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 and 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.

This letter shall notify you that [UR Agent] has reviewed your appeal and a school to school reviewer, who was not involved with the initial adverse determination, has overturned the original adverse determination. Therefore the requested plan of treatment/service is **Approved** only as stated:

Diagnosis:
Treatment/Service Requested:
Treatment Approved: [procedure/service, frequency, start and end dates]
Guideline:
Clinical Rationale (include pertinent medical information):
Reviewed By: practitioner name and school of licensure

The requested service meets the established criteria of medical necessity and reasonableness based on the information provided. If additional treatment is required, please forward the request for ongoing/concurrent care in writing at least three (3) days prior to the start/implementation date.

Please contact me if you have any questions regarding this determination at [toll free number].

Sincerely,

UR Agent Name/Title

Cc: Injured Worker
Adjuster Name/ Company