# Injury reporting packet

Geauga County

**EMPLOYEE**

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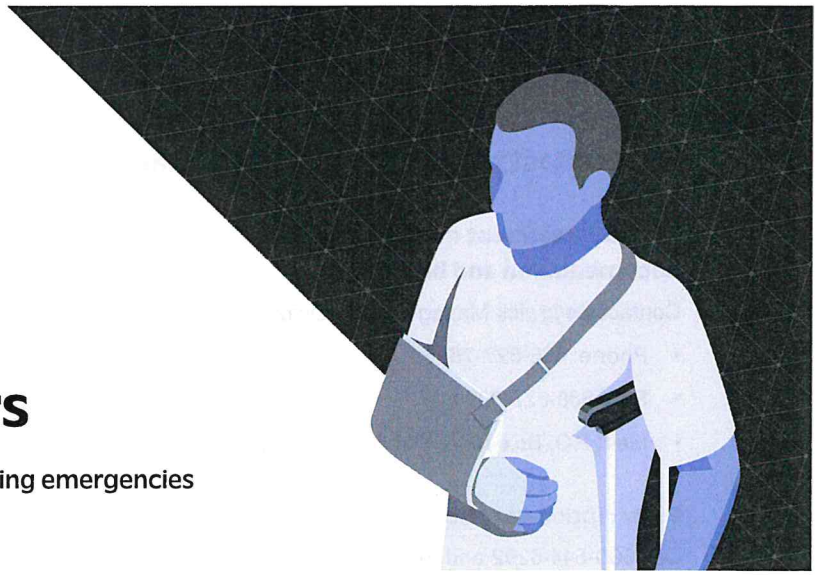

# Steps to take when a workplace injury occurs

**Call 911 immediately in case of serious or life-threatening emergencies**

## If an incident or injury occurs, we are here to help. Just follow these steps.

An injured employee, their employer or medical provider may report a work-related injury. Your company has chosen Sedgwick Managed Care Ohio to help you through this process.

### Employee instructions

1. Immediately notify your supervisor.
2. Complete the first section of the BWC First Report of Injury (FROI) form as completely as possible.
3. Seek appropriate medical treatment if needed, and provide the attached ID card at all medical appointments.
4. Keep your supervisor informed of your medical status and return all completed claim documentation to your employer promptly.

### Employer instructions

1. Assist in the completion of an injury/incident report, and/or the Employer Info section of the enclosed FROI.
2. If medical treatment is involved, ensure the incident is reported to Sedgwick MCO using one of the methods described under "Reporting a work-related injury to Sedgwick MCO."

### Reporting a work-related injury to Sedgwick MCO

**Online:**
Submit an injury form (FROI) online at sedgwickmco.com.

**Phone:**
Contact our customer service team at 888-627-7586 (available 24/7).

**Email:**
Send encrypted injury/incident reports as soon as possible to: Injury.Accident@Sedgwickmco.com.

**Fax:**
Send injury forms to 888-711-9284.

**Early documentation and reporting of injuries promotes the best results for everyone.**

## Key contacts and additional information

**Medical treatment questions, medical documentation and billing issues**

Contact Sedgwick Managed Care Ohio:

- Phone: 888-627-7586
- Fax: 888-627-0074
- Mail: P.O. Box 1040, Dublin, OH 43017

**Prescription questions**

Call 800-644-6292 and follow the prompts.

**Ohio Bureau of Workers' Compensation (BWC)**

Call 800-644-6292 or visit bwc.ohio.gov.

**Medical options and provider search**

If medical treatment is required, see a BWC-certified medical provider. For provider information, click on Find a Provider on the Sedgwick MCO website or visit the Provider Look-up page on the BWC website.

## Transitional work benefits everyone

A safe and timely return to work is important! Together, we will explore opportunities for modified duty/transitional work that can accommodate any physical limitations in order to speed your recovery, ease your transition back to work and minimize any hardship as a result of a workplace injury. Employee safety and recovery are the highest priorities. It's essential – and required – to keep Sedgwick MCO and your employer updated on your recovery status and work restrictions at all times.

