STATE OF OHIO
ADJUTANT GENERAL'S DEPARTMENT
2825 West Dublin Granville Road
Columbus, Ohio 43235-2789

MEMORANDUM

TO: **SEE DISTRIBUTION**

FROM: **Gregory L. Wayt, Major General (Ohio), The Adjutant General**

DATE: **August 24, 2004**

SUBJECT: **POLICY – State Employee Procedure Letter #12**
Workers' Compensation and Accident or Illness Report

1. **REFERENCES:**
   a. Ohio Revised Code Chapters 4121, 4123, 4127 and 4131
   b. State of Ohio Employee Benefits Handbook
   c. OCSEA/AFSCME Contract Article 34
   d. Air Force Instruction 91-204
   e. AGOR (Army) 40-5 and 385-10
2. **GENERAL:** This Policy applies to all State employees within the Adjutant General's Department. This policy does not apply to state active duty personnel. Any state employee who has a work-related illness or injury may be eligible for workers' compensation benefits. The State of Ohio seeks to provide a safe working environment. The Department of Administrative Services (DAS) handles the workers' compensation claims for the Adjutant General's Department. DAS uses the services of CompManagement, a third party administrator (TPA) to coordinate the claim activity with the Bureau of Workers' Compensation (BWC).
3. **POLICY:** Any accident or illness that occurs in the course of and arising out of your employment will be considered for workers' compensation benefits. This means that the injury or illness must be a direct result of doing your job.
   a. Psychological conditions are not covered unless they arise as a direct result of a BWC approved physical injury.
   b. Occupational Disease – Workers' compensation also may cover a disease that is contracted in the course of employment and more likely to be contracted specifically form your job than from employment in general or from just being a part of the general public.
4. **PROCEDURE:**
   a. Steps 1, 2, and 3 shall be followed whenever an employee is injured at work whether or not the employee seeks medical attention or has days off:
      i. Immediately report the injury to the supervisor on duty!
      ii. Obtain an Injured Worker's Kit. Ask the supervisor for the booklet entitled "Five steps to take if you are injured on the job".

***This letter supersedes State Employee Procedure Letter #6, dated May 27, 2004.**

iii. Complete the Accident or Illness Report Form ADM 4303 (Enclosure 1) with the supervisor. The injury may also be reported directly to CompManagement Health Systems by calling 1-800-247-4800.

iv. Seek medical treatment. Take the ID card that is in the Injured Worker's Kit when seeking medical treatment for a work-related injury.

b. The supervisor will report the injury or illness to the safety officer for the base or facility and fax the Form ADM 4303 to State Human Resources (SHRD) upon completion of the form. The SHRD fax number is 614-336-7069 or DSN 346-7069. The original should be mailed to:

Adjutant General's Department
Attn: State Human Resources Division (AGOH-SHRD)
2825 W. Dublin-Granville Road
Columbus, Ohio 43235-2789

c. The Ohio BWC has developed its own network of providers. If medical services within the BWC network are received, the employee will be fully reimbursed for all approved workers' compensation claims. If care received is outside the BWC network, payment is allowed for the first emergency visit only. The employee must ask the doctor if he or she is certified by the Ohio BWC.

d. Employees requesting workers' compensation leave benefits who are also eligible for Family Medical Leave Act of 1993 (FMLA) leave (see State Employee Procedure Letter #29) shall have up to the first twelve (12) weeks of the non-working portion of the approved benefit period count concurrently as leave covered under the FMLA. Leave while the employee's workers' compensation claim request is being reviewed may also be counted towards FMLA.

5. CLAIMS PROCESSING:

a. SHRD forwards completed Accident or Illness Report to CompManagement Health Systems, Inc.

b. CompManagement will receive information from health care provider and employee, if necessary.

c. CompManagement will provide DAS with the information regarding the medical condition.

d. DAS Benefits Administration Services will review all the information received from SHRD and CompManagement and then make a recommendation to certify or reject the claim.

e. DAS will inform CompManagement of all information regarding the claim. CompManagement will then file the claim with BWC.

f. BWC will make a formal decision to allow or disallow the claim.

