FORM 133A

The Commonwealth of Massachusetts
Department of Industrial Accidents

1 Congress Street, Suite 100 Boston, Massachusetts **02114-2017**
(617) 727-4900 ext. 7574
http://www.mass.gov/lwd/workers-compensation/

Office of Health Policy

Complaint #_____

COMPLAINT AGAINST UTILIZATION REVIEW AGENT

452 CMR §6.00, the Utilization Review and Quality Assessment regulation, is promulgated pursuant to M.G.L. ch. 152 §§5, 13, and §30. The regulation requires workers' compensation insurers and self-insurers to undertake utilization review, and sets forth the mechanisms that the Department of Industrial Accidents (DIA) will employ to ensure compliance.

Please check the appropriate box below: The UR Agent failed to:

☐ A. provide an Introductory Letter explaining the rights and responsibilities of the injured worker and the UR Agent

☐ B. timely respond to a request for approval of treatment

☐ C. provide the determination letter to both the injured worker and treating practitioner

☐ D. facilitate a time for the treating practitioner to speak with the school reviewer

☐ E. consider the diagnosis chosen by the treating practitioner when selecting the treatment guideline

☐ F. utilize a same-school practitioner to render the adverse determination

☐ G. identify the treatment guideline referenced in rendering the determination

☐ H. provide a clinical rationale to support the determination

☐ I. provide the injured worker with instructions regarding the appeal procedure

☐ J. comply with the MA mandated hours of operation

☐ K. other: _____
_____

PLEASE PROVIDE THE FOLLOWING INFORMATION:

DATE: _____

NAME OF PERSON FILING COMPLAINT: _____

COMPANY: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TEL: (_____) _____ FAX: (_____)_____EMAIL:_____

YOU ARE: **(Please Check One):**

☐ MEDICAL PROVIDER ☐ INJURED WORKER ☐ ATTORNEY ☐ OTHER (Explain)_____

PLEASE NOTE: You are required to inform the injured worker of this filing. The injured worker will be cross-copied on all responses and exhibits received during the course of the complaint investigation

INJURED WORKER'S NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____TEL: (_____) _____

FORM 133A - UR AGENT COMPLAINT FORM

EMPLOYER: _____ INSURER: _____

ADDRESS: _____ ADDRESS:

_____

CITY/STATE/ZIP: _____ CITY/STATE/ZIP: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT THE UTILIZATION REVIEW AGENT:

NAME of UR COMPANY:

_____

NAME of UR AGENT: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: (_____)_____DATE(S) OF CONTACT: _____

_____

_____

Using the following space, **summarize your complaint** about the UR Agent. Attach copies of any documents that support your complaint, including but not limited to correspondence to and from the UR Agent, person(s) contacted, etc.

SEND THIS COMPLETED COMPLAINT FORM WITH ATTACHMENT(S) TO:

Department Of Industrial Accidents
Office of Health Policy
1 Congress St., Suite 100
Boston, MA 02114-2017

A COPY OF THIS COMPLAINT AND ALL ATTACHMENTS WILL BE FORWARDED TO THE UR AGENT.