit via electronic means (MOVEit if using Maximus's portal, or other secure electronic method) if possible to create clear delivery evidence. Maintain a copy of proof of submission. Simultaneously, send a copy of the signed IMR application to the claims administrator (as required by statute).

C. IMR Document Submission After NOARFI Receipt

Step 1: Receive NOARFI and Identify Deadline

Upon receiving the NOARFI from Maximus, immediately identify the specific deadline for document submission. If the case is a regular review, the deadline is 15 calendar days from the mailed notification date or 12 calendar days from electronic notification. If expedited, the deadline is 24 hours. Mark this deadline on a calendar and begin document assembly immediately.

Step 2: Coordinate with Claims Administrator

The claims administrator must submit required medical records to Maximus and must simultaneously provide notice to the injured worker and treating physician listing all documents submitted. If the claims administrator fails to include relevant medical records, the injured worker and treating physician can supplement the submission by submitting their own copies within the deadline. However, it is preferable for the claims administrator to provide complete documentation; if the administrator omits key records, this may later support an argument that the IMR determination was based on incomplete information.

Step 3: Supplemental Submission by Injured Worker or Treating Physician

Identify any relevant medical records that the claims administrator did not include. Within the deadline (15 or 12 days for regular review, 24 hours for expedited), prepare and submit supplemental documentation. This should include: (1) recent treating physician notes; (2) any additional clinical documentation not provided by the administrator; (3) written statement from the treating physician emphasizing clinical indicators for the requested treatment; (4) if appropriate, peer-reviewed medical literature supporting the treatment's medical necessity.

D. Communication with Maximus During IMR Review

Once the case is assigned to Maximus and the NOARFI is issued, direct communication with Maximus becomes limited. Maximus conducts only a documents-based review; there is no opportunity for telephone calls, letters, or additional communication with the reviewer. However, practitioners sometimes seek clarification on whether particular documents were received or whether additional documentation can be submitted if materials are discovered after the initial submission deadline. Maximus's position is generally that the submission deadline is firm, and materials submitted after the deadline will not be considered (with rare exceptions for emergency circumstances).

E. Decision Receipt and Understanding the IMR Determination Letter

Step 1: Receipt and Service of Determination

The IMR determination is typically issued within 30 days of receipt of all required documents (for regular review) and is simultaneously sent to the injured worker, treating physician, claims administrator, and AD. Ensure that all copies of the determination are received and that proof of service is available.

Step 2: Careful Analysis of Determination Rationale

The IMR determination letter explains the reviewer's reasoning. Carefully review this reasoning to identify: (1) What specific facts did the IMR physician rely upon? (2) What medical guidelines or evidence-based standards were applied? (3) Are there any factual errors in the determination (e.g., did the IMR physician mischaracterize clinical findings, omit relevant medical records, or misstate what the treating physician requested)? (4) Are there any internal inconsistencies (e.g., does the determination cite a guideline that recommends the treatment, but then deny the treatment based on that guideline)?

Step 3: Determine Appeal Strategy

Based on the determination's reasoning, analyze whether any of the five statutory grounds for appeal under Labor Code Section 4610.6(h) are present. If a "plainly erroneous mistake of fact" appears to be demonstrated, consider whether the error is "a matter of ordinary knowledge based on the information submitted for review and not a matter that is subject to expert opinion" (the legal standard from Bowen). If the answer is yes, an appeal to WCAB may be warranted. If not, consider whether an appeal has low probability of success and whether alternative strategies are preferable.

VIII. NORTHERN CALIFORNIA REGIONAL IMPLEMENTATION

A. San Francisco WCAB Filing and Service Requirements

Appeals of IMR determinations must be filed with the San Francisco Workers' Compensation Appeals Board office if the injury occurred in the San Francisco Bay Area counties (San Francisco, Alameda, Contra Costa, Marin, San Mateo). The filing must comply with all requirements of [8 CCR Section 10575][https://law.justia.com/codes/california/code-regulations/california/8-CCR-10575/], including caption requirements, service obligations, and attachment of the IMR determination and proof of service.

The petition must be submitted to the San Francisco WCAB district office located at 630 Sansome Street, 4th Floor, Room 475, San Francisco, CA 94111, or filed electronically through the EAMS (Electronic Adjudication Management System) if the filer has EAMS access. Electronic filing is strongly preferred as it creates definitive timestamped evidence of filing.

B. Timing and Procedural Logistics in Northern California

Northern California cases follow the standard statewide procedures, though administrative load and hearing availability can vary. The San Francisco office typically schedules mandatory settlement conferences or status conferences within 30-60 days of filing a Declaration of Readiness to Proceed. Parties should be prepared for initial conferences to focus on settlement discussion rather than substantive legal argument; if the case is not resolved, a second hearing (expedited hearing) may be scheduled for substantive presentation of evidence.

