Commission on Health and Safety and Workers' Compensation
Department of Industrial Relations
State of California
1515 Clay Street
Suite 1540
Oakland, CA 94612

June 5, 2026

Re: Formal Comments — *A Promise Unkept: A Targeted Reform Agenda for California Workers' Compensation*

Dear Commission Members:

Please find attached my formal comments on *A Promise Unkept: A Targeted Reform Agenda for California Workers' Compensation* (Besh, May 2026).

The submission consists of two comments and supporting exhibits, compiled as a single PDF.

Comment 1 addresses the paper's proposal to replace the Medical Provider Network architecture with a statewide QMT list, the Preferred Provider Network layer proposed on top of it, and the volume-based exemption framework. Comment 2 addresses the paper's diagnosis that physician non-compliance with administrative requirements reflects a training deficiency, and documents why the current administrative burden on treating physicians, not inadequate training, is the primary driver of the compliance failures the paper identifies.

Two significant topics raised in the paper are not addressed in these comments. I have chosen not to submit a comment on the paper's AB 1048 proposal at this time. That proposal addresses the serious problem of PPO discounting without transparency, which is a primary driver of specialist avoidance and an obstacle to access for injured workers. However, Labor Code §4609, which has been in effect since 2004, already provides a more direct and more powerful remedy than AB 1048 proposes. If the Commission would find it useful to receive a comment documenting how §4609 operates, how it compares to AB 1048, and what the Commission can direct DWC to do without any new legislation, I am prepared to submit one.

I have also chosen not to submit a comment on the paper's Utilization Review (UR) proposals at this time. They attempt to address the collapse of the IMR appellate function, the vagueness of the underlying clinical authority, and the exclusion of QME findings from medical necessity determinations. All of these are issues that deserve careful, detailed treatment. If the Commission would find it useful to receive comments on any or all of these issues, I am prepared to submit them.

I welcome the opportunity to discuss any of the matters raised in these comments or in this letter.

Respectfully submitted,

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FORMAL COMMENT 1 of 2

Re: *A Promise Unkept: A Targeted Reform Agenda for California Workers' Compensation* (Besh, May 2026)

Submitted to the Commission on Health and Safety and Workers' Compensation

Commenter: Catherine Montgomery, CEO, daisyBill

Date: June 5, 2026

The Paper's Proposal

The paper proposes a sweeping restructuring of California's workers' compensation system based on a new credential, Qualified Medical Treater (QMT).

QMT credentialing is presented as the solution to physician reporting non-compliance, injured workers' limited access to specialists, and Medical Provider Network (MPN) dysfunction simultaneously.

Three specific architectural elements flow from that credential:

1. A statewide QMT list maintained by DWC to replace the Medical Provider Network,
2. A Preferred Provider Network layer that allows employers and carriers to designate curated networks on top of the statewide QMT list, and
3. A volume-based exemption for physicians whose workers' compensation caseload falls below a defined threshold.

This comment documents two compounding failures in the QMT proposal.

First, each of the three proposed architectural elements raises operational questions that the paper neither asks nor answers. The answers to these operational questions directly affect injured workers, employers, and the physicians the credential is meant to educate and attract.

Second, every element of this proposed architecture is assigned to DWC, an agency with a documented, consistent pattern of failing to enforce its existing obligations.

Both failures are documented here, in Comment 1.

Comment 2 addresses a third, separate problem: the current administrative burden all California physicians endure when treating an injured worker, including uncompensated forms, an outdated reporting infrastructure, and a mismatch between what the system requires and how modern medicine is practiced.

Together, the two comments establish that the paper has misdiagnosed California's injured-worker access-to-care problem and assigned the proposed solution to the wrong agency.

Neither comment disputes that the access problem is genuine and that the MPN system fails all stakeholders. However, the proposed statewide credentialing system would shift

the current failures onto a new, more complex QMT list while increasing the administrative burdens already shouldered by providers.

The One-List Proposal: More Complex Than Advertised

The paper's diagnosis of the MPN problem is correct. The provider rosters are fictitious. The architecture invites gamesmanship. The carrier audits itself. But the proposed remedy replaces an opaque MPN access barrier with a transparent QMT barrier without resolving an important underlying question: what does an injured worker do when they cannot find a QMT provider willing to treat them?

Most immediately, the paper assigns DWC the responsibility of maintaining a real-time statewide QMT provider list that is accurate, current, searchable, and self-cleaning. The paper describes the QMT list as a byproduct of the credentialing process. It is not. And the scope of the population the list must account for is far larger than the paper acknowledges.

The paper frames the QMT credential as applying primarily to treating physicians, the Primary Treating Physician who manages the case, writes the PR-2s, and closes the case with a PR-4.

The paper proposes exclusion from the QMT credentialing through a volume-based exemption, distinguishing between providers who are "central" to treatment and those whose involvement is "incidental." This provider definition does not hold.

The examples the paper offers of incidental providers — an endocrinologist clearing a patient for surgery, a cardiologist providing pre-operative clearance, an infectious disease specialist consulting on a wound complication — are genuinely incidental.

But the recovery of an injured worker rarely involves only one provider. It involves a care team. As an example:

- An orthopedic surgeon operates on the shoulder.
- A physical therapist delivers twelve weeks of post-operative rehabilitation. A psychologist treats the work-related adjustment disorder.
- An occupational therapist supervises the return-to-work functional restoration program.
- A pain management specialist manages the chronic pain that persists after surgical intervention.
- A chiropractor provides ongoing spinal manipulation.
- An acupuncturist is authorized under the treatment plan.

All of these provider can touch a claim, bill the carrier, submit treatment documentation, and participate in the authorization process. However, only when a provider is assigned the PTP role are they responsible for closing a claim with PR-4 reports and making permanent and stationary determinations.

Maintaining and managing a real-time statewide provider registry that accounts for this full population providers would require DWC to undertake a technology and administrative infrastructure project on a scale the paper does not acknowledge.

At a minimum, every function below would need to be replicated across every provider type that touches a workers' compensation claim:

- **Initial credential verification** — confirm completion of state-developed curriculum, passing test scores, and issuance of certification for every applicant.
- **License status monitoring** — real-time cross-referencing with the Medical Board of California, Osteopathic Medical Board, Board of Psychology, Physical Therapy Board, Chiropractic Board, Occupational Therapy Board, and every other licensing authority whose providers touch workers' compensation cases, to identify license suspensions, revocations, probations, and restrictions across each board's separate disciplinary infrastructure.
- **CME tracking** — verify that every QMT-certified provider completes the required continuing education hours each renewal cycle and flag those who do not.
- **Disciplinary proceeding management** — receive complaints, investigate alleged violations, conduct due process proceedings, issue determinations, manage appeals, and execute removals for thousands of treating providers statewide.
- **Provider directory maintenance** — track practice addresses, phone numbers, fax numbers, specialties, languages spoken, geographic coverage, and accepting or not-accepting workers' compensation patient status, updated in real time as providers move, retire, or change their practice parameters.
- **Data integrity auditing** — Related to the above, identify and remove ghost listings, providers who are listed but no longer practicing, no longer accepting workers' compensation patients, or no longer reachable.
- **Removal and reinstatement processing** — manage the workflow for providers who fall out of compliance, are removed, complete remediation, and seek reinstatement, with due process protections at each stage.
- **Cross-referencing with federal exclusion lists** — verify that no QMT-listed provider appears on the Medicare/Medicaid exclusion list or the OIG exclusion database.
- **Public-facing search interface** — provide a searchable, filterable, mobile-accessible directory that injured workers, employers, and carriers can use to locate QMT providers by specialty, geography, language, and availability.
- **Provider portal** — allows providers to self-update practice information, submit continuing education documentation, and manage their credential status with verification workflows to prevent inaccurate self-reporting.

Maintaining a real-time statewide provider registry of this scope is not a byproduct of QMT credentialing. This is a major state technology and administrative infrastructure project.

The paper's own Access section acknowledges that DWC lacks the staffing to audit MPNs, calling it an unfunded mandate. The QMT list would be exponentially more complex.

The Volume-Based Exemption: Added Complexity

The paper proposes that physicians who see fewer than a defined number of workers' compensation patients per year — illustratively five or ten — would be exempt from the QMT requirement. This is presented as a practical accommodation for providers who "touch workers' compensation cases incidentally."

This proposed exemption removes the credentialing requirement without reducing the administrative burden these incidental providers endure when treating injured workers. The administrative obligations that apply to incidental providers regardless of their exemption status are documented in Comment 2.

The volume threshold creates three additional problems specific to the one-list QMT architecture.

First, volume tracking. DWC has no mechanism to track how many workers' compensation patients any individual physician sees per year. Creating one requires a new data collection and reporting infrastructure layered on top of the credentialing, disciplinary, directory maintenance, and data integrity functions already assigned to the same agency.

Second, the threshold crossing problem. When a provider exceeds the volume threshold (e.g., their sixth or eleventh workers' compensation patient of the year), the paper does not address whether treatment must stop until the provider obtains QMT certification, whether patients already under their care must be transferred, whether a grace period applies, or who bears responsibility for continuity of care during any transition. Each of these questions directly impacts injured workers. None is answered.

Third, the volume cap creates a structural incentive for providers to stop seeing workers' compensation patients before they reach the threshold. A physician who has treated four workers' compensation patients and does not want to pay to obtain QMT certification has a rational incentive to decline the fifth. The reform, designed to improve access to care for injured workers, creates a new incentive for providers to limit that access through its own exemption mechanism.

The PPN: A Curation Layer With Unresolved Parameters

The paper presents the Preferred Provider Network (PPN) as architecturally distinct from a Medical Provider Network (MPN) because it sits atop universal QMT access rather than substituting for it. However, unlike an insurer or employer's MPN, a fictitious

or thin PPN roster carries no access consequences because the proposed statewide QMT list remains the operative access floor. The central deficiencies of an MPN that fails to deliver compliant provider rosters are not replicated by a PPN list.

That said, four unresolved parameters in the PPN proposal warrant attention.

Discount extraction. The paper's Access section identifies Preferred Provider Organization (PPO) discount reimbursements as a primary driver of specialists' refusal to treat injured workers. The PPN proposal does not specify whether the PPN designation can be conditioned on reimbursement discounts. A PPN that conditions its designation on discount acceptance replicates the economic dynamic the paper condemns, with PPN certification as the new mechanism that demands PPO contracting.

PPN multiplication. The paper criticizes Coventry for operating approximately 27 separate MPN products, noting that product-level opacity creates treatment chaos. The PPN architecture contains no limit on the number of PPNs a carrier may operate and no minimum size requirement. Nothing in the PPN structure prevents the same kind of opacity Coventry has achieved through product multiplication. The access consequences are reduced because the QMT floor remains intact, but the administrative friction and confusion for injured workers and providers remain.

Fallback procedure and the evidentiary burden. The paper does not specify what happens when an injured worker whose employer has designated a PPN cannot locate an available PPN provider. This gap is actually two problems: First, what are the steps the worker must take to invoke the fallback to the statewide QMT list; second, how does the worker document that the PPN was deficient, thereby justifying the fallback.

Under the current MPN architecture, proving network inadequacy has been a chronic problem. The worker calls physicians on the list, cannot obtain an appointment, and has no formal mechanism to document the failed attempts in a way the system recognizes when the carrier disputes the worker's characterization. The paper correctly identifies MPN roster inaccuracy as a structural problem, but does not specify how the PPN avoids replicating this exact dynamic at the fallback seam.

