Workers' Compensation Claims Kit

PRAIRIE STATE INSURANCE COOPERATIVE

COMPREHENSIVE
RISK SERVICES

Your Claims Team

Indemnity Adjuster	Christine Smith	(248) 916-9778	csmith@crsmi.com
Indemnity Adjuster	Collette Porter	(248) 567-2086	cporter@crsmi.com
Medical Adjuster	Julie Traskos	(248) 306-8290	jtraskos@crsmi.com
Claims Supervisor	Tiffany Wisnieski	(515) 635-4555	twisnieski@crsmi.com
VP of Claims	Debra Burnett	(248) 344-8553	dburnett@crsmi.com
Client Admin	Cassey Brooks	(248) 344-8557	cbrooks@crsmi.com
Account Executive	Chris Cramer	(616) 949-8250	ccramer@crsmi.com
President	Scott Gaffner	(248) 344-8541	sgaffner@crsmi.com
Medicare Support	Charlotte Martin	(517) 705-3688	cmartin@crsmi.com
Director of Medical Services	Angela Lindeman	(616) 502-1879	alindeman@crsmi.com

PSIC PSIC ARM

Comprehensive Risk Services, LLC
P.O. Box 240
Williamston, MI 48895
Phone: (800) 737-9875
Fax: (248) 344-8560

COMPREHENSIVE RISK SERVICES

Claim Reporting

NewClaimReporting@crsmi.com

(800) 737-9875

(248) 344-8560

https://live.origamirisk.com/Origami/IncidentEntry/Direct?token=G8u7h25IG7wQ5WLAyUBEwjXxXvGETfPEZ07BSfAbTMxEkl4RPdLkMacqcLVRQKswegYi9cUdskr%2FZFTHvS7j1SPX0fd1%2BgD%2FqbBhpnGU6GLPSA%2FI5Wga%2BCzjxQAvz1Rz

Comprehensive Risk Services
P.O. Box 240
Williamston, MI 48895

(855) 720-0241

Reporting A Claim

If an employee is injured or becomes ill because of his/her job, the incident should be promptly reported to CRS or Company Nurse. To report the claim to CRS, this may be accomplished by online system submittal, or an injury report may be completed and emailed or faxed to the numbers shown above. You may also call the claim in if necessary. Claim can be reported to Company Nurse by promptly calling (855) 720-0241.

- Serious injuries and fatalities should be reported immediately by telephone to Comprehensive Risk Services. In the event of a work-related death, the employer must notify Illinois OSHA within 8 hours by calling (217) 782-7860. All work-related hospital admissions, amputations, and losses of an eye must be reported to Illinois OSHA within 24 hours at (217) 782-7860.
- Payroll records detailing weekly earnings for the 52 weeks preceding the incident date should be sent to Comprehensive Risk Services.
- The value of discontinued benefits should be provided if applicable.

MEDICAL ONLY CLAIMS – If an employee sustains a work-related injury/illness that involves 3 days or less of lost time from work, their workers' compensation benefit is limited to related medical expenses. Wage loss benefits are not considered.

LOST TIME CLAIMS – If an employee sustains a work-related injury/illness that involves disability exceeding three (3) days, but less than 14 days, the covered benefit includes medical expenses, as well as wage loss benefits, beginning on the 4th day.

If the injury/illness involves disability lasting 14 days or more, the benefit includes medical expenses and wage loss retroactive to the first day of disability.

If an injured employee returns to work, please notify Comprehensive Risk Services immediately.

CONTROVERTED OR LITIGATED CLAIMS

- Forward all Notice of Hearings as well as any correspondence related to legal action immediately to Comprehensive Risk Services. Please keep a copy for your files.
- Comprehensive Risk Services will assign defense counsel as needed. Do not communicate directly with attorneys that request information on an employee that has a pending claim, rather, please promptly reach out to CRS.
- It will not be necessary for you to appear at pretrial conferences or trials unless specifically requested otherwise.
- Comprehensive Risk Services and/or defense counsel will advise you of all necessary witnesses required at the trial.

PENALTIES

Section 19 of the Illinois Workers' Compensation Act provides for a penalty to be paid to the employee if compensation benefits are not paid or denied in writing within 14 days of receiving a written demand for payment of benefits. Penalties will also be assessed for medical bills that are not paid or denied within 30 days. Any notice received from the state, an attorney, or employee concerning the filing for a penalty should be forwarded immediately to your Comprehensive Risk Services representative.

