Claim Coordinators

Claim Kit

FutureComp®

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Section I

Introductory Letter

Welcome,

We are pleased, on behalf of FutureComp, to provide you this customized claim kit inclusive of forms that are utilized to assist with the recovery of your employees' injury and/or illness:

- FutureComp Accident Reporting Form – Used for reporting all accidents, which involve *no lost time or lost time less than five days.*

- Form 101 Commonwealth of Massachusetts – Used for reporting all accidents involving *lost time of five or more days.*

- Wage Reporting Form – Used for lost time accidents for the purpose of calculating the average weekly wage for payment of benefits to the employee.

- FutureComp Organizational Chart – Shows all of your FutureComp Team, their function and telephone number. Please don't hesitate to call upon us for assistance.

The following are your Workers' Compensation Program Total Employee Absence Management Team:

Name	Function	Telephone *
Steve Grahn	Claims Manager	(413) 750-4250
Carolyn Scyocurka	Senior Claims Adjuster	(413) 750-4254
Sandra Feinstein	Claims Adjuster	(413) 750-4264
Sarah Depergola	MIS Manager	(413) 750-4273
Judy Burke	Managed Care Supervisor	(413) 750-4247
Carol Winetrout	Medical Case Manager	(413) 750-4253
Cheryl Humphrey	Utilization Review Nurse	(413) 750-4314

*All Team Members can also be reached by calling (800) 688-7256; the last 4 digits of the direct dial number is the extension number.

At FutureComp we look forward to working together with you and if you need any further information or have any questions, please let me know.

Sincerely,

Anthony E. Szwez
Senior Vice President, FutureComp
(413) 750-4261
(413) 739-9330 fax

Section II

FutureComp Injury Reporting Form

FutureComp®

FutureComp Injury Reporting Form

When to File:

File this form for any injury which the employee does not miss 5 or more calendar days, a medical only claim (medical treatment with no lost time) or a report only claim (no lost time or medical treatment).

Where to File:

This form should be mailed or faxed directly to FutureComp as soon as it is completed. This form is <u>not</u> to be mailed to State of Massachusetts Department of Industrial Accidents:

FutureComp
P.O. Box 3600
West Springfield MA 01090
Fax: (413) 739-9330

Workers' Compensation claims are administered by FutureComp
(800) 688-7256
Fax 739-9330

City of Springfield, Massachusetts

Human Resources Department

Employee's Notice of a Work-related Injury and/or Occupational Disease

Department	MUNIS Location Code	Last Name	First Name	M.I.

Home Telephone #	Mailing Address:	City/State	Zip Code

Social Security #	Date of Injury	Day of the Week	Time of Day	Age	Sex	Date of Hire (MM/DD/YYYY)
/ /	/ /					/ /

Regular Job Title	Work Telephone #	Location of Accident/Illness/Exposure

1-None 2-First Aid Only 3-Doctor/Medical Center 4-Hospital ER	
Primary Treatment Sought—circle numbered response	Doctor/Medical Center/Hospital Name and Location

Please describe what, where and how the accident/incident and injury/illness/exposure occurred, nature of injury(ies) (fracture, cut, sprain, strain, etc.) and specifically which body part(s) (left arm, right leg, lower back, neck, etc.) and attach additional sheets if necessary, including any doctors slips:

Name(s) of Witness(es):

I certify that the information I have provided on this form is accurate to the best of my knowledge, and I am aware that false statements could result in disciplinary and/or legal action.

_____ / /

Employee's signature — Date of signature

THE AFFECTED EMPLOYEE MUST REMEMBER TO COMPLETE "RELEASE OF INFORMATION FORM" ON THE REVERSE SIDE

The supervisor is required to review this injury/illness report **within twenty-four (24) hours** of the injury/illness/exposure incident and ensure that both sides of it have been completed and is immediately submitted to FutureComp by faxing it to (413) 739-9330.

_____ / /

Supervisor's name clearly printed, signature, and contact telephone number — Date of signature

[EMPLOYEE MUST COMPLETE "RELEASE OF INFORMATION" ON THE REVERSE SIDE.]