If the worker must demonstrate PPN deficiency before accessing the QMT list, the worker needs a documented process for doing so, including a defined number of failed contact attempts, a timeframe, a reporting mechanism to the carrier or DWC, and a carrier response obligation with a deadline. Without that infrastructure, the worker is left managing two lists in practice, with the burden of proving the inadequacy of first list falling entirely on them, and with no administrative mechanism to support that proof. The gap between the PPN and the QMT fallback is where the injured worker is most exposed, and the paper fails to explicitly specify the evidentiary and procedural infrastructure at that gap.

The two-list problem in practice. Related to the above, the paper's assurance that the worker always has access to the statewide QMT list is structurally correct but operationally incomplete. In practice, a worker whose employer has designated a PPN will be directed to that PPN first. Navigating from the PPN to the QMT list requires the worker to recognize that the fallback exists, understand the steps required to invoke it, and document their attempts adequately to survive a carrier dispute. This is a substantial administrative burden to impose on a population that is injured, often without legal representation at the point of initial care, and poorly positioned to manage evidentiary documentation.

The Agency That Cannot Do What It Is Already Asked to Do

Credentialing QMTs, maintaining one QMT list with a volume-based exemption infrastructure, and the PPN oversight obligation are all assigned to DWC. This is in addition to the existing DWC functions the paper does not propose to eliminate: IBR administration, IMR contractor oversight, UR audit obligations, and QME program management.

The evidence of DWC's performance across these existing obligations is not anecdotal. It is documented in the State's own audit findings, in DWC's own published data and public statements about what it does and does not enforce, as well as published industry analyses, including those using daisyBill's own data, spanning multiple program areas:

- **MPN list maintenance failure and carrier non-compliance.** 8 CCR §9767 et seq requires networks to maintain accurate provider rosters and to meet access standards, but DWC does not actively audit MPN rosters for accuracy, and the burden of discovering that a listed physician has retired, relocated, or does not, in fact, accept workers' compensation patients falls on the injured worker and provider. DWC has, in fact, repeatedly failed to maintain a functional public MPN list. The list has vanished and been rendered inaccessible on multiple occasions, leaving injured workers and providers unable to verify network participation. (CA DWC MPN List Vanishes Again, Again & Again, daisyBill, Jan. 2025, https://blog.daisybill.com/ca-dwc-mpn-list-vanish)
- **IBR law violations at scale.** Labor Code §4603.6(d) requires DWC, on receipt of an IBR request, to assign the request to an independent bill reviewer within 30 days. DWC's own published IBR determinations show it routinely misses that deadline: in 2025, it met the 30-day requirement in only 4% of cases, and timely assignment has declined steadily over recent years. The agency that enforces strict filing deadlines against providers does not consistently meet its own. (DWC IBR decisions, https://www.dir.ca.gov/dwc/ibr/ibr-decisions/ibr_decisions.asp ; CA DWC Broke the Law in 96% of 2025 IBR Cases, daisyBill, Jan. 2026, https://blog.daisybill.com/ca-dwc-breaks-law-ibr)
- **UR data collection mandate ignored.** Via SB 1160 (2016), the Legislature unanimously amended Labor Code §4610 to require DWC to build a system for

the mandatory electronic reporting of every utilization review decision. Subsequently, SB 537 (2019) added Labor Code §138.8, requiring DWC to publish provider-level UR data on its website on or before January 1, 2024. DWC failed to implement a system capable of either. Without the data, systemic patterns of inappropriate denials cannot be identified or corrected. Injured workers are the direct victims of DWC's failure to follow its own statutory mandate.((UR Data Supports CA Legislators' Fears, daisyBill, Dec. 2023, https://blog.daisybill.com/dauth-ur-data-proves-ca-legislators-weren-t-wrong)

- **UR denial rates used as a competitive marketing tool.** Sedgwick, the nation's largest TPA and a major administrator of California workers' compensation claims, publicly advertised a national 54% treatment denial rate as a selling point to prospective employer clients, boasting that it denied more than half of all injured worker treatment requests. Labor Code §4610(a) defines UR decisions as those based on medical necessity, while Labor Code §4610(g)(3)(B)(i) prohibits financial incentives to UR physicians based on the number of denials and modifications. A publicly advertised 5:1 ROI tied directly to the denial rate raises a reasonable question as to whether Sedgwick's program was structured in ways inconsistent with these requirements. The statistic was removed from Sedgwick's marketing website shortly after publication of this analysis; daisyBill documented the removal as well. Despite daisyBill's two published accounts, DWC took no investigative or enforcement action. (Sedgwick Boasts 54% Denial Rate for Injured Worker Treatment, daisyBill, Sept. 2024, https://blog.daisybill.com/sedgwick-boasts-54-denial-rate-for-injured-worker-treatment ; Sedgwick Removes 54% UR Denial Stat From Website, daisyBill, Oct. 2024, https://blog.daisybill.com/sedgwick-removes-54-ur-denial-stat-from-website)
- As of April 2026, daisyBill has filed formal audit complaints with DWC documenting 359,626 violations of California workers' compensation law on the part of Sedgwick. DWC has taken no documented enforcement action in response. (CA: Sedgwick Hits 359,626 Violations (and Counting), daisyBill, Apr. 2026, https://blog.daisybill.com/sedgwick-2026-audit-complaint)
- **WCIS data integrity failure, with direct consequences for this Commission.** DWC is legally required to enforce mandatory reporting to the Workers' Compensation Information System (WCIS), with statutory penalties for non-compliant claims administrators. Instead, DWC's own published guidance states that the Division "is focusing its efforts on encouraging voluntary compliance, rather than on enforcement." As a result, WCIS data are self-reported, unverified, and not available to stakeholders or the public for independent review. CHSWC reports — including the reports this Commission relies on to evaluate the system — are built on this compromised data foundation. Because CHSWC's own analyses draw on WCIS data, the Commission should weigh its system-wide conclusions, including any bearing on whether these specific reforms are warranted, against that limitation. (DWC WCIS FAQ, https://www.dir.ca.gov/dwc/WCISFAQ.htm ; Labor Code §129.5,

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=LAB§ionNum=129.5) ; DWC's Failed WCIS Taints CHSWC Reports, daisyBill, Sept. 2024, https://blog.daisybill.com/dwc-s-failed-wcis-taints-chswc-reports)

- **QME oversight.** In 2019, the California State Auditor examined DWC's administration of the Qualified Medical Evaluator process and found that DWC had not ensured an adequate supply of QMEs, had not followed its own regulations to discipline QMEs, and despite state law requiring DWC to review QME report quality continuously and report annually, had not done so since at least 2007. This is the same agency, and the same category of ongoing statutory duty (credentialing, discipline, quality review), that the QMT proposal would expand. Although the Auditor's recommendations have been mostly addressed since 2019, seven years later there are still outstanding unimplemented recommendations. (Report 2019-102, https://information.auditor.ca.gov/reports/2019-102/index.html ; Report 2019-102 Recommendations, https://information.auditor.ca.gov/reports/recommendations/2019-102)

The pattern is consistent across program areas: MPN administration, IBR compliance, UR data collection, QME oversight, and general law enforcement. As noted previously, the paper' acknowledges that DWC lacks the staffing to audit MPNs and describes the audit obligation as an unfunded mandate. That acknowledgment is internally inconsistent with the simultaneous proposal to assign DWC responsibility for credentialing, monitoring, and disciplining thousands of treating providers statewide; maintaining a real-time statewide provider directory; tracking per-physician patient volume; and overseeing PPN compliance.

The documented failures above occurred under prior DWC agency leadership. The current Acting Administrative Director has demonstrated genuine receptiveness to reform and a commitment to improving agency performance. That acknowledgment does not qualify the evidence above. It is a recognition that even capable and well-intentioned leadership inherits the consequences of institutional deterioration that took years to unfold.

Reforming a system that was allowed to decline across multiple program areas simultaneously is a massive undertaking. Assigning that same agency sweeping new credentialing, directory management, exemption monitoring, and network oversight responsibilities, before the existing backlog of non-performance is addressed, does not serve the injured workers the reforms are meant to help. It multiplies the problem with additional obligations the agency is not yet positioned to meet.

The paper's own methodology states that architecture should make rational behavior compliant behavior. That discipline should be applied here. An architecture assigned to an enforcement body with this documented record does not make rational behavior compliant behavior. It creates obligations that exist on paper and are enforced by no one. California employers and their injured workers absorb the cost of every unenforced

obligation, as they have absorbed the cost of every unenforced obligation that preceded this one.

This is not to say that DWC can never administer new functions. Rather, any reform must first address not only DWC's capacity but also its willingness to act on the duties it already has.

What the Commission Should Do

Before evaluating the QMT proposal on its merits, the Commission should read Comment 2 in full. Comment 2 documents why the current administrative burden on treating physicians, not inadequate training, is the cause of the compliance failures the paper attributes to credentialing gaps. Comment 2 also sets out what the Commission should require before accepting the paper's premise that a credentialing solution is warranted at all. The reforms proposed in this paper are only as durable as the agency assigned to implement them and only as necessary as the underlying diagnosis is correct. Comment 2 addresses both questions directly.

FORMAL COMMENT 2 of 2

Re: *A Promise Unkept: A Targeted Reform Agenda for California Workers' Compensation* (Besh, May 2026)

Submitted to the Commission on Health and Safety and Workers' Compensation

Commenter: Catherine Montgomery, CEO, daisyBill

Date: June 5, 2026

The Paper's Diagnosis

The paper states:

"The carriers themselves complain about these failures, that RFAs are not filled out properly, that PR-2s are not filled out properly, that physicians keep patients out of work too long with consequent temporary total disability (TTD) costs, and that treating physicians refuse to write PR-4 reports, which necessitates QMEs that would otherwise not be needed."

The paper attributes these failures to inadequate physician training and proposes the Qualified Medical Treater (QMT) credential as the structural remedy. This diagnosis is wrong, and so is the proposed remedy. Although we agree with Besh that physicians struggle with the system's reporting requirements, we disagree on the cause: these failures stem not from a gap in physician training but from outdated forms and the administrative overhead that overwhelms modern practices.

Treating an injured worker requires providers to devote substantial resources to completing mandated forms for which compensation is either nominal or entirely absent. The reporting dysfunction reported by carriers is not a physician failure, and no credentialing program can fix it.

Obsolete Forms Within an Outdated System

Every mandatory form in California workers' compensation was designed for a paper-based practice environment. The last substantive revision to any of these forms predates the widespread adoption of modern electronic health records. The 2015 and 2016 updates to Form 5021, the PR-2, and the PR-4 merely swapped ICD-9 labels for ICD-10. The state-imposed documentation, its structure, workflow requirements, and transmission methods are materially unchanged from an era that predates the infrastructure of modern medicine entirely.

A physician who completes proposed QMT certification and returns to treat and manage injured workers will encounter the same uncompensated forms, the same outdated reporting infrastructure, and the same mismatch between what the forms require and what EHR systems generate.

The proposed QMT credentialing fails to address the economics, the infrastructure, or the burden on providers' administrative staff who must be trained on the intricacies of every form, every submission requirement, and every claims administrator's idiosyncratic fax number.

