California Workers' Compensation Institute

Research Update

Independent Medical Review Trends and Outcomes: 2015 - 2025

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Background

Executive Summary

- Independent Medical Review (IMR) volume increased for the third year in a row in 2025, as the number of IMR determination letters climbed 7.6% to 152,350, the highest level since 2019. Although the 2025 increase was slightly less than the 8.2% jump in 2024, the overall trend reflects ongoing growth in IMR activity.
- IMR activity remains geographically concentrated in California. Los Angeles County, the Bay Area, and the Central Valley represented 71.2% of all IMR determination letters in 2025. Relative to their share of workers' compensation claims, IMR volume was disproportionately high in the Bay Area and Los Angeles County, and disproportionately low in the Inland Empire/Orange County, the Central Valley, San Diego, and the North Counties/Sierra region.
- Pharmaceutical disputes remained the largest IMR category, representing 30.5% of 2025 IMR decisions, though that share was down from 50.7% in 2015. Only 18.2% of the 2025 pharmaceutical IMRs involved opioids—the lowest percentage ever, and down from the all-time high of 32.0% in 2018, the first year after Opioid and Chronic Pain Guidelines were added to the Medical Treatment Utilization Schedule (MTUS) and the same year that the MTUS Formulary took effect. In 2025, IMR physicians upheld 91.2% of UR denials or modifications of pharmaceutical requests, including opioid requests.
- While opioids represented a declining share of pharmaceutical IMRs, disputes over dermatological drugs accounted for a record 25.4% of the prescription drug IMRs last year, up from 22.2% in 2024, and up from 15.1% in 2015. Disputes over anticonvulsants also represented a growing share of the prescription drug IMRs, as they nearly doubled from 5.4% of pharmaceutical IMRs in 2015 to 10.2% in 2025.
- The overall IMR uphold rate increased in 2025. IMR physicians upheld Utilization Review (UR) physicians' modifications or denials in 89.8% of the IMRs, up from 88.0% in 2024. Uphold rates ranged from 79.9% for Evaluation and Management (E&M) services, which were mostly requests for consultations, to 93.9% for acupuncture requests.
- In about one out of every eight IMR decisions in 2025 a UR physician found the treatment medically necessary but modified the request, usually by reducing the quantity to align with treatment guidelines. Modifications represented more than one out of five physical therapy and mental health (psych) IMRs, and more than one in six chiropractic IMRs.
- IMR requests remain highly concentrated among a small number of providers. The top 1% of requesting physicians (81 providers) accounted for 42.0% of disputed treatment requests decided by IMR last year and the top 10 individual physicians alone accounted for 11.0%.

The goal of workers' compensation is to provide injured workers with reasonable and necessary care needed to cure or relieve the effects of their injury and facilitate a timely return to work. To ensure that the medical services provided are evidence-based and clinically appropriate, for more than 20 years California has required workers' compensation claims organizations to have UR programs governed by written policies and procedures consistent with LC §4610. These programs are overseen by a medical director and must be filed with the Administrative Director of the Division of Workers' Compensation (DWC).[1]

UR implementation began in 2005, and in 2008, the California Supreme Court expanded the scope of UR by ruling that all workers' compensation treatment requests are subject to UR.[2] The UR process may include prior authorization for certain treatment requests outlined in the UR program, or simple review and approval by a claims examiner or other non-physician. However, only a physician may modify or deny a treatment request, so requests that are not approved in the initial review must be evaluated by a UR physician. UR physicians use the evidence-based clinical guidelines in California's Medical Treatment Utilization Schedule or other nationally accepted guidelines to determine if the requested services, as well as the modality, frequency, duration, and setting for the treatment, are medically necessary and appropriate for the injury or illness, and whether to authorize, modify, or deny the request.

In 2012 SB 863 fundamentally reshaped the workers' compensation medical dispute resolution process by introducing IMR, which allows an injured worker or their representative—usually an attorney—to challenge a UR modification or denial, submit additional evidence in support of the treatment request, and obtain an independent, evidence-based medicine determination. After receiving an IMR application, Maximus, the state's contracted IMR administrator, sends a notification of dispute and a records request to the claims administrator. Under state regulations the claims administrator must submit all medical reports relevant to the injured worker's current condition that were generated within the six months preceding the date of the UR decision, as well as any correspondence with the injured worker or their representative regarding the disputed medical service.[3]

The IMR physician evaluates these materials and the UR determination and decides whether the requested treatment is consistent with the applicable MTUS guidelines for the employee's condition. If the MTUS does not specifically address the condition or proposed treatment, the reviewer must apply the Medical Evidence Search Sequence established by regulation to assess evidence-based medical necessity.[4] After the review, the IMR physician either upholds or overturns the UR physician's denial or modification of the service, and Maximus issues the IMR determination letter noting the clinical rationale supporting the decision and citing the applicable guidelines or medical evidence used to make the determination.

Implementation of IMR in January 2013 shifted responsibility for resolving treatment disputes from administrative law judges to IMR physicians, while subsequent reforms further altered the process.[5]

[1] The UR program requirements were included in SB 228, a 2003 workers' compensation reform bill signed by Gov. Davis.
[2] *State Compensation Insurance Fund. v. WCAB (Sandhagen)* (2008) 44 Cal. 4th 230, 186 P.3rd, 535, 79 Ca. Rptr. 3rd 171.
[3] CCR §9792.10.5(a)(1) requires submission of relevant medical records within 15 days of mailed notification, 12 days of electronic notification or 24 hours for expedited reviews.
[4] CCR §9792.21.1
[5] The most recent reforms were finalized in December 2025, when DWC adopted changes to the UR, IMR and physician reporting regulations aimed at reducing delays in UR and treatment, accelerating medication approvals and strengthening UR oversight. Those regulations take effect April 1, 2026, so the data in this report reflect results prior to that effective date but will provide benchmarks for measuring changes in UR and IMR activity and outcomes following their implementation.

SB 1160, which took effect January 1, 2018, streamlined prospective UR requirements[6] and mandated accreditation for UR organizations.[7] At about the same time, the DWC implemented two other reforms that significantly reduced prescription drug disputes which accounted for nearly half of all IMRs:

1. Adoption of the ACOEM Opioid and Chronic Pain Guidelines into the MTUS; and
2. Implementation of the MTUS Prescription Drug Formulary, which was authorized by 2015 legislation (AB 1124). The formulary classified drugs as Exempt from prospective UR if compliant with MTUS treatment guidelines, Non-Exempt (subject to prospective UR), or Not Listed, and established subcategories of Non-Exempt drugs (Special Fill and Perioperative drugs) for special circumstances or pre- and post-operative situations in which physicians can prescribe limited amounts of certain drugs that would otherwise be subject to prospective UR and IMR.