## Responsibilities

**Sedgwick MCO**

- Initiate new claims with the BWC, collect and submit required information
- Return to work and medical case management
- Review and approval of medical treatment
- Medical bill payment
- Medical management of workers' compensation claims
- All associated managed care organization responsibilities

**BWC**

- Claim allowance and compensability determination
- Claim number assignment
- Compensation award payment(s)
- Coordination of Industrial Commission hearings

**Medical providers**

- Treating physicians must be BWC certified
- Promptly submit all medical documentation to Sedgwick MCO
- Clearly indicate work readiness and periods of disability utilizing the MEDCO-14 form

## Important BWC forms

**First report of injury (FROI)**

Initiates workers' compensation claim; complete and send to Sedgwick MCO

**MEDCO-14**

Physician's statement of workability, recovery status; send to Sedgwick MCO

**C-9**

Physician's request for treatment approval; addressed by Sedgwick MCO

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MANAGED CARE OHIO

# Workers' compensation identification information

Fill out your employer name and policy number and present this information at all medical appointments.

Provide MEDCO-14 form with any physical restrictions, as employer may have modified duty available.

This is not a guarantee of coverage.

**Employer name:**
GEAUGA COUNTY

**Policy number:**
32800001

**Send all information within 24 hours of visit:**

- Injury report and FROI fax: 888-711-9284
- Medical and authorization fax: 888-627-0074
- 24-hour customer service: 888-627-7586
- Prescription questions: 800-644-6292
  (follow prompts)

**Send all mail and medical bills to:**

Sedgwick Managed Care Ohio
PO Box 1040
Dublin, OH 43017

Cut or fold page if desired

# INJURY ON THE JOB CLAIM PROCEDURES

| EMPLOYER AND BWC POLICY # | YOUR Worker's Comp Contact: |
|---|---|
| Name: Geauga County | Name: Megan Erickson |
| Address: 12611 Ravenwood Dr., Suite 350 | Title: Benefits Specialist |
| City, State, Zip: Chardon, OH 44024 | Phone: 440-279-1671 Fax: 440-279-1309 |
| BWC Policy Number: 32800001-0 | Email: merickson@geauga.oh.gov |

## IF YOU EXERIENCE AN ON-THE-JOB INJURY:

- Report the injury/incident to your supervisor IMMEDIATELY.
- Complete the Geauga County Employee's Incident/Accident Report and return to your supervisor immediately, if possible, or within 24 hours of the injury/accident. ***If you were involved in a vehicle accident accident involving a county vehicle, complete the Vehicle Incident/Accident Report also and send that report to Kathy Hostutler: Fax: 440-279-1317.***
- If medical treatment is necessary, please use a BWC-certified medical provider (see enclosed).
- Give your MCO Identification Card and MEDCO-14 Form (in this packet) to the medical provider to ensure all bills and necessary documents are sent to the correct address.
- ***Make sure you have your completed MEDCO-14 Form when you leave your doctor/urgent care.***
- Return the MEDCO-14 form to your supervisor immediately as notification of your medical condition.

**See enclosed insert for Medical Providers**

YOUR MANAGED CARE ORGANIZATION IS:

**CompManagement Health Systems, Inc.**

| | |
|---|---|
| P.O. Box 1040 | Fax: 1-800-334-4229 |
| Dublin, Ohio 43017 | Customer Service: 1-888-247-7799 |
| Online Reporting: www.chsmco.com | Injury Reporting: 1-888-247-4800 |

Bureau of Workers' Compensation

# First Report of Injury Occupational Disease, or Death (FROI)

Submit the form to BWC in one of the following ways. **Online:** bwc.ohio.gov, **Fax:** 1-866-336-8352, **Mail:** BWC Mail Processing Center, Attn: Claims, 30 W. Spring St. Columbus, OH 43215
**Note:** If you work for a self-insuring employer, submit this form to your employer's workers' comp manager.

## Injured worker information

| First name, middle initial, last name | Date of injury/disease | Social Security number | Date of birth |
|---|---|---|---|
| | | | |

| Mailing address; add apartment number or P.O. Box, if applicable | City | State | ZIP code |
|---|---|---|---|
| | | | |

| Sex ☐ Male ☐ Female | Email address | Home phone number | Cell phone number |
|---|---|---|---|
| | | | |

| Employer name | Employer address | City | State | ZIP code |
|---|---|---|---|---|
| | | | | |

| Was the injured worker hired through a temp agency? ☐ Yes ☐ No<br>If yes, name of temp agency | Mark the days of the week you usually work<br>☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat | Regular work hours (include a.m. p.m.)<br>From To |
|---|---|---|
| | | |

| Date hired | Job title | State where hired | State where supervised | Wage rate; $ per hour | Number of hours scheduled to work the week of this injury |
|---|---|---|---|---|---|
| | | | | | |