Section III

State of Massachusetts Injury Reporting Form 101

State of Massachusetts Department of Industrial Accidents Form 101

When to File:

File this form within 7 calendar days, not including Sundays and legal holidays, of receipt of notice of any injury alleged to have arisen out of and in the course of employment, which totally or partially incapacitates an employee for a period of 5 or more calendar days from earning wages. This form is not an admission of liability but must be filed even though you may believe that the employee is not injured, or that the employee is not entitled to any benefits.

Where to File:

This form should be mailed to:

The Commonwealth of Massachusetts,
Department of Industrial Accidents – Department 101
600 Washington Street – 7th Floor
Boston, MA 02111

A copy of this form should either be mailed or faxed to FutureComp as soon as the claim form is completed.

FORM 101

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 101
600 Washington Street – 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA USE ONLY

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

THIS FORM MUST BE FILED BY THE *EMPLOYER* IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.

INSTRUCTIONS AND CODES ON THE REVERSE SIDE - Please Print Legibly or Type - Unreadable forms will be returned.

EMPLOYEE

1. Employee's Name (Last, First, MI):	2. Home Telephone Number:	3. Social Security Number*:	4. Sex: ☐ M ☐ F
5. Home Address (No., Street, City, State & Zip Code):		6. Marital Status: ☐ M ☐ S	7. No. of Dependents:
8. Date of Hire (mm/dd/yyyy):	9. Date of Birth (mm/dd/yyyy):	10. Average Weekly Wage: $ ☐ Estimated ☐ Actual	

EMPLOYER

11. Employer's Name:	12. Federal Tax I.D. Number:
13. Employer's Address (No., Street, City, State & Zip Code):	14. Employer's Telephone Number:
	15. Industry Code (See Reverse Side):
16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR):	17. W.C. Policy Number:
18. Self-Insured? ☐ Yes ☐ No If Yes, Self-Insurer Number:	19. Business Type : ☐ Service ☐ Wholesale ☐ Mfg ☐ Retail ☐ Other _____

INJURY INFORMATION

20. DATE OF INJURY (mm/dd/yyyy):

21. Was Employee Injured on Employer's Premises? ☐ Yes ☐ No	22. Location of Injury if not on Employer's Premises:
23. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	**24. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):**
25. If Employee has Died, Date of Death (mm/dd/yyyy):	26. Source of Injury (Chemicals, Machinery, etc.):

27. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved:

28. Person to Whom Injury was Reported (list position):	29. Date Reported (mm/dd/yyyy):	30. Date Reported as work related (mm/dd yyyy):
31. Injury Code(s) / Body Part Code(s) a. to body part a. b. to body part b. c. to body part c.	32. Witness(es) to Injury - Give Full Name(s), if none state as such:	
33. Has Employee Returned to Work? ☐ Yes ☐ No	34. Date Employee Returned to Work(mm/dd/yyyy):	
35. Employee's Regular Occupation:	36. Has Employee Returned to Regular Occupation: ☐ Yes ☐ No	
37. EMPLOYER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):	38. Title:	
39. EMPLOYER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE):	40. Date Prepared (mm/dd yyyy):	

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report. Form 101 - Revised 8/2001 - Reproduce as needed.

THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

FILING INSTRUCTIONS

1. WHEN TO FILE: File this form within 7 calendar days, not including Sundays and legal holidays, of receipt of notice of any injury alleged to have arisen out of and in the course of employment, which totally or partially incapacitates an employee for a period of 5 or more calendar days from earning wages. This form is not an admission of liability, but must be filed even though the Employer may believe that the Employee is not injured, or that the Employee is not entitled to benefits under M.G.L. Chapter 152.

2. WHERE TO FILE: This form should be mailed to the Department of Industrial Accidents at the address shown on the front of the form. Copies must also be provided to the Employee and to the Employer's Workers' Compensation insurer.

3. PENALTIES: Failure to report injuries on this form may result in a fine of $100.00 in accordance with M.G.L. Chapter 152, Section 6.

4. EMPLOYER'S NAME & SIGNATURE IN BOXES 37 & 39: This form must be filed by the employer or an authorized agent/representative of the employer.

