MASSACHUSETTS DIVISION OF INSURANCE

WORKERS' COMPENSATION PREFERRED PROVIDER ARRANGEMENT (PPA)

20XX ANNUAL REPORT REQUIRED UNDER 211 CMR 51.00
Covering the year ending December 31, 20XX

Pursuant to 211 CMR 51.06, each approved Workers' Compensation Preferred Provider Arrangement ("PPA") shall file information regarding any changes to its list of preferred providers with the Division of Insurance ("DOI") on or before April 30th of each year. **This Annual Report must therefore be completed and submitted no later than April 30th of every year, and should cover the annual period ending December 31st of the previous calendar year.** Please note that in addition to this annual filing, every approved PPA must, within 30 days of any material change either to its structure or constitution, including any significant change in the number, type, or geographical location of its covered persons or providers, fully report such changes.

This update is for the approved PPA named: ____

Please review the following items and supply the DOI with the requested materials if there have been changes to what has most recently been reported:

A. The applicant's articles of incorporation, by-laws, rules, regulations, annual corporate filing or other similar document regulating the conduct of the internal affairs of the PPA organization; a list of the names, business addresses and official positions of members of the board of directors or similar policymaking body of the organization as well as of any persons who are responsible for the conduct of organizational day-to-day operations of the PPA entity:

____ Upon review of this section, no new information needs to be submitted.

Also submitted are:

____ Applicant's Annual Corporate filing, if any.
____ An updated list of current board officials.
____ New address (if filing applicant's office has relocated since January 1, 20XX).

Name of staff member to serve as DOI contact:___________________________________
Telephone #: ____________________ Email address:___________________________

B. The names and business addresses, along with the number for each specialty represented at each such address, for all health care providers included in the PPA—or confirm that NO CHANGES HAVE BEEN MADE to the information currently on file with the DOI:

_____ Attached is updated provider list.
_____ Attached is the summary of any changes made in network since January 1, 20XX.
_____ No changes have been made to the provider list since the original filing or most recent reported change thereto.

C. A narrative description of the financial arrangements between (1) the PPA applicant and the insurer, self-insurer, or self-insured group, and (2) the PPA applicant and the healthcare providers involved with the PPA—or confirm that NO CHANGES HAVE BEEN MADE to the information on file with the DOI:

_____ Attached is an updated copy of financial arrangements between PPA participants with all changes explained.
_____ No changes have been made in any financial arrangement since the original filing or most recent reported change thereto.

D. A description of the Utilization Review, Quality Assurance and Return to Work Programs of each preferred provider arrangement, and a description of the relationship between the organization and the insurer:

Report the name(s) of the entity or entities performing Utilization Review & Quality Assurance for this PPA:

____.
_____ A current Dept. of Industrial Accidents UR approval letter is attached.
_____ A current Return-to-Work Program description for this PPA is attached.

E. A current list of all client employers using this PPA: include both the approximate number of covered employees and number of worksite locations for each contracting employer. **If applicable, please also include a current certificate of self-insurance for each contracting self-insured employer**.

_____ A list of employers using this WC PPA is attached. This list details the number of employers, worksites, covered employees, and includes the general type of employment for each employer**.**

F. Utilization Statistics—Attach a single document setting forth totals for each of the following during the 20XX calendar year:

_____ Number of different employees admitted to hospitals
_____ Number of total hospital discharges
_____ Number of aggregate inpatient hospital days
_____ Number of out-patient *non-physician* encounters (e.g., with Chiropractors or Physical Therapists)

G. Filing Applicant's attestation that the following required tasks have been fulfilled:

_____ Current evidence that your company has received accreditation under MGL Chapter 176O from the Bureau of Managed Care which has not expired.
_____ A document setting forth the rights and responsibilities of employees in PPA has been distributed to covered employees at least once within the last 12 months. (Include such document with this report.)
_____ A current list of PPA providers is posted at employer worksite location(s).
_____ Please acknowledge that your company will present all necessary materials, required pursuant to 211 CMR 52.00 for accreditation under MGL Chapter 176O to the Bureau of Managed Care no later than *July 1, 20XX*, if submission of such material is necessary to retain your company's accreditation. (Accreditation takes place every two years.)
_____ Please confirm that a copy of this document with all accompanying materials has been concurrently forwarded to the Director, Office of Health Policy at the Department of Industrial Accidents (DIA), 1 Congress Street, Suite 100, Boston, MA 02114.

I certify that all of the above statements and all attachments or enclosures are accurate and fully comply with 211 CMR 51.00 et seq.

Signature	Date this form completed and sent to DOI
Print Name and Title of Signatory	Telephone Number of Signatory