6. TYPES OF CLAIMS THAT MAY BE APPROVED:

a. Medical only claims – Injuries in which the employee is unable to work for seven (7) calendar days or less. If the medical claim is allowed, CompManagement Health Systems, Inc. will pay the health care provider for authorized treatments.

b. Prescription Drugs – Any approved prescription medications will be covered by BWC's pharmacy benefits manager.

c. Lost Time Claims – Lost time claims are for injuries that prevent the employee from working eight (8) calendar days or more. If the lost time claim is allowed, the employee will receive compensation checks directly from BWC.

7. APPEAL PROCESS IF CLAIM DENIED:

If any party (employee, DAS or the Adjutant General's Department) disagrees with BWC's decision, an appeal may be filed with the Industrial Commission. The letter from BWC notifying the employee of the determination will include information on appeal rights.

8. DISABILITY ADVANCEMENT OF WORKERS' COMPENSATION BENEFITS:

a. It may take several weeks for BWC to allow or disallow a claim. While the employee is waiting for BWC's decision, he/she may apply for disability benefits advancement. This makes it possible to continue to receive paychecks while waiting for the workers' compensation claim to be allowed or disallowed

b. The first 14 days of a disability are considered the waiting period and will not be paid unless the workers' compensation claim is approved. The disability advancement is subject to a twelve (12) week maximum.

c. To be eligible for workers' compensation advancement, an employee must simultaneously file a claim for workers' compensation lost time wages and a claim for disability leave benefits with SHRD.

d. Application for an advancement of disability leave benefits pending approval of a workers' compensation claim may be filed by submitting a disability application packet as described in State Employee Procedure Letter #15, paragraph 15.

e. All advanced disability leave benefits received by the employee must be reimbursed by the employee to the disability leave program if the employee has been awarded weekly wage payments by BWC for the same time period for which the advancement was made. The <u>full amount</u> received as a disability advancement must be paid back, even if the advancement is more than what is received from BWC.

9. CONTINUATION OF HEALTH INSURANCE: OCSEA/AFSCME bargaining unit employees who are awaiting approval of or receiving workers' compensation benefits for a claim arising from employment with the State of Ohio and have health insurance shall continue to be eligible for health insurance at no cost to the employee, not to exceed twenty-four (24) months. The employer has the right to recover such payments if the workers' compensation claim is denied.

10. COVERAGE FOR WORKERS' COMPENSATION WAITING PERIOD: An employee shall be allowed full pay at regular rate during the first seven (7) consecutive calendar days of absence when he/she suffers a compensable work-related injury, arising from employment with the State of Ohio, or contracts a service-related illness with a duration of more than seven (7) consecutive days. If the injury/illness has a duration of more than fourteen (14) consecutive days and the employee receives Workers' Compensation benefits for the first seven (7) consecutive days, the employee will reimburse the Employer for the payment received.

An employee may elect to take leave without pay, without exhausting accrued leave balances, pending determination of a Workers' Compensation claim.

11. LEAVE BUY BACK: If an employee elects to utilize his/her sick leave, personal leave, vacation leave or compensatory time balances pending determination of a Workers'

Compensation claim arising from employment with the State of Ohio, the employee shall be allowed, upon execution of a Wage Agreement, to buy back those leave balances as outlined below. Leave buy back is limited to employees covered by OCSEA/AFSCME Units 3, 4, 5, 6, 7, 8, 9, 13 and 14. This benefit is not currently available under any other bargaining unit agreement or for exempt employees. Eligible employees who file for BWC lost time wages have two (2) options for buying their time back without an agreement or with a Wage Advancement Agreement.

a. Without an agreement form: This option involves employees who use their leave balances while awaiting a determination on their workers' compensation claim but either fail to, or elect not to, file a Wage Advancement Agreement form at the time the application for BWC lost time benefits is filed.

   i. When temporary total benefits have been paid by BWC, the employee will have the option to buy back any portion of the leave balances used which overlap the dates BWC paid temporary total benefits. The type and quantity of leave time purchased is at the discretion of the employee. This option is limited to the first twelve (12) weeks for which the employee receives temporary total benefits from BWC. The employee must buy back the leave within two (2) pay periods after the receipt of the BWC payment.