Training physicians to navigate a broken system more proficiently is not the same as fixing the system. The carriers' complaint that providers are not completing these forms correctly is legitimate on its face. But the structural and financial burdens these forms impose lead providers to avoid workers' compensation entirely.

The Uncompensated Administrative Burden

The following summarizes the administrative requirements and their associated reimbursement:

Form	Requirement	Reimbursement
Form 5021 Doctor's First Report	Required on first visit; two copies must be sent to the employer's workers' compensation insurance carrier or the insured employer.	$0
PR-2	Required every 45 days and at each change in condition, treatment, or work status. Not reimbursable for secondary treaters.	$16.14
RFA Request for Authorization	Required for ALL recommended treatment. Must be faxed with supporting documentation. No standard fax number exists for claims administrators.	$0
PR-4	Primary Treating Physician's Permanent and Stationary Report. Maximum 7 pages. Providers routinely unaware of page-count billing requirement.	$50.00 p.1 +$30.74/pg max $234.44
EMR Clinical Notes	Required for payment on all bills. Must be generated and attached in addition to mandatory forms.	$0

The forms summarized above are reproduced in Exhibits C through F.

The Administrative Load of a Single Injured Worker

Consider what a physician faces the first day they treat a new workers' compensation patient.

They must complete Form 5021, which is 55, with 55 to 60 discrete data-entry points, signed under penalty of perjury, due within five days, and submit two copies to an insurance carrier with whom they have no relationship and likely cannot identify. Reimbursement: $0.

If they determine the patient needs any treatment — a referral, imaging, a splint, physical therapy — they must complete a Request for Authorization (RFA), assemble supporting documentation, locate a fax number that does not exist in any central directory, and transmit the RFA package by fax. They must do this even if they will not personally provide the requested treatment. Once transmitted, physicians must also contend with utilization review decisions that are too often lengthy, incorrect, noncompliant, illegible, or internally inconsistent. A redacted example is provided in Exhibit G. Referral RFA management reimbursement: $0.

If the physician is the Primary Treating Physician (PTP), they must complete a PR-2 every 45 days thereafter, signed under penalty of perjury, for $16.14. If they substitute a narrative, it is reimbursed only if the headings appear in the exact order prescribed by a form last updated in 2015.

Secondary treating physicians do not submit the PR-2; instead, they must send a clinical report to the designated PTP. Secondary treater reimbursement for sending clinical notes: $0

The PTP is required to incorporate the secondary physician's findings into a PR-2, adding an additional layer of uncompensated coordination work for every secondary treater involved in the case.

When the injured worker reaches maximum medical improvement, the PTP must complete a PR-4, which is a 6-page form that requires AMA Guides impairment ratings with table and page citations, 14 functional capacity categories, an apportionment analysis, a review of past records, future medical projections, and is signed under penalty of perjury. Maximum reimbursement: $234.44, only if they know to bill by page count, which the form does not explain.

No other payer relationship in American medicine is subject to a reporting structure as mandated by California workers' compensation. The above is not a description of an unusual or complex case. The workflow imposed on the treating physician and administrative staff is documented in Exhibit A. Moreover, this is routine workers' compensation patient care from day one. The "Automatic" authorization that applies during the first 30 days post-injury imposes an equally onerous workflow on the treating physician, as documented in Exhibit H.

Form-by-Form Analysis

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

Under the Labor Code, every physician who treats an injured worker for the first time, including the designated Primary Treating Physician or a secondary treater, is required to complete Form 5021- Doctor's First Report of Occupational Injury or Illness.

- The Form 5021 contains 26 numbered fields, which expand to approximately 55–60 discrete data-entry points when subfields are counted individually.
- The form states that it must be completed within five days of the initial examination and signed under penalty of perjury.
- The form warns that failure to file a timely report may result in the assessment of a civil penalty.
- The provider is instructed to submit two copies to the employer's workers' compensation *insurance carrier* or the *insured employer*, a requirement that is practically unworkable.

  The treating provider typically has no relationship with the employer's insurance carrier and may not know who it is. Further, they rarely have direct contact information for the employer. There are no instructions at all for state government employees whose employer is not insured. In practice, every provider sends the form to the claims administrator, whose contact information the form does not ask for and whose role the form does not acknowledge.

- Reimbursement for completing and submitting Form 5021: $0

PR-2: Primary Treating Physician's Progress Report

The Primary Treating Physician (PTP) is required to complete the Primary Treating Physician's Progress Report, known as the PR-2. The PTP must submit this form every 45 days and at every change in condition, treatment, or work status.

- The PR-2 is a two-page form containing approximately 57 discrete data-entry points, including a detailed treatment plan narrative and a work status determination with specific functional restrictions.
- It must be signed under penalty of perjury.
- Reimbursement for completing and submitting the PR-2 is $16.14.

8 CCR §9785(f) permits providers to substitute a narrative report, but that permission is effectively illusory because the narrative is reimbursed only if it reproduces the exact headings of the form in the exact order in which they appear. A narrative containing identical clinical information but organized differently is treated as non-compliant, and reimbursement is often denied. The regulation also allows reports "in any manner and form" by mutual agreement with the claims administrator, but that simply returns the physician to negotiating individually with hundreds of payers for relief from a form the state has not updated.

The Secondary treaters receive no reimbursement for their reports or notes.

RFA: Request for Authorization for Medical Treatment

California law requires the claims administrator to authorize all recommended treatment before it is provided. This requirement applies universally, including routine, straightforward items such as splints, x-rays, and injections. Treatment rendered without prior authorization will not be paid.

The RFA Form

Authorization is requested by submitting a Request for Authorization (RFA), a one-page form, last updated January 2014. The form captures employee information, physician and claims administrator information, and up to five requested treatment items. Each item requires a diagnosis, an ICD code, a specific requested service, and, if known, a CPT code.

The form has structural limitations:

- Its text blocks are frequently too small to contain the clinical information needed to substantiate the request, forcing providers to attach supplemental pages outside the form's prescribed structure
- A wet physician signature is mandatory, a requirement that is functionally meaningless since the document is transmitted by fax or email, and serves only to add a step to a process that already carries no compensation
- The RFA must be accompanied by either a Form 5021, a PR-2, or the secondary physician's report, meaning the provider must assemble a package of completed forms and supporting documentation before transmission
- Reimbursement for completing and submitting the RFA: $0.

Faxing the RFA Form

The claims administrator's contact information, including the fax number or email address designated to receive RFAs, is not standardized. No central RFA fax number is required. In some instances, the provider must independently locate a unique destination for each injured worker's claim. That burden falls entirely on the physician, at no reimbursement, for a form already being completed for free.

Scope of the Obligation

The RFA obligation is not limited to the treatment the requesting physician will personally deliver. A PTP or secondary physician who determines that a patient needs specialist evaluation, imaging, or physical therapy must complete, assemble, and transmit the full RFA package for services another provider will furnish again, at zero compensation.

Authorization Documentation Management

The administrative burden does not end with faxing the RFA. Each procedure on an RFA may generate its own separate UR or authorization document, which can arrive at

different times, in different formats, from different reviewers, and through different transmission channels.

Providers cannot designate a single fax number or email address to receive UR decisions; claims administrators transmit responses through whatever channel they choose, leaving providers to monitor multiple inboxes and fax lines to avoid missing a decision. The UR documents themselves are not standardized, ranging from single-page approvals to multi-page documents dense with boilerplate, conditions, time limits, network restrictions, and exceptions.

Despite the claims administrator's responsibility for responding to the RFA, the provider must return every resulting authorization document to the same claims administrator, along with the corresponding bill. This requires the billing staff to:

- Collect every UR document generated in response to each RFA
- Match each authorization to the corresponding procedure on the bill
- Confirm that no authorization expired before treatment was delivered
- Parse partial approvals, identifying which procedures were approved, denied, or modified
- Submit the correct authorization documents with each bill

A bill submitted without the corresponding authorization is denied, regardless of whether the treatment was clinically appropriate or whether authorization was in fact issued. The entire tracking, matching, and document management obligation falls on the provider's administrative staff. None of it is compensated.

This burden is not limited to the treatment the practice will deliver. When the requesting physician refers the patient to a specialist, an imaging center, or a physical therapist, the authorization response still arrives at the requesting physician's office. The requesting physician must receive it, review it, parse any conditions or restrictions, and forward it to an MPN provider, all without compensation, for care the practice will never furnish and never bill for.

PR-4: Primary Treating Physician's Permanent and Stationary Report

The PR-4 is a six-page form, last revised in February 2016, when the ICD-9 labels were replaced with ICD-10 labels. The paper's author correctly identifies it as an essential document in the management of an injured worker's claim. What the paper does not reckon with is the clinical and legal complexity the form demands, the economics that make completing it irrational, and what the system pays when it asks a QME to perform the same determination.

The form requires the Primary Treating Physician to document

- Objective findings with bilateral measurements,
- Apply the AMA Guides 5th Edition to derive whole person impairment ratings with specific table and page number citations for each impairment,

- Perform a pain assessment, and
- Address apportionment under Labor Codes §4663 and §4664.
- Requires a detailed functional capacity assessment across 14 physical activity categories,
- A complete list of medical records reviewed must be furnished,
- Projections of future medical treatment are required,
- A return-to-work determination is required, and
- It must be signed under penalty of perjury.

Reimbursement is $50.00 for the first page and $30.74 for each additional page, up to a maximum of seven pages, for a total of $234.44, under procedure code WC004, effective March 1, 2026.

A physician who submits a seven-page PR-4 but bills one unit receives $50.00 instead of $234.44. This billing requirement that submitted units must reflect the page count is not prominently disclosed and is largely unknown among billing staff for treating physicians. The form does not explain this unit requirement to receive full reimbursement.

The QMT proposal endorses a “nominal increase” in PR-4 reimbursement as a mechanism to reduce unnecessary QME evaluations, on the premise that a QMT-credentialed PTP who knows the patient should be able to close the case without sending it to a QME. That logic ignores the underlying lack of reimbursement for a substantial administrative burden, where many physicians are reimbursed $50.

Further, the paper does not address the amount reimbursed to QMEs for performing the permanent and stationary determination required by the PR-4. For a QME, the fee structure begins at $2,015 for a Comprehensive Initial Evaluation, plus $3 per page for medical record review, plus $650 for follow-up reports.

The PTP performing that same determination receives a maximum of $234.44, only if they know to bill by page count, which the form does not explain, and the fee schedule does not prominently disclose.

The paper attributes the PTP's reluctance to complete the PR-4 to inadequate credentialing. It does not attribute it to a form of extraordinary complexity. A nominal increase to an absurdly low rate is not a solution.

Clinical Note - Electronic Health Records (EHR)

EHR-generated clinical notes are required for payment on all bills. Forms 5021, PR-2, and PR-4 do not provide sufficient space for the clinical documentation that payers require to process payment. To receive payment, providers must generate and attach complete visit notes generated by their EHR systems.

No separate reimbursement exists for any of this documentation.

The Contrast With Every Other Payer Relationship

A Medicare encounter generates documentation natively within the EHR, transmits claims electronically, and does not require a separate form to be signed under penalty of perjury and faxed to an unidentified recipient. A commercial insured encounter operates identically. In neither relationship does the physician bear nearly as many uncompensated administrative obligations as a condition of treating the patient.

