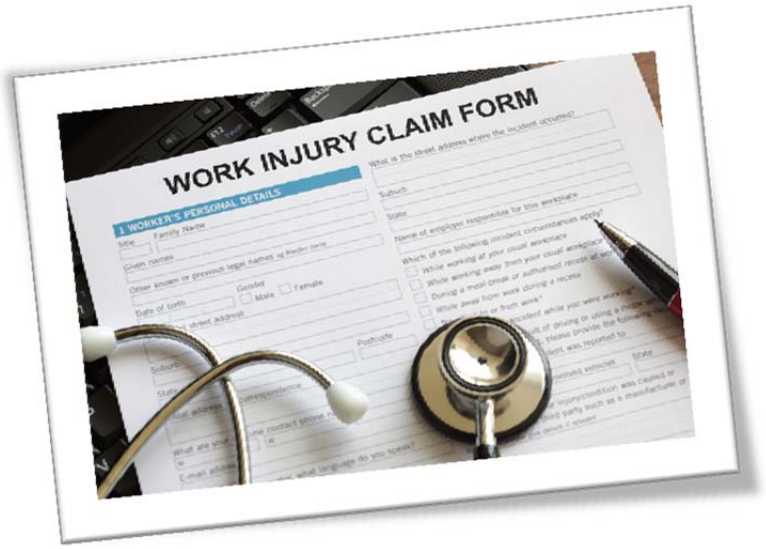


Workers' Compensation Claim Kit

PRAIRIE STATE INSURANCE COOPERATIVE

York Risk Servcies Group, Inc., publication | January 1, 2016

Prairie State Insurance Cooperative

Dedicated Service Team Roster

NAME	PHONE	EMAIL
Matt Dubin **Claims Supervisor**	**(847) 592-5381**	**matthew.dubin@yorkrsg.com**
Donald Petravick **Sr. Claims Adjuster**	**(847) 592-5364**	**donald.petravick@yorkrsg.com**
Brianne Tolzien **Medical Adjuster**	**(847) 592-5373**	**brianne.tolzien@yorkrsg.com**
Janet Dobryden **Sr. LP Consultant**	**(248) 408-3780**	**janet.dobryden@yorkrsg.com**
Heather Bustillo **Risk Services Liaison**	**(517) 338-3215**	**heather.bustillo@yorkrsg.com**
Frank Schmidt **Account Executive**	**(517) 338-3262**	**frank.schmidt@yorkrsg.com**

Claim Reporting

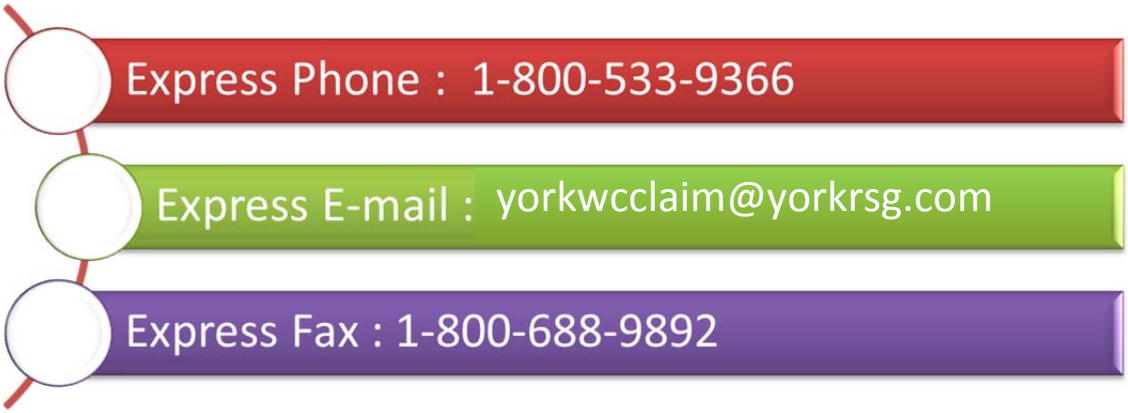
Express EMAIL	Express Fax	Express Phone
YorkWCClaim@yorkrsg.com	800-688-9892	800-533-9366

About YORK Risk Services Group, Inc.

