




Workers' Compensation Claim Kit

SILBA
Self Insured Lumber Businesses Association, Inc.

FutureComp®

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FutureComp®

Section I

Introductory Letter

FutureComp®

Welcome,

We are pleased, on behalf of SILBA to provide you with a copy of this FutureComp "Claim Kit". Included, you will find step by step instructions for entering/reporting a claim, contact information for your dedicated team, as well as a brief explanation regarding medical case management, utilization and other pertinent information that will be utilized to assist with the recovery of your employees from injury and/or illness:

I am pleased to introduce your Workers' Compensation Program Team:

Name	**Function**
Cheryl McCarthy	Lost Time Claims Specialist
Ellen Nassif	Medical Only Adjuster
Tony Vigna	TPA Claims Team Lead
Steve Grahn	Vice President, Claims
Deborah Uckno, RN,CCM	Nurse Case Managar
Kathy Leone, RN,CCM	Nurse Case Manager
Kimberly Ferris, RN,BSN,CCM	Vice President, Medical Case Management
Sarah Depergola	MIS Manager

At FutureComp we look forward to working together with you, to effectively manage your workers' compensation needs. If there is any further information you may need or simply have any questions, please let me know.

Sincerely,

Tony Szwez
Division Senior Vice President, FutureComp

Section II

Responsibilities

Employee Responsibilities

Immediately after an injury the employee should:

- Report the injury in accordance with our company's procedures
- Seek appropriate treatment at your identified emergency care provider
- Report back to their employer
- Adhere to "workplace" restrictions and/or treatment plan
- Maintain contact with their employer

Employer Responsibilities

Immediately after the injury is reported the SILBA Member should:

- Report the claim within 24 hours
- Investigate the accident/incident
- Direct injured employee to an Occupational Health provider
- Identify potential temporary alternative work
- Communicate

FutureComp Responsibilities

Immediately after obtaining first report of injury FutureComp will:

- Enter and assign claim to the SILBA dedicated appropriate adjuster within 24 hours
- Make 3 point contacts within 24 hours
- Investigate claim and determine compensability
- Evaluate and reserve for exposure
- Develop disposition plan
- Electronically report claims to the Department of Industrial Accident

Section III

FutureComp Injury Reporting Instructions

Reporting and 1st Report of Injury

There a couple of different methods to report claims to FutureComp. The preferred method would be to input claims directly into the FutureComp claims system. You also do have the ability to e-mail or fax an injury report to us.

- Entering claims via the FutureComp claims system
  - Instructions on how to file a claim are located on pages 9-17
  - If you require a user name and password please contact:

Sarah Depergola
Vice-President & MIS Systems Reporting
Tel: 413-750-4273 / Fax: 413-739-9330
Email: Sarah.Depergola@usi.com

Sonja Cruz
Technical Services Associate
Tel: 413-750-4321 / Fax: 413-739-9330
Email: Sonja.Cruz@usi.com

Heather Touchette
Technical Services Associate
Tel: 413-750-4241 / Fax: 413-739-9330
Email: Heather.Touchette@usi.com

- If submitting a claim via e-mail or fax (1st report of injury forms can be found on pages 18-19), please send the information to:

Ellen Nassif, Medical-Only [Non-Lost Time] Claims Adjuster
Tel: 603-665-6143 / Direct Fax: 610-537-2850
Email: Ellen.Nassif@usi.com

Cheryl McCarthy, Lost-Time Claims Specialist
Tel: 781-939-2026 / Direct Fax: 610-537-1905
Email: Cheryl.McCarthy@usi.com

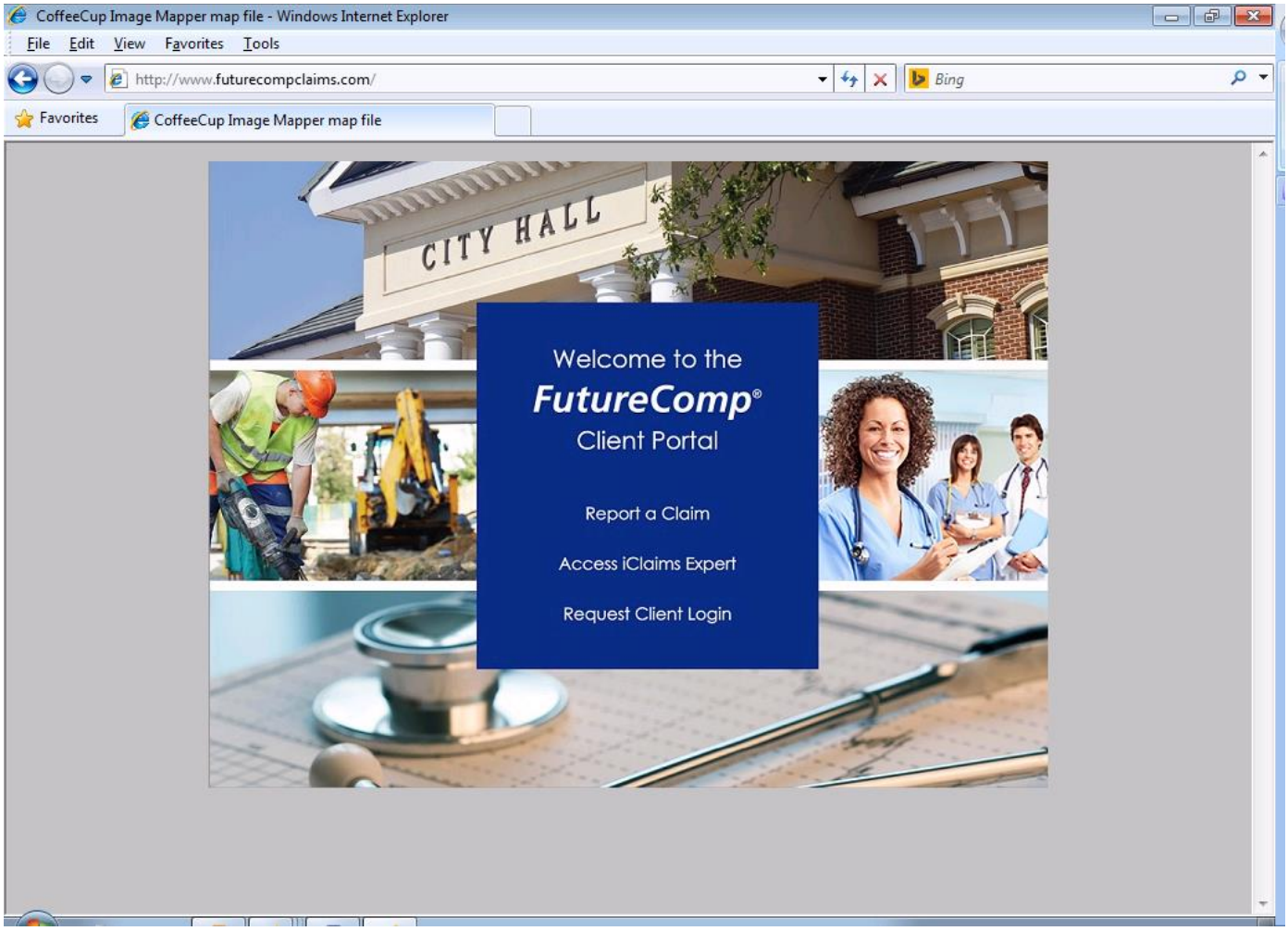
*** Do not submit First Reports of Injury to the Commonwealth of Massachusetts, FutureComp will file these electronically for you**

