Date:

Ordering Provider's Full Name
Street Address
City, MA Zip Code

RE: Patient Name:
Claim Number:
Injury Date:
UR File Number:

Dear Dr. [Provider's Full Name]:

Massachusetts workers' compensation insurers are required to undertake utilization review of health care services provided to injured workers in accordance with the Utilization Review Quality Assessment Regulation(452 CMR 6.00). The Commonwealth of Massachusetts Department of Industrial Accidents has approved [UR Agent] to conduct utilization review on Massachusetts workers' compensation claims.

After review of this request, based on the medical information submitted at this time, the following specific treatment (s) and/or service (s) for this patient is **Denied**:

Diagnosis:
Treatment/Service Requested:
Guideline:
Clinical Rationale (include pertinent medical information):
Reviewed By: practitioner name and school of licensure

A practitioner in the same school as the requesting practitioner conducted this review.

The injured employee, representative, or provider has the right to request an appeal of the adverse determination. Requests for an appeal level review should be made in writing and received by the UR agent no later than thirty (30) days from the date of receipt of the notice of adverse determination. Appeals related to a prospective and concurrent review shall be adjudicated on an expedited basis. Please see attachment titled "Expedited Appeal Level Review Notification". A standard appeal is available for an adverse determination related to a retrospective review. The adjudication of a retrospective review shall be no later than twenty (20) business days from date of the appeal request.

Sincerely,

UR Agent Name/Title
CC: Injured Worker
Adjuster Name/Company