INDUSTRY CODES

Agriculture, Forestry and Fishing
01 Agriculture Production - Crops
02 Agriculture Production - Livestock
07 Agricultural Services
08 Forestry
09 Fishing, Hunting and Trapping

Mining
10 Metal Mining
12 Coal Mining
13 Oil and Natural Gas
14 Nonmetallic Minerals, Except Fuels

Construction
15 General Building Contractors
16 Heavy Construction, Ex. Building
17 Special Trade Contractors

Manufacturing
20 Food and Kindred Products
21 Tobacco Products
22 Textile Mill Products
23 Apparel and Other Textile Products
24 Lumber and Wood Products
25 Furniture and Fixtures
26 Paper and Allied Products
27 Printing and Publishing
28 Chemicals and Allied Products
29 Petroleum and Coal Products
30 Rubber and Misc. Plastic Products
31 Leather and Leather Products
32 Stone, Clay and Glass Products
33 Primary Metal Industries
34 Fabricated Metal Products
35 Industrial Machinery and Equipment
36 Electronic and Other Electrical Equipment
37 Transportation Equipment
38 Instruments and Related Products
39 Miscellaneous Manufacturing Industries

Transportation and Public Utilities
40 Railroad Transportation
41 Local and Interurban Passenger Transit
42 Trucking and Warehousing
43 U.S. Postal Service
44 Water Transportation
45 Transportation by Air
46 Pipelines, Except Natural Gas
47 Transportation Services
48 Communications
49 Electric, Gas and Sanitary Services

Wholesale Trade
50 Wholesale Trade - Durable Goods
51 Wholesale Trade - Non-durable Goods

Retail Trade
52 Building Materials and Garden Supplies
53 General Merchandising
54 Food Stores
55 Automotive Dealers and Service Stations
56 Apparel and Accessory Stores
57 Furniture and Home Furnishing Stores
58 Eating and Drinking Establishments
59 Miscellaneous Retail

Finance, Insurance and Real Estate
60 Depository Institutions
61 Non depository Institutions
62 Security and Commodity Brokers
63 Insurance Carriers
64 Insurance Agents, Brokers and Service
65 Real Estate
67 Holding and Other Investment Offices

Services
70 Hotels and Other Lodging Places
72 Personal Services
73 Business Services
75 Auto Repair Services and Parking
76 Miscellaneous Repair Services
78 Motion Pictures
79 Amusements and Recreation Services
80 Health Services
81 Legal Services
82 Educational Services
83 Social Services
84 Museums, Botanical, Zoological Gardens
86 Membership Organizations
87 Engineering and Management Services
88 Private Households
89 Services, NEC

Public Administration
91 Executive, Legislative and Garden
92 Justice, Public Order, and Safety
93 Finance, Taxation, and Monetary Benefits
94 Administration of Human Services
95 Environmental Quality and Housing
96 Administration of Economic Program
97 National Security and International Affairs

Non-classifiable Establishments
99 Non-classifiable Establishments

NATURE OF INJURY OR ILLNESS CODES

100 Amputation or Enucleation
110 Asphyxia or Strangulation Etc.
120 Burns (Heat)
130 Burns (Chemical)
140 Concussion
160 Contusion, Crushing, Bruise
170 Cut, Laceration, Puncture
190 Dislocation
200 Electric Shock, Electrocution
210 Fracture
250 Hernia, Rupture
300 Scratches, Abrasions
310 Sprains, Strains
400 Multiple Injuries
900 No Injury
950 Damage to Prosthetic Devices
995 No Other Injury, NEC**
999 Non classifiable

Infective or Parasitic Disease
150 Infective or Parasitic Disease, UNS*
151 Amebiasis
152 Anthrax
153 Brucellosis
154 Conjunctivitis an Opthalmia
156 Tetanus
157 Tuberculosis
159 Other Infective or Parasitic Diseases

Dermatitis
180 Dermatitis, UNS*
183 Primary Infections of the Skin
184 Other Skin Conditions
185 Dermatitis, Allergenic or Contact
189 Skin Condition, NEC**