   ii. The employee is not obligated to buy back all the leave time used nor is the employee obligated to purchase the leave time in any order. Sick leave cannot be bought back under this option because temporary total wages are not awarded over the same dates an employee uses sick leave. If the employee wishes to purchase more leave time than the BWC check permits, the employee may submit a personal check for the additional leave time the employee wishes to purchase.

b. With an agreement form: This option involves employees who submit a signed Wage Advancement Agreement form with their application for BWC benefits. The agreement provides that the agency will advance the employee accrued leave balances and the employee will reimburse the agency to the extent the employee was paid by BWC over the same period of time.

   i. With this option, sick leave can be used as an advancement. Vacation leave used as vacation rather than in lieu of sick leave cannot be used as an advancement. However, the employee has a limited choice as to the type and quantity of leave time to be restored. Sick leave must be restored first. The employee may then choose the order of any other type of leave to be restored. Restoration under this option is also limited to the first twelve (12) weeks for which the employee receives temporary total benefits from BWC.

   ii. The leave must be restored to the full extent permitted by the BWC award. The employee does not have the option to have less time restored than the award permits. Since the BWC award may not cover the entire twelve-week period, the employee does have the option to submit a personal check for the additional leave time the employee wishes to purchase.

10. **OTHER LEAVE USAGE TO SUPPLEMENT WORKERS' COMPENSATION:** Employees may utilize sick leave, personal leave or vacation to supplement Workers' Compensation benefits up to one hundred percent (100%) of the employee's regular rate of pay.

11. LEAVE TO ATTEND INDUSTRIAL COMMISSION HEARING: An employee shall be granted time off with pay from regularly scheduled work hours, including travel time, sufficient to attend one hearing conducted by the Ohio Industrial Commission in the determination of the employee's workers' compensation claim. In addition, an employee will be granted time off with pay from regularly scheduled work hours, including travel time, sufficient to attend any hearing where the Employer contests the employee's workers' compensation claim.

12. RETURN TO WORK:

b. The Adjutant General's Department has developed a transitional work program (TWP) that will allow an employee to return to the workplace in a transitional capacity.

c. Prior to performing any work duties, the Transitional Work Committee (TWC) will review the workers' compensation claim and determine if transitional work can be performed by the employee. If so, the TWC will contact a vocational rehabilitation case worker to work with the employee and his/her doctor to return to work in a limited capacity. Transitional work is not the same as light duty in that the employee is gradually returned to his/her regular duties with the permission of the attending physician.

d. If an employee does not participate in the TWP, the employee must report to his/her immediate supervisor and submit a written release from the attending physician stating that the employee is able to return to a work status without restrictions **prior** to performing any work duties. No employee will be able to return to work without providing a written release.

e. The supervisor must call the SHRD office to provide verbal notification that the employee has returned to work and then mail the health care provider's release to the SHRD office.

Enclosure (1)
1. Accident or Illness Report (ADM 4303)

DISTRIBUTION:
AD

Employee Instructions for completing the ADM 4303 Injury / Illness Report

This form must be completed as part of the Workers' Compensation application process. Failure to fully complete this report may result in the denial or delay of benefits. Write legibly with a black or blue ink pen (do not use pencil) or file electronically.

Employee Statement
The injured employee is responsible for completing the following sections:

Personal Information- Please fully complete all requested information.

Incident report Information
You must notify your supervisor immediately (within 24 hours) after any accident or onset of illness.

- Follow your specific agency's accident procedures
- Provide the exact date and time the accident occurred
- Provide the exact date and time the incident was reported
- List to whom (name, title and phone #) you reported the incident

Off Work Benefits – you must make a selection, refer to your specific bargaining unit contract for details. *You cannot collect both temporary total compensation and salary continuation or OIL benefits at the same time.*

- ***Temporary Total Compensation (TT)*** – TT benefits are paid by BWC. Your injury must result in eight (8) or more calendar days of lost time from work before TT is considered. Please refer to www.ohiobwc.com for specific details

- *** ***Salary Continuation (SC)*** – SC is equal to the employee's total rate of pay not to exceed 480 hours per workers' compensation claim and paid by the employer. SC is effective the date of the injury and does not require a waiting period.