Medical Treatment

Injured employees should be sent to your approved medical facility or doctor.

- Generally, the employee may choose the provider where he or she seeks treatment. However, there may be some limitations both on the number of providers seen by the employee or on which particular providers that an employee may choose.
- Comprehensive Risk Services will schedule appropriate medical examinations and can assist with pre-employment physical referrals as well as the selection of an occupational clinic.
- Forward all medical reports, disability slips, and bills associated with the injury/illness.
- CRS will pay for the associated costs of all medical care that is reasonably necessary to cure or relieve the employee from the effects of the injury. If the employee receives any medical billing, they should contact CRS to avoid potential account delinquencies or collection attempts by the medical provider.
- Comprehensive Risk Services will approve payment of workers' compensation benefits.

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.

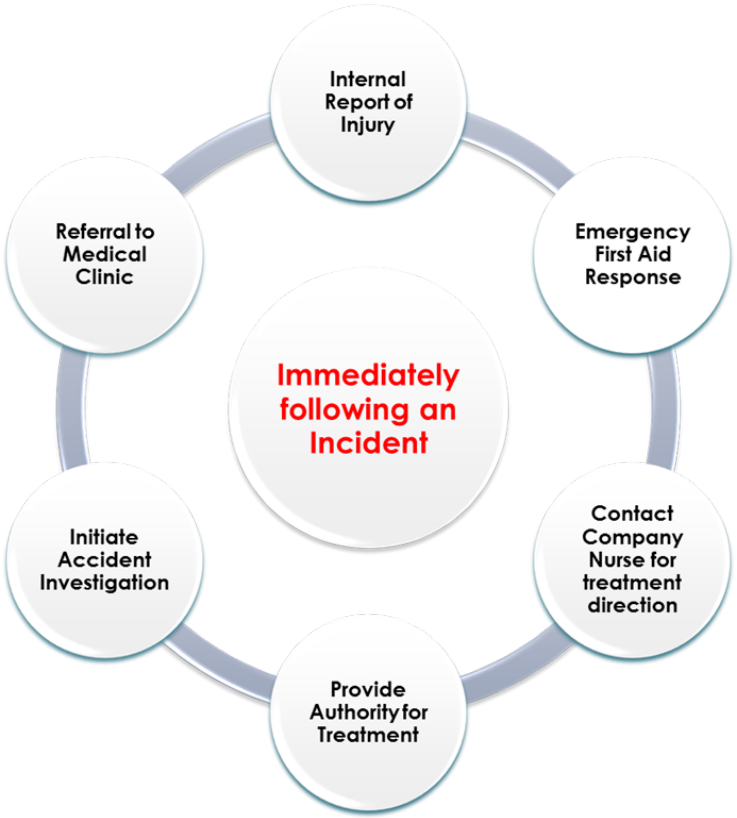
During the first 48-hours of an injury your company can set the right tone to:

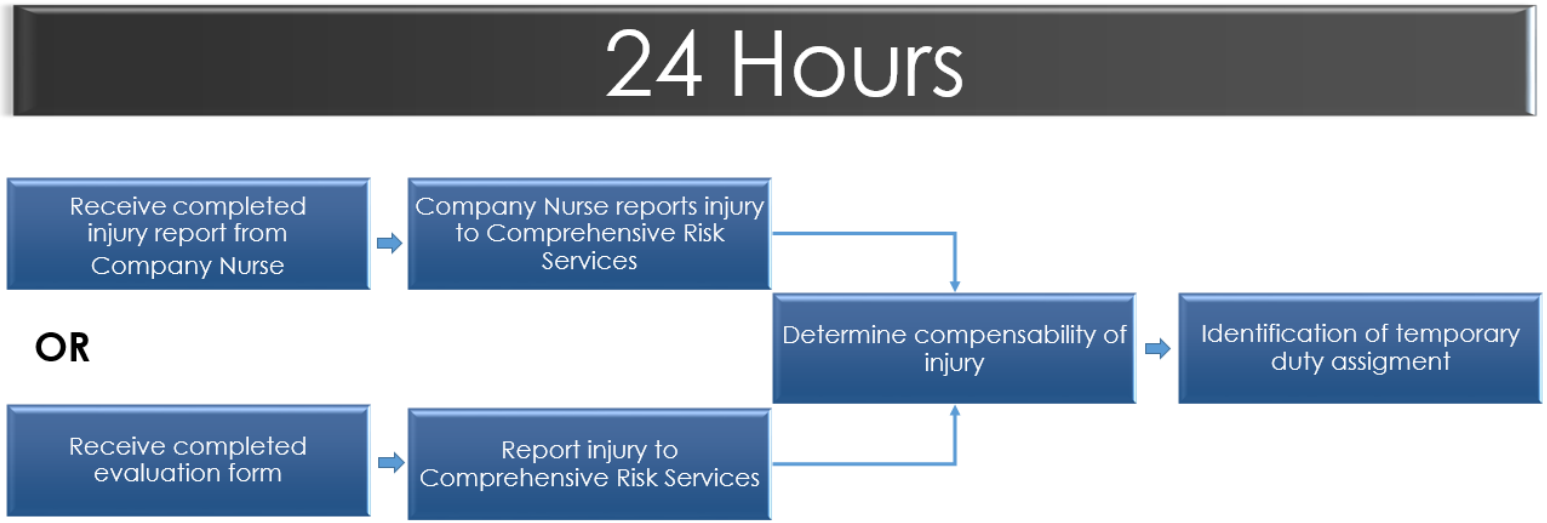
- Help the injured employee obtain the most effective medical care.
- Earn the trust of a legitimately injured employee which, in turn, prevents unnecessary attorney involvement.
- Gather evidence that will help defend the claim and avoid paying benefits that are not truly owed under the workers compensation system. For these reasons it is critical that you have a system in place that guarantees prompt response and action.

Basic steps you should take promptly after a worker injury:

- 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.
- Prompt contact to Company Nurse for direction or 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.
- Prompt reporting of the injury to Comprehensive Risk Services, if not utilizing Company Nurse. 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.

What To Do Following An Incident





What to Expect During the Contact Center Process

The following process will be utilized for reporting an incident/injury to the Company Nurse Contact Center:

- Employee calls the unique 1-800 contact center number to report an injury/incident. The contact center number is on all Company Nurse material. A supervisor may be part of this process. Each organization decides whether the supervisor is to be included. If they are, the supervisor generally starts the call and passes the call to the employee when asked to do so by the ICC (Injury Care Coordinator) or Nurse.

- An ICC asks the employee a set of questions and records demographic and injury information for the nurse. The nurse will perform the actual triage if the employee is seeking treatment. If the injured employee does not seek treatment, the ICC completes the report, marks it 'Report Only', and sends it. This could take approximately 6-8 minutes. *

- If triaged, the nurse staff will perform triage based on the injury described, and then direct the injured employee to the appropriate level of care which may include: self-care or referral to an occupational medicine clinic or other Non-ER provider or to an emergency room. This could take an additional 5-7 minutes, approximately. *

- Client-provided employee instructions specific to your organization will be read to the caller (i.e., drug testing information [optional], pre-designation instructions, work restriction instructions, etc.).

- Company Nurse submits the Injury Report to the client-provided email/fax distribution and sends a Provider Alert/Work Status form to the referral provider, if applicable.

- More than one call may be required to complete a report or to change existing reporting information. An incident ID number is given to the employee/caller enabling them to reference this number when calling in changes. This number is the permanent identification for that employee for that injury on the specific date reported.

*Periodically, there may be hold times or call backs at the contact center when the call is transferred to a nurse for triage. These are generally rare but occasionally happen when Company Nurse experiences a call surge or during off peak hours. Our peak hours are Monday-Friday 5:30 am – 7:30 pm.

What Happens During A Call?

Workplace Injury Occurs

(Ouch!)

Injured Employee Contacts Company Nurse

(Glad my employer has Company Nurse… I'll call them first!)

Injury Care Coordinator Takes Injury Report, Triage by RN Offered

(Gathers demographics and preliminary injury information)

Employee Receives Expert Medical Triage & Self-Care Advice

(Recommends the appropriate care and/or treatment)

Medical Referral

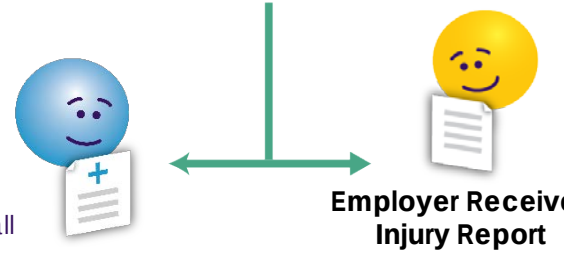
(Refers the injured employee to either self-care, clinic, or emergency room)

Self-Care

(Easy!)

