How to file a petition appealing administrative director's independent medical review determination

If you disagree with either a medical treatment determination made through the independent medical review (IMR) process or a decision from the Administrative Director (AD) denying your application for IMR, you must file a petition (appeal) in order to challenge it. To do this, you may use the attached form.

The Labor Code requires that you file the petition with your local district office of the Division of Workers' Compensation (DWC) within 30 days from the date the determination or decision was mailed, but if it was mailed in California, the time to file is extended to 35 days. You will find the date that the medical treatment determination was mailed on the first page of the IMR decision. The date the decision denying your application for IMR was mailed can be found near the AD's signature or on the accompanying proof of service.

There are only five allowable reasons for appealing the IMR determination which are listed on the attached form. Strike out any items that do not apply to your case. Be sure to identify every item that you disagree with and include a full explanation. You may attach more sheets of paper if needed.

Please note that all forms must be typed or handwritten in block letters to insure legibility. Fill out the form completely and be sure to sign and date the form.

Send copy of your petition to your local district office: http://www.dir.ca.gov/dwc/dir2.htm. You must also send a copy to all the parties including the DWC's Independent Medical Review Unit at 1515 Clay St., 18th Floor, Oakland, CA 94612.

If the WCAB reverses the independent medical review determination, your medical treatment issues will be sent to another independent medical reviewer for review.

Submit the following documents with your form filing in the order shown:

- ✓ Document Cover Sheet
- ✓ Document Separator Sheet (*for Appeal of Determination of AD-IMR*)
- ✓ Petition Appealing Administrative Director's Independent Medical Review Determination
- ✓ Verification
- ✓ Copy of the Administrative Director's Independent Medical Review Determination
- ✓ Document Separator Sheet (*for Proof of Service by Mail*)
- ✓ Proof of Service by Mail

Keep copies of your filings for your records.

In order to have your petition addressed by a judge, you must also complete and file a "Declaration of Readiness to Proceed" (DOR). For instructions on how to complete and file a DOR, please see Information & Assistance (I&A) Guide No. 5: http://www.dir.ca.gov/dwc/iwguides/IWGuide05.pdf. To request an expedited hearing, use I&A Guide No. 6: http://www.dir.ca.gov/dwc/iwguides/IWGuide06.pdf. Either request for hearing can be filed at the same time you file your petition or afterwards.

If you do not yet have an ADJ case number assigned, you will need to submit an "Application for Adjudication of Claim" which opens a WCAB case for you. To do this, please see I&A Guide No. 4: http://www.dir.ca.gov/dwc/iwguides/IWGuide04.pdf. If you already have an ADJ case number assigned, you will not need to resubmit your "Application for Adjudication".

All documents filed with the Division of Workers' Compensation district office must include a document cover sheet and a document separator sheet. Please see I&A Guide Nos. 17 and 18 to learn how to complete these forms. Additional form instructions can be found on the EAMS OCR handbook at: http://www.dir.ca.gov/dwc/eams/SampleFiles/EAMS_OCR%20handbook.pdf.

If you need help, call an Information and Assistance office, or attend a workshop for injured workers. The local I&A phone numbers are attached to this guide. You can get information on a local workshop from the I&A office or on the Web at www.dir.ca.gov/dwc.

The information contained in this guide is general in nature and is not intended as a substitute for legal advice. Changes in the law or the specific facts of your case may result in legal interpretations different than those present here.

When sending documents to a DWC District Office, please make sure they are not folded or stapled. Send them in a large manila envelope. Please see the EAMS OCR handbook for further instructions.

WORKERS' COMPENSATION APPEALS BOARD
DISTRICT OFFICES

ANAHEIM, 92806-2131
1065 N PacifiCenter Drive, Suite 170
Information & Assistance Unit **(714) 414-1800**

BAKERSFIELD, 93301-1929
1800 30th Street, Suite 100
Information & Assistance Unit **(661) 395-2514**

EUREKA, 95501-0481 * Satellite office *
100 "H" Street, Suite 202
Information & Assistance Unit **(707) 441-5723**

FRESNO, 93721-2219
2550 Mariposa Street, Suite 4078
Information & Assistance Unit **(559) 445-5355**