Accessing the Claims System from the Web

Copy and paste the web address to your browser and press Enter:

https://www.futurecompclaims.com

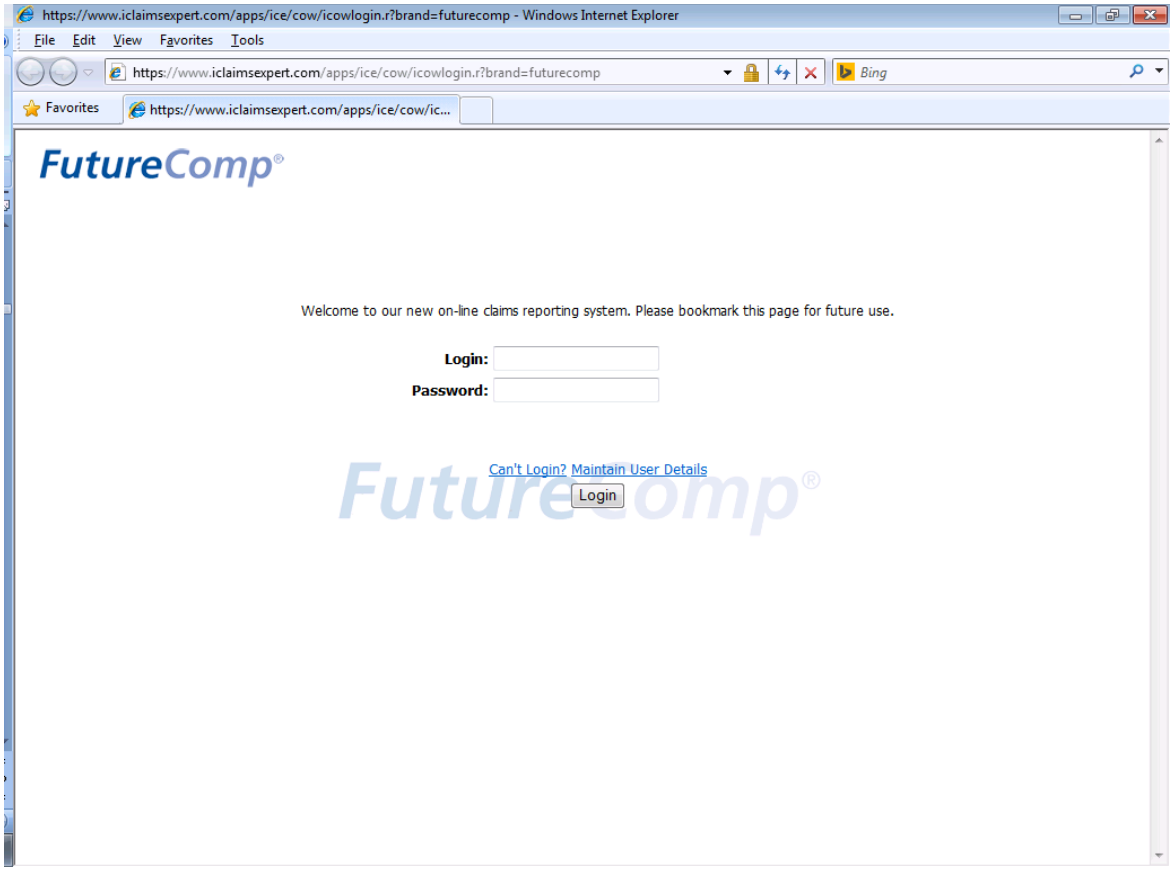
The following screen will appear.