In the 13 years since IMR took effect, CWCI has used IMR determination letters to track IMR volume and outcomes in a series of studies,[8] the most recent of which was published in May 2023. [9] This report continues the Institute's series by generating summary statistics compiled from more than 1.68 million IMR determination letters issued by Maximus during the 11-year study period. The report shows:

- The number of IMR letters issued each year;
- The distribution of services (by medical service category) that were reviewed each year;
- Uphold rates by type of medical service category from 2015 through 2025;
- Variations between the regional distribution of IMRs (based on the injured worker's home ZIP code) and the regional distribution of all workers' compensation claims;
- The distribution of prescription drug IMRs and uphold rates by drug category;
- Modification rates by service category; and
- The concentration of IMR activity among high-volume physicians named in IMR letters.

Data and Methods

The main data source for this study was the more than 1.68 million IMR determination letters issued by Maximus from 2015 through 2025. As in prior IMR analyses, the Institute converted each letter into a structured database that captured:

- Medical provider information;
- Injured worker characteristics;
- Details on the disputed treatment requests, broken out by service type, with pharmaceutical requests also classified by drug group to allow a detailed analysis of the prescription drug IMRs;
- The IMR outcome (uphold or overturn of the UR denial or modification); and
- The stated clinical rationale for the IMR decision.

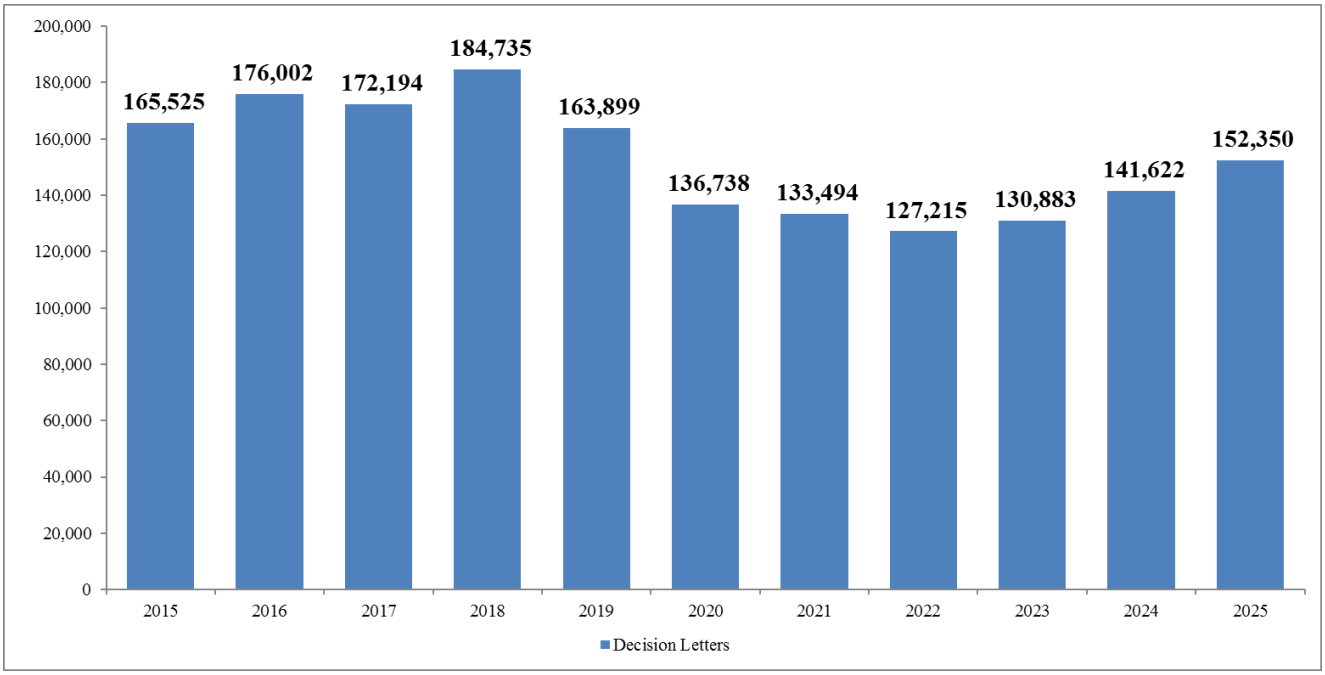
[6] In 2016, Gov. Brown signed SB 1160 which amended LC §4610 to streamline delivery of injured workers' medical care by reducing the types of services subject to prospective UR when provided within the first 30 days of injury.
[7] URAC accreditation became mandatory July 1, 2018. Labor Code §4610(g)(4).
[8] California Workers' Compensation Institute - Research (cwci.org)
[9] Bullis, R., David, R., *"Resolving Medical Disputes: Factors that Drive IMR Volume and Outcomes in the California Workers' Compensation System."* CWCI Report to the Industry, May 2023.

Results

Number of IMR Determination Letters

The distribution of IMR letters by year (Exhibit 1) shows that in 2015, Maximus issued 165,525 IMR determination letters. Although state lawmakers initially expected that medical disputes and IMR volume would quickly decline as physicians, attorneys, and others involved in the process adjusted to the rules and came to understand the types of treatment that meet evidence-based medicine standards, it was not until five years after its implementation that IMR volume peaked with a record 184,735 letters issued in 2018. After that IMR volume declined for four consecutive years, falling 11.3% in 2019, 16.6% in 2020, 2.4% in 2021, and 4.7% in 2022.

Exhibit 1: Eligible IMR Determination Letters, 2015 - 2025



The 2018-2022 decline in IMR volume reflected multiple factors, including a sharp decline in the number of pharmaceutical disputes following implementation of the Pain Management and Opioid Guidelines and the adoption of the MTUS Formulary. In addition, there was a 5.9% reduction in claim volume between 2019 and 2020 as the COVID-19 pandemic led to a short-lived recession and delayed or forgone medical treatment.[10] IMR volume, however, continued to decline in 2021 and 2022, even as the state's economy rebounded and claim volume increased, largely driven by an influx of relatively inexpensive COVID-19 claims.[11] Prior Institute research found that most AY 2020 – AY 2022 COVID-19 claims involved little or no medical intervention, with only 14.6% involving any medical treatment,[12] so few of these claims involved IMR and as a result by 2022 there were 36,684 fewer IMR letters than in the final pre-pandemic year of 2019, even though total claim volume was 7.8% higher.