For over 25 years, YORK has been a service company assisting employers in establishing and maintaining their own workers' compensation programs. As one of the largest service companies in the Midwest, we offer Third-Party Administration (TPA) workers' compensation programs for self-insured employers and group programs.

YORK's philosophy is to pay valid claims quickly and to assist in aiding your injured worker return to work quickly and safely. If you have any reason to suspect a fraudulent claim has occurred, our skilled staff will thoroughly investigate the circumstances and compensability of the claim.

Inside this resource packet, you will find information about your YORK team, along with instructions and forms to use if an injury does occur. We welcome the opportunity to partner with you in the administration of your workers' compensation claims.



TO REPORT A CLAIM

Our Mailing Address

YORK Risk Services Group, Inc..

Po Box 620

Howell, MI 48844-0620

The Importance of the first 48 hours

The steps taken within the first 48-hours of a worker injury are often more important than all the other actions taken during the scope of a workers compensation injury. A first impression is a lasting impression, the first actions in injury response are lasting actions.

During the first 48-hours of an injury your company can set the right tone to:

- Help the injured employee obtain the most effective medical care.
- earn the trust of a legitimately injured employee which, in turn, prevents unnecessary attorney involvement
- Gather evidence that will help defend the claim and avoid paying benefits that are not truly owed under the workers compensation system.

For these reasons it is critical that you have a system in place that guarantees prompt response and action.

The three basic steps you should take promptly after a worker injury:

1. Prompt recording of the injury or illness. This involves the employee immediately reporting the event to his or her Supervisor and they, in turn, reporting the event to the HR Coordinator.

2. Prompt direction of medical care and obtaining an initial medical evaluation. This involves a number of steps leading to the immediate treatment of the injury or illness and an informed assessment of the employee's return-to-work status;

3. Prompt reporting of the injury to YORK. For serious claims, this involves notifying your claims adjuster immediately.

In the real world every work-related injury is different and, as a result, the actual delivery of each of these steps will vary. However, the following should checklist should be your best practice guide

First 48 hour Best Practice Checklist

Immediate

- [ ] Emergency/First Aid response
- [ ] Internal report of injury
- [ ] Medical Referral to Panel Clinic
- [ ] Explain process, provide process sheet
- [ ] Provide Physician Packet, including authorization and evaluation form
- [ ] Initiate Accident Investigation

24 hours

- [ ] Receive completed medical evaluation form
- [ ] Report injury to insurance administrator
- [ ] Identification of temporary duty assignment
- [ ] Determine Compensability of injury

Directing Medical Care

Directing injured employees to doctors of your choice is an extremely important step in the claim management process. It provides your company with a high degree of control over the quality of medical care to the injured employee, facilitates access to potential discounts for medical services, and directs the injured employee to providers who are already fully aware and supportive of your Prompt Injury Response and Temporary Duty Programs. From the injured employee's perspective it has advantages as well. The vast majority of injured employees are reliable workers who want to get prompt, quality medical care. They are normally highly motivated to cooperate with your company in getting this care. They simply need to be instructed in how to obtain this care and feel comfortable with the process.

Best Practice Tip:

YORK has a provider network with pre-negotiated discounts on medical services. Contact your adjuster to find in-network physicians

Of key importance is finding a physician partner or clinic that will commit to being aware of your Prompt Injury Response and Temporary Duty Programs and is knowledgeable of the workers compensation system. The goal is a medical partnership that supports your efforts to give prompt, quality medical care to the injured employee and get them back to work as soon as possible.

Prompt Injury Reporting

A major action that should be taken in the first 48-hours is your prompt reporting of the worker injury to YORK. Delays here can dramatically increase the total cost of your worker injuries.

According to an insurance study, these costs start almost immediately and increase over time.

Reporting Lag	Average Claim Cost Increase
1 – 10 days	11% increase
11- 20 days	21% increase
21-30 days	33% increase
Over 30 days	55% increase

Best Practice Tip:

Report claims via the internet. YORK offers an on-line tool that gives an instant claim number and first report of injury.

The message should be clear – prompt reporting of the worker injuries equals cost savings to your company.

There are three key pieces of advice when reporting your claim:

1. If you are in doubt as to the compensability of the injury, or have witnessed red flags contact your assigned adjuster immediately.