LONG BEACH, 90802-4339
300 Oceangate Street, Suite 200
Information & Assistance Unit **(562) 590-5240**

LOS ANGELES, 90013-1105
320 W 4th Street, 9th Floor
Information & Assistance Unit **(213) 576-7389**

MARINA DEL REY, 90292-6902
4720 Lincoln Boulevard, 2nd and 3rd floors
Information & Assistance Unit **(310) 482-3858**

OAKLAND, 94612-1499
1515 Clay Street, 6th Floor
Information & Assistance Unit **(510) 622-2861**

OXNARD, 93030-7912
1901 N Rice Avenue, Suite 100
Information & Assistance Unit **(805) 485-3528**

POMONA, 91768-1653
732 Corporate Center Drive
Information & Assistance Unit **(909) 623-8568**

REDDING, 96002-0940
250 Hemsted Drive, 2nd Fl, Ste. B
Information & Assistance Unit **(530) 225-2047**

RIVERSIDE, 92501-3337
3737 Main Street, Suite 300
Information & Assistance Unit **(951) 782-4347**

SACRAMENTO, 95834-2962
160 Promenade Circle, Suite 300
Information & Assistance Unit **(916) 928-3158**

SALINAS, 93906-2204
1880 N Main Street, Suites 100 & 200
Information & Assistance **(831) 443-3058**

SAN BERNARDINO, 92401-1411
464 W Fourth Street, Suite 239
Information & Assistance Unit **(909) 383-4522**

SAN DIEGO, 92108-4424
7575 Metropolitan Drive, Suite 202
Information & Assistance Unit **(619) 767-2082**

SAN FRANCISCO, 94102-7014
455 Golden Gate Avenue, 2nd Floor
Information & Assistance Unit **(415) 703-5020**

SAN JOSE, 95113-1402
100 Paseo de San Antonio, Suite 241
Information & Assistance Unit **(408) 277-1292**

SAN LUIS OBISPO, 93401-8736
4740 Allene Way, Suite 100
Information & Assistance Unit **(805) 596-4159**

SANTA ANA, 92701-4070
605 W Santa Ana Boulevard, Bldg 28, Suite 451
Information & Assistance Unit **(714) 558-4597**

SANTA BARBARA, 93101-7538 * Satellite office *
130 E Ortega St.
Information & Assistance Unit **(805) 568-1390**

SANTA ROSA, 95404-4771
50 "D" Street, Suite 420
Information & Assistance Unit **(707) 576-2452**

STOCKTON, 95202-2314
31 E Channel Street, Suite 344
Information & Assistance Unit **(209) 948-7980**

VAN NUYS, 91401-3370
6150 Van Nuys Boulevard, Suite 105
Information & Assistance Unit **(818) 901-5374**

Rev. 5/16

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

Is this a new case? Yes ☐ No ☐ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☐

More than 15 Companion Cases ☐

_____ SSN: _____

Date:(MM/DD/YYYY)

☐ Specific Injury

_____ ☐ Cumulative Injury _____ _____

Case Number 1 (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

Please check unit to be filed on (check only one box)

☐ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

_____ ☐ Cumulative Injury _____ _____

Case Number 2 (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 3 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 4 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 5 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 6 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 7 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 8 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 9 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 10 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 11 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 12 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 13 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 14 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 15 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

☐ Specific Injury

Case Number 16 ☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

District office codes for place of venue

Legend	
Abbreviation	**Office**
AHM	Anaheim
ANA	Santa Ana
BAK	Bakersfield
EUR	Eureka
FRE	Fresno
GOL	Goleta
LAO	Los Angeles
LBO	Long Beach
MDR	Marina del Rey
OAK	Oakland
OXN	Oxnard
POM	Pomona
RDG	Redding
RIV	Riverside
SAC	Sacramento
SAL	Salinas
SBR	San Bernardino
SDO	San Diego
SFO	San Francisco
SJO	San Jose
SLO	San Luis Obispo
SRO	Santa Rosa
STK	Stockton
VNO	Van Nuys

Use this document to complete forms, but do not file this document with your forms.

Body Part Code List

The body part codes listed below are used to complete forms that require the listing of the part of the body that is in issue. Please do not file this document with your forms.

