

# Incident Investigations & Supporting Documentation for Claims



**Risk Management Division**  
**Workers' Compensation Program**



# Goals

We want you to be able to:

- ✓ Describe what you need to know about completing the Injury, Illness, Incident Data Form (IDF), and investigating a claim
- ✓ Understand what information is vital to share after the initial reporting of the injury is completed
- ✓ Understand that workers' compensation claims investigations can extend beyond the initial investigation period
- ✓ Describe your responsibility/role in the return-to-work process, maintaining contact with the employee, using the Work Ability Report and monitoring the injured employee's progress

# What do you do first?

As the workers' compensation coordinator, you play a vital role in the management work-related injuries. When an employee calls they have been injured, you should:

- ✓ Find out if there is an injury
- ✓ *If it is an emergency call 911*
- ✓ Ask "How did this happen?" and "When did this happen?"
- ✓ Complete the Privacy Statement, the IDF and the Accident Investigation Report
- ✓ Refer employees with injuries to a CorVel designated clinic in all non-emergency situations

**Workers' Compensation Program  
Department of Administration  
Information and Privacy Statement**

# Information and Privacy Statement

The Minnesota Government Data Practices Act (MN Statutes, Chapter 13) requires that you be informed of the following:

1. The data your agency or the Department of Administration collects from you, for the First Report of Injury, or during the course of investigating or managing your claim, is private data and will be collected for the purpose of assisting Admin in making an initial determination of whether your injury is work related; in determining any initial and continued eligibility to receive benefits; and in computing the amount of payment you may be entitled to receive, should it be determined that your injury is work related. The data is also collected for the purpose of reporting to the Department of Labor and Industry any injury which wholly or partly incapacitates an employee from performing labor or services for more than three calendar days. This report is required by law.
2. You are NOT legally required to provide this information to us. However, if you do not provide certain data to us, we may be unable to complete the investigation of your claim for benefits and determine eligibility for benefits. Your refusal to provide information may cause your claim to be denied, or if you are eligible for benefits, your payment may be delayed. If you provide data to us, it will assist us in making an appropriate determination of liability and benefit eligibility.
3. The information you provide will be available to:
  - those within your agency and the Department of Administration whose jobs reasonably require access, such as workers' compensation coordinators or claims management specialists;
  - your medical provider(s);
  - the state's managed care vendor, and other vendors providing services for Admin
  - the Workers' Compensation Reinsurance Association;
  - The Minnesota Department of Labor and Industry;
  - The Office of Administrative Hearings, Legislative Auditor, Attorney General's Office, Social Security Administration, applicable state retirement system, enforcement agencies with statutory authority to obtain the data, and any other person or entity authorized by law or court order.
4. You may review all the non-investigative claim information maintained by the Department of Administration, Workers' Compensation Program. There is no charge for reviewing this information; however, there is a small copy charge if you request copies.

I HAVE READ THE NOTICE REGARDING INFORMATION AND PRIVACY AS SET FORTH ABOVE.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

cc: Employee

IDF - Injury, Illness, Incident Data Form (replaces First Report of Injury or FRI)



# Injury, Illness, Incident Data Form

**Instructions:** This form is for the collection and reporting of data associated with a work-related, injury, illness or incident. Supervisors must complete this entire form and submit either by email (preferred method) or signed paper copy to the Agency Workers' Compensation Coordinator within 24 hours of receiving notice of the injury, illness or incident. Supervisors should immediately contact CorVel (the state's workers' compensation managed health care system) at 612-436-2542 or 1-866-399-8541, if an injured employee is admitted to an overnight stay at a hospital or requires immediate surgery on day of injury. Please contact your agency/facility's Workers' Compensation Coordinator with any questions. Checklists, forms, and instructions outlining supervisors responsibilities are available at: <http://www.risk-workerscomp.admin.state.mn.us/forms.htm>