2. If the injury is serious (however you wish to define "serious") contact your assigned adjuster immediately. They will want to get involved and possibly involve other resources to help in the claim management process. These resources may include an occupational nurse, rehabilitation specialists, and loss prevention consultant support.

3. If the claim has fraudulent characteristics, contact your claim adjuster immediately and explain all the facts as you know them and the concerns that you may have. As part of your initial reporting to your adjuster you should provide copies of all documents you have gathered so far, including medical information, initial temporary duty assessment, Accident Investigation Report, Employee Injury Report, and Witness Statements.

Accident Investigations

Best Practice Tip:

Use your YORK Loss Prevention consultant for Serious Injury Accident Investigations

The primary purpose of an Accident Investigation is to gather information about the event and to develop a proposed solution to the problem so that it will not happen again. It also is designed to start building a file to support claim management strategies. If properly done, the Accident Investigation is a *fact-gathering* exercise, **NOT** a faultfinding exercise.

The Accident Investigation itself should begin as soon as possible after the event has occurred since all the circumstances are still fresh in the minds of your employees. Ideally this should be within the first 24-hours after the injury occurred.

The philosophy behind your company's Accident Investigation procedures should be summed up in the following way:

- All accidents have causes. If we can eliminate the causes we can prevent future accidents;
- Causes of work-related injuries can be determined;
- It is possible to develop and implement appropriate corrective action this will eliminate the cause(s) and prevent similar accidents;
- Accident investigations are a *fact-gathering* exercise, **NOT** a Fault finding exercise.

An individual from your Safety Team (usually the departmental Supervisor) will be conducting the *initial* Accident Investigation and making observations while they are fresh in the minds of those involved. That is why it is extremely important that you conduct the investigation as quickly as practical after the accident has occurred. The initial observations and recommendations are absolutely critical to fully understanding what happened, learning from the experience and taking the proper steps to avoid its reoccurrence.

YORK duties

YORK is committed to work with you on providing necessary information and support for the management of your injury preparedness and response. The duties of YORK are as follows:

- Manage workers' compensation claims to the earliest and most cost effective resolution
- Serve as a medical consultant on the severe injury cases
- Assist in the identification and selection of the designated medical providers
- Provide necessary loss control services
- Become a partner with you on the management of your workers' compensation claims and experience
- Work with you on the potential for out-placement to other employers on unsuccessful transitions in the RTW program
- Serve as a consultant on all issues involving workers' compensation
- Serve as a continual consultant on Accident Investigation and on workers' compensation issues

GENERAL INTERVIEW QUESTIONS TO ASK

There are certain key questions that will help an investigator to complete a thorough investigation. The following will work in many instances.

1. Who was involved in the accident?

2. Were there any witnesses?

3. Where and when did the accident occur (specific location and time)?

4. What injuries were sustained?

5. What was the victim doing at the time of the accident?

6. Was the victim authorized and qualified to do this operation?

7. Were approved procedures being followed?

8. Was the victim familiar with the job and procedures?

9. Is the job or process new to the area?

10. Were proper tools or equipment being used?

11. Was the proper supervision being provided?

12. Had the victim received hazard potential training prior to the accident?

13. What was the physical condition of the area when the accident occurred?

14. Did the accident involve a motor vehicle?

YORK
Risk Services Group

PO Box 620, Howell MI 48844-0620

Submit by Email

Print

Report of an Injury to an Employee

COMPLETE AT ONCE

Phone: 800-533-9366 Fax: 800-688-9892

Has this employee been disabled for more than 3 days? **Yes** ☐ **No** ☐

If the injured employee returns to work on or before the third day, no further report is required. If he/she is **disabled three days or more,** please send corrected report of injury immediately.