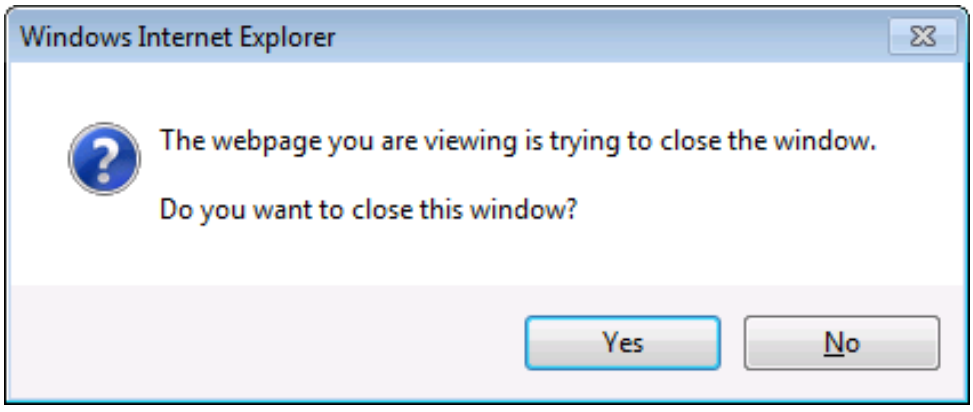
FutureComp®

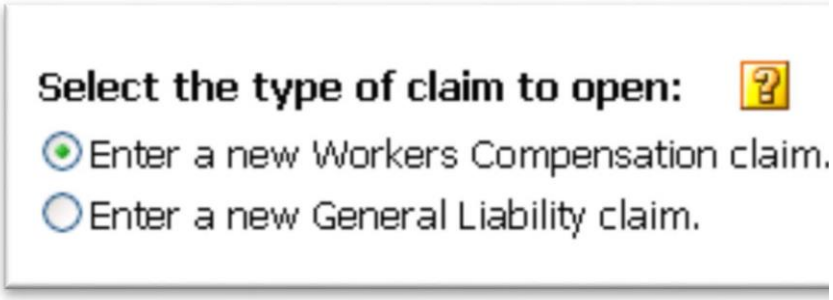
How to Report a Claim

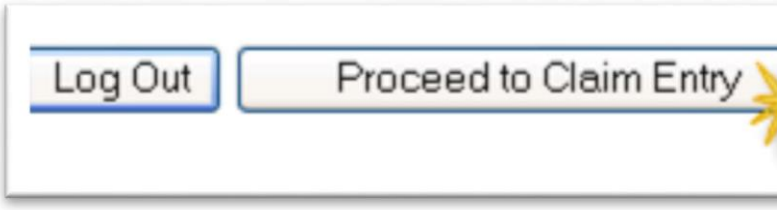
Click on "Report a Claim" and enter in your "Login" name and "Password".



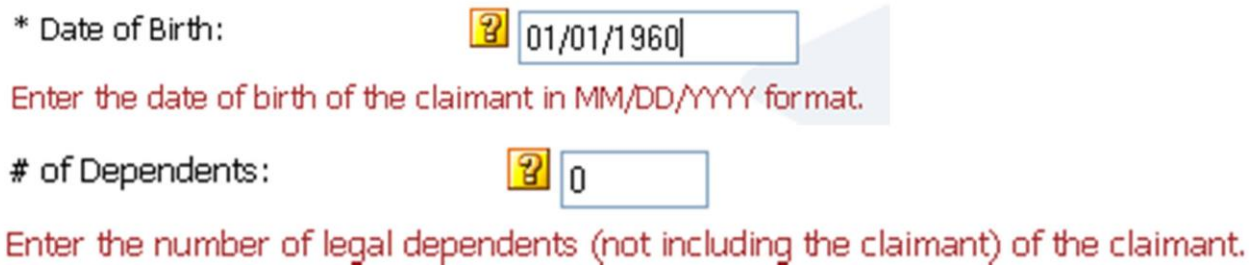
When you see this pop-up click "Yes".







Click on a yellow question mark (?) button to view help on that data field.



An asterisk (*) indicates required information

Input dates and times in the following formats:

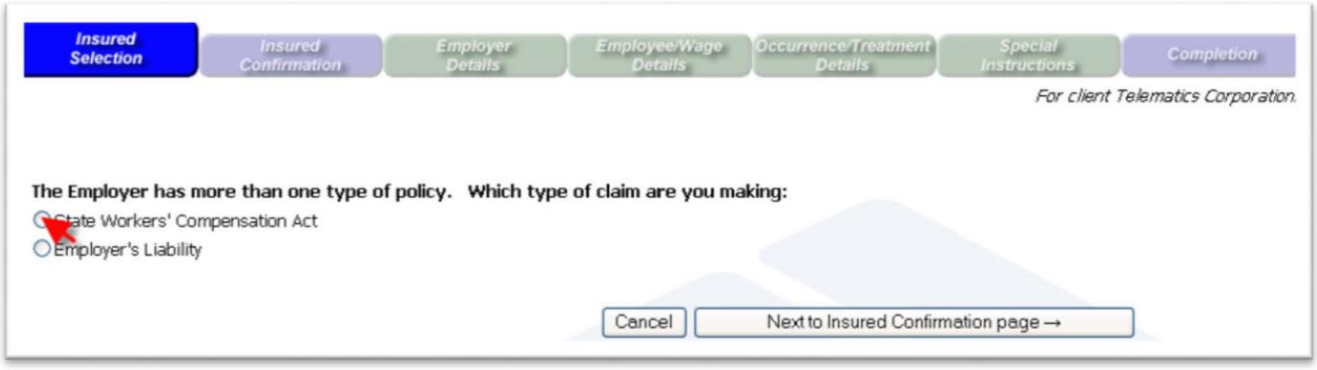
Dates: 01/01/2001 or 01/01/2001 or 01012001