Incident Details				
1. Date of incident: (MM/DD/YYYY)	2. Time of incident: <input type="checkbox"/> am <input type="checkbox"/> pm	3. Date reported: (MM/DD/YYYY)	4. Time reported: <input type="checkbox"/> am <input type="checkbox"/> pm	4. Incident type: <input type="checkbox"/> Incident <input type="checkbox"/> Injury - lost time <input type="checkbox"/> Injury - no lost time <input type="checkbox"/> Property damage
5. Description of incident: (limited to 250 characters, be sure to include detail about the body part, cause, and nature of injury) For example: "worker developed soreness in left wrist over time doing computer work" or "slipped and fell on wet floor breaking right leg"				6. Chemical, tools, equipment, or items involved: (e.g. "boxes")
				7. Specific body part:
8. Employer/Agency:	9. Facility/Location:	10. Division:	11. Exact location of incident:	
12. Incident reported to (full name):	13. Emp/State ID#:	14. Work phone: ( )	15. Has incident investigation been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Person reporting incident (full name):	17. Emp/State ID#:	18. Work phone: ( )	19. Incident result in fatality? <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Is there a witness to the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		21. Witness's full name (if more than one please attach separate page):		22. Witness's phone: ( )
23. Did incident involve travel? <input type="checkbox"/> Yes <input type="checkbox"/> No	24. Was a state vehicle damaged? <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Motor vehicle accident report completed? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Injury/Illness Details				
26. Injured person's employment status (if contract worker please stop here) <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Student <input type="checkbox"/> Intern <input type="checkbox"/> Contract worker				
27. First name of injured person:	28. Middle initial:	29. Last name:		
30. Emp/State ID #:	31. Work phone: ( )	32. Home phone: ( )	33. Start time day of injury: <input type="checkbox"/> am <input type="checkbox"/> pm	
34. Work shift (e.g. M-F 8:00am-4:30pm):	35. Does employee have second job? <input type="checkbox"/> Yes <input type="checkbox"/> No	36. Second employer name:		37. 2 <sup>nd</sup> job gross weekly income:
38. Has injured employee missed work due to injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	39. First date employee missed work:	40. Date employee last at work: <input type="checkbox"/> Yes <input type="checkbox"/> No	41. Missed work on day of injury due to injury? If yes, # of hours: <input type="checkbox"/> Yes <input type="checkbox"/> No	
42. Date employer notified of lost time:	43. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		44. Date returned to work:	
45. Was medical treatment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	46. Emergency room visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	47. Hospitalized overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No		
48. Medical facility's name: (if no medical treatment please respond "None")		49. Medical facility's address:		
50. Treating physician's name: (if no medical treatment please respond "None")		51. Physician's phone: ( )	52. Treating physician's address:	

Supervisor/Designee Certification				
53. Supervisor/Designee name:	54. Emp/State ID#:	55. Work phone: ( )	56. Signature:	57. Date:

Insurer: Minnesota Dept. of Administration, Risk Management Division, Workers' Compensation Program P.O. Box 64081, St. Paul, MN 55164-0081 Phone (651) 201-3000	For office use	Claimant Name: _____ Date entered into SEMA4: _____
		Date of Incident: _____ Entered by: _____
		WC Claim #: _____ SEMA4 Incident #: _____
		WC Claim Specialist: _____
		Agency hire date: _____ WC Location Code: _____
Injury/illness/incident Data Form rev. 2/1/09		



## Agency Claims Investigation

(SEMA+ panels are in italics)

Dept. of Administration  
 Risk Management Division  
 Workers' Compensation Program  
 PO Box 64081  
 St. Paul, MN 55164-0081  
 (651) 201-3000  
 FAX (651) 297-5471

Injured Employee's Name (Last, First, M.I.)	Agency Name
1. _____	4. _____
Date of Claimed Injury (DOI)	Agency Location
2. _____	5. _____
Employee Phone #	
3. _____	

Investigative Questions

6. Describe in detail the tasks, activities, and conditions leading up to the injury/illness. *(Inj Det-Statements ER State)*

7. Describe in detail how the injury/illness occurred. *(Inj Det-Statements ER State)*

8. Describe in detail the injury or illness. *(Inj Det-Description)*

**Complete causal factor analysis on page 2 before proceeding to questions 9-12.**

9. Provide a detailed description of all hazardous conditions, such as defective equipment, excessive noise, natural, or traffic hazards that may have contributed to this injury/illness.

*(Consequent Actions-Correct/Prevent)* Primary Hazard Condit Code: \_\_\_\_\_

10. Provide a detailed description of all unsafe acts such as failure to use safety equipment, improper use of equipment, or unsafe posture that may have contributed to this injury/illness.

*(Inj Det-Details)* Primary Unsafe Act Code: \_\_\_\_\_

11. Please describe immediate corrective actions you have taken to prevent additional injuries/illnesses. *(Consequent Actions-Corrective)*

12. Please describe all preventative actions you are taking to reduce or eliminate similar hazards in the future. *(Consequent Actions-Preventative)*

13. Name, title and phone number of individual completing this form. *(Inj Det-Role/Address)*

Name	Phone
Title	Date of Investigation

14. Agency management review

Name	Title
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# Agency Claims Investigation

**Crash Records**

445 Minnesota St. Ste. 161  
St. Paul, MN 55101-5161  
Phone: (651) 215-1335  
TTY: (651) 282-6555  
FAX: (651) 282-5512  
Web: mndriveinfo.org



DPS CRASH FILE # \_\_\_\_\_

**CRASH RECORDS REQUEST**  
(For crashes occurring in Minnesota only)

# Crash Records Request

**INSTRUCTIONS:**

Complete the crash information section and submit request form to the above address to obtain a copy of police report. Enclose \$5.00 fee. The fee covers the search and is retained whether or not a crash report is on file in this office. Make checks payable to "Driver and Vehicle Services". Please do not submit requests until twenty working days after the crash date.

Information may be disclosed to requester, their legal counsel, or a representative of the insurer; only upon signed authorization of authorized requester.

Authorized Requester is a person involved with the crash and (driver, passenger, owner of damaged property, owner of vehicle, pedestrian) recorded on the police report; next of kin, surviving spouse or legal representative of the estate. Disclosing information from crash reports, except by the Highway Traffic Regulation Act, is a misdemeanor. Request will not be processed without a valid signed authorization.

**CRASH INFORMATION: (Please Print)**

# OF DRIVERS INVOLVED \_\_\_\_\_

	Driver(s) Name(s) (first, middle, last)	Date of Birth	Driver License #	License plate number *
1.				
2.				
3.				

\* Without the license plate number of the vehicle(s) involved, the report that is being requested may not be located

Location of Crash (Street or Highway)	City / County	Date of Crash

Were any of the vehicles parked?  Yes  No      Were there any fatalities?  Yes  No

Requester hereby authorizes the Department of Public Safety to disclose accident information in accordance with Minnesota Statute, 169.09 subd.13.

Check the appropriate box:

- Driver
- Passenger
- Pedestrian
- Owner of Damaged Property
- Owner of Vehicle
- Next of Kin: Surviving spouse, Legal representative of the estate Trustee pursuant to M.S. 573.02

Signature of authorized requester

Printed Name \_\_\_\_\_

Account # \_\_\_\_\_  
Customers having pre-paid status

Mail to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To expedite service enclose a self addressed stamped envelope for the return of your request.

**For office use only:**

Comments:      Search made-No File Located      Search made-No police report available

# **Commencement of Payment or Denial of Liability Timelines**

## **Payment:**

- Within 14 days of notice to or knowledge by the employer of an injury compensable
- Within 14 days of notice to or knowledge by an employer of a new period of temporary total disability
- Commencement of payment by an employer or insurer does not waive any rights to any defense the employer has

# **Commencement of Payment or Denial of Liability Timelines**

## **Denials:**

- Denial of liability must be filed within 14 days after notice to or knowledge by the employer
- If payments have started, within 60 days of notice to or knowledge by the employer of the injury
- After the 60-day period, payment may be terminated only by the filing of a Notice of Intent to Discontinue Benefits (NOID)

**Agency Workers' Compensation Coordinator  
Claim Management Checklist**



Claimant Name:	Emp/State ID #:	Email:
Date of injury/ill/incident:	Phone #:	Cell #:
Supervisor name:	Supv. Phone #:	SEMA4 Dept ID#:
WC Claim #:	SEMA4 Incident #:	
WC Claim Specialist:	Specialist's phone:	
Cor/Vel case manager:	Case manager phone :	
QRC name:	QRC phone:	
Medical treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	Time lost <input type="checkbox"/> Yes <input type="checkbox"/> No	Status <input type="checkbox"/> Accepted <input type="checkbox"/> Denied
Unpaid leave of absence start date:	Days away (OSHA):	
Return to work date:	Days restricted :(OSHA)	
WC Coordinator name:		

The following 3-part checklist outlines steps that Agency Workers' Compensation Coordinators (WC Coord.) should take to report and manage the medical and loss time issues associated with potential work-related injuries or illnesses.

Please ensure that all agency personnel (especially supervisors) are familiar with the process to report potential work-related injuries or illnesses. Supervisors should follow WC process guidance provided on the Supervisor's Injury/Illness/Incident reporting & Workers' Compensation Checklist. Agencies are required to submit any reports of potential work-related injuries or illnesses to the State Workers' Comp Program within 3 days (required data should be inputted into SEMA4 within 2 days to meet the 3-day requirement) after being notified by an employee of such an event.

If the employee hasn't lost time or sought medical care, enter the report into SEMA4, but do not approve or send the claim to the Workers' Comp Program. Your agency may choose not to enter it into SEMA4, but to keep it in an inactive file. If you become aware at a later date that the employee has lost time or sought medical care, the report will need to be sent to the Worker's Comp Program at that time.