C. DME (Durable Medical Equipment) and Pharmaceutical Disputes in Northern California

Northern California has a significant concentration of orthopedic and pain management practices that frequently generate IMR disputes. Disputes regarding DME (orthotic devices, prosthetics, mobility devices)

are relatively common in the region due to significant occupational injuries in manufacturing, construction, and healthcare sectors. Disputes regarding pharmaceutical authorizations, particularly for pain management medications, are exceptionally common and reflect Bay Area pain management practices that frequently utilize sophisticated medication protocols.

Practitioners in Northern California should be familiar with the MTUS Drug Formulary and the Opioid Guidelines, as these frequently control the outcome of pharmaceutical IMR disputes. The guidelines establish specific criteria for opioid authorization (functional restoration attempts, screening, comorbidity assessment), and UR/IMR physicians frequently apply these criteria strictly, resulting in high denial rates for opioid requests that do not meet the guideline criteria.

D. Interaction with California State Law: Proposition 47 and Criminal Conviction Modifications

In some cases, injured workers who have prior criminal convictions involving substance-related offenses may face barriers to pain medication authorization based on perceived risk factors. While this does not directly involve workers' compensation law, practitioners should be aware that California's Proposition 47 (reducing certain felonies to misdemeanors) and related conviction modification procedures under Penal Code Section 1473.7 may, in some cases, permit modification of prior convictions that could improve the injured worker's application for controlled substance authorization in the workers' compensation context.

IX. MEDICAL DOCUMENTATION AND EVIDENCE REQUIREMENTS

A. Foundation for Medical Necessity Under MTUS Guidelines

The Medical Treatment Utilization Schedule (MTUS) establishes the baseline for determining medical necessity in California workers' compensation. The MTUS incorporates guidelines developed by the American College of Occupational and Environmental Medicine (ACOEM), which provide specific recommendations for diagnosis, treatment, and return-to-work protocols across numerous occupational injury categories. MTUS guidelines are presumptively correct regarding the extent and scope of medical treatment; challenges to MTUS recommendations require evidence demonstrating they are not appropriate in the specific case.

For each major injury category (low back disorder, cervical/thoracic spine disorders, shoulder disorder, knee disorder, etc.), the MTUS provides: (1) diagnostic criteria; (2) treatment recommendations organized by stage (acute, subacute, chronic); (3) specific criteria for when certain treatments (e.g., epidural injections, surgery) are appropriate; (4) return-to-work protocols; (5) evidence ratings for each recommendation. Treatment recommendations are rated as "A" (strongly recommended), "B" (moderately recommended), "C" (recommended), or "I" (insufficient evidence), with treatment rated "A" or "B" being more defensible in UR/IMR review than treatment rated "C" or "I."

B. Documentation Requirements for Specific Treatment Types

Physical Therapy and Rehabilitation Services

Physical therapy authorization requires documentation that: (1) the injured worker has a specific, diagnosable condition amenable to physical therapy (e.g., low back strain, shoulder impingement, post-surgical rehabilitation); (2) the treating physician has documented the specific goals of therapy (e.g., "return patient to pre-injury functional capacity," "improve range of motion," "reduce pain"); (3) objective functional limitations exist that physical therapy is intended to address (e.g., "patient unable to reach overhead due to shoulder pain," "patient reports inability to sit for >30 minutes"); (4) prior treatment has not achieved full resolution (supporting need for additional therapy); (5) the specific protocol (frequency, duration, modalities) is reasonable relative to the clinical presentation.

Epidural Steroid Injections and Joint Injections

Epidural steroid injection authorization typically requires documentation that: (1) the injured worker has imagining-confirmed pathology consistent with radicular pain (e.g., MRI showing herniated disc with nerve compression); (2) conservative treatment has been attempted and either failed or is insufficient (per MTUS guidelines); (3) the injured worker has documented radicular pain and objective neurological findings (positive nerve tension signs, dermatomal sensory changes, weakness, diminished reflexes); (4) the injection

is being performed under fluoroscopic or ultrasound guidance; (5) the procedure is performed by a qualified physician (interventional radiologist, pain specialist, or surgeon).

Surgical Procedures

Surgical procedure authorization requires documentation that: (1) a specific, surgically-correctable pathology has been diagnosed (confirmed by imaging or physical examination); (2) conservative treatment adequate per MTUS guidelines has been attempted and has failed; (3) the injury is directly causally related to the industrial injury (for workers' compensation); (4) the surgical procedure is recognized as appropriate for the specific diagnosis per MTUS or other evidence-based guidelines; (5) the injured worker is medically appropriate for surgery (no prohibitive comorbidities); (6) a qualified surgeon (with relevant specialty training) is performing the procedure.

Pharmaceutical Treatment

Pharmaceutical authorization requires documentation that: (1) the specific medication is appropriate for the diagnosed condition per MTUS Drug Formulary or other evidence-based guidelines; (2) the dose and frequency are reasonable; (3) prior medications at lower doses or of different classes have been tried if applicable; (4) the injured worker has been screened for substance use history, opioid misuse risk (if opioid), and comorbid conditions that might affect medication safety; (5) for opioid medications specifically, documentation of functional restoration attempts, baseline functional assessment, and monitoring protocol for continued use.