California's workers' compensation is distinctive among major payer relationships in imposing such onerous form-specific, penalty-of-perjury documentation obligations on the treating physician as a condition of participation, without compensation for that administrative work.

The QMT credential does not change this administrative burden. Instead, it proposes to train physicians in the substantive and procedural requirements of the system, including causation doctrine, apportionment, PR-2 and PR-4 reporting standards, the RFA process, and return-to-work guidelines.

The paper acknowledges that the QMT credential would carry an annual maintenance fee. So the full picture is this: physicians are asked to invest time and money to obtain and maintain a credential that trains them to navigate a documentation system their EHR cannot produce, transmit forms by fax to recipients they must identify individually, and complete administrative work for compensation that does not reflect the time involved.

The credential trains physicians to navigate dysfunction more competently, yet requires them to pay for the training. That is not a solution. It is an accommodation of a system that should instead be fixed, and a cost imposed on the physicians whose participation the system most needs to attract.

Why No EHR Produces, and Will Never Produce, These Forms

There are thousands of Electronic Health Records (EHR) systems in use across American medicine, ranging from enterprise installations at large health systems to small-practice solutions serving individual physicians. Most of them cannot natively generate a PR-2, and none can generate a PR-4 or Form 5021; many cannot produce an RFA. Some providers have cobbled together workarounds that include custom templates, hybrid documents, and manual transcription processes, but these are individual adaptations to a structural failure.

The reason no EHR accommodates these forms is straightforward economics. Workers' compensation represents less than two percent of all medical transactions in the United States, spread across fifty states, each with its own forms, requirements, fee schedules, and administrative rules that change continuously. For any given EHR vendor, its clients' California workers' compensation represents a sliver of their transaction volume. There is no return on investment in building and maintaining the technology required to generate native California workers' compensation forms. It will never exist under the

current architecture. No EHR vendor will build what California has not made worth building.

This is a market reality that California's documentation architecture has ignored. The state cannot compel EHR vendors to accommodate a paper-era form design when it has no leverage over that market and never will. What the state can do is stop requiring documentation that EHR systems cannot produce and start requiring documentation that every EHR already generates.

A QMT curriculum will train physicians on how to complete these forms. It will not give them an EHR that produces these forms. The credential trains physicians to do manually, repeatedly, and without compensation what every other payer relationship in American medicine has mostly automated. That is not a solution to the access problem the paper is trying to solve. It is an additional burden layered on top of the existing ones, imposed on the physicians whose participation the system most needs to attract.

California has maintained a documentation system that medicine abandoned decades ago, and then attributed the resulting compliance failures to physicians practicing in modern medicine. The Commission should name this clearly and recommend that it end.

What the Commission Should Recommend

The Commission should recommend a complete overhaul of every mandatory workers' compensation form in California.

The overhaul should be grounded in two principles. First, the forms must be rebuilt to reflect how medicine is actually practiced and documented in 2026, meaning they should be built around the capabilities of modern EHR systems rather than a paper-based workflow that no longer exists. Second, the concept of a structured form should be abandoned entirely in favor of a defined set of clinical questions.

A physician currently spending uncompensated time wrestling a PR-2 into compliance with a decades-old heading sequence would instead document their clinical findings in their own system and answer a defined list of questions, including what is the patient's current work status, what treatment is being requested, and has the condition changed since the last report. The administrative extraction happens downstream. The physician's obligation is clinical, not clerical.

This approach does three things that the current form architecture cannot. It eliminates the mismatch between state documentation requirements and EHR workflows. It reduces the barrier to participation in workers' compensation for physicians who currently find the administrative overhead prohibitive. And it places the burden of administrative compliance where it belongs: on the system's administrative infrastructure, not on the treating physician.

While this form overhaul is itself a major new duty for the DWC, the need for the overhaul is pressing. A working group should be convened to implement this overhaul, and should proceed with one structural principle that prior modernization efforts have failed to observe: namely, every question a physician is required to answer must be compensated.

Physician-reported clinical information is the foundation on which employers' disability and liability costs are determined. The system depends on the quality and completeness of that information. A system that depends on information it does not pay for will not get the information it needs. Compensating each question at an appropriate rate also creates a natural check on administrative overreach; if a claims administrator wants more information it must be willing to pay for it, which disciplines the impulse to expand requirements indefinitely.

A prior panel convened to redesign the Form 5021 produced a DWC portal that was more administratively punitive than the form it was meant to replace. Per the proposed DWC portal requirements, physician staff would be required to manually type Form 5021 information into a state portal, with an expanded set of questions that exceeds the burden of the paper form the portal was supposed to eliminate. This outcome is predictable whenever the cost of adding a question falls on the provider other than the party adding it. The structural protection against repeating that failure is that physicians must be paid to answer questions that pertain to the injury.

The Commission should further recommend that reimbursement for administrative work be reviewed against the actual time and complexity of each reporting obligation imposed.

Adequate reimbursement is not a courtesy extended to physicians. It is the mechanism by which the system gets the information it needs. Raising reimbursement rates to reflect the actual work involved is the structural incentive that produces careful, complete, and timely documentation. A credentialing requirement without that incentive produces a more qualified physician who still has no financial reason to complete the work.

The contrast with other states is instructive. Texas has chosen a different approach to physician education. The Texas Division of Workers' Compensation regularly hosts free provider training webinars and a provider boot camp, offered at state expense, that cover the substantive and procedural requirements for treating injured workers. Texas does not propose to make physicians pay for the privilege of learning the system's requirements. It provides education as a public function of the agency charged with administering the system. The author proposes that physicians obtain a credential, pay an annual maintenance fee, and navigate a documentation architecture that the state has not updated in a decade. The comparison is not flattering.

The QMT credential, as proposed, addresses the wrong problem. Before California asks physicians to invest time and money in a credentialing requirement, it owes them a system worth participating in.

Exhibits

Formal Comments on *A Promise Unkept*
Catherine Montgomery, CEO, daisyBill
Submitted to CHSWC, June 5, 2026

The following exhibits are referenced in Comment 2 and provided to document the administrative workflow and form burden imposed on treating physicians under the current California workers' compensation system.

Exhibit	Description	Page
A	Injured Worker Initial Visit Workflow: Primary Treating Physician (PTP) and Non-PTP	21–23
B	CA Injured Worker Intake Form & Authorization Information Form	24–25
C	DWC Form 5021 (Doctor's First Report of Occupational Injury or Illness)	26
D	DWC Form RFA (Request for Authorization)	27
E	DWC Form PR-2 (Primary Treating Physician's Progress Report)	28
F	DWC Form PR-4 (Primary Treating Physician's Permanent and Stationary Report)	29
G	Sample Utilization Review Decision	30-31
H	Injured Worker First 30 Days Post-Injury Workflow: "Automatic" Authorization	32–34

Exhibit A

Injured Worker Initial Visit Workflow: Primary Treating Physician (PTP) and Non-PTP

Overview. Detail views on the following pages.

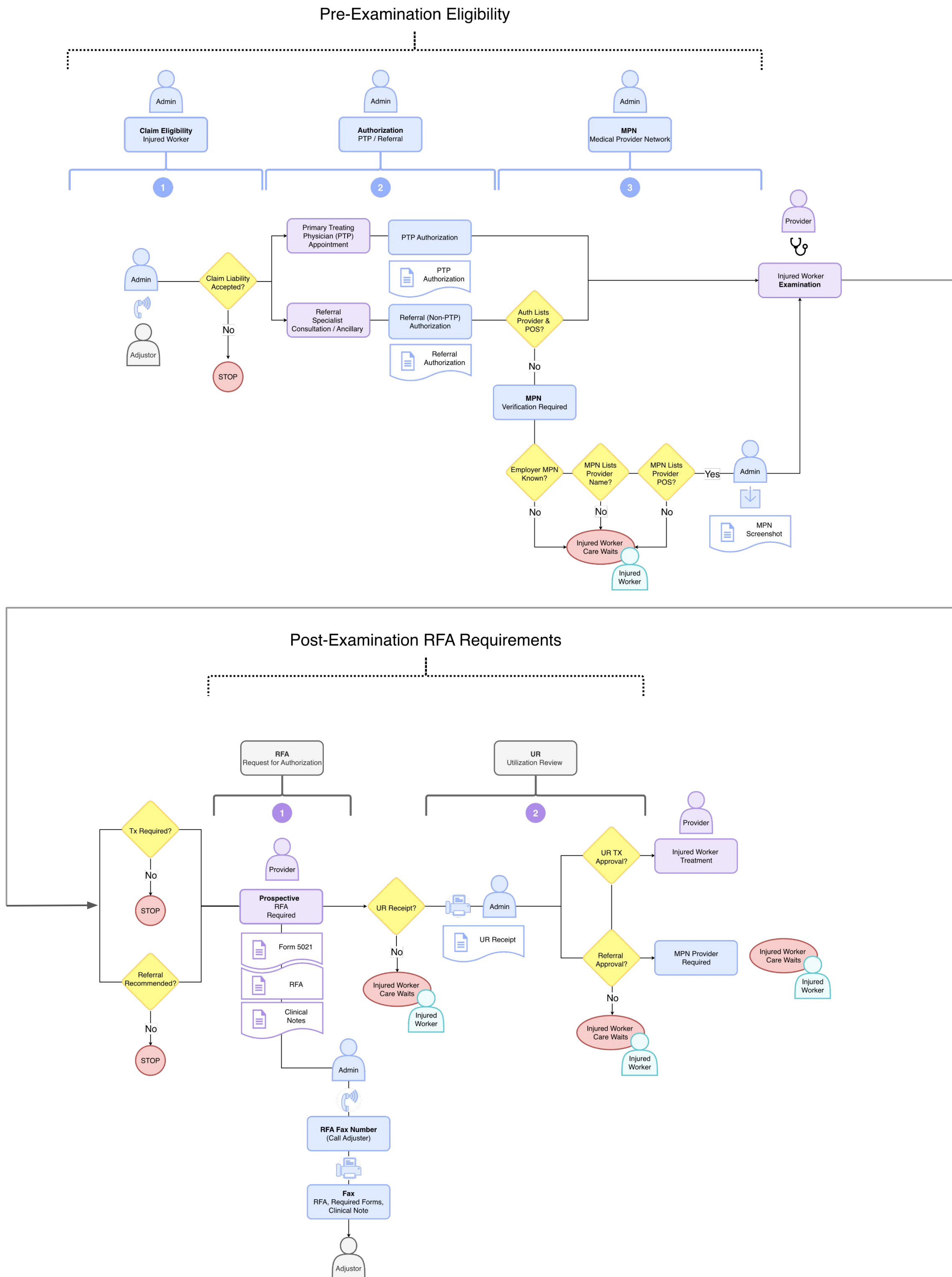
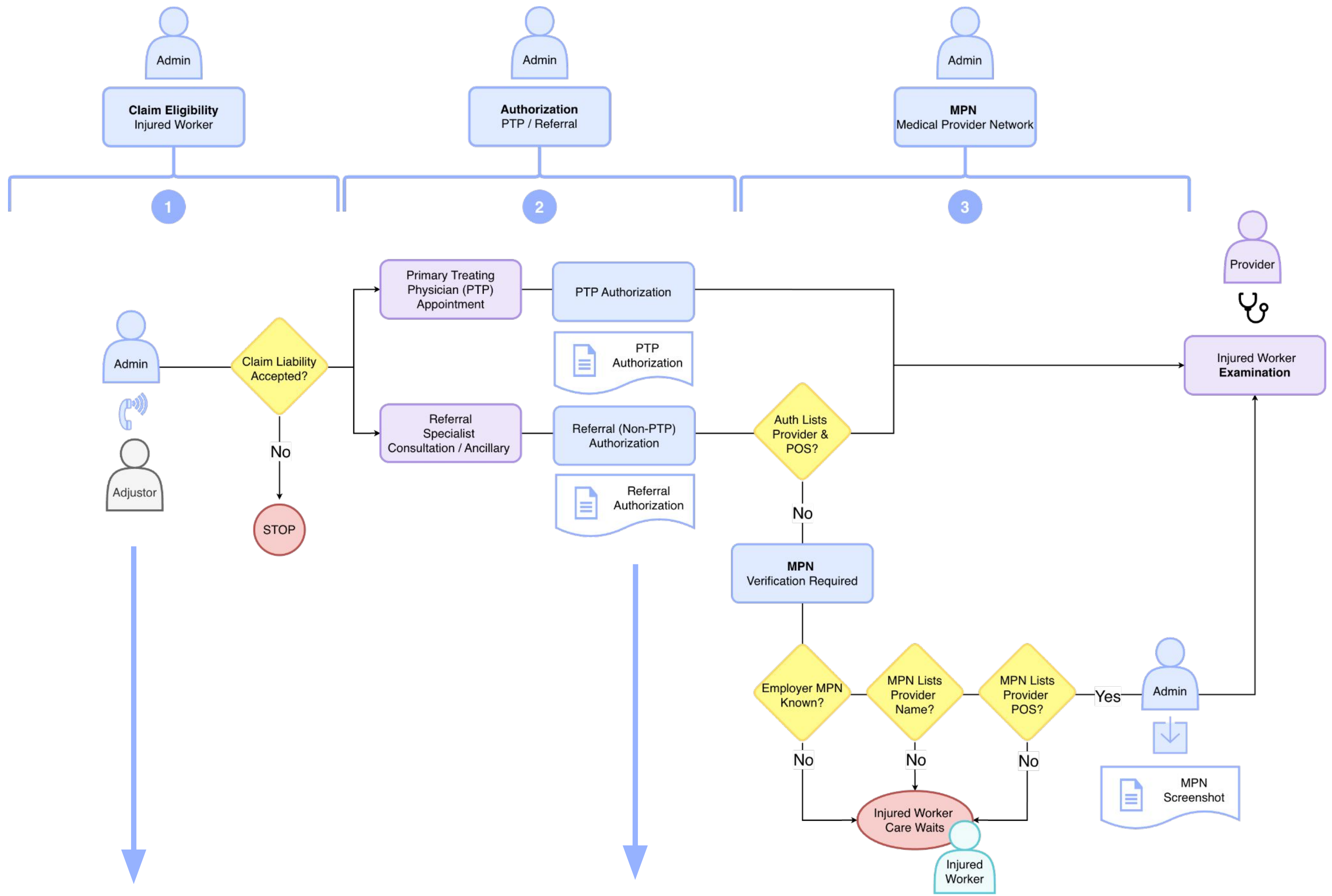