| Work number for call-offs (Number injured worker calls to reach supervisor) | Part(s) of body affected (For example: Left knee, right index finger) |
|---|---|
| | |

| Accident description (Describe the sequence of events that directly caused the injury or death.) | Will the incident cause the injured worker to miss 8 or more days from work? ☐ Yes ☐ No |
|---|---|
| | |

| Injured worker start time<br>_____ ☐ am ☐ pm | Time of injury<br>_____ ☐ am ☐ pm | Date employer notified | Was any part of a workday missed due to the injury? ☐ Yes ☐ No | Date last worked | If the injured worker has returned to work, provide the date. |
|---|---|---|---|---|---|
| | | | | | |

| Was the place of the accident or exposure on employer's premises? ☐ Yes ☐ No If no, give accident location, street address, city, state, and ZIP code. | Was injured worker hospitalized overnight?<br>☐ Yes ☐ No |
|---|---|
| | |

| Initial treatment date | Health-care office/Facility name | Treating physician/Provider name | Telephone number | Fax number |
|---|---|---|---|---|
| | | | | |

| Health-care office/Facility Street address | City | State | ZIP code |
|---|---|---|---|
| | | | |

If the injury resulted in death, answer the following.
Date of death Decedent's marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Decedent's number of dependents

## To be completed by the injured worker

**By signing this form, I:**

- **Elect to only receive compensation, benefits, or both provided for in this claim under Ohio's workers' compensation laws.**
- **Understand, waive, and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**
- **Confirm I have not received compensation and benefits under the workers' compensation laws of another state for this claim, and I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**
- **Will not file and have not filed a claim in another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**

**Furthermore, I understand that:**

- Upon request, my treating providers may submit to BWC, my employer, my employer's managed care organization or qualified health plan, or their authorized representatives medical, psychological, psychiatric, or vocational documentation relating causally or historically to physical or mental injuries relevant to this claim and necessary for me to obtain medical services, benefits, or compensation.
- Proper administration of this claim may require BWC to review and share with the employers of record, their authorized representatives, or my authorized representative any information or record maintained in this claim, or in my previous or future claims.
- Information or records maintained in my previous or future claims may affect decisions made in this claim.
- Any person who obtains compensation or benefits from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements, or accepting compensation or benefits to which he or she is not entitled, is subject to felony criminal prosecution for fraud (Ohio Revised Code 2913.48).

I certify that I have read, understand, and agree to the above statements and the information contained on this form is true and accurate to the best of my knowledge.

| Injured worker signature | Date |
|---|---|
| | |

## To be completed by the treating provider

Diagnosis(es)-narrative description including as appropriate, the location and body part, and ICD code(s). **Important:** If there is an injury, list the condition or disease, not the symptoms or exposure. For example, "sprain right knee" not "pain right knee", "toxic effect of ammonia" not "exposure to ammonia", "contusion to the head" not "headache".

| Initial treatment date | Are the medical conditions you have listed above causally related to the reported work-related accident or occupational disease? ☐ Yes ☐ No<br>Are you the physician of record? ☐ Yes ☐ No |
|---|---|
| | |

| Treating physician/Provider's name (Print) | Treating physician/Provider's signature | BWC provider number | Date |
|---|---|---|---|
| | | | |

## To be completed by the employer

| Employer name | Employer county | Phone number | Fax number | Email address |
|---|---|---|---|---|
| | | | | |

| Employer policy number | Federal ID number | Injured worker is (Check box, if applicable.) ☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation |
|---|---|---|
| | | |

**For all employers:** ☐ Certification – I certify the facts in this application are correct and valid. ☐ Rejection – I reject the validity of this claim for the reason(s) listed below.
**For self-insuring employers only:** ☐ Medical only ☐ Lost time
Clarification – I clarify and allow the claim for the condition(s) below.

| Employer signature and title | Date |
|---|---|
| | |

## To be completed by the submitter if the form is completed by someone other than the injured worker, treating physician, or employer

| Signature of person completing this form | Date |
|---|---|
| | |

**Bureau of Workers' Compensation**

# Physician's Report of Work Ability (MEDCO-14)

**Instructions**

- Use this form to provide detailed information about the injured worker's ability to work. Add comments to Section 4 or attach additional information as necessary. BWC uses the information to support a request for temporary total compensation.
- The treating physician must submit this form each time they see the injured worker unless they:
  - Have been awarded permanent and total disability.
  - Have returned to work without restrictions within seven days of the injury.
  - Are being treated after the treating physician has released them to their former position of employment (i.e., full duty job) held on the date of injury without restrictions.
- While you may use an equivalent physician-generated document (e.g., office notes, treatment plan) to the MEDCO-14, it must contain, at a minimum, the required data elements. If you've previously submitted equivalent data, indicate the date of the report on the form (e.g., 5/15/2021, office note).