Client Name or Individual Self-Insured Account Name	**Policy No.**
Location/Department No.	WC Job Class NCCI Code

Employer Name		Fed ID#		
Office Address	City	State	Zip	Phone (include area code)
Location of Injury if Different	City	State	Zip	Type of Business

Employee Name (First, Middle, Last)		Phone No. (w/area code)	Social Security No.
Date of Birth	Male ☐ Female ☐	Hire Date	Termination Date
Address	City	State	Zip
Employee's Occupation	Hourly Rate		Employee's Supervisor

Injury or Industrial Illness			
Date of Injury	Time	a.m. ☐ p.m. ☐	Last Day of Work
Date Employee First Saw Doctor	Was the Injury Fatal? Date of Death:		Date of Return To Work
Location of Injury (area of facility/department)			Was the place of the accident or exposure on the employer's premises? Yes ☐ No ☐
Nature of Illness or Injury (include what body parts affected)			
Describe How Illness or Injury Occurred			
Any Witnesses			
Doctor's Name and Address of Hospital			
If Hospitalized, Name and Address of Hospital			
Date of Report	Made Out By	Title	Phone

Please include a copy of the supervisor and/or employee report of the accident, if available.

Reference Information

Policy: What your company has determined to be standard practice.
Example: Eye protection will be worn when necessary.

Procedure: Who is responsible for, and how, the policies are to be carried out.
Example: The supervisor will see that safety glasses are worn when necessary.

Supervision: What and how the Supervisor's responsibilities are for enforcing the Policies and Procedures.
Example:
1. Determine if the task requires eye protection, and
2. If it does, will assign safety glasses to each employee, and
3. Will check to see if everyone puts them on and
4. Continues to wear them.

Equipment: Could also include tools, personal protective equipment, the work area, the product, and containers.
Example: Properly fitting Safety Glasses in good condition.

Body Part - Pick one then copy it on the front side of the form.

Upper Back	Lower Back	Head	Ear	Eye	Face
Finger/Thumb	Hand	Wrist	Arm	Shoulder	Other (describe)
Foot	Knee	Leg	Groin/Pelvic	Internal Organ	

Nature of Injury - Pick one then copy it on the front side of the form.

Strain/Sprain	Cut/Laceration	Puncture	Bruise/Contusion	Inflammation	Fracture
Repetitive Motion	Dermatitis/Rash	Eye Struck by	Burn	Shock	Crush
Amputation	Hernia	Crush	Other (describe)		

Accident Type - Pick one then copy it on the front side of the form.

Assembly Operations	Lifting/Lowering	Pushing/Pulling	Other Manual Material Handling	Operating Machine
Adjusting Machine	Repetitive Work	Vehicle Related	Office Work	Using Hand Tools
Slip/Fall Same Level	Slip/Fall From Heights	Painting	Buffing/Grinding	Construction Operations
Cooking	Welding/Burning	Agricultural	Other (describe)	

Miscellaneous Comments: _____

_____

_____

_____

_____

YORK
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PO Box 620, Howell MI 48844-0620

Supervisor's Report of Accident

Company Name_____ Employee involved _____

Dept. where accident occurred _____ Employee's Regular Dept. _____

Machine # or equipment employee was working with _____

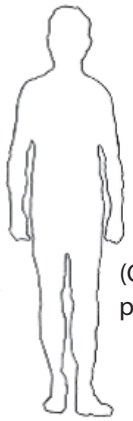
Occupation_____ Length of time on job where accident occurred _____

Date of accident _____ Time of accident_____ ◯a.m ◯p.m. Shift _____

If an injury occurred, was it treated ◯On site ◯EMS ◯Clinic ◯Hospital ◯Other (describe)_____ ◯Near miss-no injury

Following treatment the injured employee returned to work:
◯Same day ◯Next Shift ◯Lost Time at: ◯Previous job ◯Modified work

Completely describe accident (who, what, when, where, why)
_____
_____
_____
_____
_____
_____



(Circle body part injured)

Body part(s) injured (see back)_____

Nature of Injury (see back for choices) _____Accident Type (see back)_____

Analyze and then describe the underlying causes of the accident, in your opinion, considering Policies, Procedures, Equipment, Training, and Supervision Practices. (Note employee carelessness is not a cause) _____
_____
_____
_____
_____

Analyze and describe the Preventive Measures you recommend to address the underlying causes of the accident, considering Company Policies, Procedures, Equipment, Training, and Supervision Practices. (Note - just telling the injured employee to be more careful, after the accident, is an incomplete supervision practice) _____
_____
_____
_____
_____

_____ _____ _____ _____
Supervisor's Signature Date Employee Signature Date

Person or position who would be responsible for implementing the above:
_____

Action(s) or corrective action(s) taken to prevent re-occurrence of the above incident or the like: _____
_____
_____
_____
_____

Date corrective action(s) completed: _____ By: _____
Signature of individual

Reference Information

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Example: Eye protection will be worn when necessary.