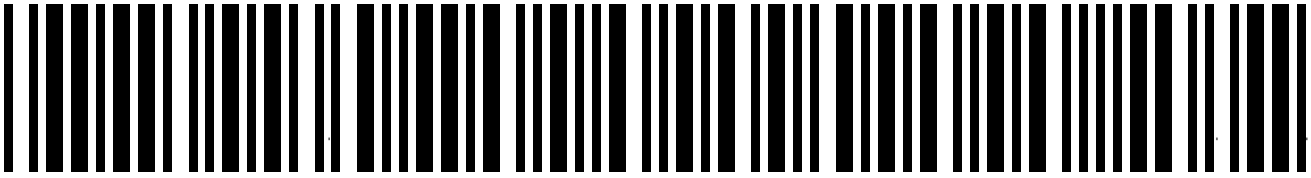
100	Head - not specified
110	Brain
120	Ear - not specified
121	Ear - external
124	Ear - internal including hearing
130	Eye - including optic nerves and vision
140	Face - not specified
141	Jaw - including chin and mandible
144	Mouth - including lips, tongue, throat and taste
145	Teeth
146	Nose - including nasal passages, sinus and smell
148	Face - multiple parts any combination of above parts
149	Face - forehead, cheeks, eyelids
150	Scalp
160	Skull
198	Head - multiple injury any combination of above parts
200	Neck
300	Upper extremities - not specified
310	Arm - above wrist not specified
311	Arm - upper arm humerus
313	Arm - elbow head of radius
315	Arm -forearm radius and ulna
318	Arm - multiple parts any combination of above parts
319	Arm - not specified
320	Wrist
330	Hand - not wrist or fingers
340	Fingers
398	Upper extremities - multiple parts any combination of above parts
400	Trunk - not specified
410	Abdomen - including internal organs and groin
411	Hernia
420	Back - including back muscles, spine and spinal cord
430	Chest - including ribs, breast bone and internal organs of the chest
440	Hips - including pelvis, pelvic organs, tailbone, coccyx and buttocks
450	Shoulders - scapula and clavicle
498	Trunk - use for side; multiple parts any combination of above parts
500	Lower extremities - not specified
510	Legs - above ankles, not specified
511	Thigh femur
513	Knee Patella
515	Lower leg tibia and fibula
518	Leg - multiple parts any combination of above parts
519	Leg - not specified
520	Ankle malleolus
530	Foot not ankle or toe
540	Toes
598	Lower extremities - multiple parts any combination of above parts
700	Multiple parts more than five major parts use only in fifth position of listing of body parts
800	Body system - not specific
801	Circulatory system - heart -other than heart attack, blood, arteries, veins, etc.
802	Circulatory system - Heart attack
810	Digestive system - stomach
820	Excretory system - kidneys, bladder, intestines, etc
830	Musculo-skeletal system - bones, joints, tendons, muscles, etc.
840	Nervous system - not specified
841	Nervous system - stress
842	Nervous system - Psychiatric/psych
850	Respiratory system - lungs, trachea, etc.
860	Skin dermatitis, etc.
870	Reproductive systems
880	Other body systems
999	Unclassified - insufficient information to identify body parts

Use this document to complete forms, but do not file this document with your forms.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

SAMPLE

DOCUMENT COVER SHEET



Is this a new case? Yes ☐ No ☐ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☐

More than 15 Companion Cases ☐

TODAY'S DATE
Date:(MM/DD/YYYY)

SSN: YOUR SOCIAL SECURITY NUMBER

☐ Specific Injury

EAMS CASE NUMBER
Case Number 1

☐ Cumulative Injury

DATE OF INJURY
(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

IF NEW CASE LEAVE BLANK

Body Part 1: _____ ← USE CODE FROM BODY PART CODE LIST, SEE PAGE 8

Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts: WHEN MORE THAN 5 BODY PARTS USE BODY PART NUMBER 700 IN THIS FIELD

Please check unit to be filed on (check only one box)