Poisoning Systemic
270 Poisoning, Systemic, UNS*
271 Due to Toxic Materials other than Lead
272 Diseases of the Blood and Blood Forming Organs
273 Upper Respiratory Conditions
274 Influenza, Pneumonia, Etc.
276 Other Diseases of the Gastro-Intestinal Tract
278 Effects of Lead
279 Other Toxic Effects of One System Only

Respiratory Systems, Conditions of
570 Respiratory Systems, Conditions of
571 Upper Respiratory
572 Asthma, Influenza, Pneumonia

Pneumoconiosis
280 Pneumoconiosis
281 Aluminosis
282 Anthracosis
283 Asbestosis
284 Byssinosis
285 Siderosis
286 Silicosis
287 Other Pneumoconioses
289 Pneumoconiosis and Tuberculosis

Nervous System, Conditions of
560 Nervous System, Conditions of - NEC**
561 Diseases of the Central Nervous System
562 Diseases of the Nerves and Peripheral Ganglia

Neoplasm Tumor
550 Neoplasm Tumor, UNS*
551 Malignant
552 Benign

Radiation Effects
290 Radiation Effects, UNS*
291 Non-Ionizing Radiation
292 Microwaves
293 Ionizing Radiation - X-Ray
294 Ionizing Radiation - Isotopes
295 Welder's Flash

Other
265 Carpel Tunnel Syndrome
510 Cardiovascular and Other Conditions of the Circulatory System
520 Complications Peculiar to Medical Care
500 Effects of Changes in Atmospheric Pressure
240 Effects of Environmental Heat
220 Effects of Exposure to Low Temperature
530 Eye, other Diseases of the Eye
230 Hearing Loss or Impairment
991 Heart Condition (Excludes Heart Attack
420 Hemorrhoids
330 Hepatitis, Serum and Infective
275 Hepatitis, Toxic
260 Inflammation of Joints, Etc
540 Mental Disorders
900 No Illness
999 Non-classifiable
950 Occupational Disease, NEC**
580 Symptoms and Ill-defined Conditions

BODY PART AFFECTED CODES

Head
100 Head, UNS*
110 Brain
120 Ear(s), UNS*
121 Ear(s), External
124 Ear(s), Internal
130 Eye(s), UNS*
140 Face, UNS*
141 Jaw, Chin
143 Mouth and Throat (vocal chords, larynx)
146 Nose
148 Face, Multiple Parts
149 Face, NEC**
150 Scalp
160 Skull
198 Head, Multiple
200 Neck & Cervical Vertebrae

UPPER EXTREMITIES
300 Upper Extremities, NEC**
310 Arm(s), UNS*
311 Upper Arm
313 Elbow(s)
315 Forearm(s)
318 Arm(s), Multiple
319 Arm(s), NEC**
320 Wrist(s)
330 Hand(s), Not Wrists or Fingers
340 Finger(s)
398 Upper Extremities, Multiple

400 Trunk, UNS*
410 Abdomen, Internal Organs
Inguinal Hernia
420 Back
430 Chest, Ribs, Breastbone
Internal Organs
440 Hip(s), Pelvis, Organs and Buttocks
450 Shoulder(s)
498 Trunk, Multiple

LOWER EXTREMITIES
500 Lower Extremities
510 Leg(s), UNS*
513 Knee(s)
515 Lower Leg(s)
518 Leg(s), Multiple
519 Leg(s), NEC**
520 Ankle(s)
530 Foot or Feet, Not Ankle
540 Toe(s)
598 Lower Extremities, Multiple

560 MULTIPLE PARTS
Applies when more than one major body part as been effected such as an arm and a leg
999 NON-CLASSIFIABLE - Insufficient information to identify part of body effected. Includes damage to prosthetic devices.

*UNS - UNSPECIFIED

**NEC - NOT ELSEWHERE CLASSIFIED

Section IV

Wage Reporting Form 117

State of Massachusetts Department of Industrial Accidents Form 117

When to File:

File this form as soon as it is known that the injured employee will miss 5 or more days from work. This form is used for the calculation of the injured employee's compensation rate.

