

**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 NON-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 Texas license number and specialty of the physician, doctor, or other health care provider that denied the request: *[insert Texas license No. and specialty]*.
- The criteria and treatment guidelines used to make this denial: *[insert a description of treatment guidelines used under 28 TAC Chapter 137 or Labor Code §504.054(b)]*.

**Our Internal Appeal Process**

The employee, the employee's representative, and the provider of record have the right to appeal this adverse determination orally, or in writing. If the appeal relates to **preauthorization or concurrent denials**, the requestor must send us the request for appeal within 30 days of receipt of the written 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]*.

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

- **Preauthorization:** not later than the 30th day of receipt of the appeal
- **Concurrent:** three working days of receipt of the appeal
- **Inpatient Stay:** One working day of receipt of 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, his/her representative and his/her provider of record can request an immediate review by an independent review organization (IRO) and are not required to follow our internal appeal procedures. Review the following information about the independent review.

### Independent Review

If we deny the appeal (continue to deny the services or treatment previously described) or the employee has a life-threatening condition or an interlocutory order, the employee, 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 independent review no later than the **45th calendar day** after receipt of the denial of the appeal.

To request the independent review, [*complete the enclosed Request for Review by an IRO form (TDI Form LHL009)*] [*complete the Request for Review by an IRO form (TDI Form LHL009), which is available on TDI's website at [www.tdi.texas.gov/forms](http://www.tdi.texas.gov/forms), or call us at the number listed above to request a copy of the form*]. 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](http://www.tdi.texas.gov)

**CC:** {employee, employee representative}  
 {Provider of Record}

[*Attachment: TDI LHL009 Form*]