☐ ADJ ☐ DEU ☐ SIF ☐ UEF ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

Case Number 2

☐ Cumulative Injury

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____

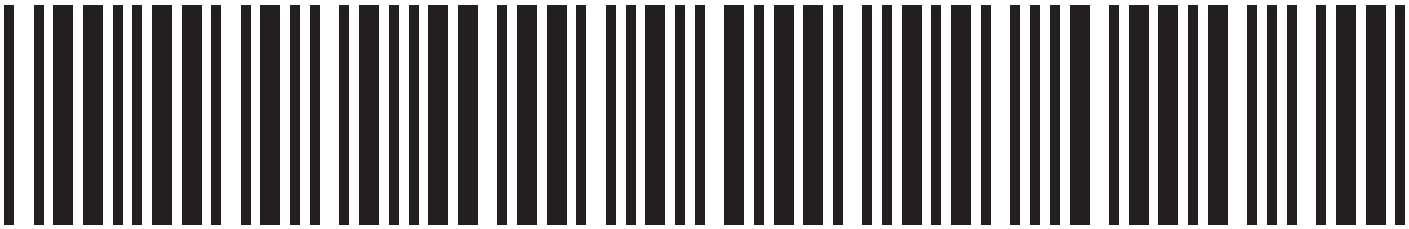
Body Part 2: _____

Body Part 3: _____

Body Part 4: _____

Other Body Parts: _____

DOCUMENT SEPARATOR SHEET



Product Delivery Unit _____

Document Type _____

Document Title _____

Document Date _____
MM/DD/YYYY

Author _____

Office Use Only

Received Date _____
MM/DD/YYYY

DOCUMENT SEPARATOR SHEET SAMPLE

Product Delivery Unit: ADJ

Document Type: IMR

Document Title: APPEAL OF DETERMINATION OF AD-IMR

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: YOUR NAME

Office Use Only

Received Date
MM/DD/YYYY

STATE OF CALIFORNIA

WORKERS' COMPENSATION APPEALS BOARD

Applicant,

Vs.

Defendants,

ADJ Case #
IMR Case #

PETITION APPEALING ADMINISTRATIVE DIRECTOR'S INDEPENDENT MEDICAL REVIEW DETERMINATION

A determination was made in the above-entitled case on _____. The Applicant is aggrieved by said determination and hereby petitions for appeal of the administrative director's independent medical review (IMR) determination upon the following grounds: (Strike out items not applicable.)

1. The administrative director acted without or in excess of the administrative director's powers.

2. The determination of the administrative director was procured by fraud.

3. The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5.

4. The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.

5. The 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 pursuant to Section 4610.5 and not a matter that is subject to expert opinion.

In support of the above, petitioner gives the following details, including a statement of each basis for objecting to the decision and a statement of all relevant facts upon which petitioner relies:

WHEREFORE, Petitioner requests that the appeal of the administrative director's independent medical review determination be granted; further proceeding be had; and that decision be made to give petitioner all the benefits to which petitioner is entitled under the Labor Code of the State of California, including the relief requested herein.

Dated: _____

_____
Attorney (if any) for Petitioner

_____
Petitioner's Signature

STATE OF CALIFORNIA

WORKERS' COMPENSATION APPEALS BOARD

SAMPLE

YOUR NAME

Applicant,

Vs.

YOUR EMPLOYER

Defendants,

ADJ Case #
IMR Case #

PETITION APPEALING ADMINISTRATIVE DIRECTOR'S INDEPENDENT MEDICAL REVIEW DETERMINATION

A determination was made in the above-entitled case on THE DATE OF THE MAXIMUS DETERMINATION LETTER. The Applicant is aggrieved by said determination and hereby petitions for appeal of the administrative director's independent medical review (IMR) determination upon the following grounds: (Strike out items not applicable.)

1. The administrative director acted without or in excess of the administrative director's powers.
2. The determination of the administrative director was procured by fraud.
3. The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5.
4. The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.
5. The 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 pursuant to Section 4610.5 and not a matter that is subject to expert opinion.

In support of the above, petitioner gives the following details, including a statement of each basis for objecting to the decision and a statement of all relevant facts upon which petitioner relies:

COMPLETELY DESCRIBE YOUR DISAGREEMENT WITH THE DETERMINATION BY MAXIMUS. BE SURE TO INCLUDE YOUR REASON(S) WHY THE DETERMINATION SHOULD BE CHANGED.