Where to File:

The form should be mailed or faxed to:

FutureComp
P.O. Box 3600
West Springfield MA 01090
Fax: (413) 739-9330

FutureComp®

AVERAGE WEEKLY WAGE COMPUTATION SCHEDULE

PLEASE PRINT OR TYPE: Date (MM/DD/YY): / /

Employer Name and Address		Insurer Case File Number
Employee Name	# Children Under 18 Years Old	Dependents Other Than Children
Date of Injury (MM/DD/YY):	First Date of Disability (MM/DD/YY):	Date Employed (MM/DD/YY): / /
Has Employee been certified by U.S. Veterans Administration for any type of disability? ☐ Yes ☐ No		

Indicate only those wages earned by the injured employee during the 52 week period immediately preceding the accident. If the injured employee has worked less than 52 weeks, report wages for the time worked and, for the remaining weeks on this schedule, substitute wages of a fellow employee in the same class of employment who has worked for one year or more.

Week No	Year / Week Ending Month	Day	Gross Amount Paid Including Overtime	No. of Meals Per Week	Week No	Year / Week Ending Month	Day	Gross Amount Paid Including Overtime	No. of Meals Per Week	Week No	Year / Week Ending Month	Day	Gross Amount Paid Including Overtime	No. of Meals Per Week
1					19					37				
2					20					38				
3					21					39				
4					22					40				
5					23					41				
6					24					42				
7					25					43				
8					26					44				
9					27					45				
10					28					46				
11					29					47				
12					30					48				
13					31					49				
14					32					50				
15					33					51				
16					34					52				
17					35									
18					36					TOTAL:				

Was Room Furnished To Employee? ☐ Yes ☐ No	If Tips or Other Benefits Were Earned, Describe and State Value Per Week:
Comments	

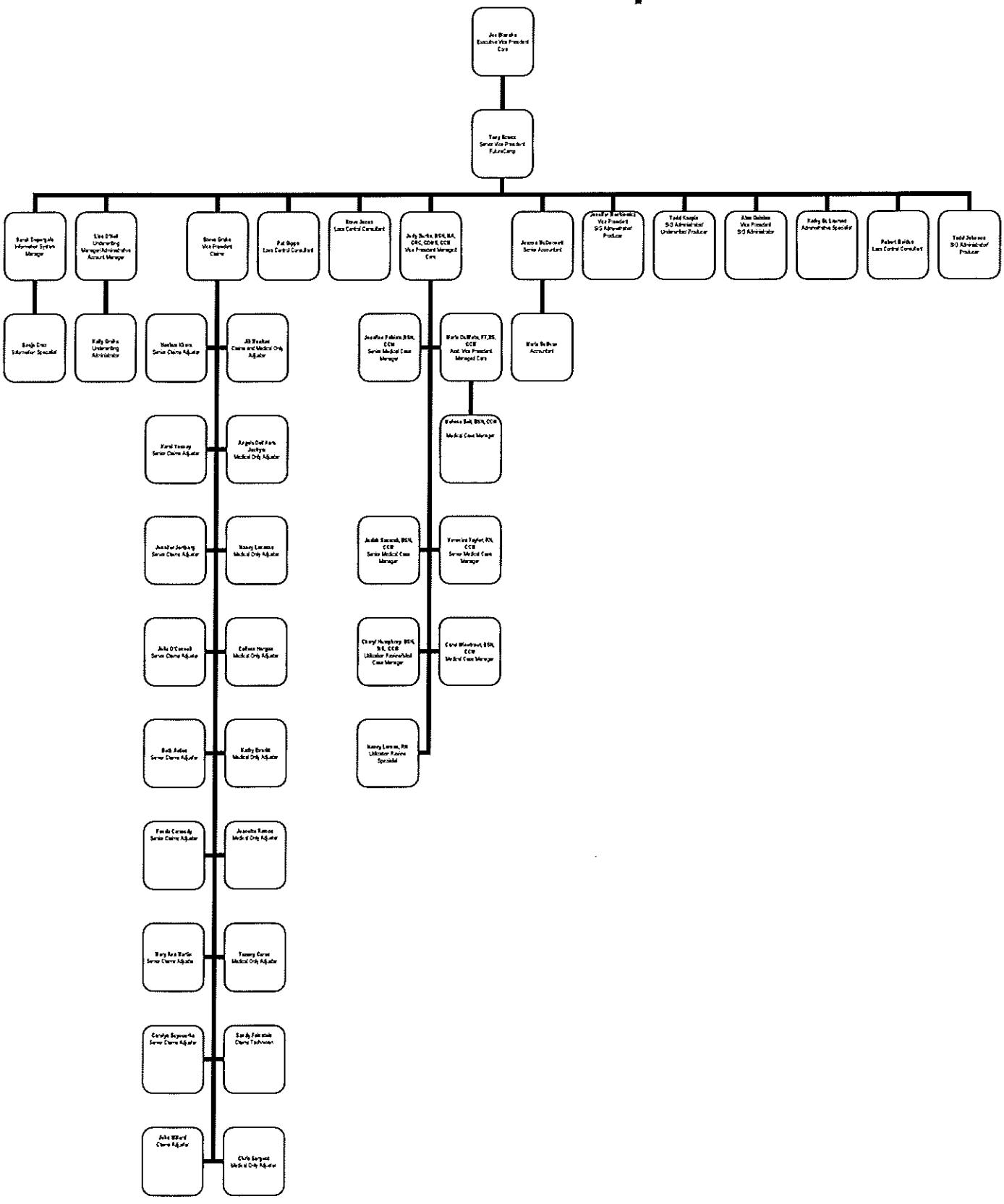
THIS IS A TRUE COPY OF THE PAYROLL RECORDS OF THE ABOVE NAMED EMPLOYEE OR OF A FELLOW EMPLOYEE IN THE SAME CLASS OF EMPLOYMENT.

Name of Fellow Employee	Employer Preparer's Signature	Preparer's Title

Section V

FutureComp Organizational Chart

FutureComp®


Joe Blando
Executive Vice President
Core
Tony Bosco
Senior Vice President
FutureComp
Sandi Degenaro
Information System
Manager
Lisa O'Neil
Underwriting
Manager/Administrative
Account Manager
Steve Grube
Vice President
Claims
Pat Biggs
Loss Control Consultant
Steve Jones
Loss Control Consultant
Judy Burke, BSN, MA,
CRC, CDMS, CCM
Vice President Managed
Care
Jessica McDermott
Senior Accountant
Jennifer Bienkowski
Vice President
SIG Administrator/
Producer
Todd Knapik
SIG Administrator/
Underwriter/Producer
Alex Quinlan
Vice President
SIG Administrator
Kathy St. Laurent
Administrative Specialist
Robert Bubka
Loss Control Consultant
Todd Johnson
SIG Administrator/
Producer
Sandi Degenaro
Information System
Specialist
Kelly Grube
Underwriting
Administrator
Nathan Klein
Senior Claims Adjuster
Jill Bracket
Claims and Medical Only
Adjuster
Jennifer Fellows, BSN,
CCM
Senior Medical Case
Manager
Marie DeWaste, FF,BS,
CCM
Asst. Vice President
Managed Care
Marie DeWaste
Accountant
Karol Treacy
Senior Claims Adjuster
Angela DeFrees
Jostyns
Medical Only Adjuster
Wellness Ball, BSN, CCM
Medical Case Manager
Jennifer Jostberg
Senior Claims Adjuster
Nancy Lacroix
Medical Only Adjuster
Judith Sacarob, BSN,
CCM
Senior Medical Case
Manager
Veronica Taylor, RN,
CCM
Senior Medical Case
Manager
Julie O'Connell
Senior Claims Adjuster
Colleen Horgan
Medical Only Adjuster
Cheryl Humphrey, BSN,
RN, CCM
Utilization Review/Field
Case Manager
Carol Woodruff, BSN,
CCM
Medical Case Manager
Beth Julien
Senior Claims Adjuster
Kathy Brodt
Medical Only Adjuster
Nancy Lorenz, RN
Utilization Review
Specialist
Pamela Carmody
Senior Claims Adjuster
Jeanette Ramos
Medical Only Adjuster
Mary Ann Martin
Senior Claims Adjuster
Tammy Carow
Medical Only Adjuster
Carolyn Szymanska
Senior Claims Adjuster
Sandy Fabrizio
Claims Technician
John Willard
Claims Adjuster
Chris Sargent
Medical Only Adjuster