Approved Medical Provider Receives Provider Injury Alert

(Shares all the facts, to all stakeholders instantly)



Employer Receives Injury Report

(Shares immediate, detailed facts)

Forms

- Illinois Form 45: Employer's First Report of Injury
- Authority for Treatment
- Supervisor's Report of Accident
- EHIM Prescription Certificate
- Authorization to Release Medical Records
- Illinois OSHA Injury & Illness Reporting

COMPREHENSIVE
RISK SERVICES

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case? ☐ Yes ☐ No
Employer's name		Doing business as	
Employer's mailing address			Employer's email address
Nature of business or service			SIC code
Name of workers' compensation carrier/admin.		Policy/Contract #	Self-insured? ☐ Yes ☐ No
Employee's full name			Birthdate
Employee's mailing address			Employee's e-mail address
Gender ☐ Male ☐ Female	Marital status ☐ Married ☐ Single	# Dependents	Employee's average weekly wage
Job title or occupation			Date hired
Time employee began work	Date and time of accident		Last day employee worked
If the employee died as a result of the accident, give the date of death.		Did the accident occur on the employer's premises? ☐ Yes ☐ No	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of body affected and explain how it was affected.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care professional			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in an emergency room? ☐ Yes ☐ No		Was the employee hospitalized overnight as an inpatient? ☐ Yes ☐ No	
Report prepared by	Signature	Title and telephone #	Email address

Please send this form to: **ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE RD SPRINGFIELD, IL 62703**

By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any way. This information is confidential. IC45 8/12

Authority for Treatment

TO: Doctor_____ Date:_____

Patient Name:_____ Date of Birth: _____

Employer: _____ Street Address:_____

Date of Injury: _____ **Nature of Injury:** _____

_____

Instructions/comments: _____

_____

Authorized By: _____

Title: _____

Phone: (____) _____

Date: _____

Billing :

Comprehensive Risk Services
c/o Review Works
21500 Haggerty Road, Suite 250
Northville, MI 48167

DOCTOR: PLEASE SEND EMPLOYEE WITH WRITTEN DISABILITY STATUS AS IT RELATES TO THE ALLEGED WORK INJURY. PLEASE INCLUDE THE DIAGNOSIS AND WHETHER THE EMPLOYEE IS ABLE TO RETURN TO FULL DUTY OR RESTRICTED DUTY WORK. PLEASE DOCUMENT ALL MEDICAL RESTRICTIONS.

COMPREHENSIVE
RISK SERVICES

Supervisor's Report of Accident

Company Name_____ **Employee Involved**_____

Occupation_____ **Length of time on job where accident occurred**_____

Date of Accident_____ **Time of Accident**_____ **Shift**_____

Department where accident occurred_____ **Employee's Regular Dept.**_____

Machine # or equipment employee was working with:_____

If an injury occurred, was it treated? ☐ **Onsite** ☐ **EMS** ☐ **Clinic** ☐ **Hospital** ☐ **Other** ☐ **No Treatment**

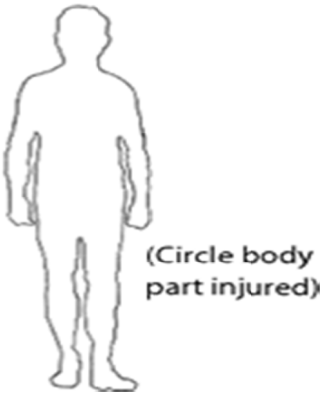
If other, describe:_____

Following treatment the injured employee returned to work:

☐ **Same Day** ☐ **Next Shift** ☐ **Lost Time** **as** ☐ **Full Duty** ☐ **Modified Work**

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

_____
_____
_____
_____
_____
_____



Body part(s) injured:_____

Nature of Injury:_____

Accident Type:_____

Analyze and describe the underlying causes of the accident considering policies, procedures, equipment, training and supervision practices: _____
_____
_____
_____

Analyze and describe the preventative measures recommended to address the underlying causes of the accident:_____
_____
_____

Person or position responsible for implementing the above: _____

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

Date:_____ **By:**_____

Reference Information

Policy: **What your company has determined to be standard practice.**
Example: Eye protection will be work 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, assign safety glasses to each employee, and**
3. **Check to see if everyone wears the glasses as instructed, and**
4. **Continues to follow the safety policy.**

Equipment: **Could also include tools, personal protective equipment, the work area, the product and containers.**

Example: Safety glasses are properly fitting and in good condition.