Times: 09:00 (select AM or PM)

Reporting a Workers Compensation Claim

Insured Selection

In this example, choose “State Workers’ Compensation Act”

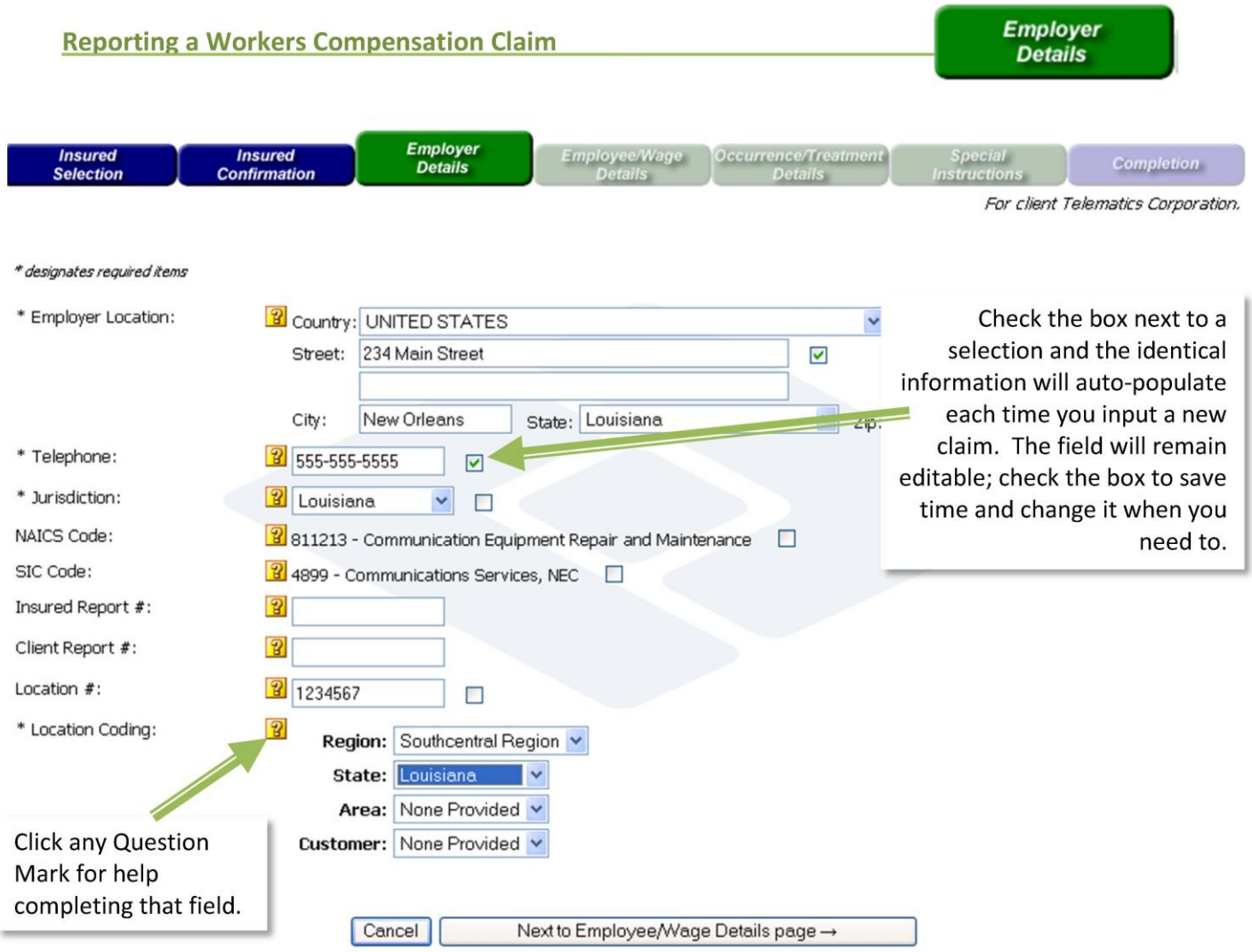


Reporting a Workers Compensation Claim

Insured Confirmation

The Insured Confirmation page confirms that you are opening a Workers Compensation claim:

.


Employer Details
Insured Selection
Insured Confirmation
Employer Details
Employee/Wage Details
Occurrence/Treatment Details
Special Instructions
Completion
For client Telematics Corporation.
* designates required items
* Employer Location:
Country: UNITED STATES
Street: 234 Main Street
City: New Orleans
State: Louisiana
Zip:
* Telephone: 555-555-5555
* Jurisdiction: Louisiana
NAICS Code: 811213 - Communication Equipment Repair and Maintenance
SIC Code: 4899 - Communications Services, NEC
Insured Report #:
Client Report #:
Location #: 1234567
* Location Coding:
Region: Southcentral Region
State: Louisiana
Area: None Provided
Customer: None Provided
Cancel
Next to Employee/Wage Details page →
Check the box next to a selection and the identical information will auto-populate each time you input a new claim. The field will remain editable; check the box to save time and change it when you need to.
Click any Question Mark for help completing that field.
At the bottom of each screen, click "Next" to continue.

Employee/Wage Details

Insured Selection | Insured Confirmation | Employer Details | Employee/Wage Details | Occurrence/Treatment Details | Special Instructions | Completion

For client Telematics Corporation.