In the event of any serious, life threatening, or fatal injuries, notify the Workers' Compensation Program by telephone at 651-201-3000 within 24 hours. Employers are also required by law to report occupational accidents in which an employee is killed or three or more employees are hospitalized to OSHA (Occupational Safety & Health Administration) within eight hours.

It is a good practice to identify light duty work within the agency that might facilitate the return of injured employees back to work in accordance with their work restrictions.

All communications with the WC Program (either email or fax) should include the employee's full name, date of injury, and claim number if available.

It is important to provide the WC Program and your WC Claim Specialist all requested information in a timely manner until the claim is resolved.

Further information regarding the reporting of work related injuries or the workers' compensation process can be found at: Workers' Compensation home page.

**Agency Workers' Compensation Coordinator  
Claim Management Checklist**



Claimant Name:	Date of injury/illness/incident:	WC Claim #:
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**Reporting a claim**

Item	Action
___ 1.	Send e-mail notice to supervisor acknowledging receipt of injury report: "We received a report of injury for (employee name). The reported Date of Injury was _____. Please immediately let us know if he/she misses any work or seeks medical attention for this injury." Include in e-mail if any forms are missing and when they are due to agency's workers' compensation coordinator (within 24 hours from day of injury).
___ 2.	Verify that employee was given <u>WC Employee Information Packet</u> .
___ 3.	Verify that all five (5) <u>WC forms</u> have been received and are completed (contact supervisor for any missing information) <u>Workers' Compensation Information and Privacy Statement</u> <u>Employee Statement regarding incident</u> <u>Incident Data Form (IDF)</u> <u>Agency Claims Investigation</u> <u>Leave Supplement Form</u>
___ 4.	Determine the appropriate workers' compensation location code and SEMA4 location code for the claim and insert on IDF in "agency use" section.
___ 5.	Collect agency hire date from SEMA4 or other personnel information source and insert on IDF in "agency use" section.
___ 6.	Use <u>Workers' Compensation Coding handbook</u> to properly code body part, nature, source, cause, unsafe act, and unsafe conditions and insert on IDF in "agency use" section.
___ 7.	If the employee <b>loses time or receives medical treatment</b> , and <b>does not</b> have a SEMA4 employment record (volunteers, quasi-state agencies) complete <u>Non-SEMA4 Employee Details Form</u> and <u>26 Week Wage Statement</u> and email all forms to WC Program attention <a href="mailto:johnathan.carver@state.mn.us">johnathan.carver@state.mn.us</a> within 48 hours of the date that the supervisor/designee became aware of the work-related injury or illness.
___ 8.	If the employee <b>loses time or receives medical treatment</b> and <b>does</b> have a SEMA4 employment record, enter the report into <u>SEMA4</u> within 48 hours of the date that the supervisor/designee became aware of the work-related injury or illness
___ 9.	Send employee correspondence indicating that claim has been filed with the Workers' Compensation Program. Copy Supervisor. <u>Sample correspondence</u>
___ 10.	If the employee did not lose time or seek medical care at time of injury send employee correspondence indicating that claim is inactive and has not been filed with Workers' Compensation Program. Copy Supervisor. <u>Sample correspondence</u>
___ 11.	If the employee originally did not lose time or seek medical care at time of injury but later misses work or seeks medical care, submit claim information as indicated above within 48 hours of the date that the supervisor/designee became aware of the loss time or medical care related to the injury or illness.
___ 12.	E-mail the WC Claim Supervisor to report any particular concerns or to inform them of any lost time or medical that wasn't received prior to entering the report into SEMA4.
___ 13.	Send copies of the IDF and Agency Claims Investigation form to your agency Safety Officer and other interested parties per the agency's loss control policy.
___ 14.	Coordinate with appropriate agency personnel to meet OSHA recordkeeping requirements.

**Agency Workers' Compensation Coordinator  
Claim Management Checklist**



Claimant Name:	Date of injury/illness/incident:	WC Claim #:
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**Medical Management**

Item	Action
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- \_\_\_ 15. If the employee lost time or went to a health care provider due to the injury or illness, verify that a Report of Work Ability statement was received. Review the Report of Work Ability statement and work with the supervisor to determine whether the employee can be accommodated.
- \_\_\_ 16. Notify CorVel case manager directly as to whether you are able to accommodate work restrictions.
- \_\_\_ 17. Also notify WC Claim Specialist of you discussion with CorVel as to whether you are able to accommodate restrictions.
- \_\_\_ 18. Send copies of ALL medical / doctor statements to assigned WC Claim Specialist immediately after receiving them.
- \_\_\_ 19. Ensure that payroll does not process sick leave for the day of injury. Employee will receive normal pay for scheduled hours on date of injury. Sick leave usage if necessary begins on the second day. A comment should be included on employee's time sheet detailing what actually occurred (e.g. ee medical appt 2 hour, out 6 hrs.). Email or fax copy of employee's time sheet for the pay period that includes the date of injury.
- \_\_\_ 20. Assist supervisor with review of Reports of Work Ability received after each medical appointment and assist with the coordination of appropriate temporary work assignments within the agency until there are no further restrictions or restrictions are determined to be permanent by the treating physician.
- \_\_\_ 21. Document each temporary light duty assignment in writing. Sample correspondence
- \_\_\_ 22. If work restrictions are not changing and/or appear to be permanent contact the WC Program's State Placement Coordinator at 651-201-3033.
- \_\_\_ 23. If restrictions are permanent or employee has been on restrictions for 4 months, and/or employee requests an accommodation – review ADA policy and discuss with HR. Discuss with supervisor and managers to determine if you can accommodate.
- \_\_\_ 24. Send Return to Work (RTW) notice to WC Claim Specialist immediately to avoid overpayments to employee. Specifically indicate whether employee has returned to full hours or partial hours.

**Agency Workers' Compensation Coordinator  
Claim Management Checklist**



Claimant Name:	Date of injury/illness/incident:	WC Claim #:
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**Lost Time Management**

Item	Action
___ 25.	Send email to WC Claim Specialist detailing employees lost time and scheduled work hours from day of injury through the remaining pay period (for lost time claims only).
___ 26.	Notify human resources of the event so that a preliminary FMLA decision can be made. If applicable, send FMLA leave packet to the employee. Inform supervisor if FMLA qualified. Time sheet coding will change.
___ 27.	Forward information about event to human resources so that a determination about Injured on Duty Pay (IOD) can be made (may pertain to DPS, DOC, DNR, DHS, Veterans Affairs) <input type="checkbox"/> Not Eligible for IOD Pay <input type="checkbox"/> Eligible for IOD Pay = send letter to ee.
___ 28.	Only send copies of time sheets beyond pay period of date of injury to notify the WC Claims Specialist of any change in work status, such as the employee is not working, has returned to work part-time or has returned to work full-time. Preference is that notice of a change in work status be document in the employees' biweekly time reports. Timesheets should include the employees' current hourly rate and be faxed or emailed to the WC Program by Friday following the pay period end date. Fax to the WC Claims Specialist at (651)-297-5471.
___ 29.	Immediately notify supervisor, payroll office and safety if a claim denial is received. (Example: "We received notice from WC Program that they denied the workers' compensation claim for (employee name) date of injury was (date). The WC Program Claim Specialist has sent a denial to the employee for notification purposes.")
___ 30.	If employee is on an Unpaid LOA, WC Program has accepted the claim, and the employee is insurance eligible: Code in SEMA4 as LOA, WC-9 (employer pays employer portion of insurance, employee pays their portion - billed by Mn Management & Budget). IF the employee is NOT insurance eligible: Code in SEMA4 as LOA, WCL.
___ 31.	Send letter to employee when unpaid leave begins. <u>Sample correspondence</u> . Unpaid leave begins when an employee elects not to supplement or when supplement ends.
___ 32.	Inform HR, WC Claim Specialist, and WC State Placement Coordinator when the employee has been on an unpaid LOA for more than six (6) months. Discuss again with HR and WC State Placement Coordinator when employee reaches ten (10) months of being on unpaid LOA.
___ 33.	When the employee returns to work (RTW), notify WC Program Claim Specialist and agency payroll of the RTW date. If the employee misses additional time from work re-notify WC and payroll each time.