**Note:** Physician assistants and nurse practitioners may complete this form; however, they may only certify temporary disability for the first six weeks after the date of injury. Subsequent periods of temporary disability require a co-signature by the treating physician.

- Fax form to the managed care organization if the employer is state-fund or to the employer if self-insured.
- **Important:** Failure to provide complete information may delay compensation payments to the injured worker.

| Injured worker name | Claim number | Date of injury |
|---|---|---|
| | | |

| Date of ***last*** appointment/examination | Date of ***this*** appointment/examination | Date of ***next*** appointment/examination |
|---|---|---|
| | | |

**1 Submission type (Select one of the options below.)**

☐ Initial MEDCO-14. ***Proceed to Section 2.***
☐ Subsequent MEDCO-14, **no** changes ***Proceed to Section 6.***
☐ Subsequent MEDCO-14, **with changes.** Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.

**2 Job description and work status** ☐ Reporting changes from last evaluation ☐ No changes

- Have you reviewed the injured worker's job description? ☐ Yes ☐ No
  - **If yes,** who provided the job description ☐ Injured worker ☐ Employer ☐ MCO/BWC
- Does the injured worker have any physical or health restrictions **related to the allowed conditions in the claim** on the date of this exam? ☐ Yes ☐ No
  - **If yes,** are the restrictions: ☐ Permanent? ☐ Temporary?
  - **If no,** check the box to indicate the injured worker is released to return to full duty as of the date of this exam. ☐ ***Proceed to Section 6.***
- If there are restrictions, can the injured worker return to their full duty job held on the date of injury as of the date of this exam? ☐ Yes ☐ No
  - **If yes, *Proceed to Section 6.***
  - **If no,** provide date restrictions began ____/____/____ and estimated full duty return-to-work date ____/____/____. ***Proceed to Section 3.***

**3 Disability information** ☐ Reporting changes from last evaluation ☐ No changes

Complete the chart below for all **work-related allowed conditions being treated**.

| Narrative description of the **work-related allowed condition** | Site/Location if applicable | ICD code | Is the condition preventing full duty release to the job injured worker held on the date of injury? |
|---|---|---|---|
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |

List all other conditions that **impact treatment** of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

| Injured worker name | Claim number | Date of injury |
|---|---|---|
| | | |

**4 Abilities, clinical findings, and recovery progression** ☐ Reporting changes from last evaluation ☐ No changes

- Is the Injured worker taking prescribed medication for the allowed conditions that may be a safety hazard? ☐ Yes ☐ No
- Dominant hand: ☐ Right ☐ Left
- Circle the injured worker's physical abilities for the activities in the chart below and provide comments as necessary.

| Frequency scale | Strength level (lbs.) | Body side indicator |
|---|---|---|
| **N** = Never<br>**S** = Seldom 0-1 hour<br>**O** = Occasional 1-3 hours<br>**F** = Frequent 3-6 hours<br>**C** = Constant 6-8 hours | **S** = Sedentary 0-10<br>**L**= Light 0-20<br>**M** = Medium 0-50<br>**H** = Heavy 0-100<br>**VH** = Very heavy >100 | **L** = Left<br>**R** = Right<br>**B** = Both<br>*Indicate **limitations ONLY** |

| Activity | Frequency | Activity | Strength | Frequency | Activity | Side |
|---|---|---|---|---|---|---|
| Sit | N S O F C | Floor lift (0-17") | S L M H VH | N S O F C | Front/Lateral reach | L R B |
| Stand/Walk | N S O F C | Knee lift (18-29") | S L M H VH | N S O F C | Overhead reach | L R B |
| Climb stairs | N S O F C | Waist lift (30-36") | S L M H VH | N S O F C | Wrist flex/extension | L R B |
| Squat/Kneel | N S O F C | Chest lift (37-60") | S L M H VH | N S O F C | Grasp | L R B |
| Crawl | N S O F C | Overhead lift (>60") | S L M H VH | N S O F C | Finger manipulation | L R B |
| Twist | N S O F C | Push/Pull | S L M H VH | N S O F C | Keyboarding | L R B |
| Bend/Stoop | N S O F C | Carry | S L M H VH | N S O F C | Operate foot controls | L R B |

- Injured worker can work _____hours per day and _____ hours per week.
- Are there any functional restrictions based only on the allowed psychological conditions? ☐ Yes ☐ No
  - o If yes, describe any functional restrictions in comments below and reference the MEDCO-16 as needed.
- Provide your clinical and objective findings supporting your medical opinion. List barriers to return to work, reason(s) for delayed recovery, and proposed treatment plan (e.g., modalities, therapies, surgery), including estimated duration of each treatment or indicate if all or part of this information is in office notes (include date(s) of notes).