- *** ***Occupational Injury Leave (OIL)*** – An employee who incurs a work-related injury or illness inflicted by a ward of the State may be entitled to OIL. OIL is equal to the employee's total rate of pay not to exceed 960 hours per workers' compensation claim and paid by the employer. Refer to your specific bargaining unit contract for details, as OIL applies to certain agencies.

WILMAPC PROVIDER

*** IN ORDER TO RECEIVE SALARY CONTINUATION OR OCCUPATIONAL INJURY LEAVE, YOU MUST SEEK MEDICAL TREATMENT FROM A PHYSICIAN ON THE WILMAPC APPROVED PHYSICIAN LIST IF YOU ARE INJURED ON THE JOB AND QUALIFY.

YOU MAY ACCESS THE WILMAPC PROVIDER LIST OR CONTACT YOUR MCO REPRESENTATIVE

http://www.das.ohio.gov/Divisions/CollectiveBargaining/Wilmapc/tabid/479/Default.aspx

Employee Accident Description
You must explain in DETAIL how you were injured, including

- What caused injury/illness, where the accident occurred, how the accident occurred, explain what you were doing at the time of the accident, include the ACTUAL SPECIFIC location where the incident occurred and list any witnesses to the incident

Nature of Injury/Illness
Indicate the body part affected and the illness or injury that resulted from the incident. Include details of any medical attention sought or that you plan to seek.

- Did you seek on-site medical treatment? Check yes or no. If yes, provide details of treatment rendered in "nature of Injury/Illness" section.
- Be sure to indicate name of outside medical provider

Injured Worker Signature/Date
Please read and complete this form in its entirety. Be sure to date and sign it before returning it to your employing agency designee/personnel officer.

NOTICE: "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."

Injury / Illness Report

Employee Statement *(completed by employee)*

Check all that apply:

____ Full time Employee
____ Part-time Employee
____ Interim Employee
____ Exempt
____ Seasonal / temp
____ Other: _____

____ OCSEA *Unit* _____
____ FOP Unit 2
____ 1199
____ ORC 124.381
____ ORC 124.15
____ OSTA
____ Other: _____

PERSONAL INFORMATION

Employee's name:			
Address (Street / City / State / Zip):		Social Security #:	
Phone # (Home / Work):	Date of Birth:	Age:	Sex:
Your employer's name:	Job Title:	Employer's BWC Policy #:	
Regular work hours: From _____ am/pm To _____ am/pm	Work Days: ___Sun ___Mon ___Tues ___Weds ___Thurs ___Fri ___Sat		

INCIDENT REPORT INFORMATION

Date/Time of Injury:

Were you working overtime when this injury occurred? ____ Yes ____ No

Reported to (Name/Title): Date/Time Reported:

OFF WORK BENEFITS:

Check one benefit type:

____ Temporary Total Compensation
____ Salary Continuation*
____ Occupational Injury Leave*; inflicted by a ward of the State (inmate, patient, resident, client, youth or student)

*Must seek medical treatment from WILMAPC

Exact location of incident (Include name of building/area and location within building/area or town, county, State Route or mile marker):

Were there any witnesses? Please list names:

Are you working, in any capacity, for another employer: ____Yes ____ No If yes, employer name:

EMPLOYEE ACCIDENT DESCRIPTION (Please DESCRIBE how the injury happened in DETAIL)

What duties were you performing?

What caused the injury? (e.g. I slipped on the ice.)

NATURE OF ILLNESS/INJURY (PLEASE BE VERY SPECIFIC)

Indicate body part(s) affected:

Describe the illness or injury resulting from the incident:

On-site medical treatment sought/rendered? ____Yes ____ No | If yes, from?