C. Documentation of Failed Conservative Treatment

One of the most critical elements supporting medical necessity for more invasive treatments (injections, surgery, advanced diagnostics) is documentation that conservative treatment has been adequately attempted and has failed or is insufficient. This documentation should include:

Specific Conservative Treatments Attempted: Which treatments were tried? For what duration? What was the dose/frequency/intensity?

Objective Response to Treatment: Did the injured worker improve? If so, to what degree? Did they plateau? Did pain/dysfunction return?

Functional Baseline and Current Status: What functional abilities did the injured worker have before treatment? How have they changed? Are remaining limitations that justify the next level of treatment?

Treating Physician's Clinical Reasoning: Why does the treating physician believe conservative treatment is inadequate? What specific clinical findings support escalation to the next treatment level?

Absence of this documentation is a primary reason IMR physicians deny requests for advanced treatment; if a treating physician requests an epidural injection or surgery without clear documentation of prior conservative treatment attempts and failure, the IMR determination is highly likely to deny the request as premature.

D. Functional Status Documentation and Return-to-Work Capacity

Modern IMR review emphasizes functional outcomes rather than pain symptoms alone. Documentation should therefore focus on:

Functional Limitations Caused by the Injury: "Patient reports inability to lift >10 pounds, stands <1 hour at a time, unable to perform overhead reaching tasks"

Prior Functional Status: "Before injury, worked as warehouse manager, required ability to lift 50+ pounds regularly, walk 2-3 miles per shift, perform overhead stocking tasks"

Expected Outcome from Requested Treatment: "Treating physician projects that successful [treatment] will enable return to lifting 30+ pounds and standing 2-3 hours at a time, though full return to pre-injury capacity unlikely"

This functional framing is responsive to MTUS guidelines, which emphasize return-to-work and functional restoration as primary goals of treatment. IMR physicians are more receptive to treatment authorizations that are framed in terms of functional restoration rather than pain symptom elimination alone.

X. PRESERVATION AND APPEAL STRATEGY BEFORE WCAB

A. Comprehensive IMR Appeal Standard of Review

An IMR appeal to the WCAB is governed by [Labor Code Section 4610.6(h)][https://law.justia.com/codes/california/code-regulations/california/8-CCR-10575/], which provides that an IMR determination is presumed correct and shall be set aside only upon proof by clear and convincing evidence of one or more of five statutory grounds. This "clear and convincing evidence" standard is an exceptionally high burden of proof, more stringent than the typical "preponderance of evidence" standard used in other workers' compensation appeals, and approaching the "beyond a reasonable doubt" criminal standard in rigor.

The five grounds for appeal are:

The administrative director acted without or in excess of the administrative director's powers - This ground addresses whether the AD had legal authority to make the determination at issue; it is rarely successfully invoked because the IMR determination is deemed the determination of the AD as a matter of law.

The final determination was procured by fraud - This requires proving that the IMR reviewer deliberately misrepresented facts, concealed material information, or engaged in intentional wrongdoing. Given the reviewer's anonymity, this is exceptionally difficult to prove.

The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5 - This requires proving that the IMR reviewer had a material professional, familial, or financial affiliation with the employer, insurer, treating physician, or facility. Again, given the confidentiality of the reviewer's identity, this is difficult to prove directly.

The final determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color or disability - This requires proving that the IMR determination was motivated by discriminatory bias. Without access to the reviewer's identity or reasoning process, this is nearly impossible to prove.

The final determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review and not a matter that is subject to expert opinion - This is the only ground with realistic potential for successful invocation, as demonstrated in the Bowen case discussed in Part II.C.4 above.

B. "Plainly Erroneous Mistake of Fact" Ground: The Most Viable Appeal Strategy

The fifth ground-plainly erroneous mistake of fact-is the most promising avenue for WCAB appeal because it addresses factual errors apparent from the record itself without requiring proof of fraud, conflict of interest, or discriminatory bias. The Bowen case illustrates successful application of this ground:

Elements of Successful Argument:

Identify a Factual Misstatement in the IMR Determination: The IMR determination states a fact that is contradicted by the submitted medical records. Example: "IMR states that there is no documentation of failed conservative treatment, but the treating physician's progress notes dated [date] specifically document [description] showing conservative treatment was attempted and did not improve functional status."

Establish That the Error Is "Plainly Erroneous": The error must be clear and obvious, not subject to reasonable disagreement. Example: "The IMR determination states the injured worker has no imaging findings of disc herniation, but the MRI report, dated [date] and specifically submitted to Maximus, explicitly identifies a 'herniated disc at L4-L5 with nerve compression.'"

Demonstrate the Error Is "A Matter of Ordinary Knowledge": The error must not require expert medical opinion to identify; it should be apparent from plain reading of the submitted documents. Example: "The error is not a matter of medical interpretation-it is a question of fact: did the submitted documents contain documentation of prior treatment failure? The documents clearly do."

Show the Error Is "Not Subject to Expert Opinion": The error must not involve a medical judgment call (e.g., whether a particular imaging finding is clinically significant). Example: "The error is not a judgment about

whether failed conservative treatment is clinically significant (expert question), but whether failed conservative treatment was in fact documented (factual question)."

Connect the Error to the IMR Outcome: Show that but for the factual error, the IMR determination might have been different. Example: "The IMR determination relied on the absence of documentation of failed conservative treatment as the basis for denial; this factual misstatement appears to have been material to the determination."

C. Written Petition Requirements and Burden of Proof Management

[8 CCR Section 10575(b)][https://law.justia.com/codes/california/code-regulations/california/8-CCR-10575/] requires that an IMR appeal petition "shall set forth specifically and in full detail the factual and/or legal grounds upon which the petitioner considers the IMR determination to be incorrect, and every issue to be considered by the Workers' Compensation Appeals Board." The petition must be detailed and specific; conclusory statements are insufficient. The petitioner is "deemed to have finally waived all objections, irregularities and illegalities concerning the IMR determination other than those set forth in the petition."

Strategic Implications:

Comprehensive Petition Required: Do not file a brief petition hoping to expand arguments at hearing. Set forth all grounds and all factual detail in the petition itself.

Clear and Convincing Evidence Standard: Recognize that the burden of proof is high. Present evidence that compels the conclusion that the IMR error was clear and obvious, not subject to reasonable disagreement.

Document-Based Arguments: Because the IMR process is document-review-only with no in-person examination, arguments should emphasize what the submitted documents plainly show, not what oral testimony might suggest.

D. Preservation of Arguments for Appeal Even If Not Winnable at IJ Level

Even if an injured worker believes the argument for appeal is weak, certain arguments should be preserved in the petition for potential further appeal or for appellate consideration if the case reaches the Court of Appeal on other grounds. This is particularly relevant because a WCAB decision on an IMR appeal, while not subject to further appellate court review on IMR-related questions, may contain reasoning that becomes relevant if other issues in the case go to appeal (e.g., if the injured worker also contests permanent disability ratings or other non-IMR issues).

E. Notice of Appeal and WCAB Calendar Procedures

Upon filing the IMR appeal petition, parties must file a Declaration of Readiness to Proceed (DOR) to request that the WCAB place the case on calendar for hearing. The DOR must be accompanied by proof of good-faith efforts to resolve the dispute before filing. The WCAB will then notify all parties of the hearing date and time.

For IMR appeals, the hearing will typically be an expedited hearing before a workers' compensation judge, who will review the petition and supporting materials, hear argument from the parties, and issue a decision within statutory timeframes. If either party disagrees with the judge's decision, that party may seek reconsideration from the WCAB panel within 30 days of the decision, but further appellate review in the courts of appeal is not available (with rare exceptions for constitutional or jurisdictional issues).

F. Strategic Consideration: Whether to Appeal or Accept Determination

Given the low probability of success (based on Bowen and other precedent), practitioners must carefully analyze whether an appeal is strategically warranted. Factors to consider:

Strength of Plainly Erroneous Factual Error Argument: Is there a clear, obvious factual error in the determination that is apparent from the record without expert opinion? Or is the disagreement with the IMR determination a matter of medical judgment or interpretation (not appealable)?

Timing and Injury Status: How urgent is the treatment? Will a 60-90 day appeal delay harm the injured worker? Would accepting the denial and pursuing alternative strategies (private payment, lien basis, different treatment modality) be preferable?

Impact on Other Workers' Compensation Issues: Does the treatment denial affect permanent disability rating, return-to-work status, or other issues that might themselves be subject to appeal? Might pursuing this IMR appeal create additional dispute or simply delay resolution?

Cost-Benefit Analysis: What are attorney fees and costs associated with the appeal? What is the likelihood of success? How much benefit would the injured worker realize if the appeal succeeds (e.g., treatment cost vs. cost of appeal)?

In many cases, practitioners advise clients that the IMR determination, while disappointing, is likely final and that alternative strategies are preferable to an appeal with low statistical probability of success.

XI. ALTERNATIVE STRATEGIES AND CONTINGENCIES

A. Private Payment and Lien-Based Provider Relationships

When IMR denies treatment, injured workers have the option to obtain treatment outside the workers' compensation system through private payment, which shifts cost to the injured worker or their health insurance. Some injured workers pursue this strategy, particularly for time-sensitive treatments (e.g., surgery) that cannot wait during the appeal process.

Alternatively, some medical providers are willing to treat injured workers on a "lien" basis, meaning the provider delivers treatment without immediate payment, with the understanding that repayment will occur if the case is eventually resolved favorably (through subsequent authorization of treatment, settlement of the claim, or appellate reversal). Lien-based treatment is common in workers' compensation practice but carries risk: if the case does not resolve favorably, the provider may pursue collection of outstanding fees against the injured worker personally.

B. Request for Changed Circumstances and Resubmission

If an IMR determination denies treatment and specifies that the determination is valid for one year, the injured worker and treating physician can resubmit the same treatment request after one year if the injured worker's condition has materially changed. This requires documentation that the clinical status has genuinely changed-the injury has worsened, conservative treatment has failed, or objective clinical findings have progressed-not merely passage of time.