**Comments:**

**Health and Behavioral Assessment:** (HBA evaluates cognitive, emotional, social, and behavioral barriers that might impact physical health problems and treatments which are associated with the allowed physical injury in the claim.)

- Is the injured worker's recovery not progressing, or progressing slower than expected? ☐ Yes ☐ No
- Do cognitive, emotional, social, or behavioral barriers exist that may be interfering with expected healing? ☐ Yes ☐ No

**Vocational rehabilitation** is a voluntary program for an eligible injured worker who needs assistance to remain at work or return to work. Is the injured worker currently able to participate in a vocational rehabilitation program? ☐ Yes ☐ No

**5 Maximum medical improvement (MMI) status** ☐ Reporting changes from last evaluation ☐ No changes

**MMI** is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the definition above? ☐ Yes ☐ No

- **If yes**, give MMI date: ____/____/____. ***Note:*** *An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. So, periodic medical treatment may still be requested and, if approved, provided.*

**6 Treating physician's signature – mandatory (See exceptions at the top of the form.)**

I certify the information on this form is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may be punished, under appropriate criminal provisions, by a fine or imprisonment or both.

| Treating physician's name (Print legibly.) | | Address, city, state, nine-digit ZIP code | |
|---|---|---|---|
| Treating physician's signature | | | |
| BWC provider (PEACH) number | Date | Telephone number | Fax number |

EMPLOYEE'S REPORT OF INCIDENT AND INJURY
**PLEASE PRINT IN INK** To be completed by Employee

**Employer: Geauga County** **Policy No: 32800001-0**
**Location of Injury/Incident:** _____

Name_____ Social Sec. No._____
Home Address_____ Birth Date_____ Sex: ☐ Male ☐ Female
City/State/Zip_____ Telephone: ( )_____

Date of injury **or** onset of symptoms_____ Time_____ ☐ am ☐ pm
Described what caused the injury/symptoms, what you were doing **just before** the incident, and what you did **after** the incident (if you need more space, write on the back of this form). **Be specific - name any objects or substances involved:**_____
_____
_____
_____

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who?_____
Did you report this incident to anyone? ☐ Yes ☐ No If not, why not?_____
If yes, to whom did you report it?_____ Title/Position_____ When?_____

**What part(s) of your body was/were affected? (BE SPECIFIC:** for example, right elbow, left knee, right index finger):
_____
_____

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull)_____
_____

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe:_____
_____
Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?_____
Where?_____ If treatment was not sought immediately, explain why: _____
_____

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury? _____ By whom or where?_____
Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury:_____
_____

**Medical Release**

***Under current workers' compensation law, the employer is entitled to a signed medical release***

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative, **Sedgwick** A copy of this form will serve as the original.

Employee Name (print)_____

Employee Signature_____ Date (required)_____

# Vehicle Incident/Accident Report

**REPORT THE ACCIDENT IMMEDIATELY AND PROVIDE ADDITIONAL DOCUMENTS AS SOON AND POSSIBLE.**

County Vehicle Year, Make, Model

_____

Location/Address of
Accident_____ Date/Time_____

Weather Conditions_____

Road Conditions_____
Traffic Controls _____
Responding Police Agency_____
Officer_____ Phone _____

Damage Description _____
_____
Owner's Vehicle, Name and Address
_____
_____

Insurance Carrier_____ Agent _____ Phone _____
Describe action taken _____
_____

Estimated Cost of Repair _____
Who will do the repairs?_____

| Vehicle | Driver's Name & Address | DOB | Driver's License # | Vehicle Description & License Plate # |
|---|---|---|---|---|
| #1 | | | | |
| #2 | | | | |
| #3 | | | | |
| | | | | |

| Injured Party: Name/Address/Phone | Describe Injury: Reported/Observed |
|---|---|
| | |