EMPLOYEE INFORMATION													DEPARTMENT ID													
NAME - LAST			FIRST			EMPLOYEE I.D.			JOB TITLE				155													
Last Name			First Name			0000000																				
DIVISION					BARGAINING UNIT #			BARGAINING UNIT NAME				<input type="checkbox"/> Full-time Managerial, Professional & Supervisory Employees <input type="checkbox"/> I have performed the duties of my position to be compensated for 80 hours this pay period, including any leave taken as indicated below.														
Earnings Type & Description		PAY PERIOD BEGIN: 2/6/2008											PAY PERIOD END: 2/19/2008											HOURS or %		ACCOUNT
DATE		2/6	2/7	2/8	2/9	2/10	2/11	2/12	2/13	2/14	2/15	2/16	2/17	2/18	2/19											
EARN TYPE		W	TH	F	SA	SU	M	TU	W	TH	F	SA	SU	M	TU											
REGULAR HOURS WORKED		REG	8	8	0			0	0	0	4	1			3	0	24									
VACATION HOURS TAKEN		VAC																								
SICK LEAVE HOURS TAKEN		SLK									3			1	4	8										
COMP TIME HOURS TAKEN		CTT																								
HOLIDAY HOURS TAKEN		HOL																								
FLOATING HOLIDAY TAKEN		FLH																								
OVERTIME @ 1.0		OT1																								
OVERTIME @ 1.5		OTR																								
COMP TIME EARNED @ 1.0		CET																								
COMP TIME EARNED @ 1.5		CT15																								
VAC HRS EARNED - HOLIDAY		HVC																								
COMP HRS EARNED - HOLIDAY		HCT																								
SHIFT DIFFERENTIAL		S																								
ALT HOLIDAY CONVERSION		CT																								
FSLA		LWO																								
OTHER LIST:		LWO							4	4				4	4	16										
Total of All Hours*			8	8	0	0	0	0	0	8	8	0	0	0	8	8	48									
REMARKS		EMPLOYEE'S SIGNATURE I certify entries above are correct.							BALANCES		VACATION BALANCE		SICK BALANCE		COMP BALANCE		FLOATING HOLIDAY									
WC OFF WORK 2/9-2/13 HOL/ LT DUTY BEGAN 2/14 2/15 WC MED APPT CR SMITH 3 HRS 2/18 WC PT APPT 2/19 MED APPT-CHILD NOT WC H.S.M.R.									BEGINNING BALANCE HOURS		119.00		14.00		0.00		1									
									HOURS TAKEN		0.00		8.00		0.00											
									BALANCE BEFORE EARNED		119.00		6.00		0.00		1									
									HOURS EARNED		0.00		4.00													
									ENDING BALANCES		119.00		10.00		0.00		1									

# Employee Bi-Weekly Timesheet

- ✓ Clear and Concise
- ✓ Hourly Pay Rate

**ATTENTION: ALL EMPLOYEES REGARDING WORK-RELATED INJURIES**

Your employer has enrolled with CorVel, a Minnesota Certified Managed Care Plan, to provide all necessary medical management for workers' compensation injuries.

**How To Obtain Medical Care Through CorVel Managed Care Plan**

You are entitled to receive an initial evaluation from a participating medical provider within 24 hours of your initial request for medical care. If you live within the 7-county metro area, the provider must be geographically convenient and within a 30-mile radius of your workplace or residence. If you live in rural Minnesota, the provider must be geographically convenient and within a 50-mile radius of your workplace or residence. CorVel has a complete provider network which includes the following medical specialties: medical doctor; chiropractor; podiatrist; osteopath; or dentist. You may obtain medical care from a doctor within any of these specialties provided the treatment is available within your community and is appropriate for the injury or illness being reported.

**24 HOUR INFORMATION LINE  
612-436-2542 or 866-399-8541**

CorVel has a 24 hour information line to assist in providing access to medical services under the Managed Care Plan and to address any questions or complaints regarding managed care services. The CorVel 24 hour information line is answered by CorVel staff during regular business hours (8 a.m. to 5 p.m., Monday through Friday, except holidays) and a nurse is available after hours. In addition, all employees may view a copy of the CorVel Provider Directory which is available via a link from the State of Minnesota website. Employees may also obtain information about access to providers by calling the 24 hour information line.

**How to Obtain an Initial Appointment:**

1. Prior to obtaining an appointment, report your injury to the person or department at your agency that has been designated to receive reports of work-related injuries. Upon reporting your injury, you will be provided with a Patient Identification Card and Managed Care Instruction Brochure.
2. Your employer has chosen a designated medical facility to provide you with an initial evaluating appointment within 24 hours of your request for care. See the Workplace Poster for your designated clinic's name and location.
3. Please present the Patient Identification Card to the medical provider when you begin treatment.

**IF YOU ARE UNABLE TO OBTAIN AN INITIAL APPOINTMENT  
WITHIN 24 HOURS AT THE DESIGNATED FACILITY,  
CALL THE CORVEL 24 HOUR INFORMATION LINE**

**How to Obtain Emergency Medical Care or Urgently Needed Medical Services:**

In the event of a medical emergency, seek treatment at the nearest medical facility **IMMEDIATELY**. Other urgently needed medical services may be obtained at the nearest available urgent care center. Emergency or urgently needed medical services may be obtained from any qualified provider regardless of participation in CorVel's Provider Network. Either you or your representative must call the **CorVel information line** within 48 hours of your initial emergency medical treatment. If you need additional medical care, CorVel will assist you in choosing an approved medical provider.

