

URA LOGO, ADDRESS, ETC., AND TDI URA CERTIFICATION NUMBER

Date

Addressee Name

Address

City, State, ZIP Code

THIS IS A NOTICE OF ADVERSE DETERMINATION-WC NETWORK

Re: *[describe health care services or treatment that URA is denying]*

On behalf of _____ *[Insert name of carrier/payor]*, we decided that the services or treatments described above are not medically necessary or appropriate. This means that we do not approve these services or treatment.

- The principal reason(s) for denying these services or treatment: *[insert principal reason]*.
- The clinical basis for denying these services or treatment: *[insert clinical basis]*.
- The screening criteria and treatment guidelines used to make this determination: *[insert a description or source of screening criteria used, including a description of treatment guidelines used, if applicable]*.
- The Texas license number and specialty of the physician, doctor, or other health care provider that made the adverse determination: *[insert Texas license No. and specialty]*.

Our Internal Appeal Process

The employee or the employee's representative and the provider of record have the right to request an appeal of this adverse determination orally or in writing. If the appeal relates to **preauthorization or concurrent** denials, the requestor must send us the appeal no later than the 30th day after the date of issuance of the written notification of the adverse determination. If the appeal relates to **a denial of a claim** (retrospective denial after services rendered), the requestor must send us the appeal no later than 10 months from the date of service.

- **Written Appeal:** To submit a written appeal, mail or fax the written appeal to the following address or fax number: *[insert URA's address and fax number]*.
- **Oral Appeal:** To file an oral appeal, call the following toll-free number: *[insert URA's toll-free number]*.

There are two types of appeals:

- **Standard Appeal:** An appeal that does not involve urgent care such as poststabilization treatment, life-threatening conditions, or continued hospitalization.
- **Expedited Appeal:** An expedited appeal is available for denials of proposed health care services involving poststabilization treatment or life-threatening conditions, and for denials of continued hospitalization.

Acknowledgment of the Request for Appeal: Within five calendar days of receipt of the appeal, we will send the requestor a letter acknowledging that we received the appeal. This letter will include the date we received the appeal and a list of documents that we may need for the appeal.

Our deadlines to resolve the appeal and send a written decision to the employee or the employee's representative and the provider of record are:

- **Standard Appeal:** 30 calendar days of receipt of the appeal
- **Expedited Appeal:** One calendar day from the date we receive all information necessary to complete the appeal
- **Retrospective (claim) Appeal:** 30 calendar days after receipt of the appeal. However, we may extend this deadline once for a period not to exceed 15 days.

Life-Threatening Conditions and Interlocutory Orders: If the employee has a life-threatening condition or the request involves a medical interlocutory order, the employee or the employee's representative and the provider of record can request an immediate review by an independent review organization (IRO) and is not required to follow our internal appeal procedures. See below for more information about the IRO review.

Independent Review

If we deny the appeal (continue to deny the services or treatment described above), the employee or the employee's representative and the provider of record have the right to request a review by an IRO. The IRO does not have an affiliation with the insurance company, the employee's doctors, or the URA. The requestor must ask for the IRO review no later than the **45th calendar day** after the date of the denial.

To request the IRO review, [*fill out the enclosed TDI form (LHL009)*] [*fill out the TDI form (LHL009), which is available at TDI's website at www.tdi.texas.gov/forms or call us at the number listed above to request a copy of the TDI form (LHL009)*]. Return the completed form to [*insert URA's address and fax number*].

Complaint Procedures

- **You can send a complaint to us (the URA):** Employees, their representatives, and health care providers may file a written or oral complaint about our utilization review process or procedures. Use the telephone numbers and address referenced above to file your oral or written complaint. We will respond to the oral or written complaint in writing within 30 days.
- **Complaints to TDI:** A complainant also has the right to file a complaint with TDI by contacting TDI at the following address, telephone numbers, or website:

Texas Department of Insurance
 PO Box 149091
 Austin, TX 78714-9091
 1-800-252-3439
 Fax: 512-490-1007
 Online: www.tdi.texas.gov

CC: {employee or representative}
 {Provider of Record}

Attachment: TDI LHL009 Form