[10] CWCI's Claims Characteristic and Trends Interactive Application, 1/27/26.
[11] The Claims Characteristics and Trends Interactive Application estimates that COVID-19 claims accounted for about one out of every nine claims in 2021 and one out of every seven claims in 2022.
[12] Russell, A., Albino, E. *Long COVID Claim Characteristics and Treatment in California Workers' Compensation.* CWCI Research Note, June 2025.

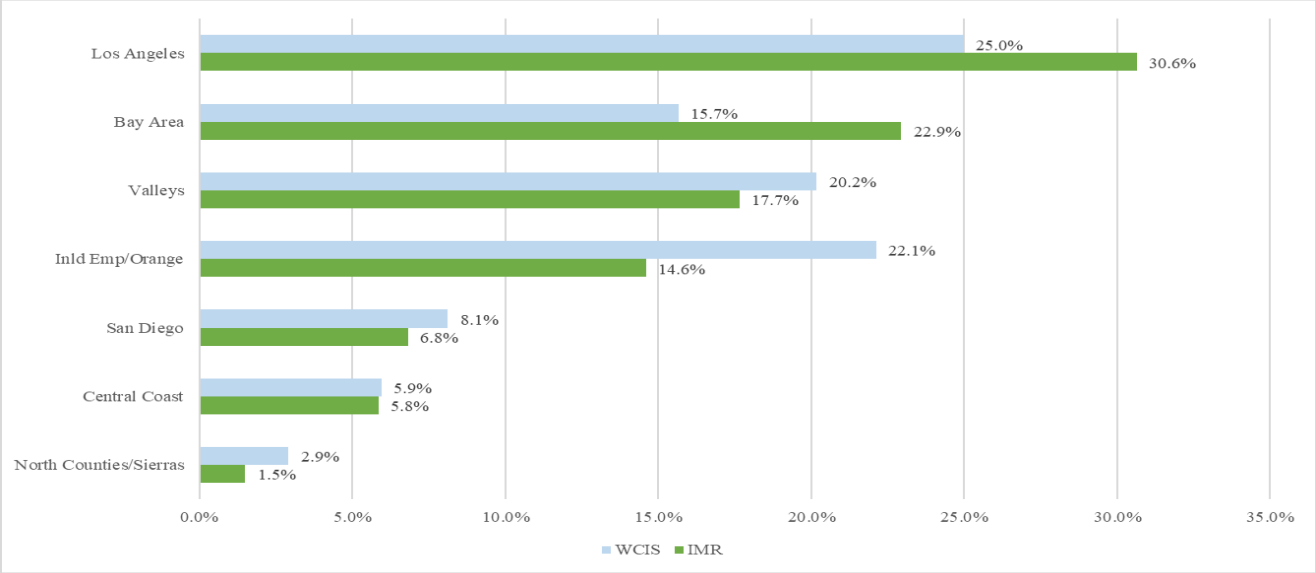
The four-year decline in IMR volume ended in 2023 as the California economy continued to grow and overall employment expanded as hundreds of thousands of new payroll jobs were added during the post-pandemic recovery,[13] while the number of COVID-19 claims, few of which involved IMRs, declined by nearly 77% from 110,764 claims in 2022 to 25,792 in 2023. At the same time, IMR letter volume, which had fallen to a historic low of 127,215 in 2022, began to rise, increasing by 2.9% in 2023.

California's relatively healthy employment picture in 2023 became cloudier in 2024 as job growth, fueled by growth in the health care and education sectors, continued early in the year, but then weakened as the year progressed.[14] In 2025, the labor market continued to slow, with modest job gains and rising unemployment leading to what the Public Policy Institute of California described as "a year in neutral" for the state's job market.[15] With employment remaining flat in 2024 and 2025, workers' compensation claim volume plateaued, declining 0.8% in 2024 and 1.8% in 2025. Despite these marginal changes in claim volume, the uptrend in IMR volume continued as the number of IMR letters jumped 8.2% in 2024, and 7.6% in 2025. While the latest letter counts confirm the peak in IMR activity in 2018, followed by the steep decline during the pandemic and the subsequent growth over the last three years, the following sections provide an updated look at the trends in other IMR metrics before, during and after the pandemic.

Regional Distribution of 2025 Claims vs. IMR Determination Letters

IMR determination letters include an address for the injured worker or their representative. Using the ZIP codes from those addresses, the authors determined the distribution of the 2025 IMR letters across seven regions of the state. They then compared the regional distribution of IMR letters to the regional distribution of 2025 claims as identified by DWC's Workers' Compensation Information System (WCIS)[16] to identify regions where IMR was disproportionately high or low relative to claim volume (Exhibit 2).

Exhibit 2: 2025 Regional Distribution of WC Claims vs. IMR Letters



[13] The California Employment Development Department reports that total nonfarm payroll employment in the state increased by about 311,000 jobs, or roughly 1.7% from December 2022 to December 2023.
[14] Alamo, C. *Early Data Revision Shows No Job Creation During 2024 Q4.* California Legislative Analyst's Office, June 24, 2025.
[15] Bohn, S. Cremin, S. *A Year in Neutral for California's Job Market*. Public Policy Institute of California Blog. January 29, 2026.
[16] The Workers' Compensation Information System (WCIS) uses electronic data interchange to collect claims data from workers' compensation claims administrators to help the Department of Industrial Relations oversee the workers' compensation system and to provide data for research.

Compared to the percentage of claims in each region, the volume of IMR letters was disproportionately high in the Bay Area, which accounted for 15.7% of all California workers' compensation claims last year, but 22.9% of the IMR letters; and in Los Angeles County, which had 25.0% of the claims, but 30.6% of the IMR letters. IMR letters were disproportionately low in the Inland Empire/Orange County, which had 22.1% of the claims, but 14.6% of the IMR letters; the Central Valley, which had 20.2% of the claims but 17.7% of the letters; San Diego, which had 8.1% of the claims but 6.8% of the letters; and in the North Counties/Sierra region which had 2.9% of the claims but 1.5% of the letters. The percentage of claims and the percentage of IMR letters were about equal in the Central Coast region.

IMR Distribution by Medical Service Category

Since IMR was first implemented, the major categories of medical services that undergo the process have remained fairly consistent, as noted in Exhibit 3. Though pharmaceuticals remain the largest IMR category, their share of the IMRs has declined steadily, falling by more than 20 percentage points since 2015.

