

**State of New Jersey
Department of Banking and Insurance**

**ANNUAL REPORT
WORKER'S COMPENSATION MANAGED CARE ORGANIZATION**

A. ADMINISTRATIVE INFORMATION

Name of WCMCO _____

Main Administrative Address: _____
Street and Number

City, State and Zip Code _____

Internet Website Address: _____

Telephone: _____

Fax: _____

New Jersey Office: _____
Street and number

City, State and Zip Code _____

Telephone: _____

Fax: _____

Contact Person: _____
Name Area Code & Phone Number

E-mail Address _____ **Fax Number** _____

As an Officer of the WCMCO, I certify that for the reporting period above, all information and statements made in this Annual Report are true, complete and current to the best of my knowledge and belief.

Name _____ **Title** _____ **Signature** _____ **Date** _____

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B. NETWORK

1. Are the network providers under direct contract with the WCMCO?

Yes _____ No _____

2. Identify the entities with which the WCMCO has current contracts for network formation:

C. WCMCO SERVICES

Please indicate whether the following services are performed by the WCMCO or contracted to another entity. If the latter, please identify the entity:

Function	In-house	Entity
Billing		
Case Management		
Early Return to Work Program		
Care Management		
Fraud Detection Program		
Grievance Program		
1. Members		
2. Providers		
Quality Assurance		
Utilization Review		

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D. BUSINESS ACTIVITY

Please complete the following two charts. Do not attach financial statements or reports. Report only Managed Care Worker's Compensation activity in New Jersey. Do not report the entire financial results of the entire company.

If a WCMCO has subcontracted any claim function to another entity, please include the figures from them. The claims of any carrier who identified your WCMCO for the purposes of the premium reduction should be included. Any time an employee presents for injury, the claims should be included no matter which of your contracted networks is involved. If an employer is identifying your WCMCO as their managed care network, then their claims should be included whether case management was involved or not.

Definitions:

CLAIM: A claim is defined as each bill for a separate encounter for medical services. Please use date bill was paid for reporting purposes.

CASE: Number of new cases opened during the calendar year. A case is defined as a work-related injury or illness resulting in a need for medical care. This may involve numerous claims over an extended period of time.

CHARGES BY PROVIDERS: Charges are defined as total provider billed charges, both in and out-of-network, for which payment is legitimately due. This excludes charges related to duplicate bills and charges related to medical care that is denied.

PAID TO PROVIDERS: Payments made to in and out-of-network medical providers for eligible medical expenses.

WCMCO	Income	Expenses	Gain or Loss
2020			
2021			

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WCMCO	# of New Cases	#Claims submitted to MCO	Charges by Providers	Paid to Providers
2020				
2021				

- The WCMCO has no business to report**
- The WCMCO is not in contract with any insurers**
- The WCMCO is in contract with insurers but has no business to report.**

E. CHANGES IN OPERATIONS

Pursuant to N.J.A.C: 11:6-2.4 (b) WCMCOs are required to report all changes in operations to the Department of Banking and Insurance within 30 days of said change(s), including but not limited to, contractual changes, name changes, mergers, acquisitions, sale of the WCMCO and additions or termination of preferred provider organizations serving as the network. Such changes should be submitted under separate cover with all supporting documentation to the following address:

New Jersey Department of Banking and Insurance
Office of Managed Care
20 West State Street, 9th floor
PO Box 329
Trenton, New Jersey 08625-0329

CERTIFICATION:

- This certifies that no changes described by N.J.A.C: 11:6-2.4(b) are applicable for calendar year 2021.

(Printed Name)

(Signature and Title)

- This certifies that changes described by N.J.A.C: 11:6-2.4(b) have occurred during the calendar year 2021 and were submitted or will be submitted by

_____.

(Printed Name)

(Signature and Title)