Section VI

FutureComp Dedicated Claims Unit

FutureComp®

Dedicated Claims Unit

Tony Szwez- (413) 750-4261
SeniorVice President, FutureComp
Tony.Szwez@tdinsure.com

Steve Grahn - (413) 750-4250
Claims Manager
Steve.Grahn@tdinsure.com

Judy Burke R.N.- (413) 750-4247
Managed Care Supervisor
Judy.Burke@tdinsure.com

Carolyn Scyocurka - (413) 750-4254
Senior Claims Adjuster
Carolyn.Scyocurka@tdinsure.com

Cheryl Humphrey – (413) 750-4314
Utilization Review
Cheryl.Humphrey@tdinsure.com

Sandra Feinstein - (413) 750-4264
Claims Adjuster
Sandra.Feinstein@tdinsure.com

Carol Winetrout - (413) 750-4253
Medical Case Manager
Carol.Winetrout@tdinsure.com

Sarah Depergola – (413) 750-4273
MIS Manager
Sarah.Depergola@tdinsure.com

Fax: 413-739-9330

All telephone numbers can be reached by calling (800) 688-7256.
The last four digits are the extension numbers.

Section VII

Utilization Review

Utilization Review

We are working with your employer to ensure that you receive timely, quality and appropriate medical treatment for your on-the-job injury. Your employer has contracted with FutureComp to provide Utilization Review services. Revisions of Workers' Compensation statutes require prospective review of treatment plans related to your on-the-job injury.

What is Prospective Review?

Prospective Review is a process of reviewing treatment plans for appropriateness of treatment and setting by our review nurse prior to treatment.

How do I have medical treatment prospective reviewed?

Our toll-free telephone number is 800-817-5307. By contacting our review nurse, your provider can discuss your medical condition and treatment requirements.

Who will determine my treatment plan?

Your provider will still determine the treatment plan appropriate for your recovery, however our nurse reviewer will discuss with your provider the most appropriate treatment for your injury.

Will Utilization Review effect my coverage?

No. While prospective review does not guarantee acceptance of a claim, it does provide you with assurance that the planned course of treatment is appropriate for your injury.

You and your medical provider have the right to appeal adverse decisions made by our review nurse. An appeal can be made by calling our toll-free telephone number 800-817-5307 or in writing.

Utilization Review Service

FutureComp's Utilization Review Service incorporates prospective, concurrent, and retrospective reviews, as well as pre-admission certification. This ensures appropriateness of care at the time of injury. Utilization Review programs usually result in cost effective, quality medical treatment with target outcomes. Our first objective is to ensure quality medical care which will result in your recovery and return to work. Our review process includes:

- Review of procedure requirements and appropriateness of setting;
- A concentrated review of diagnoses and treatment plans;
- Physician review

Upon seeking medical treatment for a work-related injury, employees should present their I.D. card (the card will be mailed to you) to the provider. This card gives employee identification information as well as our toll-free telephone number twenty-four hours a day. Calls will be returned to providers within twenty-four hours. Our Utilization Review Specialist will review the diagnosis and treatment plan with the medical provider. Treatment will not be denied or delayed while waiting for a Utilization Review decision.

The intent of utilization Review is to provide quality medical care utilizing standard treatment practices, recognized for soundness and appropriateness of care, and to design treatment plans that have objectives and targets. Each case will be analyzed and a determination made upon the particulars presented by both patient and diagnosis. Our review decisions can be appealed and will be referred to a physician advisor upon appeal. Please use our toll-free telephone number inquires: (800) 688-7256 extension 4312 for all questions and inquires.

Notification of Adverse Determination

1. A practitioner of the "same school" may review all adverse determinations reached as a result of a provider's submission of detailed descriptions of services rendered. Notification will be made to all interested parties, including employee and provider by telephone followed by written notification. *Prospective reviews:* Notification will be given within two business days of the receipt of the request and receipt of all information required to complete the review. *Concurrent reviews:* Notification will be within one day prior to implementation, i.e., admission, discharge or treatment. *Retrospective reviews*: Notification will be within two days of the adverse determination.