Exhibit 3: IMR Distribution by Medical Service Category, Jan. 2015 – Dec. 2025

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Service Requested	**% of Service Requests**										
Pharmaceuticals	50.7%	49.5%	47.8%	46.5%	41.1%	39.1%	34.9%	33.3%	32.2%	33.4%	30.5%
Physical Therapy	8.3%	8.6%	9.7%	10.2%	12.0%	12.2%	13.4%	13.2%	13.4%	13.1%	14.0%
Injections	6.9%	7.6%	8.3%	9.1%	10.1%	10.8%	11.7%	12.1%	12.4%	12.4%	12.8%
DME/POS	7.3%	6.9%	6.5%	7.0%	7.8%	8.5%	9.4%	8.2%	8.9%	8.9%	9.4%
MRI/CT/PET	4.3%	4.6%	4.8%	4.6%	4.8%	5.0%	5.0%	5.5%	6.0%	5.4%	5.4%
Acupuncture	2.2%	2.3%	2.5%	3.0%	3.7%	3.9%	4.3%	4.5%	4.6%	4.8%	5.1%
Surgery	3.1%	3.0%	2.9%	2.9%	3.4%	3.6%	3.4%	3.6%	3.5%	3.9%	3.6%
Diagnostic Test/Measure	3.5%	3.6%	3.4%	3.4%	3.2%	3.1%	3.0%	2.8%	2.8%	2.4%	2.5%
Chiro Manipulation	1.7%	1.7%	1.7%	1.8%	2.2%	2.2%	2.5%	2.7%	2.7%	2.6%	2.8%
Evaluation & Mgt	2.2%	2.3%	2.2%	2.0%	2.0%	2.2%	2.3%	2.6%	2.4%	2.5%	2.9%
Laboratory Services	2.8%	3.3%	3.3%	2.5%	2.1%	1.7%	1.7%	1.5%	1.5%	1.3%	1.2%
Psych Services	1.4%	1.4%	1.3%	1.2%	1.3%	1.5%	1.6%	1.7%	1.6%	1.6%	1.5%
Other	5.5%	5.4%	5.6%	5.7%	6.3%	6.4%	6.9%	8.2%	8.0%	7.7%	8.4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Most of that decline came after the DWC added the Opioid and Chronic Pain Guidelines to the MTUS in late 2017 and implemented the MTUS Formulary in January 2018. The medical service categories that have seen the most growth in their share of the IMR disputes since 2015 are physical therapy, which jumped from 8.3% of the disputes in 2015 to 14.0% in 2025; and injections, which increased from 6.9% to 12.8% over that 11-year span. At the same time, disputes over durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) increased from 7.3% of the IMRs in 2015 to 9.4% in 2025. Other medical services that have seen significant growth in their share of the IMR disputes since 2015 include acupuncture, where the share of disputed service requests more than doubled from 2.2% to 5.1%; and chiropractic manipulation which increased from 1.7% of the disputes to 2.8%.

Other than pharmaceuticals, the only medical service categories that had a declining share of the IMRs between 2015 and 2025 are diagnostic tests and measurements, which dropped from 3.5% to 2.5%; and laboratory services, which declined from 2.8% to 1.2%. In both cases, most if not all of the declines occurred after 2018, which coincides with the sharp drop in the number of pharmaceutical disputes, so

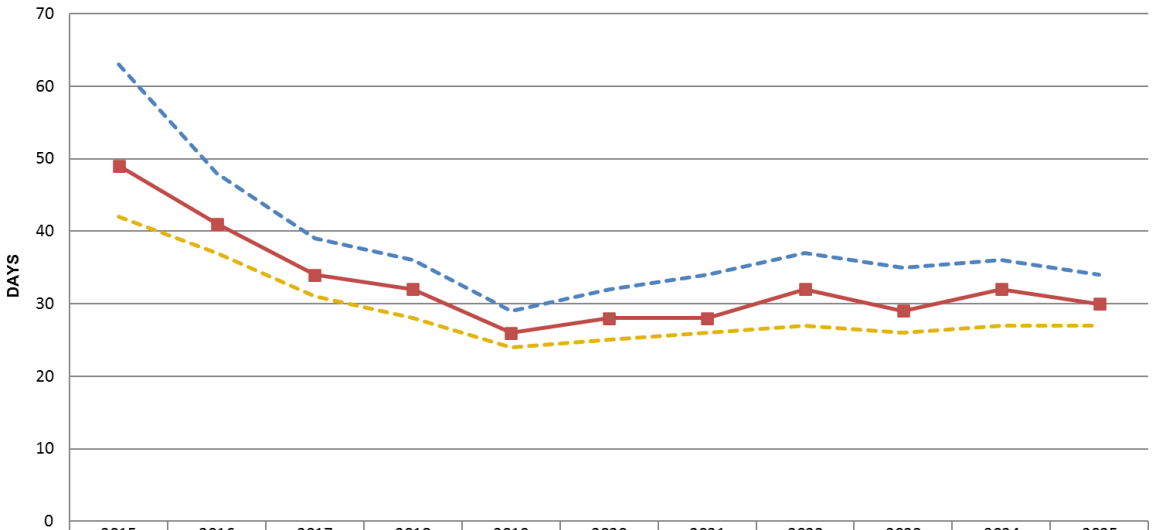
these declines likely reflect a decline in disputes over drug testing for opioids and other controlled substances and the associated lab work. Overall, these changes in the distribution of IMRs among the different medical service categories indicate that as the prescription drug reforms reduced pharmaceutical disputes, IMR activity largely shifted toward physical medicine and alternative pain management services.

IMR Response Time

Each IMR determination letter shows the date of the UR denial or modification, the date the IMR application was received, and the date of the determination letter which is considered the review completion date. After Maximus receives an IMR application from an injured worker or their representative (typically an attorney) it must confirm the eligibility of the application; request, receive, and process the medical records; and assign the case to a reviewing physician. IMR regulations require a determination letter to be issued within 30 days of the receipt of the application and supporting records[17] but they also allow 12 to 15 days for the receipt of the records, depending on how the notification was sent,[18] so Maximus may have up to 45 days to issue the determination letter).[19]

Exhibit 4 shows the median time that elapsed between Maximus' receipt of an IMR application and the date of the determination letter, with results broken out by the year in which the decision was issued. Maximus' response time improved from 2015 through 2019 when the response time fell to 26 days, but since then the median has ranged between 28 and 32 days. In 2025, the median number of days from receipt of an IMR application to issuance of a decision letter was 30; with 25% of the applications decided within 27 days, and 75% determined within 34 days, all well within the regulatory timeframe.

Exhibit 4: Days from Application Date to Determination Letter Date, 2015 - 2025 IMRs



	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Median	49	41	34	32	26	28	28	32	29	32	30
25th%	42	37	31	28	24	25	26	27	26	27	27
75th%	63	48	39	36	29	32	34	37	35	36	34

[17] CCR §9792.10(g)
[18] CCR §9792.10(a)(1) allows up to 15 calendar days from mailing if the notification is sent by mail; 12 calendar days if it is sent electronically.
[19] In *Tyni v. City of Montebello (WCAB Case No. ADJ9661661, June 2016*), the WCAB ruled that the 15-day period is distinct from and in addition to the 30-day period for Maximus to issue its final determination letter.