Exhibit A

Pre-Examination Eligibility



Injured Worker Intake Form

POWERED BY daisyBill

California Injured Worker Intake Form

* Indicates required for compliant workers' compensation medical billing

Injured Worker Demographics

Last Name:*	First Name:*	Middle Initial:
Date of Birth:*	SSN:	Gender:* ☐F ☐M ☐U
Address:*	City:*	
State:*	Zip:*	Telephone:

Claims Administrator Information

Claims Administrator Name:*		
Adjustor Name:	Telephone:	Fax:
Email:		

Injury Claim Information

Claim Number:*	Injury Start Date:*
Injury Description:	Claim Status: ☐ Accepted ☐ Disputed ☐ Denied ☐ Other

Request for Authorization Information

RFA Fax Number:*

Employer MPN Information

Employer Name:*	
MPN Name:	MPN ID Number:
MPN Provider Roster Website:	MPN Provider Roster Password:

Billing Information (Not required for daisyBill clients)

Electronic Bills	Clearinghouse: ☐WorkComp EDI ☐CorVel ☐Jopari ☐Availity ☐P2P ☐Other
☐Not Accepted	Payer ID:
Bill Mail Address	

Page 1

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Authorization Form

POWERED BY daisyBill

California Injured Worker Authorization Information

* Indicates required information to dispute authorization payment denials.

Primary Treating Physician Authorization

If the provider is the injured worker's PTP, a document from the claims administrator's adjuster confirming the provider's PTP status is required. Without this document, the claims administrator may deny reimbursement for bills, citing the provider as out-of-network, or deny reimbursement for PR-2 reports, citing the provider as not the PTP.

Is the provider being designated as Primary Treating Physician (PTP)?* ☐ Yes ☐ No *If no, proceed to Referral Appointment (Non-PTP) Authorization*
Authorized PTP Name:
Authorized PTP Place of Service address:
PTP Document Receipt?* ☐ Yes ☐ No *For billing purposes, upload the document received designating the provider as PTP to the Claim Injury documents in daisyBill*

Referral Appointment (Non-PTP) Authorization

If the injured worker is referred to a provider for secondary or incidental treatment or services, a document from the claims administrator's adjuster confirming that the provider is authorized to furnish such treatment or services is required. Without this authorization document, the claims administrator may deny reimbursement for bills, citing that the provider is out-of-network.

Referral Appointment (Non-PTP)?* ☐ Yes
Referral Authorization Receipt? ☐ Yes ☐ No Referral Lists Provider Name? ☐ Yes ☐ No Referral Lists Provider Place of Service? ☐ Yes ☐ No *For billing purposes, upload the document received authorizing Referral appointment to Claim Injury documents in daisyBill*
Authorized Provider Name:
Authorized Provider Place of Service (POS) Address:

Additional Notes

Completed By: ______________________ Date: ______________

Page 2

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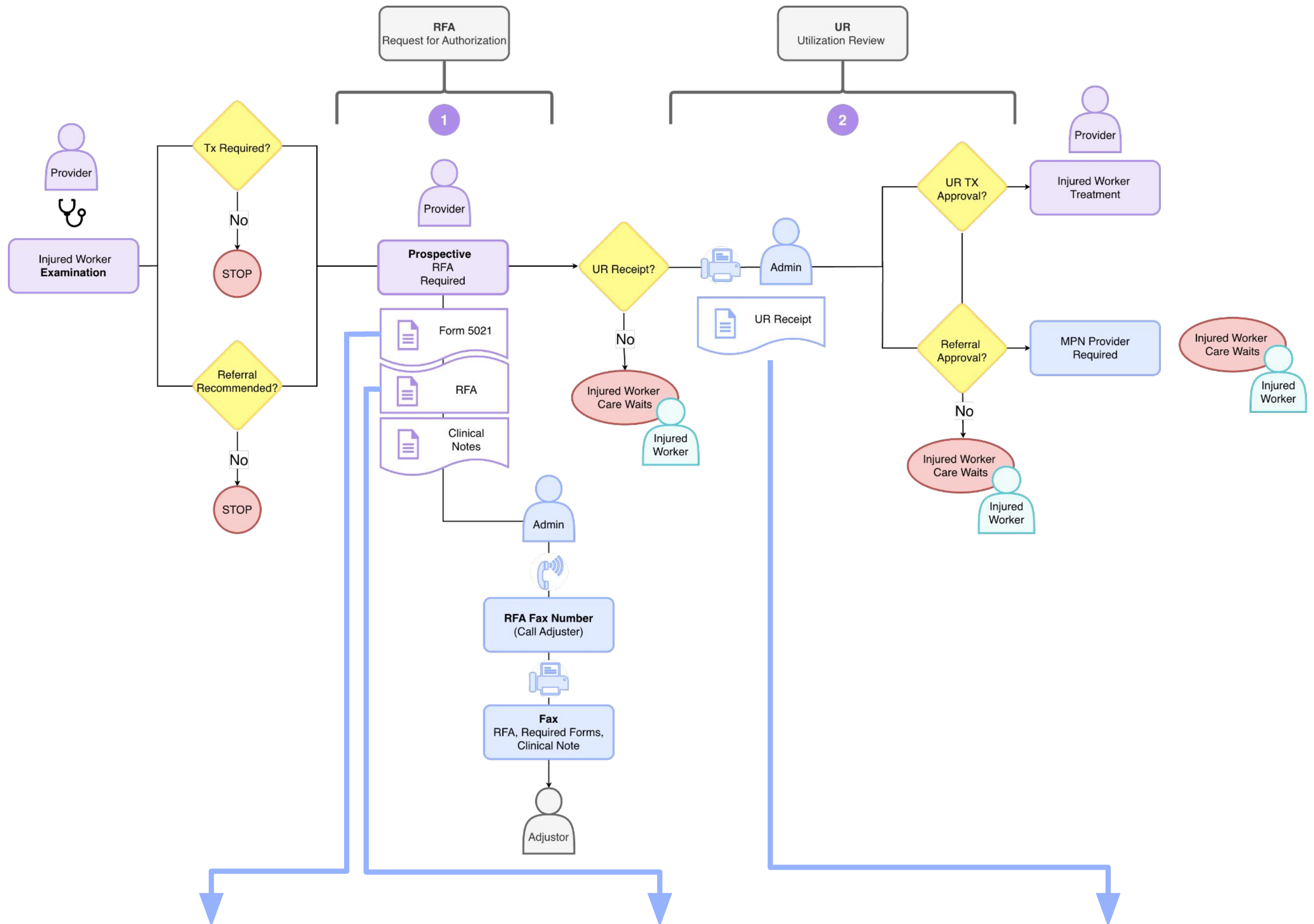
Exhibit A

Post-Examination RFA Requirements



Form 5021

Print Form | Reset Form

STATE OF CALIFORNIA
DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Department of Industrial Relations, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. Insurer Name and Address
2. Employer Name
3. Address No. and Street | City | Zip Code
4. Nature of business (e.g. food manufacturing, building construction, retailer of women's clothes.)
5. Patient Name (first Name, middle initial , last name) | 6. Sex | 7. Date of Birth
8. Address No. and Street | City | Zip Code | 9.Phone Number
10. Occupation (Specific job title) | 11. Social Security Number | 12. Address No.& Street Where Inj. Occurred
City Where Injury Occ. | County | 13. Date and hour of injury or onset of illness
14. Date last worked | 15. Date and hour of 1st exam or treatment | 16. Have you or your office previously rendered treatment

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **Describe how the accident or exposure happened.** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS**

19. **Objective Findings**

A. Physical Examination

B. X-ray and laboratory results (State if none or pending.)

Form 5021 (Rev. 5) 10/2015 | Sheet 1 of 3

DWC Form RFA

State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☐ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information
Name (Last, First, Middle):
Date of Injury (MM/DD/YYYY): | Date of Birth (MM/DD/YYYY):
Claim Number: | Employer:

Requesting Physician Information
Name:
Practice Name: | Contact Name:
Address: | City: | State:
Zip Code: | Phone: | Fax Number:
Specialty: | NPI Number:
E-mail Address:

