State of California
Division of Workers' Compensation Medical Unit

Utilization review complaint form

What it is and how to use it

In California, all employers or insurance companies handling workers' compensation claims are required to have a utilization review (UR) program. A UR program allows an employer or insurance company to review a treatment request made by an injured worker's physician to determine if the treatment is medically necessary. Following this review, the treatment request can be approved, denied, or modified. The UR process is governed by Labor Code section 4610 and implemented through regulations beginning at California Code of Regulations, title 8, section 9792.6.

Medical providers, injured workers or others who find that UR has not been performed as it is required by statute or 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.

All valid complaints will be used to assist DWC during our utilization review organizations (URO) investigations in oversight of the UR organizations and programs.

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

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, including the accepted request for treatment (RFA) form with a copy of the appropriate (applicable) medical report, and corresponding URO decision letters.

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 the request for treatment (RFA form), the relevant treating physician's medical report, and the corresponding URO decision letters or faxes regarding modification, delay or denial of specific treatment request(s).
MTUS:	"Medical Treatment Utilization Schedule" means the set of treatment guidelines adopted by the Administrative Director pursuant to Labor Code section 5307.27 and set forth in Article 5.5.2 of this Subchapter, beginning with section 9792.20. The state of California now uses the MTUS as its medical treatment guidelines to assist in appropriate UR decision making.
URO:	**"**Utilization Review Organization" or "UR Company" means the agency or company that provides utilization review (UR) services for employers, claims administrators, or insurers. UR services are used to determine the medical necessity of proposed medical treatments for injured workers.

DWC USE ONLY

UR complaint #_____

Utilization Review (UR) Complaint Form

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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.

Today's date: _____ Name of person making complaint _____ Phone Number: _____ E-mail Address: _____

Address: _____ City _____ Zip Code _____

Person making complaint (check one):

☐ Injured worker ☐ Attorney ☐ Health Care Provider ☐ other: _____

Name of injured worker _____ Date of Injury _____ Claim Number _____

Physician/ Provider _____ Physician / Provider phone number _____ UR Company _____

Name of insurance co. or claims administrator _____ Name & phone number of claims adjuster _____

Nature of complaint (check all that apply):

☐ Decision to modify, delay, or deny treatment was made by a non-physician.

☐ Inadequate explanation of the reasons for UR decision.

☐ Medical criteria or guidelines used to make decision were not disclosed.

☐ UR decisions were not made or communicated within required time limits.

☐ Treatment denied solely because the condition was not addressed by the MTUS Guidelines.

☐ There is no statement in the decision letter that dispute shall be resolved in accordance with the Independent Medical Review provisions of Labor Code section 4610.5 and 4610.6.

☐ The completed Application for Independent Medical Review (DWC Form IMR) was not included in the modify, delay, or deny treatment decision letter.

☐ The information required on the completed Application for Independent Medical Review (DWC Form IMR) was missing or incorrect.

☐ Requested services were denied for lack of information, but the reviewer did not request additional information.

☐ Other _____

If you had trouble contacting the UR reviewer (check all that apply):

☐ Modification, delay or denial (MDD) letter did not contain the reviewer's contact information for the use of the requesting physician.

☐ Failure to specify in MDD letter a four hour time block when reviewer will be available to discuss decision with the requesting physician.

☐ The requesting physician was unable to reach reviewer to discuss treatment decisions.

☐ Failure to maintain telephone access for UR authorization from 9 a.m. to 5:30 p.m. PST on normal business days.

☐ The requesting physician was unable to leave a message after business hours.

☐ No decision was sent to the appropriate parties.

Please provide a brief description of the complaint and attach all supporting documentation (which includes copies of the medical report and the accompanying request for authorization (RFA) and the decision letter related to the request for authorization).

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**: DWCUR@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.