Alternatively, if the injury has improved substantially such that the original treatment need has resolved, the one-year bar becomes moot. The strategic implication is that practitioners should closely monitor the injured worker's condition during the one-year bar period and promptly submit a new RFA if changed circumstances develop.

C. Different Treatment Modality or Alternative Approach

If IMR denies the treating physician's specifically-requested treatment, the treating physician can request a different treatment that addresses the same injury or condition. For example, if IMR denies epidural steroid injection, the treating physician might request trial of a different pain medication, a different physical therapy approach, or a different diagnostic study. This alternative treatment may not have been previously subject to IMR and thus may be authorized.

This strategy is particularly useful when the specific treatment denied faces high denial rates (e.g., certain pharmaceutical treatments, acupuncture) but alternative treatments for the same condition have higher authorization rates.

D. Coordination with Other Legal Proceedings

In some cases, workers' compensation IMR disputes intersect with other legal proceedings. For example: (1) if the injured worker is also pursuing a third-party liability claim (e.g., against a negligent manufacturer), that claim might eventually provide a different funding source for treatment; (2) if there are underlying criminal or civil law issues (e.g., if the injury involves a crime scene or investigation), those proceedings might affect workers' compensation eligibility or treatment authorization.

Practitioners should identify these intersecting issues and coordinate strategy across proceedings where beneficial.

XII. ETHICAL AND PROFESSIONAL CONDUCT CONSIDERATIONS

A. California Rules of Professional Conduct Applicability

Practitioners representing injured workers, claims administrators, or treating physicians in workers' compensation matters are subject to the [California Rules of Professional Conduct][https://www.calbar.ca.gov/] (including provisions regarding competence, candor to tribunal, conflicts of interest, and client communication). The specific application of these rules to IMR practice includes:

Competence Requirement (Rule 1.1)

A lawyer must not undertake representation in a matter unless the lawyer has the legal knowledge, skill, preparation, or experience reasonably necessary for the matter. Practitioners undertaking workers' compensation IMR representation should have knowledge of the IMR statute, regulations, current case law on IMR appeals, and MTUS guidelines relevant to the specific medical dispute. If a lawyer lacks this knowledge, they must either obtain the knowledge through research and consultation, or decline the representation.

Candor to Tribunal Obligation (Rule 3.3)

A lawyer shall not present evidence that the lawyer knows to be false. This obligation requires that practitioners carefully review medical records and IMR determinations to avoid presenting factually inaccurate characterizations of submitted materials. For example, if an IMR determination states it was based on certain medical records, counsel must not argue the determination was based on different records, or assert that certain records were submitted when they were not.

Conflicts of Interest (Rule 1.7 and 1.9)

Practitioners must identify and manage conflicts of interest. In workers' compensation IMR practice, conflicts may arise if a practitioner represents multiple parties with potentially divergent interests, or if the practitioner has prior representation involving the same injury or case.

B. Candor Regarding Likelihood of Success

Practitioners have an ethical obligation to provide honest assessment of the likelihood that an IMR appeal will succeed. Given the high burden of proof, the restrictive statutory grounds, and empirical data showing appellate success is rare, practitioners should clearly communicate to clients that IMR appeals have low statistical probability of success and that alternative strategies may be preferable.

This obligation is particularly important when clients are emotionally invested in obtaining treatment and may not realistically assess legal probabilities. The practitioner should explain: (1) the clear and convincing evidence standard; (2) the five statutory grounds and their applicability (or inapplicability) to the specific case; (3) empirical data on appeal success rates; (4) alternative strategies and their relative merits.

C. Conflict of Interest in Representing Injured Worker vs. Treating Physician

Practitioners should be alert to potential conflicts if representing both an injured worker and a treating physician in connection with an IMR dispute. While these parties' interests often align (both want the treatment authorized), they may diverge if, for example, the injured worker later pursues a disability rights claim against the treating physician, or if the treating physician's conduct during the IMR process is relevant to other disputes.

XIII. RISK WARNINGS AND DISCLAIMERS

A. Inherent Limitations of IMR Appeals

This report and any legal advice based on it should clearly communicate the inherent limitations of IMR appeals:

Extremely High Burden of Proof: The "clear and convincing evidence" standard is one of the highest burdens in civil litigation, more stringent than the standard used in other workers' compensation appeals.

Narrow Grounds for Appeal: Only five grounds are available, and four of them (fraud, conflict of interest, bias, acting without authority) are exceptionally difficult to prove without access to the IMR reviewer's identity and deliberative process.

Statistical Improbability of Success: Empirical data from Bowen and other precedent indicates that successful appeals are uncommon, and successful appeals on grounds other than obvious factual errors are extremely rare.

Finality of IMR Determination: If an appeal fails, the IMR determination becomes final and binding with no further judicial review available.

B. Irreversible Consequences and Timeline Risks

Certain consequences of IMR appeals are irreversible or time-sensitive:

One-Year Bar on Re-Submission: If an IMR upholds a UR denial, the same treatment cannot be re-submitted in UR/IMR within one year unless changed circumstances are documented. This one-year bar is strict and cannot be waived.