Clinician observation / assessment:

Clinician initials: _____

Outside medical treatment sought/rendered? ____Yes ____No (If yes, provide the **name and phone number** of medical provider below)

Physician's name & phone #:

Benefit application/medical release – I am applying for a claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I affirm that I elect to receive benefits under the Ohio workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, and the Ohio Rehabilitation Services Commission (where relevant) to release medical, psychological, psychiatric, vocational or social information that is causally or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to: BWC, the Industrial Commission of Ohio, DAS, employing agency, the employer's BWC MCO and their authorized representatives. I understand that social security numbers are used to match individuals with other employment records that may be required in the processing of this claim and are used for informational purposes only. A photocopy of this authorization shall be as valid as the original.

Employee Signature	Date

Injury / Illness Report
Employer Statement *(completed by WC designee)*

Date received by personnel:

EMPLOYER INFORMATION

Employee's Name:	BWC Claim # and/or injury date:
Agency (Specify operating location or Central Office):	BWC Policy #:
Address (Street / City / State / Zip):	Work County:

Hire date:	Employment type: ____PT ____FT ____Interim ____Temp

Bargaining Unit Status: OCSEA Unit _____ FOP____ 1199____ Exempt____ Other: _____

Did employee seek nursing/first aid care? ____Yes ____No	If yes, from?

Employee has applied for payment under: ____Salary Continuation ____OIL ____WC-TTD ____Disability Other: _____

Was employee off work seven (7) consecutive days? ____Yes ____No

Did employee use sick leave, vacation leave, personal leave, or any other leave with pay for any of the lost work days? ____Yes ____No

If yes, have you attached a calendar of wages showing leave usage? ____Yes ____No

What was the last date the employee worked? DATE _____	Has the employee returned to work? ____Yes ____No	
	If YES, give ACTUAL date:	If NO, give estimated RTW date:

Was a Transitional Work Assignment offered to this employee? ____Yes ____No

Is a Position Description and / or Job Analysis attached? ____Yes ____No

Did this injury result in a fatality? ____Yes ____No	If yes, give date of death:
Date faxed/called in to MCO:	By whom:

SC or OIL BENEFITS: *(Check if applicable) A completed calendar of wages must be submitted if SC or OIL is requested*

____ **SALARY CONTINUATION** ____ **OCCUPATIONAL INJURY LEAVE**	**OIL** - Do you believe this is a legitimate OIL injury? ___ Yes ___ No Appointing Authority Signature: _____ **Date:** **Coordinator's initials:**
Date employee became disabled: Total hours being requested: Treating with an approved WILMAPC physician? ___Yes ___No	Comments:

EMPLOYER CLAIM CONTACT **(please print clearly)**

Name	Title	Phone #

EMPLOYER CLAIM POSITION **(check applicable section)**

____ CERTIFICATION	____ UNKNOWN	____ REJECTION
Based on the information known at this time the employer CERTIFIES that the facts in this application are correct and valid. This certification does not waive any appeal rights that may exist if the employer so chooses to exercise those rights.	This claim is still in process and pending further investigation and claim research.	The employer rejects the claim for the following reason(s):

Employer signature	Date

Injury / Illness Report

Supplemental Statement ***(completed by Supervisor and Safety & Health Coordinator)***

Employee Name: _____

BWC Claim #: _____

Supervisor Statement ***(to be completed by the Supervisor)***	
Date Injury reported to supervisor:	Time Injury reported to supervisor:
Contributing weather or environmental factors:	Any equipment involved? _____ Yes _____ No If yes, please specify:
Was the employee performing his/her regular job duties? _____ Yes _____ No If No, please explain:	
Specific action taken to avoid another injury:	
Will disciplinary action be initiated? _____ Yes _____ No Please explain:	

Supervisor full name:	Work phone #:	
Job title:	Regular shift:	Days off:
Supervisor's signature:		Date:

Safety & Health Statement ***(to be completed by the S&H Coordinator)***		
Fully describe the accident (What occurred, what was the injury type, what object directly harmed the employee?):		
What was the employee doing immediately before the accident?:		
What conclusions can be drawn?:		
Comments and/or recommendations to improve safety:		
S & H Coordinator full name:	Work phone #:	
Job title:	Regular shift:	Days off:
S & H Coordinator's signature:		Date: