DIVISION OF WORKERS' COMPENSATION

FACT SHEET A

ANSWERS TO YOUR QUESTIONS ABOUT UTILIZATION REVIEW

Utilization review (UR) is the process used by employers or claims administrators to review treatment to determine if it is medically necessary.

All employers or claims administrators handling their workers' compensation claims are required by law to have a UR program. This program is used to decide whether or not to approve medical treatment recommended by your doctor.

What are the medical treatment guidelines set by the state?

California's medical treatment utilization schedule (MTUS) details treatments scientifically proven to cure or relieve work-related injuries and illnesses. The MTUS lays out treatments that are effective for certain injuries, how often the treatment should be given, the extent of the treatment and other details.

Where can I look at the MTUS?

Go to www.dwc.ca.gov. In the left navigation pane, under "I want to," click on "find a publication". Scroll down to schedules and click on medical treatment utilization schedule (MTUS).

What if the treatment my doctor recommends isn't in the MTUS?

Your doctor needs to use other scientifically-based medical treatment guidelines generally accepted by the national medical community to support the recommended treatment.

I was awarded future medical treatment for my work injury. I have a copy of the award. Does UR apply to me?

Yes. The law requiring UR went into effect Jan. 1, 2004. It applies to all medical treatment being given, even if you received your award before Jan. 1, 2004.

Who can evaluate the medical treatment my doctor has recommended?

Anyone handling claims can **approve** the treatment recommended by your doctor. However, a decision to **deny** or **change** your treatment can only be made by a doctor who understands the type of injury or illness you have and the treatment being recommended.

What happens when my doctor recommends treatment and the claims administrator does a UR?

The claims administrator must do the review and make a decision within five days of the date your doctor requested the treatment. If it needs more time, the claims administrator can have up to 14 days. This is called "prospective review" because it's done before you get the treatment.

What if my doctor has already provided the treatment and the claims administrator does a UR?

The review must be done and the decision given to your doctor within 30 days. This is called a "retrospective review".

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What happens if I got treated and the claims administrator says they won't pay for it? Do I have to pay?

Most likely, no. This is a problem your doctor and the claims administrator need to work out.

What if my doctor requests treatment while I am in the hospital?

Unless your doctor requests an "expedited review", the review process and timeframe is the same as in the "prospective review". This is called "concurrent review" because the review is being done while you're receiving treatment.

What is an expedited review?

This happens when your doctor recommends treatment and says you face a serious threat to your health if you don't receive it. That could mean possible loss of life, limb or other major bodily function. It could also mean the normal time frame for a decision could harm your life or health, or could permanently risk your ability to recover to the fullest.

For more information, call 1-800-736-7401 or visit the DWC Web site at www.dwc.ca.gov to find a local I&A office. You may also download I&A guides and get information on workshops for injured workers.

How long does an expedited review take?

The claims administrator has 72 hours from when they get the information they need to make the decision. If your condition is so serious that 72 hours is too long, they have to make the decision sooner.

Can the claims administrator stop my treatment if I'm in the hospital?

The claims administrator can't stop treatment recommended by your doctor until they talk to your doctor and figure out another plan your doctor agrees to. This applies to any concurrent review.

Will the claims administrator tell me if they decide to change, delay or deny my doctor's request to treat me?

Yes. The claims administrator has to tell you and your doctor in writing, and state why they are changing, delaying or denying your treatment.

What if I disagree with the claims administrator's decision?

There are specific timelines you must meet or you will lose important rights. You must object to the decision in writing within 20 days of getting it. Once you do that, the claims administrator will give you a qualified medical evaluator (QME) panel request form to submit to the DWC Medical Unit. See Information & Assistance (I&A) guide 2 for instructions on filing the QME request form.

Is there any way to help make the UR go smoothly?

UR works best when your doctor stays in contact with the claims administrator's doctor throughout the process. Your doctor must state the reasons for the treatment being requested when making the request. And if the claims administrator's doctor asks for more information, your doctor should respond.

If I have completed the QME process and the claims administrator is still denying the treatment, what do I do?

You'll need to see a workers' compensation judge to get the disagreement resolved. File a declaration of readiness to proceed to expedited hearing to go before a judge. See I&A guide 6 for specific instructions. If you do not have an existing case open at the local WCAB office, you also need to file an application for adjudication of claim (see I&A guide 4), which opens a WCAB case for you.

What if more than 14 days have gone by since my doctor requested treatment and we haven't heard or received anything from the claims administrator?

If your doctor has not been able to get a response from the claims administrator, file a declaration of readiness to proceed to expedited hearing. See above answer for more details.