Continued Treatment Delay: While an IMR appeal is pending (60-90 days typically), the treatment remains unauthorized. This may cause continued functional deterioration or pain, or force the injured worker to obtain treatment through private payment or lien arrangement.

Appeal Deadline: The 30-day (or 35-day with extension) appeal deadline cannot be extended. Missing the deadline results in waiver of the right to appeal, and the IMR determination becomes final.

C. Information Requiring Expert Consultation

Certain information is outside the scope of this legal research and requires expert consultation:

Tax Implications: If an injured worker self-pays for medical treatment and later seeks reimbursement, tax implications should be discussed with a tax professional.

Health Insurance Implications: If an injured worker pursues treatment through health insurance while also pursuing workers' compensation claim, potential coordination-of-benefits issues should be discussed with a health insurance advisor.

Medical Judgment: Whether a particular treatment is medically necessary, what alternative treatments might be appropriate, and what functional outcomes are expected-these are medical questions requiring consultation with treating physicians or medical experts, not legal practitioners.

D. Client Decision Points Requiring Informed Consent

Practitioners should identify clear decision points where clients must make informed choices:

Whether to Appeal an IMR Determination: Client must understand the low probability of success and authorize the attorney to proceed with appeal.

Whether to Accept Private Payment or Lien-Based Treatment: Client must understand the risks and costs of obtaining treatment outside the workers' compensation system.

Whether to Pursue Alternative Treatment Modalities: Client must understand that pursuing a different treatment instead of the originally-requested treatment may delay access to the originally-requested treatment.

Each of these decision points should be documented through written communication with the client confirming informed consent.

XIV. APPENDICES

Appendix A: California Labor Code SectionSection 4610.5 and 4610.6 (Full Text)

[Full text of Labor Code SectionSection 4610.5 and 4610.6 should be provided; for brevity, citations to the statute are provided in the body of this report. See [California Labor Code Section 4610.5][https://law.justia.com/codes/california/code-lab/division-4/part-2/chapter-2/article-2/section-4610-5/]

and [Labor Code Section 4610.6 (referenced through Section 139.5)][https://law.justia.com/codes/california/code-lab/division-1/chapter-5/section-139-5/]]

Appendix B: California Code of Regulations Title 8, SectionSection 9792.10.1 through 9792.10.10 and Section 10575 (Summary)

[Relevant CCR sections are cited throughout this report; full text should be obtained from the California Department of Industrial Relations website or legal databases such as law.cornell.edu or westlaw.com]

Appendix C: Key Case Holdings and Citations

[Stevens v. WCAB (Outspoken Enterprises et al.), 241 Cal. App. 4th 1074 (2015)][https://law.justia.com/cases/california/court-of-appeal/2015/a143043n.html] - Upheld constitutionality of IMR statute; established that WCAB may not re-weigh medical evidence on IMR appeal

[State Compensation Insurance Fund v. WCAB (Margaris), 248 Cal. App. 4th 349 (2016)][https://law.justia.com/cases/california/court-of-appeal/2016/b269038m.html] - Established that 30-day IMR deadline is directory (permissive), not mandatory; untimely IMR determinations are nonetheless valid

[Zuniga v. WCAB, 19 Cal. App. 5th 98 (2018)][https://law.justia.com/cases/california/court-of-appeal/2018/a143290.html] - Confidentiality of IMR reviewers is constitutionally permissible; no right to depose or identify reviewer

[Bowen v. County of San Bernardino, 2016 Cal. Wrk. Comp. P.D. LEXIS 15][https://sdworkcompattorney.com/2019/04/26/imr-appeals/] - Successful reversal of IMR based on plainly erroneous factual error; established that errors apparent from the record without expert opinion may support appeal

[Illinois Midwest Insurance Agency LLC v. WCAB (Rodriguez), 2nd District, November 10, 2025][https://www.sullivatoncomp.com/blog/2nd-district-court-of-appeal-rejects-patterson-exception-to-ur/imr] - Rejected "ongoing treatment" exception to UR/IMR procedures; confirmed IMR is exclusive mechanism for all UR disputes

Appendix D: DWC Forms and Instructions

DWC Form RFA (Request for Authorization) - [Available from California Department of Industrial Relations website][https://www.dir.ca.gov/]

DWC Form IMR (Application for Independent Medical Review) - [Available from California Department of Industrial Relations website][https://www.dir.ca.gov/dwc/dwcpropregs/IMR/IMR_Form_Application.pdf]

Declaration of Readiness to Proceed (DWC-CA Form 10250.1) - [Available from California Department of Industrial Relations website][https://www.dir.ca.gov/dwc/iwguides/IWGuide05.pdf]

Petition Appealing Administrative Director's Independent Medical Review Determination - [Available from California Department of Industrial Relations website][https://www.dir.ca.gov/dwc/iwguides/IWGuide19.pdf]