Claims Administrator Information
Company Name: | Contact Name:
Address: | City: | State:
Zip Code: | Phone: | Fax Number:
E-mail Address:

Requested Treatment (see instructions for guidance; attached additional pages if necessary)
List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)

Requesting Physician Signature: | Date:

Claims Administrator/Utilization Review Organization (URO) Response
☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)
Authorization Number (if assigned): | Date:
Authorized Agent Name: | Signature:
Phone: | Fax Number: | E-mail Address:
Comments:

DWC Form RFA (version 01/2014) | Page 1

UR Decision

From: GB System User Fax: +18888742017 To: Fax: [redacted] Page: 1 of 15 05/05/2026 4:07 PM

GB CARE

377 Riverside Drive
Suite 400
Franklin, TN 37064
Ph: 888-878-6012
Fax: 615-778-5135

[redacted]
USA

State of California
Utilization Review Determination

Notice of Review Outcome

Patient Name	[redacted]	**Referral ID**	[redacted]
Claim Number	[redacted]	**Review Type**	Prospective
Date of Birth (Age)	[redacted]	**Requesting Provider**	[redacted]
Date of Injury	[redacted]	**RFA Received Date**	04/28/2026
Jurisdiction	California	**Decision Date**	5/5/2026

GB Care Contacts

Case Reviewer	[redacted]	**Case Reviewer Phone**	
Resolution Manager	[redacted]	**Resolution Manager Phone**	[redacted]

Decision Summary

Non-Certified

Treatment Request	Procedure Code	Body Part	Request Qty	Approved Qty	Effective Date	End Date
Right Wrist Endoscopic VS Open carpal tunnel release (29848, 64721)	29848 - NDSC WRST SURG W/RLS TRANSVRS CARPL LIGM	Wrist - Right	1	0	05/05/2026	05/05/2026
Pre-Op Medical Clearance and Pre-Op Labs: CBC, BMP, EKG (99205, 85025, 80048, 93000)	85025 - BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC	Wrist - Right	1	0	05/05/2026	05/05/2026
Post-Op Physical therapy treatment for the right wrist, 2 times per week for 4 weeks (97110)	97110 - THERAPEUTIC PX 1/> AREAS EACH	Wrist - Right	8	0	05/05/2026	05/05/2026

GBCARE: URAC Certificate Number WUM010030 effective through 1/1/2028

Exhibit B

CA Injured Worker Intake Form

Information required to send bills for payment

POWERED BY

California Injured Worker Intake Form

* Indicates required for compliant workers' compensation medical billing

Injured Worker Demographics

Last Name:*	First Name:*	Middle Initial:
Date of Birth:*	SSN:	Gender:* ☐F ☐M ☐U
Address:*	City:*	
State:*	Zip:*	Telephone:

Claims Administrator Information

Claims Administrator Name:*		
Adjustor Name:	Telephone:	Fax:
Email:		

Injury Claim Information

Claim Number:*	Injury Start Date:*
Injury Description:	Claim Status: ☐ Accepted ☐ Disputed ☐ Denied ☐ Other

Request for Authorization Information

RFA Fax Number:*

Employer MPN Information

Employer Name:*	
MPN Name:	MPN ID Number:
MPN Provider Roster Website:	MPN Provider Roster Password:

Billing Information (Not required for daisyBill clients)

Electronic Bills	Clearinghouse: ☐WorkComp EDI ☐CorVel ☐Jopari ☐Availity ☐P2P ☐Other
☐Not Accepted	Payer ID:
Bill Mail Address	

Page 1

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Exhibit B

CA Injured Worker Authorization Information

Information required to dispute payment denials

POWERED BY daisyBill

California Injured Worker Authorization Information

* Indicates required information to dispute authorization payment denials.

Primary Treating Physician Authorization

If the provider is the injured worker's PTP, a document from the claims administrator's adjuster confirming the provider's PTP status is required. Without this document, the claims administrator may deny reimbursement for bills, citing the provider as out-of-network, or deny reimbursement for PR-2 reports, citing the provider as not the PTP.

Is the provider being designated as Primary Treating Physician (PTP)?* ☐ Yes ☐ No *If no, proceed to Referral Appointment (Non-PTP) Authorization*
Authorized PTP Name:
Authorized PTP Place of Service address:
PTP Document Receipt?* ☐ Yes ☐ No *For billing purposes, upload the document received designating the provider as PTP to the Claim Injury documents in daisyBill*

Referral Appointment (Non-PTP) Authorization

If the injured worker is referred to a provider for secondary or incidental treatment or services, a document from the claims administrator's adjuster confirming that the provider is authorized to furnish such treatment or services is required. Without this authorization document, the claims administrator may deny reimbursement for bills, citing that the provider is out-of-network.

Referral Appointment (Non-PTP)?* ☐ Yes
Referral Authorization Receipt? ☐ Yes ☐ No Referral Lists Provider Name? ☐ Yes ☐ No Referral Lists Provider Place of Service? ☐ Yes ☐ No *For billing purposes, upload the document received authorizing Referral appointment to Claim Injury documents in daisyBill*
Authorized Provider Name:
Authorized Provider Place of Service (POS) Address:

Additional Notes

Completed By: ______________________ Date: ______________

Page 2

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Exhibit C

Form 5021: Doctor’s First Report of Occupational Injury or Illness

Transmission: Mail two copies | Reimbursement: $0

STATE OF CALIFORNIA
DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Physician Signature: *(original signature, do not stamp)*

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3.

Physician signature ____________ Cal. License Number: ____________

Executed at: ____________ Date *(mm/dd/yyyy)*: ____________

Physician Name ____________ Specialty: ____________

Physician address: ____________ Phone Number ____________

Any person who makes or causes to be made any knowingly fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

PRIVACY NOTICE: The Administrative Director is authorized to maintain the records of the Division of Workers' Compensation (DWC). (Cal. Lab. Code § 126.) The Information Practices Act of 1977 and the Federal Privacy Act require the Administrative Director to provide this notice to individuals who submit information to the DWC pertaining to a workers' compensation claim. (Cal. Civ. Code § 1798.17; Public Law 93-579.)
The principal purpose for requesting information from injured workers, dependents, lien claimants, physician, employers or their representatives is to administer the California workers' compensation system. Each form shows which fields are required to be completed for DWC to process the form. If a required field in a form is incomplete or unreadable, the DWC may return the form to the individual for correction or may reject the form. Providing a social security number is required on this form pursuant to Labor Code § 6409. If you do not provide your security number, the DWC may return the form to you for correction or reject the form. If you do not have a social security number, indicate this in the space provided for the injured worker's social security number. As permitted by law, social security numbers are used to help properly identify injured workers and to conduct statistical research as allowed under the Labor Code.

As authorized by law, information furnished on this form may be given to: you, upon request; the public, pursuant to the Public Records Act; a governmental entity, when required by state or federal law; to any person, pursuant to a subpoena or court order pursuant to any other exception in Civil Code § 1798.24.

An individual has a right of access to records containing his/her personal information that are maintained by the Administrative Director. An individual may also amend, correct, or dispute information in such personal records. (Cal. Civ. Code §§ 1798.34-1798.3.) You may request a copy of the DWC's policies and procedures for inspection of records at the address below. Copies of the procedures and all records are ten cents ($0.10) per page, payable in advance. (Cal. Civ. Code § 1798.33.) Requests should be sent to: Division of Workers' Compensation- Medical Unit, P.O. Box 71010, Oakland, CA 94612. Tel: (510) 286-3700 or (800) 794.6900. Fax: (510) 622-3467.

Form 5021 (Rev. 5) 10/2015 Sheet 3 of 3

STATE OF CALIFORNIA **DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS**

20. **DIAGNOSES**(if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved?

1. ____________ ICD-10 ____
2. ____________ ICD-10 ____
3. ____________ ICD-10 ____
4. ____________ ICD-10 ____
5. ____________ ICD-10 ____
6. ____________ ICD-10 ____
7. ____________ ICD-10 ____
8. ____________ ICD-10 ____
9. ____________ ICD-10 ____
10. ____________ ICD-10 ____
11. ____________ ICD-10 ____
12. ____________ ICD-10 ____

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? If "no," please explain below:

22. Is there any other current condition that will impede or delay patient's recovery? If "yes," please explain below:

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalized as inpatient, give hospital name and location

Date admitted Estimated length of stay

26. WORK STATUS - Is patient able to perform usual work? ☐ Yes ☐ No

If "no", date when patient can return to Regular work Modified work

Specify restrictions

Form 5021 (Rev. 5) 10/2015 Sheet 2 of 3

Print Form Reset Form

STATE OF CALIFORNIA
DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Department of Industrial Relations, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. Insurer Name and Address
2. Employer Name
3. Address No. and Street City Zip Code
4. Nature of business (e.g. food manufacturing, building construction, retailer of women's clothes.)
5. Patient Name (first Name, middle initial , last name) 6. Sex 7. Date of Birth
8. Address No. and Street City Zip Code 9.Phone Number
10. Occupation (Specific job title) 11. Social Security Number 12. Address No.& Street Where Inj. Occurred

City Where Injury Occ. County 13. Date and hour of injury or onset of illness

14. Date last worked 15. Date and hour of 1st exam or treatment 16. Have you or your office previously rendered treatment

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **Describe how the accident or exposure happened.** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS**

19. O**bjective Findings**

A. Physical Examination

B. X-ray and laboratory results (State if none or pending.)

Form 5021 (Rev. 5) 10/2015 Sheet 1 of 3

Exhibit D

DWC Form RFA

Transmission: Fax | Reimbursement: $0

State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

☐ New Request ☐ Resubmission – Change in Material Facts
☐ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
☐ Check box if request is a written confirmation of a prior oral request.

Employee Information	
Name (Last, First, Middle):	
Date of Injury (MM/DD/YYYY):	Date of Birth (MM/DD/YYYY):
Claim Number:	Employer:

Requesting Physician Information			
Name:			
Practice Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
Specialty:		NPI Number:	
E-mail Address:			

Claims Administrator Information			
Company Name:		Contact Name:	
Address:		City:	State:
Zip Code:	Phone:	Fax Number:	
E-mail Address:			

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)

Requesting Physician Signature:	Date:

Claims Administrator/Utilization Review Organization (URO) Response

☐ Approved ☐ Denied or Modified (See separate decision letter) ☐ Delay (See separate notification of delay)
☐ Requested treatment has been previously denied ☐ Liability for treatment is disputed (See separate letter)

Authorization Number (if assigned):		Date:
Authorized Agent Name:		Signature:
Phone:	Fax Number:	E-mail Address:
Comments:		

DWC Form RFA (version 01/2014) Page 1

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Page 2

Exhibit E

PR-2 - Primary Treating Physician’s Progress Report

Transmission: Send with bill | Reimbursement: $16.14

Print Form Reset Form

State of California

Additional pages attached ☐

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

☐ Periodic Report (Required 45 days after last report) ☐ Change in treatment plan ☐ Release From Care
☐ Change in work status ☐ Need for referral or consultation ☐ Response to request for information
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Request for authorization
☐ Other

Patient

Patient last name: Patient first name: MI
Patient Street Address/PO Box Patient City State Zip Code Sex
Occupation Phone Number Date of Birth
Date of Injury

Claims Administrator

Claims Administrator Name Claim number
Claims Administrator Street Address/ Claims Administrator City State Zip Code
Phone Number Fax Number Employer Name Phone Number

Subjective Complaints (The information below must be provided. You may use this form or you may substitute or append a narrative report):

Objective findings: *(Include significant physical examination, laboratory, imaging, or other diagnostic findings.)*

Diagnoses:

1.	ICD-10		7.	ICD-10	
2.	ICD-10		8.	ICD-10	
3.	ICD-10		9.	ICD-10	
4.	ICD-10		10.	ICD-10	
5.	ICD-10		11.	ICD-10	
6.	ICD-10		12.	ICD-10	

DWC Form PR-2 (Rev. 10/2015) Sheet 1 of 2

Treatment Plan: Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/ referral, surgery, and hospitalization. Identify each physician and non-physician provider**.** Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any **changes** in treatment plan? If so, why?