IMR Uphold Rates of UR Decisions on Primary Service Requests

The IMR physician assigned by Maximus reviews the injured worker's medical records, the applicable guidelines, and any additional materials submitted in support of a medical service request to determine if the treating physician's request is medically appropriate. Based on that determination, Maximus issues the determination letter upholding or overturning the UR physician's denial or modification of the request.

Exhibit 5 shows that the overall IMR uphold rate has remained consistently high throughout the 11-year study period, ranging between 88.0% and 92.4%. This indicates strong alignment between UR decisions and evidence-based clinical guidelines and confirms that IMR continues to serve as a meaningful secondary review process.

Exhibit 5: IMR Uphold Rates by Medical Service Category, 2015 – 2025 IMR Determinations

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Service Requested	**% of Service Requests**										
Pharmaceuticals	89.7%	92.5%	91.9%	89.4%	89.4%	90.7%	93.3%	91.8%	90.6%	89.7%	91.2%
Physical Therapy	92.2%	93.0%	93.6%	91.7%	90.4%	90.8%	92.9%	93.9%	91.6%	90.0%	90.4%
Injections	87.4%	89.4%	89.5%	89.1%	88.8%	91.2%	95.0%	95.9%	91.4%	90.7%	93.1%
DME/POS	89.6%	91.4%	91.6%	89.2%	90.1%	91.8%	93.5%	91.9%	91.4%	89.3%	89.5%
MRI/CT/PET	86.3%	88.6%	89.2%	87.6%	86.3%	88.2%	91.6%	91.5%	88.3%	85.4%	87.6%
Acupuncture	91.6%	93.6%	93.9%	92.7%	89.7%	87.7%	90.5%	93.6%	93.1%	93.0%	93.9%
Surgery	86.3%	88.3%	90.7%	88.0%	88.7%	87.2%	88.7%	86.5%	87.2%	80.8%	86.1%
Diagnostic Test/Measure	84.5%	91.3%	91.3%	89.0%	86.7%	88.7%	92.4%	91.5%	86.2%	83.5%	87.7%
Chiro Manipulation	90.8%	92.0%	93.8%	92.2%	89.0%	86.7%	89.3%	87.0%	88.5%	89.8%	90.8%
Evaluation & Mgt	66.4%	77.0%	77.7%	75.9%	74.9%	80.9%	84.9%	82.8%	76.1%	74.9%	79.9%
Laboratory Services	82.6%	88.4%	86.4%	82.9%	81.6%	82.2%	87.4%	84.3%	81.4%	77.4%	81.1%
Psych Services	83.3%	85.2%	84.4%	78.6%	79.0%	81.9%	85.1%	82.5%	83.5%	80.7%	81.3%
Other	86.0%	88.1%	87.6%	85.6%	86.1%	88.6%	90.8%	89.5%	85.4%	81.9%	86.0%
Total	**88.3%**	**91.1%**	**90.9%**	**88.8%**	**88.5%**	**89.8%**	**92.4%**	**91.6%**	**89.6%**	**88.0%**	**89.8%**

The overall uphold rate in 2025 for all medical services was up 1.8 percentage points from the prior year, increasing from 88.0% in 2024 to 89.8% in 2025 as the uphold rates increased across all major medical service categories. The largest increase in the uphold rate was for surgery, which went from 80.8% in 2024 to 86.1% last year. Among the top three service categories, which together accounted for 57.3% of IMR volume in 2025, the uphold rates increased by 1.5 percentage points for pharmaceuticals, 0.4 percentage points for physical therapy, and 2.4 percentage points for injections. As usual, E&M services, which are often requests for consultations, had the lowest uphold rate last year (79.9%), so IMR physicians overturned UR physicians' determinations on E&M service requests about 20% of the time in 2025, though that was down from about 25% in 2024.

Prescription Drug IMR Distribution by Drug Category

Maximus issued more than 46,000 IMR determination letters in response to prescription drug disputes last year, with opioids accounting for 18.2% of those disputes, the lowest percentage since IMR was introduced, and down from nearly a third of the prescription drug disputes in 2018, the first full year after the Opioid and Chronic Pain Guidelines were incorporated into the MTUS and the MTUS Formulary took effect.

Prior Institute research documented the recent growth of high-priced topical analgesics which are often used as non-opioid alternatives.[20] Many of these drugs are subject to prospective UR under the Formulary, so as disputes over opioids declined, dermatological drug disputes increased. Exhibit 6 notes that dermatological drugs' share of the pharmaceutical IMRs more than doubled from 12.3% in 2018 to 25.4% in 2025, and in 2024 and 2025 they supplanted opioids as most common drug category submitted for IMR.

Exhibit 6: Distribution of Rx Drug IMR Decisions by Therapeutic Drug Group, 2015 - 2025

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Drug Group	**Percent of Service Requests**										
Analgesic-Opioid	30.3%	28.6%	29.1%	32.0%	30.7%	28.0%	25.0%	23.9%	23.1%	20.8%	18.2%
Musculoskeletal	12.7%	13.4%	13.5%	14.5%	15.6%	16.9%	17.8%	17.9%	18.1%	17.9%	17.4%
Dermatological	15.1%	14.8%	14.4%	12.3%	14.0%	15.9%	17.8%	18.9%	20.1%	22.2%	25.4%
Anticonvulsant	5.4%	5.7%	6.2%	8.2%	8.8%	10.2%	10.3%	10.2%	10.1%	10.1%	10.2%
Anti-Inflammatory	8.5%	9.6%	10.3%	7.7%	6.4%	6.4%	7.4%	8.0%	7.4%	7.7%	8.1%
Antidepressant	3.9%	4.1%	4.2%	4.9%	5.1%	4.5%	3.4%	3.4%	3.3%	3.8%	3.5%
Ulcer Drug	7.3%	7.4%	7.2%	4.7%	3.6%	3.5%	3.5%	3.3%	3.2%	3.3%	3.2%
Hypnotic	3.9%	3.8%	3.1%	2.7%	2.4%	2.0%	1.8%	1.7%	1.4%	1.2%	1.1%
Antianxiety	2.7%	2.8%	2.6%	2.4%	2.2%	1.9%	1.8%	1.6%	1.4%	1.4%	1.2%
NonNarcotic Analgesic	1.1%	1.4%	1.8%	2.2%	1.9%	2.1%	2.0%	1.8%	2.2%	2.2%	2.1%
Other	9.1%	8.4%	7.6%	8.3%	9.3%	8.7%	9.1%	9.3%	9.7%	9.4%	9.6%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

The effort to find alternatives to opioids also led to substantial growth in the off-label use of musculoskeletal drugs—such as cyclobenzaprine HCL (Flexeril), baclofen (Lioresal), and tizanidine (Zanaflex)—as well as anticonvulsants commonly prescribed for neuropathic pain, including gabapentin (Neurontin) and pregabalin (Lyrica). Most of these medications are classified by the Formulary as Non-Exempt or Not Listed drugs, making them subject to UR. As a result, their share of pharmaceutical IMRs began to increase as soon as the MTUS Formulary took effect in 2018. As shown in Exhibit 6, both groups' share of the IMRs increased by about 4 percentage points from 2017 to 2025. Thus, beyond the increase in dermatological drug disputes, the decline in opioid-related IMRs also resulted in a shift in the prescription drug IMRs toward musculoskeletal drugs and anticonvulsants.