** designates required items*

* Employee ID: Employee Social Security Number is: 222222222

* Name: First Middle Last Suffix — Joe | | Smith

* Address: Country: UNITED STATES
Street: 123 Main St.
City: Slidell State: Louisiana Zip: 70458

* Telephone: 5045555555

* Date of Birth: 01/01/1975

* State of Hire: Texas

Gender: ○ Unknown ◉ Male ○ Female

Marital Status: ○ Unknown ○ Single ◉ Married ○ Separated ○ Divorced ○ Widowed

Spoken Language: English

# of Dependents: 2

Date of Hire: 01/01/2013

Occupation:

Insured Employee Id:

Employee Supervisor:

Employment Status: Regular employee

NCCI class Code: 0951 - SALESPERSON - OUTSIDE

Wages: $ 12.00 Per: ◉ Hour ○ Day ○ Week ○ Month ○ Year ○ Other:

days worked per week: ○ 1 ○ 2 ○ 3 ○ 4 ◉ 5 ○ 6 ○ 7

Full pay for day of injury: ◉ Yes ○ No

Did salary continue: ○ Yes ◉ No

← Back to Employer Details page | Cancel | Next to Occurrence/Treatment Details page →

Input the Social Security Number, then click on the **Tab** key.

If an employee has prior claims in the YCE system, much of the information on this page will auto-complete.

If not, insert details on this page.

Be sure to note here if:

- Employee was paid for the date of injury
- Salary is continued

Occurrence/Treatment Details

Insured Selection | Insured Confirmation | Employer Details | Employee/Wage Details | Occurrence/Treatment Details | Special Instructions | Completion

For client Telematics Corporation.

* designates required items

Be sure to use the correct format for **Date** (01/01/2001, 01-01-2001, or 01012001) and **Time** (09:00)

Employee began work: ( ) AM ( ) PM

* Date of accident: 05/15/2013 * Time: 09:00 (•) AM ( ) PM

* Did injury cause death: ( ) Yes (•) No If yes, give date of death:

* Date employer notified: 05/15/2013 * Time: 09:30 (•) AM ( ) PM

* Nature of injury: Specific Injury Concussion

* Part of body: Head Skull

* Cause of injury: Fall, Slip, or Trip Injury On Ice or Snow

* How accident occurred: Employee was walking into building from car (returning from meeting with client) and slipped on ice outside main entrance, landing on back and hitting head.

* Where accident occurred: Did injury/illness exposure occur on employer's premises: (•) Yes ( ) No

Specify the department or location on the premises: outside main entrance

* State of Accident: Texas

Doing usual work: (•) Yes ( ) No

Contact Name:

	First	Middle	Last	
Title	Walter		Jones	Suffix

Telephone: 222-222-2222

Equipment, materials or chemicals involved: None.

Specific activity engaged in when occurred: Walking into building from parking lot.

Work process engaged in when occurred: Returning from meeting with client.

Safeguards provided: ( ) Yes (•) No

Safeguards used: ( ) Yes (•) No

Witnesses:

	First	Middle	Last		Phone
Title				Suffix	
Title				Suffix	

Date last worked: 05/15/2013

Date disability began: 05/16/2013

Date returned to work:

Initial treatment:
- ( ) No medical treatment
- ( ) Minor: by employer
- ( ) Minor: by clinic or hospital
- ( ) Emergency care
- ( ) Hospitalized > 24 Hrs.
- (•) Future major medical / Lost Time anticipated

Physician/Health Care provider:

	First	Middle	Last	
Title	John		Smith	Suffix

Country: UNITED STATES
Street: 123 High Street
City: Slidell State: Louisiana Zip: 70458

Hospital:
Name:
Country: UNITED STATES
Street:
City: State: Select State Zip:

← Back to Employee/Wage Details page | Cancel | Next to Special Instructions page →

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For client Telematics Corporation.

Almost finished! Please tell us if you have any special instructions. These items are not shown on the first report of injury.

** designates required items*

* Send first report of injury to: lisa.sudbury@yorkrsg.com

Note: You may enter multiple email addresses seperated by commas

Contact me first: Check this box to alert the adjuster to contact you prior to any investigation.

Any message for the adjuster: Place a message for the claims examiner here.

Would you like an investigator involved:

Based upon the information provided, a new Indemnity claim will be opened momentarily. If you believe that this is an incorrect decision, change this decision now by selecting one of: No Change

This is your last chance, press "Cancel" now if you want to abandon this claim opening. Otherwise, press "Next to Completion page" to submit the claim and generate the first report of injury.