Procedure: Who is responsible for, and how, the policies are to be carried out.
Example: The supervisor will see that safety glasses are worn when necessary.

Supervision: What and how the Supervisor's responsibilities are for enforcing the Policies and Procedures.
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1. Determine if the task requires eye protection, and
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4. Continues to wear them.

Equipment: Could also include tools, personal protective equipment, the work area, the product, and containers.
Example: Properly fitting Safety Glasses in good condition.

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Upper Back	Lower Back	Head	Ear	Eye	Face
Finger/Thumb	Hand	Wrist	Arm	Shoulder	Other (describe)
Foot	Knee	Leg	Groin/Pelvic	Internal Organ	

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Strain/Sprain	Cut/Laceration	Puncture	Bruise/Contusion	Inflammation	Fracture
Repetitive Motion	Dermatitis/Rash	Eye Struck by	Burn	Shock	Crush
Amputation	Hernia	Crush	Other (describe)		

Accident Type - Pick one then copy it on the front side of the form.

Assembly Operations	Lifting/Lowering	Pushing/Pulling	Other Manual Material Handling	Operating Machine
Adjusting Machine	Repetitive Work	Vehicle Related	Office Work	Using Hand Tools
Slip/Fall Same Level	Slip/Fall From Heights	Painting	Buffing/Grinding	Construction Operations
Cooking	Welding/Burning	Agricultural	Other (describe)	

Miscellaneous Comments: _____

_____

_____

_____

_____

MUST BE COMPLETED PRIOR TO GOING TO CLINIC

Incident Investigation Report

(COMPLETED REPORT MUST BE SUBMITTED TO THE SAFETY ENGINEER WITHIN 24 HOURS)

Personal Information

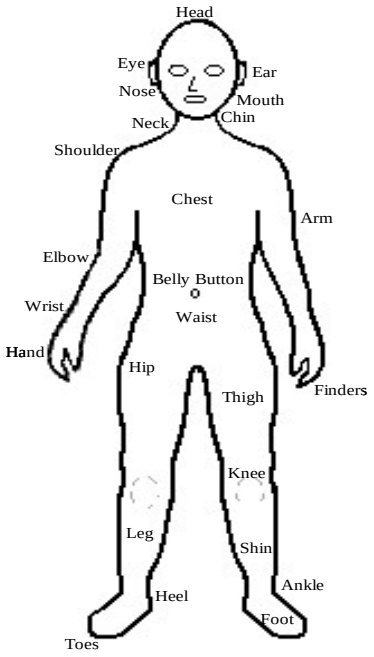
Associate Name:	Clock #:		❑ Action	❑ Other Co
Job Classification:	Department:		Line:	
Facilitator:	Length of Service on this job?		Time work began:	
Amount of hours worked this week: Shift:	Who notified:		Date notified:	

Incident Information

Incident Type:	❑ Accident	❑ Injury	❑ Damage	Incident Location :		Station #:	
Type of Injury (cut, strain, etc.) Be Specific:				Body Part (Be specific and circle below):			
Date and Time of Incident:				Medical Treatment:	❑ Hospital	❑ Clinic	❑ 1st Aid Room
Who Authorized Medical Treatment?				❑ Does Not Seek Medical Treatment at This Time			
Type of First Aid Administered -**MEDICAL TEAM ONLY:**				Who Administered First Aid?			

Description of Incident:

Circle Location of Injury



If this incident results in professional medical treatment, I understand it will be my responsibility to make and keep every follow-up appointment. I must submit documentation to my Facilitator upon my return or within 24 hours of my appointment if I am placed off work. I further understand if I am unable to keep a scheduled appointment, I will contact the Physician and reschedule as soon as possible and inform my Facilitator. Refusal to make or keep follow-up appointments will be subject to the rules of conduct and/or denial of continued worker's compensation claim. In addition, I understand if I am prescribed restrictions it is my responsibility to follow all restrictions. Refer to the Emergency Medical Process 4.4.7.P3.