Prescription Drug IMR Uphold Rates by Therapeutic Drug Group

Disputes over pharmaceutical requests can involve a number of factors: the appropriateness and strength of the drug, the quantity and duration of the prescription, as well as contraindications with other prescribed medicines, all of which may be considered by UR and IMR physicians in determining whether a request should be modified or denied. In 2025, IMR physicians upheld UR physicians' modifications or denials of prescription drug requests 91.2% of the time, while since 2015 the uphold rate has shown little variation, ranging between 89.4% and 93.3% over that 11-year span.

Exhibit 7 shows the uphold rates for UR physicians' modifications or denials of prescription drug requests by therapeutic drug group. While dermatological drugs were the number one drug category submitted for IMR over the past two years and accounted for more than a quarter of the prescription drug determinations last year, they have consistently had one of the highest IMR uphold rates since 2015, with IMR physicians

[20] Young, B., Jones, S. *"Cost Driver Medications in the Top California Workers' Comp Therapeutic Drug Groups, Part II, Dermatologicals, Opioids, and Antidepressants."* CWCI Spotlight Report, May 2023.

upholding between 92.3% and 97.1% of UR physician denials or modifications of dermatological drug requests over the 11-year study period. Similarly, musculoskeletal drugs, which represented about one out of every six prescription drug IMRs since 2020 have also had one of the highest uphold rates over the years, ranging between 95.5% and 98.6% since 2015. Hypnotic drugs, which account for a much smaller share of the pharmaceutical IMRs, is the other drug group that has consistently had one of the highest uphold rates, with the UR decisions on these drugs ranging between 97.2% and 98.3% over the 11-year span. Notably, the uphold rates for opioids ranged between a low of 88.0% in 2015, but for the past seven years they have stayed above 90.0%, and in 2025, the uphold rated hit a record high, with 95.3% of the denied or modified opioid requests upheld by IMR.

Exhibit 7: Rx Drug IMR Uphold Rates by Therapeutic Drug Group, 2015 - 2025

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Drug Group	**Percent of UR Denials/Modifications Upheld by IMR**										
Analgesic-Opioid	88.0%	90.2%	90.1%	89.8%	90.8%	91.8%	94.4%	93.2%	92.6%	94.1%	95.3%
Musculoskeletal	96.4%	97.1%	97.2%	95.8%	95.5%	96.6%	98.5%	98.5%	98.2%	97.9%	98.6%
Dermatological	96.3%	97.1%	97.0%	94.9%	93.8%	93.2%	95.1%	95.8%	93.7%	92.3%	93.8%
Anticonvulsant	82.0%	87.3%	87.7%	80.7%	82.0%	86.1%	91.3%	91.9%	90.4%	90.0%	92.9%
Anti-Inflammatory	82.5%	90.0%	88.7%	84.3%	81.7%	83.4%	85.7%	80.7%	76.3%	74.2%	74.7%
Antidepressant	74.5%	83.8%	82.2%	75.9%	74.8%	79.8%	82.4%	74.1%	78.2%	74.7%	78.1%
Ulcer Drug	89.0%	93.0%	91.7%	88.4%	87.9%	86.7%	89.7%	83.1%	80.8%	78.7%	80.4%
Hypnotic	97.4%	98.2%	97.7%	97.2%	97.2%	97.9%	98.2%	97.5%	97.9%	98.3%	97.7%
Antianxiety	96.3%	97.1%	95.0%	94.4%	92.5%	94.6%	94.5%	91.7%	90.6%	89.1%	92.7%
NonNarcotic Analgesic	88.7%	92.6%	91.9%	92.0%	90.6%	92.5%	92.2%	87.8%	85.6%	81.8%	81.1%
Other	87.9%	90.7%	89.2%	85.8%	85.9%	86.6%	89.7%	86.5%	83.8%	81.3%	84.6%
Total	**89.7%**	**92.5%**	**91.9%**	**89.4%**	**89.4%**	**90.7%**	**93.3%**	**91.8%**	**90.6%**	**89.7%**	**91.2%**

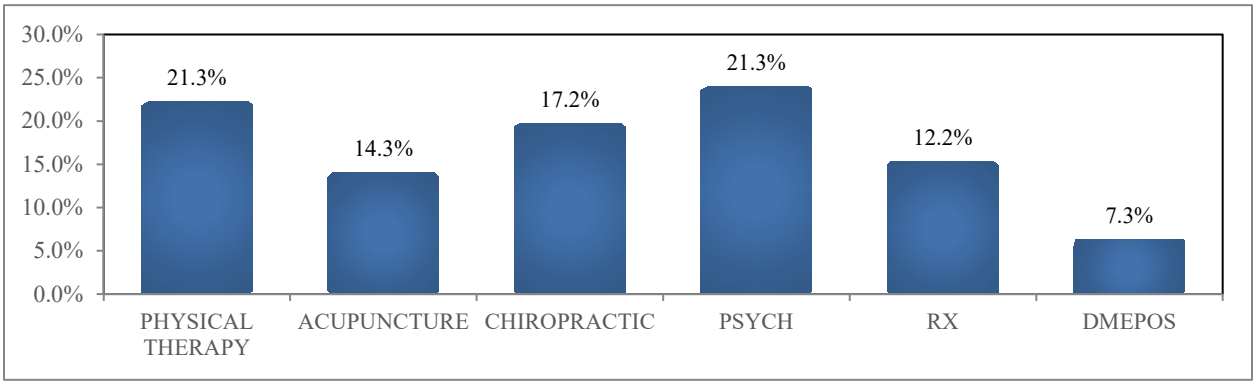
The four drug groups with the lowest uphold rates both in 2025 and throughout the study period were anti-inflammatories, which had uphold rates ranging from 74.2% to 90.0% during the 11-year span; antidepressants, where uphold rates ranged between 74.1% and 83.8%; ulcer drugs, which had uphold rates between 78.7% and 93.0%; and non-narcotic analgesics, where the uphold rates were 81.1% to 92.6%.

IMR Reviews of UR Modifications

In 2025, roughly one out of eight IMRs involved a modification of a treatment request, rather than a denial. Any UR modification may be submitted to IMR, including those where the UR physician approves the medical necessity of the service but reduces the quantity of the treatment to a level consistent with the MTUS or other applicable treatment guidelines. A common example is when a doctor requests a medication with multiple refills, but the UR physician approves the prescription with a single refill or without a refill to comply with the guidelines. If the doctor thinks additional refills are needed they can submit another Request for Authorization (RFA).

In addition to prescription drugs, several other types of service requests tend to be subject to these types of modifications. Exhibit 8 shows six service categories where the service itself was not modified, only the quantity or purchase arrangement. The six categories represented 63.3% of all IMRs and 75.2% of all UR modifications reviewed in IMR in 2025. Overall, 11.9% of all IMRs in 2025 involved disputes over service modifications in one of the six categories shown in Exhibit 8 rather than over the necessity of treatment.

Exhibit 8: UR Modifications as a Percent of Total IMRs for Selected Services in 2025



A review of the modified requests shows that nearly all of last year's mental health (psych) and physical therapy modifications sent to IMR involved changes to the quantity of visits. Modifications to the number of requested visits represented about one in five physical therapy and mental health IMRs in 2025; more than one in six chiropractic IMRs, and one in seven acupuncture service requests that underwent IMR. Modifications to prescription drug requests typically involved limits on the number of refills or on the number of pills, and these represented one out of eight pharmacy services reviewed. DMEPOS modifications often involve switching an equipment purchase to a rental or changing the length of time the DMEPOS will be used, and these modifications represented about one out of every 13 DMEPOS IMRs.

Concentration of IMR Determinations Among High-Volume Providers

As in prior years, in 2025, a small number of medical providers accounted for a disproportionate share of the medical service requests submitted to IMR. The determination letters noted 8,140 unique providers who requested the disputed services, with the top 1% named in 42.0% of the letters. Exhibit 9 shows the proportion of requests originating from the top 10, top 25, and top 50 providers in each of the 11 years studied, as well as the proportion linked to the top 1% and top 10% of providers based on IMR volume.

Exhibit 9: Top Providers, 2015 – 2025 Determinations

Providers	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Top 10	11.9%	11.3%	12.5%	9.5%	9.9%	10.2%	10.7%	11.3%	11.4%	11.4%	11.0%
Top 25	20.7%	20.3%	21.5%	18.1%	18.6%	19.4%	20.6%	21.2%	21.4%	21.2%	21.2%
Top 50	29.9%	30.0%	30.8%	28.2%	28.2%	29.9%	31.1%	31.6%	32.2%	32.8%	32.8%
Top 1% (81)	45.4%	45.3%	45.5%	44.2%	41.2%	39.6%	39.9%	39.9%	40.2%	41.9%	42.0%
Top 10% (814)	85.4%	85.1%	86.9%	84.6%	83.5%	82.1%	82.6%	82.9%	83.1%	83.9%	84.4%

Data on the medical specialties of the top 10 providers who were identified in 11.0% of all IMR decision letters in 2025 shows that six were pain management specialists, one was a general practitioner, one was an orthopedist, and two were physical medicine and rehabilitation specialists. Among the top 5 requesting physicians, four were pain management specialists and four—including the top three— practiced in the Bay Area, which contributed to the disproportionate share of IMR disputes originating from that region.

Discussion

When lawmakers included IMR in the 2012 workers' compensation reforms they anticipated that the number of disputes would decline over time as providers, attorneys, and claims administrators became more familiar with the MTUS Treatment Guidelines and aligned their practices accordingly. That expectation was not met during the first several years after IMR took effect, however, with the only decline being a modest 2.2% drop in 2017. Instead, IMR volume increased steadily, finally reaching a record level in 2018 when Maximus issued 184,735 IMR determination letters.

After peaking in 2018, IMR volume declined for four consecutive years (falling 11.3% in 2019, 16.6% in 2020, 2.4% in 2021, and 4.7% in 2022) with 2022 marking a historic low. More recent data included in this report show that downward trend has now reversed as IMR volume has increased 19.8% over the past three years, reaching a post-pandemic high of 152,350 determination letters in 2025. This recent growth signals that while certain reforms reduced pharmaceutical disputes, other factors driving IMR utilization remain firmly in place.

To some extent, the high volume of IMR in the first few years was influenced by applicant attorney practices. Because IMR is the exclusive remedy for appealing timely UR determinations,[21] and failure to file within 30 days bars further challenges,[22] some attorneys adopted a strategy of submitting virtually all UR denials and modifications to IMR,[23] which initially overwhelmed the system and led to a huge backlog of unresolved disputes. But over the years other factors impacting the growth of IMR also came into play.

Two of the most notable factors were the prescription drug reforms implemented in late 2017 and early 2018—the addition of ACOEM's Chronic Pain and Opioid Guidelines into the MTUS and the adoption of the MTUS Formulary. Prior to those reforms, prescription drug disputes accounted for nearly half of all IMRs, but following their adoption, pharmaceutical IMRs declined sharply, which helped to fuel an 11.3% drop in overall IMR volume between 2018 and 2019. As noted in Exhibit 6, opioid disputes, in particular fell sharply, reflecting more consistent adherence to the evidence-based prescribing standards.

Other data in this report confirm the ongoing impact that the prescription drug reforms have on IMR. Exhibit 7 shows the uphold rate for opioid IMRs rose from 88.0% in 2015 to 95.3% in 2025, while the uphold rate for musculoskeletal drugs, which are on the Formulary's Non-Exempt drug list and subject to prospective UR, reached a record 98.6% in 2025. In addition, the uphold rate for anticonvulsant drugs increased from 80.7% in 2018 to 92.9% in 2025 while other categories of drugs that can be addictive or where there can be dangerous drug interactions—including dermatological drugs, hypnotics, and anti-anxiety medications—also had uphold rates above 92% last year. These consistently high uphold rates indicate that UR physicians are largely applying MTUS Guidelines correctly and that IMR is reinforcing evidence-based decision-making.

The COVID-19 pandemic also had a significant impact on IMR activity. The number of workers' compensation claims declined in AY 2020 and remained below pre-pandemic levels until AY 2022, when a surge of COVID cases temporarily increased overall claim volume, even as IMR volume bottomed out.[24] Since 2023, however, the number of COVID claims has dwindled and total claim counts have stabilized within a relatively narrow range while IMR volume has increased.