Body Part – Examples

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 – Examples

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 – Examples

Assembly Operations	**Lifting/Lowering**	**Pushing/Pulling**	**Manual Material Handling**	**Operating Machine**	**Adjusting Machine**
Repetitive Work	**Vehicle Related**	**Office Work**	**Using Hand Tools**	**Slip/Fall**	**Grinding**
Cooking	**Welding**	**Agriculture**	**Other (describe)**		

Miscellaneous Comments:

_____

_____

Employee Health Insurance Management

FIRST FILL
PRESCRIPTION CERTIFICATE

Below is your prescription ID Card.

- First Fill dispensing is limited to a 5 day duration.
- A list of participating pharmacies in your area is printed on the back of this certificate.
- Please present this certificate to any participating pharmacy for your prescriptions.

Employee Health Insurance Management

Plan Name: **Comprehensive Risk Services**
Employer: **Prairie State Insurance Cooperative**

Type: **Pharmacy**

SSN

Date of Injury

Group Number: **60011124FF**

Cardholder's Name

DOB

BIN: **005285**

PCN: **ACB**

EHIM Pharmacy Benefit Manager
Prescription Drug Program

If you have any questions or need additional assistance, please call EHIM at:
248-204-6411 or Toll-Free 800-311-3446 (EHIM)

Instructions to Provider
Please complete the section above providing patient information, including name, SS#, and date of injury. Provide this certificate to the employee to take to the pharmacy.

Instructions to the Pharmacist

1. Bill claim to EHIM (**800-311-3446**)
2. EHIM BIN Number is **005285**
3. Processor Control Number is **ACB**
4. Relationship = Cardholder
5. Required Billing Fields are:
    a. Cardholder ID Number (SSN)
    b. Group Number
    c. Valid Date of Birth
    d. Valid Gender

Your EHIM Prescription Drug Program is accepted at over 63,000 pharmacies nationwide. Some examples are listed below for your convenience.

Participating Chain Pharmacies				
Costco	CVS Pharmacy	Kroger	Rite Aid	Walgreens
Henry Ford Pharmacies	VG's Pharmacy	Walmart	Sam's Club	Meijer
Sav-Mor Pharmacy	Hometown Pharmacy			

EHIM is also contracted with many independent pharmacies. For additional pharmacies in your area, you may visit EHIM's website at www.ehimrx.com or contact our Pharmacy Help Desk at 800-311-3446.

Pharmacy Benefits. Managed.

Thank you for selecting EHIM for your Prescription Benefit Management Services.

To best serve employees upon the first report of injury, EHIM offers a First Fill Certificate to proactively manage medication filled by employees. The First Fill Program is designed to allow injured workers to fill their prescriptions with no out-of-pocket cost upon the first report of injury to their employer. The EHIM First Fill Certificate should be given to the employee by the employer or clinic when seeking medical treatment.

The EHIM certificate will allow the employee to receive a limited quantity of medication to ensure appropriate care is being provided. This proactive approach will allow the employee to utilize any EHIM participating pharmacy to fill written prescriptions to treat the work related injury while also ensuring a controlled claim management process.

To utilize the EHIM First Fill Certificate, the employer or specified clinic, will provide the EHIM certificate to the employee. When providing the certificate, the provider will fill in the employee's social security number, name and date of injury. The employee will then take the certificate along with their prescription(s) to their preferred pharmacy. Billing instructions for the pharmacy are printed directly on the certificate along with EHIM's contact information. Once the injury has been reported, a determination regarding ongoing prescription benefits can be made as the First Fill Certificate will not allow for medication refills.

For further information or for any questions regarding the First Fill program, please feel free to contact EHIM's pharmacy helpdesk 24/7/365.

Thank you,
EHIM Injury Claims Department
Phone: (800) 311-3446

This CONFIDENTIAL and PROPRIETARY information is owned by EHIM. It is protected by agreement(s) and/or laws that require the recipient to keep it confidential. Distribution or use without EHIM's permission is not permitted and will entitle EHIM to equitable relief or damages. It may not be disclosed to any third party without the prior consent and written approval of EHIM.

