Utilization Review (UR) Complaint Form State of California Division of Workers' Compensation Medical Unit

Utilization review complaint form

What it is and how to use it

Utilization review (UR) is the process used by employers or insurance companies to review treatment to determine if it is medically necessary. All employers or the insurance companies handling workers' compensation claims are required by law to have a UR program. This program will be used to decide whether or not to approve medical treatment recommended by a physician.

The UR process is governed by Labor Code section 4610 and regulations written by the CA Division of Workers' Compensation (DWC). The DWC regulations are contained in Title 8, California Code of Regulations, sections 9792.6 et seq.

Medical providers, injured workers or others who find that UR is not being done according to the regulations can file a complaint with the DWC. The attached form may be used to register a complaint regarding UR services connected with workers' compensation injuries and treatment.

Injured workers may also benefit from reading the UR fact sheet (A) at <u>http://www.dir.ca.gov/dwc/iwguides.html</u>.

Please fill out the form as completely as possible, checking all complaint boxes that apply. Please include any additional information or documentation required to clarify the details of your complaint.

Completed complaint forms can be sent by U.S. mail, fax or e-mail to the address provided at the bottom of the form.

Glossary of terms:

Supporting documentation:	All written material related to the complaint(s), including letters or faxes regarding modification, delay or denial of specific treatment request(s).
ACOEM:	The American College of Occupational and Environmental Medicine. The state of California is currently using the ACOEM Practice Guidelines, Second Edition, as its medical treatment guidelines.

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Please fill out this form as completely as possible. This information will remain confidential, except to the extent necessary to investigate the complaint. If information is not known, leave item blank.				
Name of person Today's date: making complaint:	Ph #:	DWC USE ONLY UR complaint #		
Address:	City:	ZIP Code		
Person making complaint (check one):				
Name of injured worker	/ / Date of injury	Claim number		
Physician/ Provider Pr	ovider phone number	UR company		
Name of insurance co. or claims administrator	Name & phone num	Name & phone number of claims adjuster		
Nature of complaint (check all that apply):	If you had trouble contacting apply):	If you had trouble contacting the UR reviewer (check all that apply):		
Decision to modify, delay, or deny treatment was made a non-physician		Modification, delay or denial (MDD) letter did not contain the reviewer's contact information		
Inadequate explanation of the reasons for UR decision		☐ Failure to specify in MDD letter a four hour time block when reviewer available		
Medical criteria or guidelines used to make decision were not disclosed		Unable to reach reviewer to discuss treatment decisions		
UR decisions were not made within required time limits		Failure to maintain telephone access for UR authorization from 9 a.m. to 5:30 p.m. PST on normal business days		
Treatment denied solely because the condition was no addressed by the ACOEM Practice Guidelines.	ot	Unable to leave a message after business hours		
□ No statement in decision that dispute shall be resolved in accordance with Labor Code section 4062	1 UR reviewer calls you after	UR reviewer calls you after CA business hours		
Payment denied even though service was authorized				
Requested services denied for lack of information, but the reviewer did not request additional information				
Other				

Please provide a brief description of the complaint and attach all supporting documentation. If necessary, add extra pages for description:

To submit this complaint to the DWC Medical Unit, either:
1. Print this form and mail or fax it to: DWC Medical Unit-UR, PO Box 71010, Oakland, CA 94612—Attn: UR Complaints. Fax: (510) 286-0686
2. Save the completed form to your computer and e-mail it to: DWCManagedCare@dir.ca.gov. Please put "UR complaint" in the subject line.

However you submit this form, be sure to keep a copy for your records.