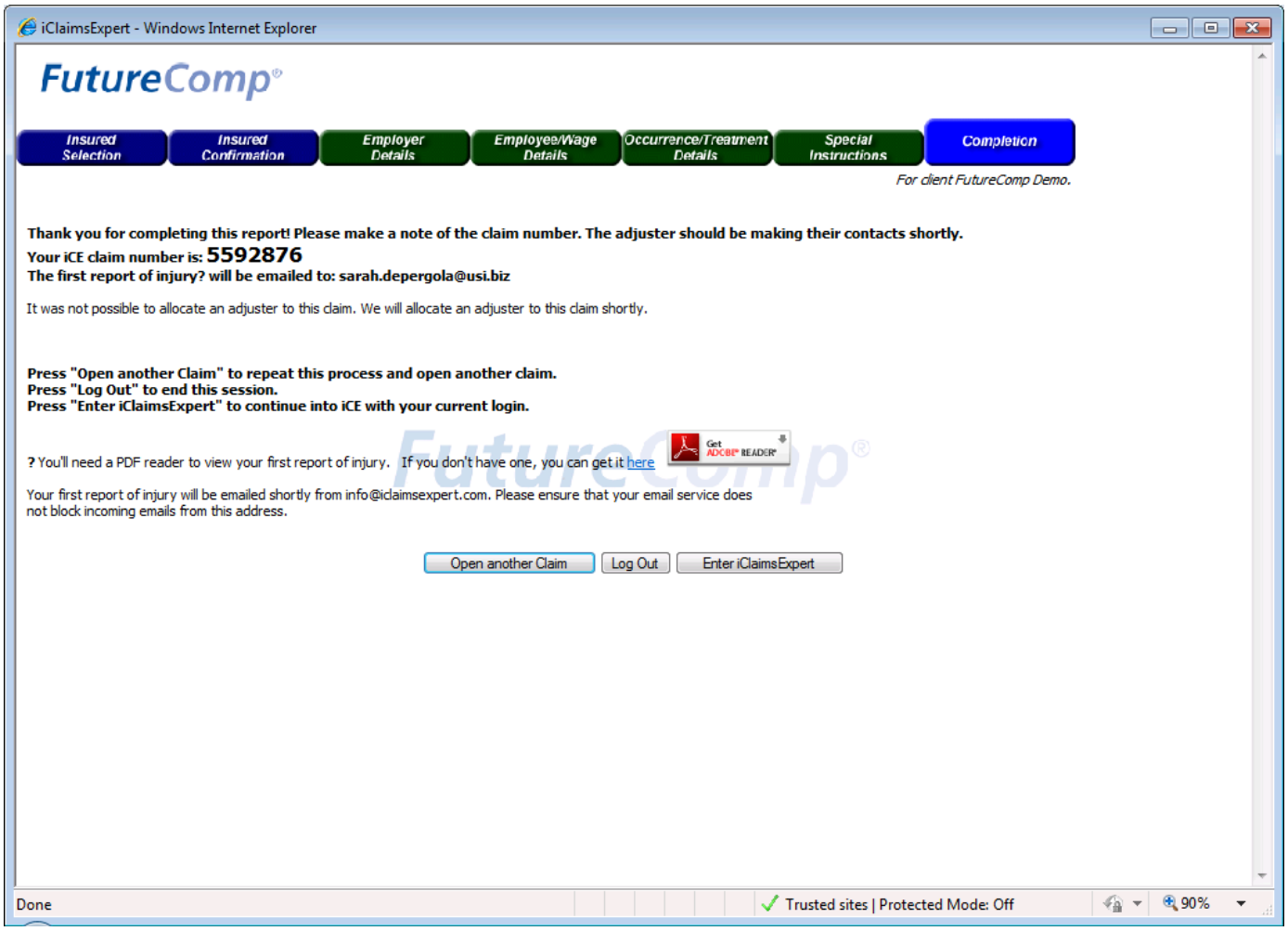
← Back to Occurrence/Treatment Details page | Cancel | Next to Completion page →

At this point, you have 3 choices:

Open another Claim, Log Out or Enter iClaimsExpert.

If you select Enter iClaimsExpert

it will bring you into the claims system.



FORM 101

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 101
1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA USE ONLY

Print Form

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):	5a. Native Language Code: Other:	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):**		**20a. Insurer's Case/Claim File No.:**		
	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			
PREPARER	37. PREPARER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):	38. PREPARER'S Title:			
	39. PREPARER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE):	40. Date Prepared (mm/dd/yyyy):	40a. PREPARER'S e-mail address:		

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report. Form 101 - Revised 7/2010 - 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.

NATIVE LANGUAGE CODES

1 – English / 2 – Portuguese / 3 – Haitian Creole / 4 – Spanish / 5 – Chinese / 6 – Vietnamese / 7 – Cape Verdean / 9 – Other

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 Merchandizing
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 Officers

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 Enucloation
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 and 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 Carpal 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
320 Hemorrhoids
330 Hepatitis, Serum and Infective
275 Hepatitis, Toxic
260 Inflammation of Joints, Etc.
540 Mental Disorders
900 No Illness
999 Non-classifiable
990 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
144 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
700 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 devises.

***UNS - UNSPECIFIED** ****NEC - NOT ELSEWHERE CLASSIFIED**

Section IV

FutureComp Service Team

SELF-INSURED LUMBER BUSINESSES ASSOCIATION - SERVICE TEAM LISTING

ADMINISTRATIVE TEAM

Katherine I. Camire, Administrator
Account Executive - FutureComp
Tel: 603-665-6121
Email: Kathy.Camire@usi.com

Todd R. Johnson, Administrator
President
Tel: 781.376.2682
Email: Todd.Johnson@usi.com

Stefania Mahar, Administrative Assistant
Tel: 413-750-4216 **Email:** Stefania.Mahar@usi.com

FINANCE

Maria Sullivan, Finance Director
Tel: 413-750-4257 / Fax: 413-739-9330
Email: Maria Sullivan@usi.com

Seth Pratt, Senior Accountant
Tel: 603-665-6001
Email: Seth.Pratt@usi.com

UNDERWRITING

Sherry Shevlin, Underwriter
Tel: 413-750-4208 / Fax: 610-537-2379 **Email:** Sherry.Shevlin@usi.com *

***Certificate of Insurance Requests**: FutureCompCertRequest@usi.com

CLAIMS & CASE MANAGEMENT TEAM

Cheryl McCarthy, Lost-Time Claims Specialist
Tel: 781-939-2026 / Fax: 610-537-1905
Email: Cheryl.McCarthy@usi.com

Ellen Nassif, Medical-Only Claims Adjuster
Tel: 603-665-6143 / Fax: 610-537-2850
Email: Ellen.Nassif@usi.com

Tony Vigna, AIC, TPA Claims Team Lead
Tel: 781 376 2610 / Fax: 610-537-4080
Email: Anthony.Vigna@usi.com

Steve Grahn, Vice-President Claims
Tel: 413-750-4250 / Fax: 413-739-9330
Email: Steve.Grahn@usi.com