Work Status: This patient has been instructed to:

○ Remain off-work until

○ Return to *modified* work on with the following limitations or restrictions. (List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

○ Return to full duty on with no limitations or restrictions.

Primary Treating Physician: *(original signature, do not stamp)* Date of Exam

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3.

Physician signature Cal. License Number:
Executed at: Date *(mm/dd/yyyy)*:
Physician Name Specialty:
Physician address: Phone Number

PRIVACY NOTICE: A statement of current data collection and use policies and certain privacy rights of injured workers may be found at the following website: http://www.dir.ca.gov/od_pub/privacy.html.

DWC Form PR-2 (Rev. 10/2015) Sheet 2 of 2

Exhibit F

PR-4: Primary Treating Physician's Permanent and Stationary Report

Transmission: Send with bill | Reimbursement: $50 first page, $30.74 for each additional pages 2 - 7. Maximum reimbursement: $234.44

Print Form | Reset Form

State of California Additional pages attached ☐

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT(PR-4)

This form is required to be used for ratings prepared pursuant to the 2005 Permanent Disability Rating Schedule and the AMA Guides to the Evaluation of Permanent Impairment (5th Ed.). It is designed to be used by the primary treating physician to report the initial evaluation of permanent disability to the claims administrator. It should be completed if the patient has residual effects from the injury or may require future medical care. In such cases, it should be completed once the patient's condition becomes permanent and stationary.
This form should not be used by a Qualified Medical Evaluator (QME) or Agreed Medical Evaluator (AME) to report a medical-legal evaluation.

Patient

Patient last name: Patient first name: MI

Patient Street Address/PO Box Patient City State Zip Code Sex

Occupation Date of Birth Phone Number

Claims Administrator

Claims Administrator Name Claim number

Claims Administrator Street Address Claims Administrator City State Zip Code

Phone Number

Employer

Name

Street Address City State Zip Code

Phone Number

You must address each of the issues below. You may substitute or append a narrative report if you require additional space to adequately report on these issues. *(For dates use mm/dd/yyyy.)*

Date of Injury Last Date Worked Date of Last Exam Date of Current Exam Permanent & Stationary Date

Description of how injury/illness occurred (e.g., Hand caught in punch press; fell from height onto back; exposed 25 years ago to asbestos):

Patient's Complaints:

DWC Form PR-4 (Rev. 02/2016) Sheet 1 of 6

State of California - Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

Objective Findings:

Physical Examination: (Describe all relevant findings; include any specific measurements indicating atrophy, range or motion, strength, etc.; include bilateral measurements - injured/uninjured - for upper and lower extremity injuries.)

Diagnostic tests results (X-ray/Imaging/Laboratory/etc.):

Diagnoses:

1. ICD-10
2. ICD-10
3. ICD-10
4. ICD-10
5. ICD-10
6. ICD-10
7. ICD-10
8. ICD-10
9. ICD-10
10. ICD-10
11. ICD-10
12. ICD-10

Impairment Rating: Report the whole person impairment (WPI) for each impairment using the AMA Guides, 5th Edition, and explain how the rating was derived. List tables used and page numbers.

Impairment WPI% Table #(s) Page #(s)
Explanation

Impairment WPI% Table #(s) Page #(s)
Explanation

Impairment WPI% Table #(s) Page #(s)
Explanation

Impairment WPI% Table #(s) Page #(s)
Explanation

DWC Form PR-4 (Rev. 02/2016) Sheet 2 of 6

State of California - Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

Pain Assessment:

If the burden of the worker's condition has been increased by pain-related impairment in excess of the pain component already incorporated into the WPI rating under Chapters 3-17 of the AMA Guides, 5th Edition, specify the additional whole person impairment rating (0% up to 3% WPI) attributable to such pain. For excess pain involving multiple impairments, attribute the pain in whole number increments to the appropriate impairments. The sum of all pain impairment ratings may not exceed 3% for a single injury.

Apportionment:

Effective April 19, 2004, apportionment of permanent disability shall be based on causation. Furthermore, any physician who prepares a report addressing permanent disability due to a claimed industrial injury is required to address the issue of causation of the permanent disability, and in order for a permanent disability report to be complete, the report must include an apportionment determination. This determination shall be made pursuant to Labor Code Section 4663 and 4664, set forth below:

Labor Code Section 4663. Apportionment of permanent disability; Causation as basis; Physician's report; Apportionment determination; Disclosure by employee

(a) Apportionment of permanent disability shall be based on causation.

(b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.

(c) In order for a physician's report to be considered complete on the issue of permanent disability, it must include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring it the course of employment an what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician stall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.

(d) An employee who claims an industrial injury shall, upon request, disclose all previous permanent disability or physical impairments.

Labor Code section 4664. Liability of employer for percentage of permanent disability directly caused by injury; Conclusive presumption from prior award of permanent disability; Accumulation of permanent disability awards

(a) The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment.

(b) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. This presumption is a presumption affecting the burden or proof.

(c)(1) The accumulation of all permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662. As used in this section, the regions of the body are the following:

(A) Hearing.

(B) Vision.

(C) Mental and behavioral disorders.

(D) The spine.

(E) The upper extremities, including the shoulders.

(F) The lower extremities, including the hip joints.

DWC Form PR-4 (Rev. 02/2016) Sheet 3 of 6

State of California - Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

(G) The head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed in subparagraphs (A) to (F), inclusive.

(2) Nothing in this section shall be construed to permit the permanent disability rating for each individual injury sustained by an employee arising from the same industrial accident, when added together, from exceeding 100 percent.

Is the permanent disability directly cased by an injury or illness arising out of and in the scope of employment? ☐ Yes ☐ No

Is the permanent disability caused, in whole or in part, by other factors besides this industrial injury or illness, including any prior industrial injury or illness? ☐ Yes ☐ No

If the answer to the second question is "yes," provide below: (1) the approximate percentage of the permanent disability that is due to factors other than the injury or illness arising out of and in the course of employment; and (2) a complete narrative description of the basis for your apportionment finding.

If you are unable to include an apportionment determination in your report, state the specific reasons why you could not make this determination. You may attach your findings on a separate sheet.

Future Medical Treatment: Describe any continuing medical treatment related to this injury that you believe must be provided to the patient. ("Continuing medical treatment" is defined as occurring or presently planned treatment.) And describe any medical treatment the patient may require in the future. ("Future medical treatment" is defined as treatment which is anticipated at some time in the future to cure or relieve the employee from the effects of the injury.) Include medications, surgery, physical medicine services, durable equipment, etc

Comments:

Functional Capacity Assessment:
Note: The following assessment of functional capacity is to be prepared by the treating physician, solely for the purpose of determining a claimant's ability to return to his or her usual and customary occupation, and will not be considered in the permanent impairment rating. For injuries occurring on or after 1/1/13 also complete DWC-AD Form 10133.36

Limited, but retains MAXIMUM capacities to LIFT (including upward pulling) and/or CARRY:

☐ 10 lbs. ☐ 20 lbs. ☐ 30 lbs. ☐ 40 lbs. ☐ 50 +lbs

FREQUENTLY LIFT and/or CARRY:

☐ 10 lbs. ☐ 20 lbs. ☐ 30 lbs. ☐ 40 lbs. ☐ 50 +lbs

OCCASIONALLY LIFT and/or CARRY:

☐ 10 lbs. ☐ 20 lbs. ☐ 30 lbs. ☐ 40 lbs. ☐ 50 +lbs

STAND and/or WALK a total of:

☐ < 2/8 hours ☐ < 4/8 hours ☐ < 6/8 hours ☐ < 8/8 hours

SIT a total of:

☐ < 2/8 hours ☐ < 4/8 hours ☐ < 6/8 hours ☐ < 8/8 hours

PUSH and/or PULL (including hand or foot controls):

☐ UNLIMITED ☐ LIMITED

(Describe degree of limitation)

DWC Form PR-4 (Rev. 02/2016) Sheet 4 of 6

State of California - Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

Other:

Primary Treating Physician (original signature, do not stamp)

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3.

Physician signature Cal. License Number:

Executed at: Date (mm/dd/yyyy):

Physician Name Specialty:

Physician address: Phone Number

PRIVACY NOTICE: A statement of current data collection and use policies and certain privacy rights of injured workers may be found at the following website: http://www.dir.ca.gov/od_pub/privacy.html.

Sheet 6 of 6

DWC Form PR-4 (Rev. 02/2016)

State of California - Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-4)

ACTIVITIES ALLOWED:

Activity			
Climbing:	☐ Frequently	☐ Occasionally	☐ Never
Balancing:	☐ Frequently	☐ Occasionally	☐ Never
Stooping:	☐ Frequently	☐ Occasionally	☐ Never
Kneeling:	☐ Frequently	☐ Occasionally	☐ Never
Crouching:	☐ Frequently	☐ Occasionally	☐ Never
Crawling:	☐ Frequently	☐ Occasionally	☐ Never
Twisting:	☐ Frequently	☐ Occasionally	☐ Never
Reaching:	☐ Frequently	☐ Occasionally	☐ Never
Handling:	☐ Frequently	☐ Occasionally	☐ Never
Fingering:	☐ Frequently	☐ Occasionally	☐ Never
Feeling:	☐ Frequently	☐ Occasionally	☐ Never
Seeing:	☐ Frequently	☐ Occasionally	☒ Never
Hearing:	☐ Frequently	☐ Occasionally	☐ Never
Speaking:	☐ Frequently	☐ Occasionally	☐ Never

Describe in what ways the impaired activities are limited:

Environmental restrictions (e.g., heights, machinery, temperature extremes, dust, fumes, humidity, vibration, etc.):

Can this patient now return to his/her usual occupation? ☐ Yes ☐ No

List information you reviewed in preparing this report, or relied upon for the formulation of your medical opinions:
Medical Records:

Written Job Description (You may attach form DWC-AD 10133.33 for injuries occurring on or after 1/1/13):

Sheet 5 of 6

DWC Form PR-4 (Rev. 02/2016)

Exhibit G

Sample Utilization Review Decision

From: GB System User Fax: +18888742017 To: Fax: [redacted] Page: 1 of 15 05/05/2026 4:07 PM

377 Riverside Drive
Suite 400
Franklin, TN 37064
Ph: 888-878-6012
Fax: 615-778-5135

Utilization Review Decision

USA

State of California
Utilization Review Determination

Notice of Review Outcome

Patient Name		**Referral ID**	
Claim Number		**Review Type**	Prospective
Date of Birth (Age)		**Requesting Provider**	
Date of Injury		**RFA Received Date**	04/28/2026
Jurisdiction	California	**Decision Date**	5/5/2026

GB Care Contacts

Case Reviewer		**Case Reviewer Phone**	
Resolution Manager		**Resolution Manager Phone**	

Decision Summary

Non-Certified

Treatment Request	Procedure Code	Body Part	Request Qty	Approved Qty	Effective Date	End Date
Right Wrist Endoscopic VS Open carpal tunnel release (29848, 64721)	29848 - NDSC WRST SURG W/RLS TRANSVRS CARPL LIGM	Wrist - Right	1	0	05/05/2026	05/05/2026
Pre-Op Medical Clearance and Pre-Op Labs: CBC, BMP, EKG (99205, 85025, 80048, 93000)	85025 - BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC	Wrist - Right	1	0	05/05/2026	05/05/2026
Post-Op Physical therapy treatment for the right wrist, 2 times per week for 4 weeks (97110)	97110 - THERAPEUTIC PX 1/> AREAS EACH	Wrist - Right	8	0	05/05/2026	05/05/2026

GBCARE: URAC Certificate Number WUM010030 effective through 1/1/2028

Exhibit G

Sample Utilization Review Decision

From: GB System User Fax: +18888742017 To: Fax: Page: 15 of 15 05/05/2026 4:07 PM

application form.) The application will indicate your filing deadline at the end of the form.