	Does the Associate agree with the above statement?
Facilitator Signature: _____ **Date:** _____	**Associate Signature:** _____ **Date:** _____

Facilitator Investigation: (PLEASE ATTACH WITNESS STATEMENTS AND LIST OF NAMES)

Were Pictures Taken? ❑ Yes ❑ No	Safety Specialist Contacted? ❑ Yes ❑ No
Equipment Involved:	Were There Witnesses? ❑ Yes ❑ No (attach Witness Statement)

Root Cause	Unsafe Acts: (check all that apply)	Unsafe Conditions:
❑ Man (Associate)- caused by individual ❑ Machine- caused by machine or components ❑ Material- material used in process ❑ Method- inadequate process and procedures	❑ Lockout Violation (man) ❑ Improper equipment for work (material) ❑ Failure to follow procedure/ process (man) ❑ Failure to wear/ improper use of PPE (man) ❑ Other:_____ _____ _____ _____	❑ Defective Equipment (machine) ❑ Poor TPM/ 5s (method) ❑ Inadequate guards (machine) ❑ Floor/surface faulty (man) ❑ Design of Equipment (machine) ❑ Other:_____ _____ _____

Facilitator's Incident Analysis

Why?	Answer (Fact Finding)	Action
1.		
2.		
3.		
4.		
5.	Root Cause:	

Prevention: How? (CAN THIS CONDITION BE PREVENTED)

6.

Manager's Summary of Findings:

Signatures:	**Date:**	**Signatures:**	**Date:**
1) Facilitator		3) Dept Management	
2) Associate		4) Safety Engineer	
5) Safety Committee			

YORK
Risk Services Group

PO Box 620, Howell MI 48844-0620

Authority for Treatment

TO: Doctor _____ Date _____

FROM: _____ (Employer/Division)

_____ has authorization
(EMPLOYEE NAME)

to be seen and treated on_____
(DATE)

Nature of injury: _____

_____

_____

Employee address: _____ Phone: _____

X _____ _____
Authorized Signature-Company Name Title

(DETACH HERE) (DETACH HERE)

Date _____

DOCTOR: COMPLETE AND RETURN THIS PORTION WITH THE EMPLOYEE

Employer:_____ Employee: _____

History of injury_____

Medical Diagnosis: _____

Total Disability? _____(yes or no) Estimated Length _____

Can employee return to work?_____ (yes or no)

Restrictions (be specific), if any? _____

Is condition work related? _____(yes or no) Explain: _____

Recommended treatment _____

Next appointment _____

Physician information (PRINTED, please): Name:_____

Address: _____Phone:_____

X _____
Physician's Signature

AUTHORIZATION

I, _____, hereby authorize and direct any physician, surgeon (his/her designee), hospital or other medical facility (including treatment centers and clinics) or its director, designee or medical record department to release information contained in my patient records and to disclose any such information to YORK, and/or any of its vendors, representatives or designees. This specifically includes, but is not limited to, alcohol and drug abuse records protected under the regulations provided in 42 Code of Federal Regulations, Part 2, if any, psychiatric or psychological services records, if any, and social work records, if any, including communications made by me to a social worker, psychiatrist, psychologist or any other professional associated with a doctor or medical facility (including treatment centers and clinics) which has examined or treated me.

This authorization of release of my patient records also includes releasing information regarding communicable diseases, serious communicable diseases, and infections which can include venereal disease, tuberculosis, HIV, AIDS or ARC.

THIS IS NOT A RELEASE OF CLAIMS FOR DAMAGES

Dated _____ Signed _____

This_____ day of _____, 20_____

PO Box 620 ▪ Howell, MI 48844-0620 *Phone* | 800 - 533- 9366 *Fax* | 517 - 548 - 9246

www.yorkrsg.com

Mail Room Faxes, PO Box, and E-Mails

For Medical Bills only:
E-mail – YorkMedical@yorkrsg.com
Fax – 877-365-9774

For New Injuries only:
E-mail for YORK Claims – YorkWCClaim@yorkrsg.com
(Sender will receive a reply)

Fax YORK – 1-800-688-9892
YorkFaxClaim@yorkrsg.com (517-338-5125)

General Documents:

Should be sent to the adjuster e-fax or e-mail

E-mail – YorkPDFImage@yorkrsg.com

Phone: 800-533-9366

Fax – 517-548-9246

Mail – P.O. Box 620, Howell, MI 48844