Kathy Leone RN CCM, Nurse Case Manager
Tel: 413-750-4229 | | Fax: 610-537-9490
Email: Kathy.Leone@usi.com

Deborah Uckno RN CCM, Nurse Case Manager
Tel: 203-634-2838| | Fax: 610-537-4605
Email: Deborah.Uckno@usi.com

Kimberly Ferris, RN, CCM, Vice President Medical Case Management
Tel: 413-750-4213 / Fax: 610-537-2729 / **Email**: Kimberly.Ferris@usi.com

***Loss Run Requests:** FutureComp-WCSupport@usi.com

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Heather Touchette, Technical Services Associate
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Email: Heather.Touchette@usi.com

Sarah Depergola, VP MIS Systems Reporting
Tel: 413-750-4273 / Fax: 413-739-9330 **Email:** Sarah.Depergola@usi.com

LOSS CONTROL & SAFETY

Dan McCarthy, CPEA, Loss Control VP / Team Leader
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MARKETING

Ryan Foye, Vice President FutureComp
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Section V

Medical Case Management

Medical Case Management

Medical case management is a collaborative process assess, plans, implements, coordinate, monitor and evaluate the options and services required to meet an individual's health needs; using communication and available resources to promote quality, cost effective outcomes. The underlying premise of FutureComp case management is that when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individual being served, their support system, the health care delivery system and the reimbursement sources or payers.

The goals of medical case management are:

- Assist the employee to achieve an optimal level of wellness and function by facilitating timely and appropriate health services.
- Facilitate early return-to-work through transitional/light duty return-to-work programs.
- Assure appropriateness of treatment.
- Assure appropriate duration of treatment.
- Through communication and consultation with claim adjusters facilitate appropriate expenditure of claims and timely claim determinations.
- Channel injured workers to their approved Preferred Provider Network providers when appropriate.
- To assure that the injured worker receives quality, cost effective medical care.
- Enhance employee productivity, satisfaction and retention.

Medical Case Management consists of the following steps:

- Information gathering
- Assessment/Problem identification
- Rehabilitation plan development/Goal setting
- Rehabilitation plan implementation
- Ongoing and timely reporting
- Rehabilitation plan follow through and outcome assessment

Section VI

Utilization Review

Utilization Review

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 FutureComp to conduct utilization review on Massachusetts workers' compensation claims. FutureComp's approved Utilization Review agent number is 12-020.

As part of the utilization review process, FutureComp health care professionals review the medical treatment provided or proposed by the injured worker's health care provider to determine if the services are medically necessary and appropriate and in compliance with 452 CMR 6.00.

FutureComp's Claim Department will mail the injured worker an identification card that the injured worker should present to their treating medical practitioner each time they receive health care services for their work-related injury. This card lists the fax number to send written requests and the toll-free number that the treating medical practitioner can call before they begin health care services. This card is for identification purposes only and does not guarantee payment for services. All eligibility/financial questions should be referred to FutureComp Claim Department.

All requests for services should be faxed to (866) 293-8018.

In case of emergency, utilization review agents allow 24 hours after an emergency admission, service or procedure to notify us and request approval for the health care services.

Injured workers, providers and employers can call our toll-free number at (800) 817-5307 with any questions or concerns regarding Utilization Review. Please note that FutureComp has an appeal process if the injured worker, provider or representative is not in agreement with Utilization Review decisions. Our Utilization Review Department is available Monday through Friday from 9:00 am to 5:00 pm. The toll-free number takes messages on a 24 hour 7 days a week basis.

Section VII

The 10 Most Frequently Asked Questions

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

1. **Does the injury information form need to be completed in its entirety?**

   There is minimal information that needs to be completed for a claim to begin the process and receive a claim number. The adjuster will gather the remaining portion of information during the investigation process.

2. **How are lost wages calculated when an employee is out of work?**

   When an injured employee is totally disabled from working, their benefits will be based on 60% of the gross (pre-tax, pre-benefits) average weekly wage for the 52 weeks prior to date of injury. When paid, these wages are also exempt from taxes.

3. **I am approved to receive claim reports, who do I call for them?**

   Loss Run information or any customized report request should be emailed to:
   FutureComp-WCSupport@usi.com

   Sarah Depergola
   Vice-President & MIS Systems Reporting
   Tel: 413-750-4273 / Fax: 413-739-9330
   Email: Sarah.Depergola@usi.com

   Sonja Cruz
   Technical Services Associate
   Tel: 413-750-4321 / Fax: 413-739-9330
   Email: Sonja.Cruz@usi.com

   Heather Touchette
   Technical Services Associate
   Tel: 413-750-4241 / Fax: 413-739-9330
   Email: Heather.Touchette@usi.com

4. **Is it all right to fax/email first reports of injury?**

   While the preferred method of reporting a claim is directly into the FutureComp claims system via the web portal; yes, fax/email is an acceptable manner of reporting a claim to FutureComp. The first report of injury needs to arrive in an expeditious manner allowing FutureComp to begin the claims process. We would enter the claim on your behalf.

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. **Who do I contact if I have a claim or I receive a medical bill?**

   Reach out to your Medical-Only or Lost-Time Claim Adjuster, Their contact information is on the Service Team Listing [page 21].

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

   Reimbursement checks are mailed every Thursday.

8. **Do injured employees get reimbursed for mileage, tolls and parking when they attend medical visits?**

   Yes, the injured employee is paid the Federal mileage reimbursement rate that is in place at the time. Tolls 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 begin the investigation. 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. **Are injured employees entitled to any benefit 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.

If there are any questions regarding your program, please do not hesitate to contact us.