COMPREHENSIVE
RISK SERVICES

Claim Number: _____
Date of Injury: _____

WORKERS' AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR WORKERS' COMPENSATION PURPOSES

I, _____, hereby authorize the health care provider (HCP) for the use or disclosure of my health information as described in this authorization.

Injured Worker:		**Date of Birth:**	
Address:			

1. I authorize the Health Care Provider (HCP) who has examined or treated me, to disclose and release complete copies of any and all information concerning my physical or psychiatric condition, care and treatment, to Comprehensive Risk Services, Inc, their attorneys, and/or bill review contractor. Copies of all documentation released pursuant to this authorization shall be disclosed to the entity requesting the information and may be used to determine my eligibility for workers' compensation benefits on a continuing basis.
2. I understand and approve release of the following: any and all medical records, including but not limited to: clinical notes; therapeutic reports; radiological reports, including actual images; and all other tests; invoices for services rendered; payments received; and any other relevant and material information maintained by the HCP.
3. **The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.**
4. Right to revoke: I understand that I have the right to restrict the information that may be provided and/or revoke this authorization to the extent provided by law. I understand I have the right to revoke this authorization at any time by notifying Comprehensive Risk Services in writing, sent to their address set forth herein, by certified mail or courier, and that the revocation is only effective after receipt is acknowledged. I further understand that my revocation of this authorization may affect my eligibility for workers' compensation benefits. I understand that this authorization will expire within **one (1) year** of the date I signed it.
5. A photocopy, electronic copy or e-signature of this Release shall be considered as effective and valid as the original.

Signature of Injured Worker: _____ Date: _____

DISCLOSURES FOR WORKERS' COMPENSATION PURPOSES
[45 CFR 164.512(l)]
The HIPAA Privacy Rule does not apply to entities that are either workers' compensation insurers, workers' compensation administrative agencies, or employers, except to the extent they may otherwise be covered entities. The Privacy Rule permits covered entities to disclose protected health information to workers' compensation insurers, State administrators, employers, and other persons or entities involved in workers' compensation systems, without the individual's authorization.

Comprehensive Risk Services
P.O. Box 240
Williamston, MI 48895
Phone: (800) 737-9875 Fax: (248) 344-8560

ILLINOIS: EFFECTIVE JANUARY 1, 2015

ILLINOIS OSHA Injury & Illness Reporting

Effective January 1, 2015 (October 19, 2015 for Illinois Public Sector), OSHA has changed its reporting requirements. The new changes require the following be reported:

Report any work-related:

- Fatality: within 8 hours
- Hospitalization: within 24 hours
- Amputation: within 24 hours
- Loss of an eye: within 24 hours

An **amputation** is defined as the traumatic loss of a limb or other external body part. Amputations include a part, such as a limb or appendage that has been severed, cut off, or amputated (completely or partially). This includes a fingertip amputation without bone loss, medical amputations resulting from irreparable damage, and amputations of body parts that are successfully reattached.

Employers do not have to report a hospitalization if it was for diagnostic testing or observation only. A **hospitalization** is defined as a formal admission to the inpatient service of a hospital or clinic for care or treatment.

When a work-related fatality, hospitalization, amputation, or loss of an eye occurs, call Illinois OSHA to report the incident within the timeline listed above. Reporting requirements now require you contact OSHA in the event of any work-related hospitalization and have also added reporting all amputations or loss of an eye.

Reporting of fatality, in-patient hospitalization, amputation, or loss of an eye options:

- PUBLIC SECTOR: By telephone to Illinois OSHA at **800-782-7860 or 217-782-7860**
- PRIVATE SECTOR: By telephone to Federal OSHA at **800-321-OSHA (6742)**
- The reporter must give the following information for each incident:
  - A. Establishment name
  - B. Location of the incident
  - C. Time of the incident
  - D. The number of fatalities or hospitalized employees
  - E. The names of the injured employees
  - F. The reporter's contact person and his/her telephone number
  - G. A brief description of the incident

For further information, refer to ***ILLINOIS DEPARTMENT of LABOR*** website at:

https://www2.illinois.gov/idol/Laws-Rules/safety/Pages/default.aspx

On the home page refer to the far-right column.
Second header down under REPORT FATALITIES & INJURIES (Public or Private Sector).

COMPREHENSIVE
RISK SERVICES