**Medical Care Following Your Initial Appointment:**

1. If you received an initial evaluation from your designated provider and you require treatment beyond your initial appointment, you may continue care with the same provider who performed your initial evaluation, as long as the required treatment is within this provider's scope of practice.
2. You also have the right to select a different treating provider following the initial evaluation. To obtain an appointment with a new provider, call the **CorVel 24 hour information line**.
3. If you received your initial evaluation under emergency conditions and the provider who performed your initial evaluation is not a member of the CorVel network and you wish to continue care with this provider, then the conditions outlined under *Medical Care Outside Of The CorVel Provider Network* must be met.

**Medical Care Outside of CorVel's Regular Business Hours:**

CorVel's regular business hours are 8 a.m. to 5 p.m., Monday through Friday, excluding holidays. If you require non-emergency medical care outside of regular business hours, you may obtain care through one of the following options:

1. Call the **CorVel 24 hour information line** and speak with the after hours nurse.
2. Seek care at the nearest available medical facility. Then call the CorVel information line within 48 hours. If you require further care, a member of CorVel's 24 hour information line staff will provide any necessary assistance in obtaining a medical appointment on your behalf.

**How to Change Treating Providers:**

If you are not satisfied with your medical treatment, you are allowed to change treating providers at least once. To change treating providers, call the **CorVel information line**.

**Note:** Selecting a different treating provider following the initial evaluation does not count as a change of treating provider unless you have seen the evaluating provider more than once for your current injury.

**Medical Care Outside Of The CorVel Provider Network**

If you have sustained a work-related injury prior to this notice, you may continue to receive treatment for that injury from a medical provider outside of the CorVel network until you decide to change doctors. Then you must change to a doctor within the CorVel network.

For work-related injuries occurring after this notice, you may seek medical treatment with a medical provider outside of the CorVel network in the following cases:

1. If you have established a history of treatment with a healthcare provider who maintains your medical records and you can document receiving medical care from this provider at least twice in the last two years. If your treatment history with a provider does not meet the standard (twice within the last two years), you must seek approval from CorVel or the workers' compensation insurer. The treatment for your work-related injury must also be within this provider's scope of practice.
  - You must provide CorVel with documentation of previous treatment within 10 days of notice to employer of an injury.
  - If you decide to change providers, it must be to a doctor within the CorVel network.
2. If the nearest provider available within the CorVel network is beyond the state mileage guidelines (30-mile radius in the 7-county Metro area and 50-mile radius in rural Minnesota) from your place of employment and residence.
3. If you require emergency or urgently needed medical services.

**Questions Or Concerns Regarding CorVel's Certified Managed Care Plan**

CorVel will be happy to respond to questions about its Certified Managed Care Plan - please call:

**612-436-2542 or 866-399-8541**

You may also contact the Minnesota Department of Labor & Industry with questions at:

**800-342-5354 (St. Paul)  
800-365-4584 (Duluth)**

CorVel welcomes feedback regarding its services. To voice a comment or concern about services you have received from CorVel's Certified Managed Care Plan, call the CorVel 24 hour information line at:

**612-436-2542 or 866-399-8541**

**Formal Dispute Resolution Process Available To Employees**

If you wish to file a dispute regarding services you have received from CorVel's Certified Managed Care Plan, please make a formal written request to initiate CorVel's Dispute Resolution Process to the attention of the Managed Care Manager at:

**CorVel Corporation  
3001 NE Broadway Street, Suite 610  
Minneapolis, MN 55413-2658**

Upon request, CorVel will make a formal written request on your behalf to initiate the dispute resolution process. This process will be completed within 30 days after your written request is received by CorVel's Managed Care Manager.

**CorVel Does Not Determine Compensability**

2/2008

7-1-2005

Effective Date

**C O R V E L**

**MINNESOTA CERTIFIED  
MANAGED CARE PLAN  
INSTRUCTION BROCHURE**

*For the State of Minnesota*



**PLEASE TAKE THIS INSERT TO THE PHARMACY**

***Injured Worker's First Fill Prescription Information Sheet***

**Injured Worker Name:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Date Of Injury:** \_\_\_\_\_

***Dear Injured Worker,***

On your first visit, please give this notice to any pharmacy listed on this insert to expedite the processing of your approved Worker's Compensation prescriptions, based on the established parameters by **MN Dept of Admin**. With the CorVel CorCareRx program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Information Sheet to the pharmacy. You should not incur any costs or co-payments at the pharmacy and will allow up to a **10** day supply of medications.

***Dear Pharmacist,***

Please use the Injured Worker's **SSN plus 8 digit Date of Injury** (SSN+MMDDYYYY) as their 17 digit Identification number when entering the following information to process an online claim to CorVel on behalf of State of MN injured workers:

**BIN:** 004336  
**PCN:** ADV  
**RxGrp:** RXFFWC162

Pharmacies can contact CorVel **Pharmacy Help Desk** at (800)364-6331 for assistance with claims processing. The Pharmacy Help Desk is available 24 hours a day, 7 days a week for your convenience.