Section VIII

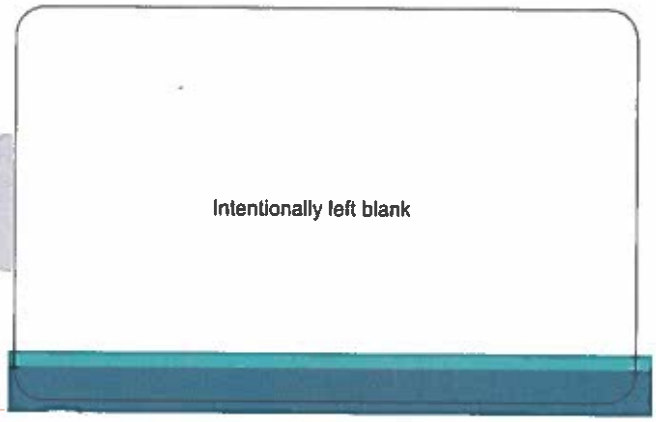
Sample Forms Injured Employees Will Receive When a Claim is Filed

Prescription Cards
(Bi-Lingual are Available)

FutureComp FUTURECOMP
711 E MAIN ST STE 201
CHICOPEE, MA 01020
NX6

myMatrixx
An Express Scripts Company

Prescription Cards: Available in Bi-Lingual



2019999999 - 000000001 CID PMM-CWK

JOHN Q SAMPLE
123 ANYSTREET
APT. 456
SOMETOWN, US 99999-9999

0010100000666660

Your Workers' Compensation Prescription ID Card

FutureComp has chosen myMatrixx, an Express Scripts company to manage your Workers' Compensation pharmacy program. Attached above is your prescription ID card that you can use immediately at an in-network pharmacy for your work-related injury or illness. By using your prescription ID card at an in-network pharmacy you won't pay up front or need to submit reimbursement requests to FutureComp.

In-Network Pharmacies Located Near You

Here is a partial list of in-network pharmacies located close to the address we have on file for you. For additional pharmacy locations, go to www.myMatrixx.com and click on Pharmacy Search or call the customer care number on the backside of your pharmacy card.

*This list is subject to change without notice

Pharmacy1Name
Pharmacy1Addr1
Pharmacy1Addr2
P1City, S1

Pharmacy2Name
Pharmacy2Addr1
Pharmacy2Addr2
P2City, S2

Pharmacy3Name
Pharmacy3Addr1
Pharmacy3Addr2
P3City, S3

Protection from Unsafe Drug Interactions

It is important to fill your prescription through an in-network pharmacy rather than receiving medication directly through your doctor because it does not go through the customary safety checks provided at a pharmacy. A pharmacist provides oversight and knows about all medications you may be taking as well as your medical history. This can help protect you against unsafe drug interactions.

Sign Up for Home Delivery

myMatrixx utilizes the Express Scripts Pharmacy to provide home delivery of medications for greater convenience, service and safety. The benefits of home delivery are:

- Get a 90-day supply conveniently by mail
- Delivered to your home with free standard shipping
- Easy refills online, phone or mail

To sign up for home delivery, call myMatrixx today at 800.945.5951.

Questions?
Call myMatrixx at 800.945.5951, 24/7.

IIWCI02F LTR 01/2019

Sample Utilization Review Card

MA Utilization Review - Letter of Introduction for Employee

Agent: #12-020

Dear John Doe:

Massachusetts workers' compensation insurers are required to undertake utilization review of the health care services provided to insured workers in accordance with the Utilization Review and Quality Assessment Program (452 CMR 6.00).

FutureComp is the claims administrator of your employer's and/or insurer's workers' compensation program. The Commonwealth of Massachusetts Department of Industrial Accidents has approved FutureComp to conduct utilization review on Massachusetts workers' compensation claims. FutureComp is an approved UR agent (#12-020). As part of the utilization review process, FutureComp's health care professionals assess the medical treatment suggested by your Practitioner to determine if the medical care is reasonable and appropriate and in accordance with 452 CMR 6.00.

At the bottom of this letter is your identification card that you should present to your treating medical practitioner each time you receive medical treatment for your work related injury. This card lists the toll free number that you or your treating medical practitioner should call before you begin treatment. This card is for identification purposes only and does not guarantee payment for services.

In case of emergency, utilization review agents allow 24 hours after an emergency admission, service of procedure for you or your representative to notify us and request approval of treatment at (855) 874-0123.

If at any time an injured employee, ordering provider, or employee representative believes the utilization review agent's conduct to be in violation of the Code of Massachusetts Regulations, 452 CMR 6.00 et seq. a complaint may be filed with the Department of Industrial Accidents by contacting the Department by phone at (617) 727-4900 x438 and requesting a UR agent complaint from (133A). A copy of this form is posted on the Department's website at www.mass.gov/lwd/workers-compensation/dia/

Please feel free to call your claims adjuster at (855) 874-0123 if you have any questions or concerns regarding Utilization Review. Please note that FutureComp has an appeal process if you are not in agreement with any Utilization Review decisions. The Utilization Review staff is available Monday through Friday from 9:00 a.m. to 5:00 p.m.

All eligibility/financial questions should be referred to your claims adjuster in the claims department at the number of (855) 874-0123.

If you have any questions regarding this letter or need a replacement Utilization Review identification card please contact FutureComp Claim Department.

FutureComp

John Doe
59 GLENN DR
WILBRAHAM, MA 01095

For Utilization Review please call FutureComp
Direct Fax: (866) 203-8038
Fax: (413) 739-9830
For billing inquiries or to speak to an adjuster please call
(855) 874-0123

FutureComp

05/30/2017
John Doe
6490011