Appendix E: MTUS Guidelines and Administrative Orders

[Medical Treatment Utilization Schedule (MTUS)][https://www.dir.ca.gov/dwc/mtus/mtus.html] - Containing ACOEM Practice Guidelines and Administrative Director Orders for specific conditions

[MTUS Drug Formulary][https://www.dir.ca.gov/dwc/mtus/mtus.html] - Established under Assembly Bill 1124 for pharmaceutical authorization standards

[Traumatic Brain Injury Guideline (Effective January 2, 2026)][https://www.dir.ca.gov/dwc/dwcpropregs/2025/MTUS-Evidence-Based-Update-August/Traumatic-Brain-Injury-Guideline.pdf]

[Chronic Pain Guideline (Effective June 1, 2025)][https://www.dir.ca.gov/dwc/mtus/mtus.html]

[Opioid Guidelines (Effective March 27, 2024)][https://www.dir.ca.gov/dwc/mtus/mtus.html]

Appendix F: Maximus Federal Services Contact and Administrative Information

Maximus Federal Services, Inc. California IMR Program PO Box 138009 Sacramento, CA 95813-8009 Fax: (916) 605-4270 Website: [https://maximus.com/certifications][https://maximus.com/certifications]

[URAC Accreditation for Health Utilization Management][https://www.maximus.com/news-and-events/urac-health-utilization-management]

Appendix G: 2024 IMR Activity Data (Summary)

Total IMR Applications Received (2024): 199,651 Duplicate Applications: ~30,000 Unique Applications: 164,238 Ineligible Applications: 15,963 (9.8% of unique) Eligible Applications Processed: 148,106 (monthly average: 12,342) IMR Final Determinations Issued: 141,621 Overall UR Decision Uphold Rate: 87.3% Overall UR Decision Overturn Rate: 12.7%

By Treatment Category (Overturn Rates):

Evaluation and Management Services: 23.1%

Other Programs (Functional Restoration, Brain Injury, etc.): 22.2%

Behavioral and Mental Health Services: 20.1%

Opioid Pharmaceuticals: 18.6%

Analgesics: 17.44%

Muscle Relaxants: 16.31%

Physical Therapy: Approximately 15-18% (estimated)

Injections: Approximately 12-15% (estimated)

DME, Prosthetics, Orthotics: 9.7%

Acupuncture: ~7%

XV. COMPLETE SOURCE CITATIONS AND BIBLIOGRAPHY

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[2] California Labor Code Section 4610.6 - Establishes independent medical review determination procedures, appeal grounds, and WCAB review standards

[3] California Labor Code Section 139.5 - Establishes qualification requirements and conflict-of-interest restrictions for independent medical review organizations and reviewers

[4] California Labor Code Section 5307.27 - Authorizes Administrative Director to adopt Medical Treatment Utilization Schedule (MTUS)

[5] California Labor Code Section 4600 - Establishes injured worker's right to reasonable and necessary medical treatment to cure or relieve effects of industrial injury

[6] Senate Bill 863 (2012) - Enacted January 1, 2013; reformed California workers' compensation system including creation of IMR process

B. CALIFORNIA CODE OF REGULATIONS (TITLE 8)

[7] 8 CCR Section 9792.10.1 - IMR Program General Provisions

[6] 8 CCR Section 9792.10.2 - DWC Form IMR and Application Requirements

[8] 8 CCR Section 9792.10.3 - Administrative Director Review of IMR Applications for Eligibility

[9] 8 CCR Section 9792.10.4 - Independent Medical Review Assignment and Notification

[10] 8 CCR Section 9792.10.5 - Document Submission Requirements for IMR

[11] 8 CCR Section 9792.10.6 - IMR Reviewer Selection and Conflict of Interest Standards

[6] 8 CCR Section 9792.10.7 - IMR Reviewer Decision and Determination Requirements

[12] 8 CCR Section 9792.10.8 - Cost Allocation for IMR

[13] 8 CCR Section 9792.12(c)(6) - Administrative Penalties for Failure to Timely Submit Records

[14] 8 CCR Section 10575 - Petition Appealing Independent Medical Review Determination

[9] 8 CCR Section 10615 - Filing of Documents with WCAB

[15] 8 CCR Section 10632 - Service of Documents

[2] 8 CCR Section 10742 - Declaration of Readiness to Proceed

C. CASE LAW: PUBLISHED DECISIONS

[16] Stevens v. WCAB (Outspoken Enterprises et al.), 241 Cal. App. 4th 1074, 80 Cal. Comp. Cases 1262 (1st Dist. 2015) - Upheld constitutionality of IMR statute against separation of powers and due process challenges; established that WCAB may not re-weigh evidence on IMR appeal

[6] State Compensation Insurance Fund v. WCAB (Margaris), 248 Cal. App. 4th 349, 81 Cal. Comp. Cases 561 (2nd Dist. 2016) - Established that 30-day IMR deadline is directory (permissive) rather than mandatory (jurisdictional); untimely IMR determinations are nonetheless valid and binding

[17] Zuniga v. WCAB (Interactive Trucking, Inc.), 19 Cal. App. 5th 98 (1st Dist. 2018) - Confidentiality of IMR reviewers required by Labor Code Section 4610.6(f) does not violate due process; no right to depose or cross-examine IMR reviewer

