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 should 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 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.

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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DWC USE ONLY
UR complaint #________

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: _____ Ph #: _____

Address: _____ City: _____ ZIP Code: _____

Person making complaint (check one):
☐ Injured worker ☐ Attorney ☐ Provider ☐ Other: _____

_____	_____	_____
Name of injured worker	Date of injury	Claim number
_____	_____	_____
Physician/ Provider	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 within required time limits

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

☐ No statement in decision that dispute shall be resolved in accordance with Labor Code section 4062

☐ Payment denied even though service was authorized

☐ Requested services 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

☐ Failure to specify in MDD letter a four hour time block when reviewer available

☐ 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

☐ Unable to leave a message after business hours

☐ UR reviewer calls you after CA business hours

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 420603, San Francisco, CA 94142-0603—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.