INJURED EMPLOYEE WORKERS COMPENSATION PACKET

The Commonwealth of Massachusetts is the worker's compensation insurer for all state employees. Workers compensation insurance pays for medical expenses associated with job-related injuries and may also provide a weekly income if you are unable to work due to such an injury for five (5) calendar days or more.

PROCESS FOR REPORTING A WORK-RELATED INJURY OR ILLNESS

All work-related injuries, serious or otherwise, must be reported to your immediate supervisor and to Human Resources on the day they occur.

- The supervisor, first responder, or authorized individual arranges for any immediate medical attention required.

Within 48 hours of the injury, the supervisor and employee must make sure the Notice of Injury report has been files with Human Resources and accompanied with the Authorization for Release of Medical Records. Human Resources will open a claim. The claim number and assigned adjuster will be provided to the injured employee as confirmation that the claim was filed and if ongoing claim administration is required.

MEDICAL TREATMENT

If the injury requires medical attention:

- The employee must inform the treating medical provider that the injury is work related and not to bill the employee's insurance.
- The employee must provide the treating medical provider with Physicians Report the items listed below and included in this packet to the treating medical provider.

Documents included in this packet:

Injured Workers Guide to Medical Treatment - know your responsibilities and rights as an injured worker and provide this guide to your treating medical provider for billing information.
Physicians Report - to be completed by the treating medical provider.
Authorization for Release of Medical Records: allows workers compensation to receive medical documentation needed to process your claim.
First Fill Form - for prescriptions filled after medical evaluation.
Concurrent Employee Review - for employees who may work with another employer in addition to their Fitchburg State University employment.

RESOURCES: Human Resources, 978-665-3172; email humanresources@fitchburgstate.edu

Claims Administration: Kalia Legere, HRD/Workers' Compensation Unit, 100 Cambridge St, Suite 600, Boston, MA 02114, Phone: (617) 878-9734, Fax: (617) 727-8331

Medical Providers Seeking Payment (medical bills and related records): All bills must be received on a HICFA 1500 or UB 90 form with a detailed description of the services rendered attached and mailed to HRD/Workers' Compensation Unit, P.O. Box 211134, Eagan, MN 55121

EXECUTIVE OFFICE FOR ADMINISTRATION & FINANCE
COMMONWEALTH OF MASSACHUSETTS
HUMAN RESOURCES DIVISION
100 CAMBRIDGE STREET, SUITE 600
BOSTON, MA 02114

MAURA T. HEALEY
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CHIEF HUMAN RESOURCES OFFICER

Injured Workers' Guide to Medical Treatment

The Human Resources Division/Worker's Compensation Unit (HRD/WC) is the insurer and the Utilization Review provider for your industrial accident. Your agency workers' compensation agent will provide you with an HRD/WC Notice of Injury Packet and an my Matrixx an Express Script (hereinafter ESI) First Fill Form. Please make sure that your agency workers' compensation designee has completed the entire packet and advised HRD/WC of your claim. Upon receipt of your claim, the HRD/WC will assign a file number. If you have questions regarding your claim, you may call HRD/WC 1(617) 727-3437 and ask to speak with the adjuster for your employer agency.

The Department of Industrial Accidents (DIA) requires all workers' compensation insurers to perform utilization review to determine the medical necessity of health care services. You or your medical provider must contact HRD regarding treatment for your work-related injury. You may contact the Utilization Review department once a claim has been filed at 1(800) 266-7991 or by fax at 1(617) 727-7816.

Please notify your medical provider to forward medical bills and their attachments to HRD/Workers' Compensation Unit, P.O. Box 211134, Eagan, MN 55121. Under no circumstances should you provide your employing agency as the insurer. HRD does not reimburse for co-payments resulting from the use of another insurance policy.

The Executive Office of Health and Human Services (EOHHS) has statutory authority under M.G.L. c. 152, §13 and M.G.L. c. 118G to regulate rates of payment for hospitals, health care providers and prescription drugs covered by insurers under the Workers' Compensation Statute. The rates of payment provided by HRD/WC is consistent with the fee schedule established by EOHHS. Reimbursement for health care services is considered payment in full; your provider may not bill you more than the established rate of reimbursement. Please inform your medical provider, that to be considered for reimbursement, all bills must be received on a HICFA 1500 or UB 04 form with a detailed description of the services rendered attached.

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Injured workers are required to use the First Fill Form referenced above to fill prescriptions related to the work injury. A prescription card will be mailed to you directly from ESI after your claim has been filed. ESI is a pharmacy benefit management company that is uniquely set up to provide prescription medications for work-related injuries. Please refer to the First Fill Form in your Notice of Injury Packet for information and participating pharmacy.