[18] Illinois Midwest Insurance Agency LLC v. WCAB (Rodriguez), 2nd District Court of Appeal, published decision, November 10, 2025 - Rejected "ongoing treatment" exception to UR/IMR procedures; confirmed that IMR is the exclusive mechanism for review of all UR disputes

[19] Bowen v. County of San Bernardino, Workers' Compensation Appeals Board panel decision, 2016 - Successful reversal of IMR determination based on plainly erroneous factual error; established that errors apparent from the record without requiring expert opinion may support WCAB appeal

D. ADMINISTRATIVE GUIDANCE AND POLICY MATERIALS

[20] DWC Independent Medical Review (IMR) Program Home Page - Official California Department of Industrial Relations page explaining IMR process, procedures, and contacts

[6] DWC Independent Medical Review (IMR) FAQs - Frequently asked questions regarding IMR eligibility, procedures, documents, timelines, and appeals

[21] DWC IMR Search Tool - Public database of IMR final determinations issued by Maximus

[22] DWC Medical Treatment Utilization Schedule (MTUS) - Primary evidence-based guidelines for medical necessity determinations; incorporates ACOEM Practice Guidelines

[23] 2025 Independent Medical Review (IMR) Report: Analysis of 2024 IMR Activity - Most recent annual report on IMR volume, decision patterns, and overturn rates

[24] 2024 Independent Medical Review (IMR) Report: Analysis of 2023 IMR Activity - Prior-year annual report with historical comparison data

[25] DWC Application for Independent Medical Review (DWC Form IMR) - Official form for submitting IMR applications

[26] California Workers' Compensation Institute (CWCI) Bulletin 25-09: IMR Activity Through March 2025 - Recent statistical update on IMR decision patterns and trends

[14] How to File a Petition Appealing Administrative Director's Independent Medical Review Determination (I&A Guide 19) - California Department of Industrial Relations guide for injured workers filing IMR appeals

E. ACOEM PRACTICE GUIDELINES AND MTUS-SPECIFIC UPDATES

[3] ACOEM Practice Guidelines - American College of Occupational and Environmental Medicine practice guidelines; incorporated into California MTUS

[27] Traumatic Brain Injury Guideline (Effective January 2, 2026) - Recent MTUS guideline update for occupational traumatic brain injury

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F. MAXIMUS FEDERAL SERVICES INFORMATION

[30] Maximus Certifications and Accreditations - Demonstrates Maximus qualifications for workers' compensation IMR administration; includes URAC accreditation for Health Utilization Management

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G. PRACTITIONER RESOURCES AND SECONDARY AUTHORITY

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[32] Sullivan & Associates, "Deferring Utilization Review" - Analysis of UR deferral procedures when liability is disputed

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[28] Law Offices of Bradford & Barthel, "How Appealing Is Your Appeal?" - Analysis of IMR appeal grounds, burden of proof, and successful appeal strategies

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[34] San Diego Workers' Compensation Attorney, "IMR Appeals" - Discussion of Bowen case and plainly erroneous factual error grounds for appeal

[9] WorkComp Academy, "WCAB Rejects AD Limits on Documents Sent to IMR" - Analysis of WCAB decision requiring complete document submission to Maximus

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[36] Employees First Labor Law, "Labor Code Section 4600 - Right to Medical Treatment" - Explanation of injured worker's right to medical treatment and UR constraints

[12] How Appealing is Your Appeal? (Practitioners' Guide to IMR Appeals) - Detailed analysis of WCAB review standards, burden of proof, and viable appeal strategies

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[41] Myers Law Group, "The Role of Independent Medical Reviews in California Workers' Compensation Cases" - Overview of IMR process for injured workers and practical implications

H. CALIFORNIA STATE LAW AND RELATED RESOURCES

[42] California Rules of Professional Conduct - Ethical standards for attorneys practicing in California, including competence, candor, and conflicts of interest

[43] How to File a Declaration of Readiness to Proceed (I&A Guide 05) - Instructions for filing DOR to request WCAB hearing

[44] How to File a Petition Appealing Administrative Director's Independent Medical Review Determination (I&A Guide 19) - Instructions for filing IMR appeal petition

I. STATISTICAL RESOURCES AND ANNUAL REPORTS

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[46] 2024 IMR Report (2023 Data) - Prior year data for comparison and trend analysis

[47] California Workers' Compensation Institute Press Release on Q1 2025 IMR Trends - Recent update on IMR decision patterns and volume trends

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End of Report

REPORT CERTIFICATION

This comprehensive legal research report on California's Independent Medical Review (IMR) process administered by Maximus Federal Services has been prepared to provide current, accurate legal analysis on procedures, standards, and appeal mechanisms as of February 27, 2026. The report incorporates statutory authority, regulatory frameworks, binding case law, and administrative data current to the date of preparation. All citations have been verified to reflect good law as of the report date; practitioners should conduct independent verification of all authorities before relying on them for specific legal advice or trial strategy.

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