WHEREFORE, Petitioner requests that the appeal of the administrative director's independent medical review determination be granted; further proceeding be had; and that decision be made to give petitioner all the benefits to which petitioner is entitled under the Labor Code of the State of California, including the relief requested herein.

Dated: DATE MAILED

YOUR SIGNATURE

Attorney (if any) for Petitioner

Petitioner's Signature

VERIFICATION

I, the undersigned, am the petitioner in the above-entitled action. I have read the foregoing Petition Appealing Administrative Director's IMR Determination and know the contents of said petition. I certify that the contents are true of my own knowledge, except for those matters which are stated upon my information and belief, and as to those matters, I believe them to be true. I declare under penalty of perjury that the foregoing is true and correct.

Executed on _____ at _____, California.
(Date) (City)

Signature: _____

Print Name: _____

Date: _____

_____ _____
Attorney (if any) for Petitioner Petitioner's Signature

Sample

VERIFICATION

I, the undersigned, am the petitioner in the above-entitled action. I have read the foregoing Petition Appealing Administrative Director's IMR Determination and know the contents of said petition. I certify that the contents are true of my own knowledge, except for those matters which are stated upon my information and belief, and as to those matters, I believe them to be true. I declare under penalty of perjury that the foregoing is true and correct.

Executed on date mailed (Date) at your city (City), California.

Signature: your signature

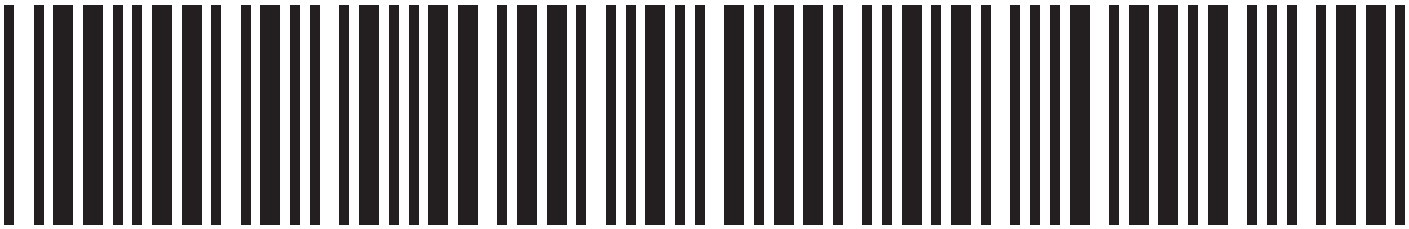
Print Name: your name

Date: date mailed

Attorney (if any) for Petitioner

your signature
Petitioner's Signature

DOCUMENT SEPARATOR SHEET



Product Delivery Unit _____

Document Type _____

Document Title _____

Document Date _____
MM/DD/YYYY

Author _____

Office Use Only

Received Date _____
MM/DD/YYYY

DOCUMENT SEPARATOR SHEET SAMPLE

Product Delivery Unit: ADJ

Document Type: LEGAL DOCS

Document Title: PROOF OF SERVICE

Document Date: DATE YOU FILLED OUT THE FORM
MM/DD/YYYY

Author: YOUR NAME

Office Use Only

Received Date
MM/DD/YYYY

PRINT CLEAR

Proof Of Service By Mail

I declare that:

I am (resident of / employed in) the county of _____ California. I am over the age of eighteen years, my (business / residence) address is:

-

-

On _____, I served the attached _____ on the _____ in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at _____ addressed as follows _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on (date) _____, at _____ California.

Type or print name _____

Signature _____

SAMPLE

Proof Of Service By Mail

I declare that:

I am (resident of/employed in) the county of YOUR COUNTY California. I am over the age of eighteen years, my (business/residence) address is:

PUT YOUR HOME ADDRESS HERE

On TODAY'S DATE, I served the attached NAME OF DOCUMENT on the INSURANCE COMPANY in said case, by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United State mail at CITY WHERE YOU MAILED THIS addressed as follows

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on (date) TODAY'S DATE, at CITY California.

Type or print name PRINT YOUR NAME

Signature SIGN YOUR NAME