From: GB System User Fax: +18888742017 To: Fax: Page: 14 of 15 05/05/2026 4:07 PM

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

From: GB System User Fax: +18888742017 To: Fax: Page: 13 of 15 05/05/2026 4:07 PM

Employee Signature Date

From: GB System User Fax: +18888742017 To: Fax: Page: 12 of 15 05/05/2026 4:07 PM

State: Zip Code: Telephone Number:

Fax Number:

From: GB System User Fax: +18888742017 To: Fax: Page: 11 of 15 05/05/2026 4:07 PM

DWC DIVISION OF

Division of Workers' Compensation

Department of Industrial Relations

From: GB System User Fax: +18888742017 To: Fax: Page: 10 of 15 05/05/2026 4:07 PM

From: GB System User Fax: +18888742017 To: Fax: Page: 9 of 15 05/05/2026 4:07 PM

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From: GB System User Fax: +18888742017 To: Fax: Page: 7 of 15 05/05/2026 4:07 PM

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From: GB System User Fax: +18888742017 To: Fax: Page: 2 of 15 05/05/2026 4:07 PM

From: GB System User Fax: +18888742017 To: Fax: Page: 1 of 15 05/05/2026 4:07 PM

GB CARE

377 Riverside Drive
Suite 400
Franklin, TN 37064
Ph: 888-878-6012
Fax: 615-778-5135

USA

State of California
Utilization Review Determination

Notice of Review Outcome

Patient Name		**Referral ID**	
Claim Number		**Review Type**	Prospective
Date of Birth (Age)		**Requesting Provider**	
Date of Injury		**RFA Received Date**	04/28/2026
Jurisdiction	California	**Decision Date**	5/5/2026

GB Care Contacts

Case Reviewer		**Case Reviewer Phone**	
Resolution Manager		**Resolution Manager Phone**	

Decision Summary

Non-Certified

Treatment Request	Procedure Code	Body Part	Request Qty	Approved Qty	Effective Date	End Date
Right Wrist Endoscopic VS Open carpal tunnel release (29848, 64721)	29848 - NDSC WRST SURG W/RLS TRANSVRS CARPL LIGM	Wrist - Right	1	0	05/05/2026	05/05/2026
Pre-Op Medical Clearance and Pre-Op Labs: CBC, BMP, EKG (99205, 85025, 80048, 93000)	85025 - BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC	Wrist - Right	1	0	05/05/2026	05/05/2026
Post-Op Physical therapy treatment for the right wrist, 2 times per week for 4 weeks (97110)	97110 - THERAPEUTIC PX 1/> AREAS EACH	Wrist - Right	8	0	05/05/2026	05/05/2026

GBCARE: URAC Certificate Number WUM010030 effective through 1/1/2028

Exhibit H

Injured Worker First 30 Days Post Injury: “Automatic” Authorization

Overview. Detail views on the following pages.

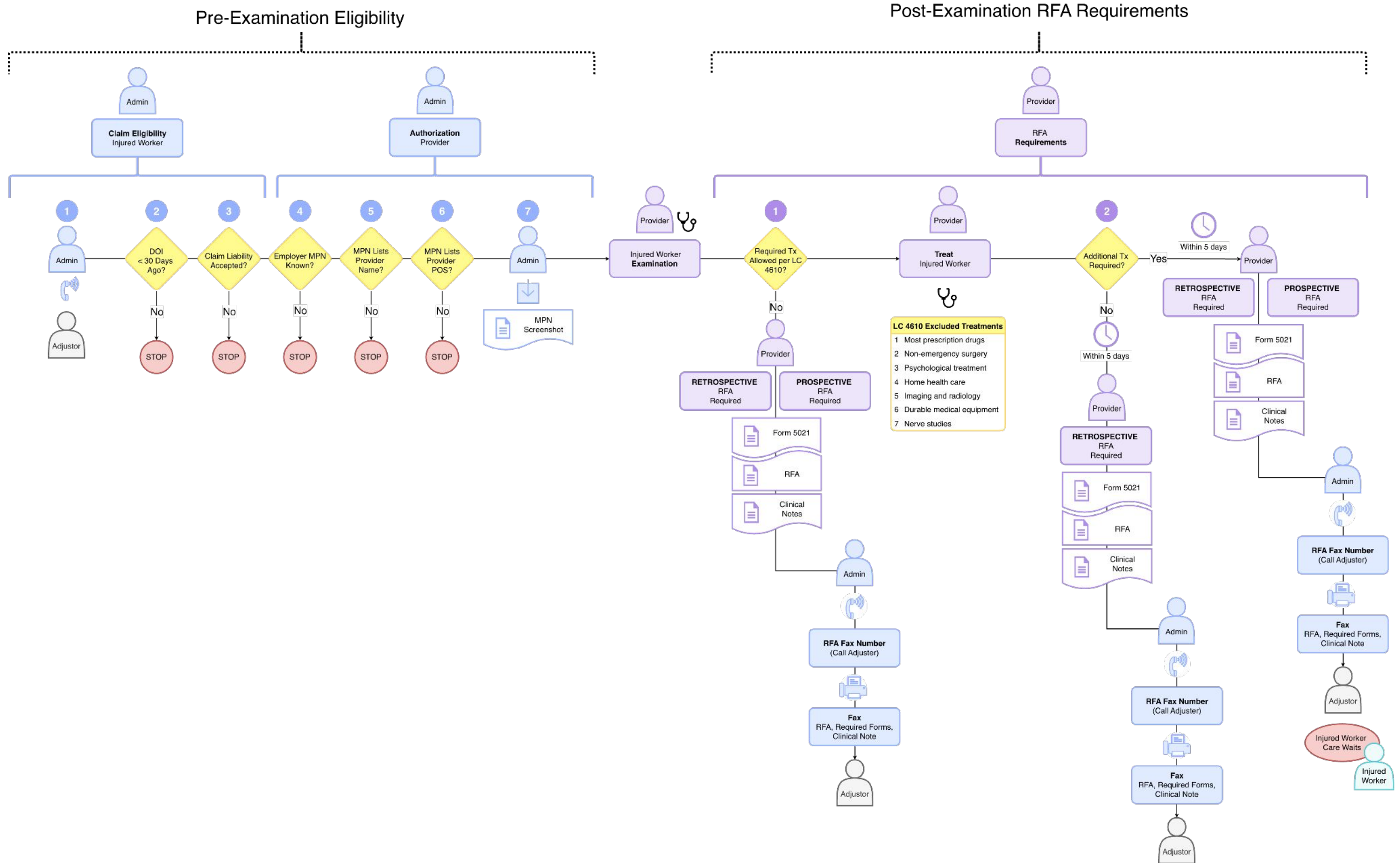

Exhibit H

"Automatic" Authorization Pre-Examination Eligibility

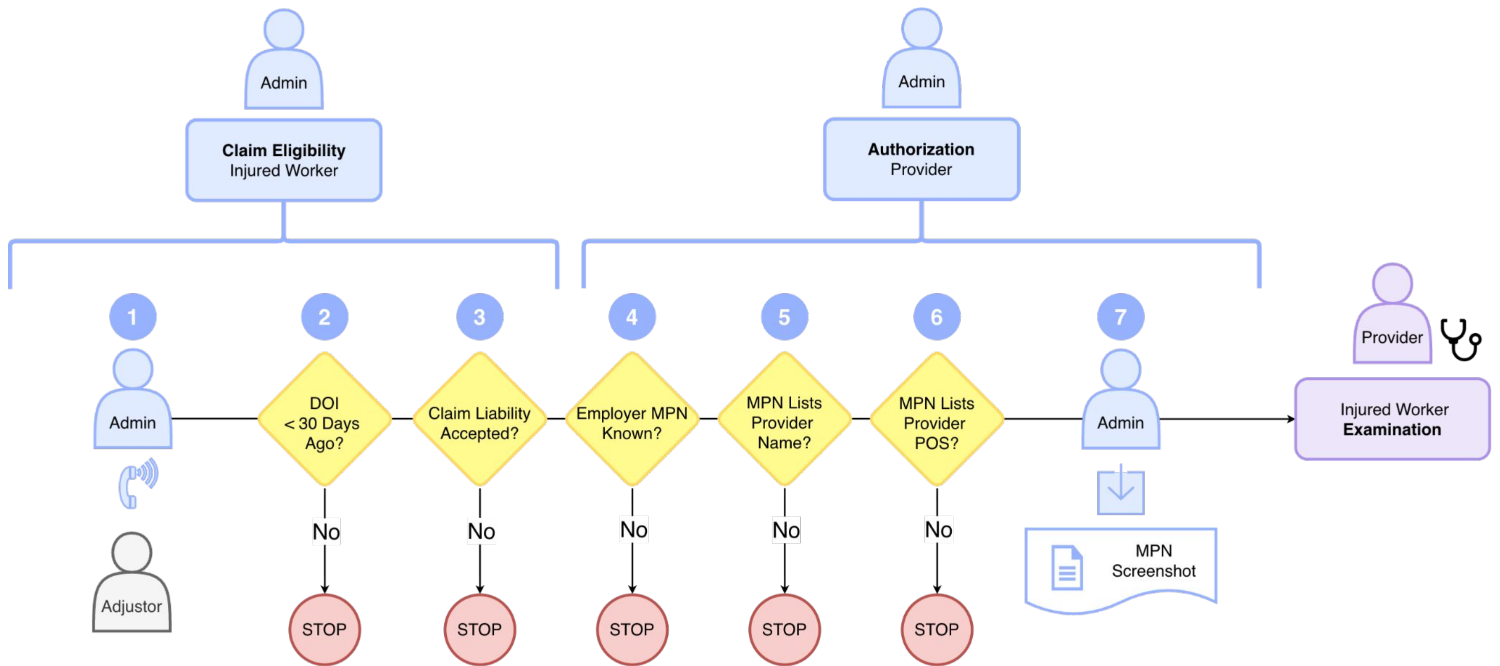

Exhibit H

"Automatic" Authorization
Post-Examination RFA Requirements