There are 70,000 Participating Pharmacies in the CorVel Network. Below is a sample listing.

Amcare Walker Pharmacy	Hanson Drug	Rite Aid
Anderson Drug	Health Partners	Salk Drug
Apothecary Shop	HY-Vee Pharmacy	Sam's Club Pharmacy
Bloomington Drug	K Mart Pharmacy	Samuelson's Drug
Butler Drug	Kennedy Snyder Drug	Snyder's Drug Store
Cash Wise Pharmacy	Lakes Area Pharmacy	Target Pharmacy
Cub Pharmacy	Medicine Shoppe	Town & Country Pharmacy
Curt's Pharmacy	Moudry Apothecary Shop	Walgreens Pharmacy
CVS Pharmacy	Pamida Pharmacy	Wal-Mart Pharmacy
Falk's Newman Pharmacy	Rainbow Pharmacy	Watertown Health Mart

**\*REPORT OF WORK ABILITY**  
 CorVel Corporation, 3001 NE Broadway St #610, Minneapolis MN 55413  
 Telephone (866)399-8541 or (612)436-2542 ~ Fax (612)436-2499

# Report of Work Ability

1. PATIENT INFORMATION		
Last Name	First	Middle Initial
Social Security Number	Date of Injury/Illness	
Job Title/Description	Home Phone	
Employer	Supervisor or Contact	Employer Phone
Work Comp Insurer	Claim Number	

2. AUTHORIZATION TO RELEASE INFORMATION	
I hereby authorize my medical provider to release or exchange information acquired in the course of my examination or treatment for the following medical condition to my employer or employer representative.	
Patient Signature:	Date:

3. TREATING PROVIDER'S EVALUATION-COMplete IN FULL FOR EACH VISIT	
Treatment Date	For: <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Follow-up Appointment
	Nature of Visit: <input type="checkbox"/> Work Related <input type="checkbox"/> Not Work Related <input type="checkbox"/> Unknown
Describe Circumstances of the Injury/Illness	
Diagnosis (include ICD-9 code)	
Treatment	
Medication (when ordering a medication, MN Rules require the words "Work Comp" or "W.C." be included on the prescription)	
Maximum Medical Improvement Reached (see instructions on the reverse side)	
<input type="checkbox"/> Yes <input type="checkbox"/> No Date of MMI:	
Disability Permanency Rating (PPD) if applicable	
Referral/Consult	
Next Appointment	Doctor:
Date:	Time:

**CONFIDENTIAL**

4. RETURN TO WORK											
<input type="checkbox"/> May return to work with no restrictions:	<input type="checkbox"/> Immediately, or <input type="checkbox"/> Beginning _____										
<input type="checkbox"/> Injury will result in loss of time from work: from _____ through _____											
<input type="checkbox"/> May return to work with the following restrictions: from _____ through _____ (note: schedule appointment)											
Patient's capabilities:											
Patient is able to lift up to: _____ lbs.											
Patient is able to use Hands: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both											
Hand / Wrist / Elbow / Shoulder restrictions: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both											
In an 8 hour day patient may (in hours):											
Stand and Walk	<table border="0"> <tr> <td>none</td><td>1-2</td><td>2-4</td><td>4-6</td><td>6-8</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> </table>	none	1-2	2-4	4-6	6-8	<input type="checkbox"/>				
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Bend and Lift	<table border="0"> <tr> <td>none</td><td>1-2</td><td>2-4</td><td>4-6</td><td>6-8</td> </tr> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> </table>	none	1-2	2-4	4-6	6-8	<input type="checkbox"/>				
none	1-2	2-4	4-6	6-8							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
Other Restrictions: _____											
Estimated Return to Full Duty is: _____ / _____ / _____ (If unable to return on full duty date, patient should return to clinic)											

5. TREATING PROVIDER	
Provider Name (please print)	Clinic Name
Provider Signature	Clinic Address

**Report of Work Ability** is used to:

- ✓ Identify essential tasks the employee can perform
- ✓ Determine which tasks can be modified to fit restriction

**Report of Work Ability** is the basis for the determination of light duty job:

- ✓ The employee is obligated to comply
- ✓ Establishes light duty performance standards
- ✓ It is updated after each doctor visit

# Why have an early return to work program?

Implementing an early return to work program:

- ✓ Communicates to the employee that he or she is wanted back at work and is valued as part of the work unit
- ✓ Keeps employees productive and connected to the workforce
- ✓ Reduces work comp costs