2. All notification of adverse decisions will include the review criteria and reason for the decision as well as a detail of the appeal process.

Appeal Process

- Telephone Appeal of an Adverse Determination Prior to or During an Ongoing Service Requiring Review (800) 688-7256 extension 4314.

- When adverse determinations are made not to approve health care services made prior to or during ongoing service, and the injured employee and/or provider have the opportunity to appeal this determination over the telephone to our physician reviewer or a practitioner of the "same school" on an expedited basis.

- When consideration is being given to make an adverse determination, the Utilization review specialist and our physician reviewer will discuss this. If agreement can be reached, approval is given.

If the approval is not given after this initial consultation, the provider may supply additional information and documentation via fax or overnight mail. If upon review of this additional material the reviewing physician agrees with the provider, approval for the requested service is given and the provider and the injured employee are notified.

If after review of additional information the reviewer still does not agree with the treating provider, the provider and the injured employee will be notified by phone and letter and will be informed of the opportunity for further appeal. This appeal must occur no later than 30 calendar days from the date of receipt of notice of adverse determination. This appeal the proceeds as follow:

FutureComp's Appeals Policies and Procedures for Adverse Decisions

Providers may file an appeal on their own behalf or on the behalf of an injured employee. Appeals can be made in writing, or expedited through the use of telephone or fax communications.

If an injured employee, provider or facility wishes to appeal an adverse decision, we must be notified by phone or receive an appeal in writing within thirty days of the date of notification of the adverse decision notification. A provider and/or facility that has been unsuccessful in overturning an adverse decision telephonically is provided in writing the medical basis for the determination, the source of the screening criteria and the procedure for appeal. We will complete the adjudication of all non-expedited appeals of adverse determinations and respond in writing within one week of receipt of the appeal and all information required.

After exhaustion of the process outlined above appealing the determination of utilization reviewer, or if payment of an approved claim has not been issued within forty five days, a provider or injured employee may file a claim of complaint in accordance with 452 CMR 1.07 under the provisions of M.G.L. c. 152 ss (8) (4) and/or 10.

Section VIII

The 10 Most Frequently Asked Questions

How Can We Help You ... Please Call Us.
The 10 Most Frequently Asked Questions

1. Do the first reports of injury need to be completed in their entirety?

Yes, all the information is needed to input the claim accurately and monitor the information for loss runs.

2. Should my employer give me time off during the workday to attend medical appointments?

Yes, the employer is obligated to allow you time off during the workday to attend medical appointments.

3. I am the Workers' Compensation Coordinator, who do I call for claim reports?

Loss run information or any customized report request should be directed to Sarah Depergola, Data Coordinator at (800) 688-7256 extension 4273.

4. Is it all right to fax first reports of injury instead of mailing them?

Yes, in fact faxing is preferred as the first report of injury arrives in an expeditious manner allowing ***FutureComp*** *to begin the claims process.*

5. What information is needed to pay a medical bill?

Two things are needed, an itemized bill and a medical report. If the bill is a balance forward or there is no medical report attached the bill is sent back to the provider requesting proper information.

6. When mailing claims information or medical bills should we send them to **FutureComp**?

All information regarding workers' compensation claims should be directed to ***FutureComp****: P.O. Box 3600, West Springfield, MA 01090-3600.*

7. When are Indemnity/Medical/Expense reimbursements mailed?

Reimbursement checks are mailed every Thursday unless Thursday happens to fall on a holiday in which case the checks would be mailed on Wednesday.

8. Do I get reimbursed for mileage, tolls and parking when I attend medical visits?

Yes, the injured employee is paid $.45 per mile; toll and parking are paid at face value.

9. How quickly does a new injury need to be reported?

All injuries need to be reported immediately. The sooner ***FutureComp*** *receives the claims information, the sooner we can help you. The more time that lapses in the reporting of a claim the less information can be gathered. There is also a State-mandated requirement that requires that a claim be reported within seven calendar days.*

10. Am I entitled to any financial remuneration for permanent scarring due to work related injuries?

Yes, but only if the scar happens to be on the face, neck or hands. The amount of remuneration depends on the length, width and color of the scar.

Thank You!!

FutureComp®