sedgwick | managed care ohio

Steps to take when a workplace injury occurs

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

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

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

Employee instructions

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

Employer instructions

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

Reporting a work-related injury to Sedgwick MCO

Online:
Submit an injury form (FROI) online at https//:resources.sedgwickmco.com.

Phone:
Contact our customer service team at 888.627.7586 (available 24/7).

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

Fax:
Send injury forms to 888.711.9284.

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

Detach ID card below and present at all medical appointments

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Workers' compensation identification card

24-hour customer service: 888.627.7586

Employer name: Stark County
Policy number: 37600001-0

Key contacts and additional information

Medical treatment questions, medical documentation and billing issues

Contact Sedgwick Managed Care Ohio:

Phone: 888.627.7586
Fax: 888.627.0074
Mail: P.O. Box 1040, Dublin, OH 43017

Prescription questions

Call 800.644.6292 and follow the prompts.

Ohio Bureau of Workers' Compensation (BWC)

Call 800.644.6292 or visit bwc.ohio.gov.

Medical options and provider search

If medical treatment is required, see a BWC-certified medical provider. For more information, see the Sedgwick MCO website at sedgwickmco.com.

Transitional work benefits everyone

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

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

Please send all information within 24 hours of visit.

Injury report and FROI fax:	888.711.9284
Medical and authorization fax:	888.627.0074
Customer service:	888.627.7586
Prescription questions:	800.644.6292 (follow prompts)

Send all mail and medical bills to:

Sedgwick Managed Care Ohio
PO Box 1040
Dublin, OH 43017

This card is not a guarantee of coverage.

Responsibilities

Sedgwick MCO

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

BWC

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

Medical providers

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

Important BWC forms

First report of injury (FROI)

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

MEDCO-14

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

C-9

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

Employee's Report of Incident and/or Injury

Please print in Ink – To be completed by Employee same day as incident/injury.

Name_____ SS# _____
Home Address_____ Birth Date _____
City/State/Zip _____ Sex: □ Male □ Female
Telephone: ( ) _____ Alternate Phone: ( ) _____

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

Did anyone see you get hurt? □ Yes □ No If yes, who? _____
Did you report this incident to anyone? □ Yes □ No If not, why not? _____
If yes, to whom did you report it? (Name and Title/Position)_____
When? (Date and Time)_____
Did the Police respond to the scene of the that accident/injury?: □ Yes □ No
If yes, what was the Report Number, and who was the responding _____
Officer_____

What part(s) of your body was/were affected? (Be specific – for example: right elbow, left knee, right index finger):
_____
What type of injury did you experience? (Be specific – for example: bruise, scrape, laceration, pull)
_____

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

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

Medical Release

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

Employee Name (Print) _____ Signature _____

Date (Required)_____

STARK COUNTY COMMISSIONERS
HUMAN RESOURCES DEPARTMENT
110 CENTRAL PLAZA SOUTH
SUITE 101
CANTON, OHIO 44702
Phone: 330.451.7999
Fax: 330.451.7906

Stark County Commissioners
Authorization to Release Medical Information

I hereby authorize any healthcare provider (person or facility) that attends, treats or examines me to release all medical, chiropractic, psychological and/or psychiatric information (excluding psychotherapy notes) that is causally or historically related to my workers' compensation claim, to my employer, Stark County Commissioners, and its representatives.

In addition to the above, I understand and agree to the following:

- I understand I am authorizing the release of this information to my employer, the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio; the employer's managed care organization or qualified health plan and any authorized representatives.
- I understand this information is being released to the above-referenced person and/or entities for use in administering my workers' compensation claim.
- The authorization to release medical, chiropractic, psychological and/or psychiatric information shall remain in effect for as long as my worker's compensation claim remains open under Ohio Law. I understand I have the right to revoke this authorization at any time. However I must submit my revocation in writing and file it with BWC. My decision to revoke this authorization will be effective, except in a case that a healthcare provider already has relied on my authorization and released information.
- I understand the provider (s) may not make my completing and signing this authorization a condition of my treatment.
- I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be re-disclosed by them and may no longer be protected by the federal privacy requirements. I understand such re-disclosures may include but are not limited to the following:
    - A copy of the medical information the employer receives may be forwarded to the BWC by the employer;
    - A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

Date: _____ Signature: _____

SSN: XXX-XX-_____ Print Name: _____

Date of Birth: _____

Bureau of Workers' Compensation

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

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

Injured worker information

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

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

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

Employer name	Employer address	City	State	ZIP code
Stark County				

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

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

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

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

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

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

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

Health-care office/Facility street address	City	State	ZIP code

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

To be completed by the injured worker

By signing this form, I:

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

Furthermore, I understand that:

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

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

Injured worker signature	Date

To be completed by the treating provider

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

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

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

To be completed by the employer

Employer name	Employer county	Phone number	Fax number	Email address
Stark County				

Employer policy number	Federal ID number	Injured worker is (Check box, if applicable.) ☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation
3760000-0		

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

Employer signature and title	Date

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

Signature of person completing this form	Date

Bureau of Workers' Compensation

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

Employer Name: Stark County

Policy Number: 3760006-0

Instructions

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

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

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

Injured worker name	Claim number	Date of injury

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

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

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

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

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

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

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

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

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

Injured worker name	Claim number	Date of injury

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

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

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

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

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

Comments:

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

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

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

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

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

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

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

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

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

Stark County Commissioners

HUMAN RESOURCES DEPARTMENT
110 CENTRAL PLAZA SOUTH, SUITE 101
CANTON, OHIO 44702
Phone: 330.451.7999
Fax: 330.451.7906

Witness Statement Form – Injury at Work

Name of Injured Employee: (print) _____ **Shift:** _____

Job Title: _____ **Date of Injury:** _____ **Day of Week:** _____ **Dept.:** _____

Your name has been given as a witness to an incident alleged by the above individual.
Through your cooperation, information can be obtained to complete the investigation of this incident.
Therefore, it would be appreciated if you would answer each of the following questions and
promptly return your completed statement the same shift and day that the injury occurred.

Witness Name: (print) _____ **Job Title:** _____ **Dept.:** _____

Witness Address: _____ **City/State/Zip:** _____ **Phone Number:** ( ) _____

Did you physically witness an accident involving the above employee? □ **Yes** □ **No**

If yes, date of accident: _____ **Time:** _____ **If not, how did you learn about the accident?** _____

_____

STATEMENT

Describe in detail what you physically witnessed and/or heard regarding the employee alleging this accident: (Please print)

_____

_____

_____

_____

_____

_____

_____

_____

_____

The information I have provided in this report is true and correct to the best of my knowledge. This report contains everything I can recall and I gave this statement within the same shift and day of witnessing said accident.

Witness Name: (print) _____ Signature: _____ Date: _____

Supervisor's Name: (print) _____ Supervisor Signature: _____ Date: _____