[21] LC §4610.5
[22] CCR §9792.10.1(b)(1)
[23] California Applicants' Attorneys Association. "In Case You Missed It, The Problem with IMR is UR." November 13, 2013.
[24] CWCI Claim Characteristics and Trends Interactive Application. 1/20/26.

This divergence suggests that recent IMR growth has not been driven by claim volume, but by other factors, including shifts in the types of treatment used in workers' compensation and the heavy concentration of IMR activity among a small group of high-volume providers.

Exhibit 3 noted the changes in the mix of services submitted for IMR, showing that as pharmaceutical disputes declined, IMRs involving physical therapy, DMEPOS, injections, E&M services, and acupuncture increased. From 2015 to 2025 the most pronounced shift was the increase in physical therapy disputes, which jumped from 8.3% to 14.0% of all IMRs. Over the last three years most treatment categories saw relatively minor changes in their share of the IMRs, but total IMR volume increased by more than 25,000 cases from 2022 to 2025, so even modest percentage increases point to substantial growth in the number of disputes involving those services.

The recent increases in IMR volume were not only noted across several medical service categories, but across all geographic regions of the state as well, though that growth was not uniform across the state, nor did it match the changes in claim volume within each region. Exhibit 2 showed the disparities between the percentage of claims and the percentage of IMRs in each of the seven major regions of the state. Although IMR activity increased throughout the state in 2025, the gap between claim volume and IMR volume was most notable in the Bay Area, which accounted for 15.7% of all California work injury claims but 22.9% of the IMR determination letters. This 7.2 percentage-point differential exceeded the 5.6 percentage point differential in Los Angeles County and contrasted sharply with the Inland Empire/Orange County, San Diego, the Central Valley, and the North Counties/Sierra regions, where the percentage of claims exceeded the percentage of IMR letters.

The location of the high-volume providers appears to be a key factor contributing to these disparities. The latest data show that the top 1% of requesting physicians (81 doctors) accounted for 42% of all disputed service requests in 2025, with the top 10 physicians alone accounting for 11.0% of the requests. Furthermore, four of the top five requesting physicians were pain management specialists and four of them, including the top three requesting physicians, practiced in the Bay Area. This level of concentration indicates that IMR activity continues to be disproportionately driven by a small number of providers, many of whom are located in the nine-county Bay Area.

Despite the recent increase in IMR submissions, IMR uphold rates remain stable and strongly supportive of UR determinations. Exhibit 5 showed that the overall uphold rate rose to 89.8% in 2025, up from 88.0% in 2024, with increases noted across all major treatment categories. The biggest increase last year was in surgery, where the uphold rate rose by 5.3 percentage points. Conversely, 10.2% of the 2025 IMRs resulted in a modification or reversal of the UR physician's determination, demonstrating that while UR decisions are confirmed in the vast majority of cases, IMR continues to function as a meaningful safeguard, particularly in categories such as E&M, mental health, and laboratory services, where overturn rates approached 20%.

As in prior years, a significant share of 2025 IMRs—nearly one in eight—involved disputes over modifications to the treatment request rather than outright denials. Examples include reductions in the number of visits to MTUS-consistent levels or conversion of DMEPOS purchases to rentals. Given that the medical necessity of the treatment is not an issue, and the physician can request additional treatment if the service proves beneficial, the value of putting such disputes through IMR remains a subject of debate as the cost and time associated with IMR may outweigh its benefit when there is no disagreement regarding the appropriateness of treatment.

Conclusion

Taken together, the latest findings indicate that IMR has functioned as intended in reinforcing evidence-based medical decision-making and confirming the accuracy of UR determinations in nearly 90% of cases. The data clearly show that the pharmaceutical reforms succeeded in reducing inappropriate prescribing and strengthened consistency in high-risk drug categories, though overall IMR volume remains highly sensitive to provider behavior, regional practice patterns, and dispute strategies rather than claim frequency alone.

These results reflect the dispute resolution process that was in place for the past 11 years, but at the end of 2025 the DWC adopted revisions to the UR, IMR, and physician reporting regulations intended to reduce UR delays and disputes, expedite injured worker access to care and medications, and strengthen regulatory oversight of claims administrators and UR organizations. Those regulations take effect April 1, 2026. Key provisions clarify various aspects of the UR process, confirming that both primary treaters and secondary physicians can submit RFAs and establishing that a UR denial for the same treatment request from the same doctor or another doctor in the requesting physician's practice group remains valid for 12 months unless there is a documented material change in circumstances. The rules also expand UR decision documentation standards, requiring clear clinical explanations for denials or modifications, disclosure of the UR organization, confirmation that the reviewing entity is URAC accredited, and details on the timing of requests for supplemental information, exams, or consultations.

The regulations also create processes to speed medical care delivery and dispute resolution and clarify that treating physicians may provide medically necessary care in the first 30 days without prior authorization if the body part or condition has been accepted as compensable and the treatment complies with the MTUS, though non-exempt drugs, non-emergency surgery, advanced imaging, and spinal injections still require prospective UR. At the same time, the regulations now specify that the timeline of five business days for reviewing non-exempt drug requests may not be extended and that requests for additional information related to those requests must be made within four business days. The rules also expand reporting and information-sharing requirements between claims administrators and doctors, allow physician reports to be sent electronically, and overhaul DWC's UR oversight program, eliminating the performance-rating audit system and automatic waivers, and raising penalties for noncompliance, even for administrative errors. As a result, claims administrators and UR vendors will need to adjust their operations to ensure transaction-level compliance and adherence to the documentation, accreditation, and timeliness requirements.

Over the past 11 years, IMR has evolved into a stable and predictable component of the California workers' compensation system, and the data now show its primary effect has not been to correct widespread UR error, but rather to validate guideline-based decision-making while providing a meaningful avenue for review. The changes that are about to take effect may streamline the process and accelerate the delivery of medical care to injured workers, but the recent rebound in IMR submissions—despite stable claim counts and high UR uphold rates—suggests other changes could also reduce IMR volume and improve the effectiveness of the medical dispute resolution process without altering the basic framework of UR and IMR, which is largely functioning as designed. For example, two areas that policymakers could examine include whether certain modification disputes should remain eligible for IMR and whether more oversight and training of high-volume requesting providers could improve system efficiency.

CWCI will continue to monitor IMR activity and outcomes and will issue additional analyses as new data becomes available and new issues and trends emerge. CWCI members can also access a series of exhibits that are updated quarterly offering detailed statistics on IMR activities and outcomes. The exhibits are available in the Independent Medical Review section under the Research tab on our website.

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California Workers' Compensation Institute

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