Human Resources Division
Workers' Compensation Section
100 Cambridge Street, Suite 600
Boston, MA 02114

PHYSICIAN'S REPORT

Report status: Initial_____Follow-up _____

TO BE COMPLETED BY EMPLOYER:

1. Name of Facility/Agency_____phone ( )_____
   Address:_____
   Name/Title of Workers' Compensation Contact:_____

TO BE COMPLETED BY EMPLOYEE:

2. Full Name _____Date of Birth:___/___/___
   First Middle Last
   Address:_____
3. Date of Injury:_____Social Security No.:_____-_____-_____
4. Has employee received prior medical treatment for this injury? Yes_____ No_____
   If yes, by whom?_____

TO BE COMPLETED BY MEDICAL PROVIDER/OFFICE STAFF:

5. Physician Name (print or type):_____Date of Exam____/___/____
   License No.:_____Specialty:_____Date of Report___/___/____
6. Mailing Address:_____

TO BE COMPLETED BY PHYSICIAN(MEDICAL EXAMINATION RESULTS):

7. Provide patient's statement as to how the injury occurred:_____
   _____
8. Is there a history/evidence of pre-existing injury/disease: Yes _____ No_____
   If yes, explain:_____
9. Subjective Complaints:_____
   _____
10. Objective Findings:_____
    _____
11. Neurological Findings (if any):_____
    _____
12. Diagnosis:_____
13. Plan of Treatment:_____
14. In your opinion, was the accident/exposure a producing/contributing cause of the injury? Yes___ No____
15. Is the employee able to perform his/her regular work duties? Yes____ No____
    If no, employee may return to full duty in _____days/weeks. (Circle one)

16. ***FUNCTIONAL LIMITATIONS***:
    Temporary modified work may be available at state facilities. The employer may develop a modified job based on any restrictions described below. Patient ***CANNOT:***

SIT	more than _____hours/day
STAND/WALK	more than _____hours/day
CARRY/LIFT	more than ___10___20___30___40___50___lbs.
PUSH	more than ___10___20___30___40___50___lbs.
PULL	more than___ 10___20___30___40___50___lbs.
DRIVE VEHICLE	Yes_____ No_____
OTHER (please describe):	_____

17. (Physician Referrals Only) Indicate Physician:_____Specialty:_____

SIGNATURE OF PHYSICIAN

I certify under the pains and penalty of perjury that I have personally examined the above named employee.
Signature:_____Date:_____
(I am a duly licensed physician)

Commonwealth of Massachusetts
Human Resources Division

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

CLAIMANT'S NAME:_____

SOCIAL SECURITY #:_____

ADDRESS:_____

_____

TELEPHONE NUMBER:_____

EMPLOYING AGENCY AND LOCATION: _____

_____

DATE OF INJURY: _____

I am filing a claim for workers' compensation benefits and hereby authorize any hospital or other medical provider to release to the Human Resources Division (HRD), Workers' Compensation Section, ***any and all information relative to my claim for benefits, including, but not limited to, psychiatric records, records pertaining to HIV (AIDS) or other records especially those protected by law***. I understand that HRD may share this information with my employer, medical and or vocational rehabilitation consultants, utilization review consultants, physicians and other medical care providers and other state agencies involved in the workers' compensation process and I hereby authorize such release to the other persons and entities described.

SIGNATURE:_____ DATE:_____

PLEASE COMPLETE THIS AUTHORIZATION AND RETURN TO:

Human Resources Division
Workers' Compensation Section
100 Cambridge Street, Suite 600
Boston, MA 02114

Workers' Compensation Temporary Prescription ID Card

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer). Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at **(800) 945-5951**.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitation is $150.00, or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at **(888) 786-9640**.

Pharmacy Processing Steps

Step 1: Enter bin number 003858
Step 2: Enter processor control A4
Step 3: Enter the group number as it appears above
Step 4: Enter the injured worker's nine-digit ID number
Step 5: Enter the injured worker's first and last name
Step 6: Enter the injured worker's date of injury
(enter in DOI field in the format YYYYMMDD)

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____ /_____ /_____
MM/DD/YYYY

Group #: M5AA

Employee Date of Birth: _____ /_____ /_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare. *Please see other side for a list of participating retail network pharmacies.*

To the Supervisor: Please fill in the information requested for the injured worker.

Employer Name
Commonwealth of Massachusetts

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

EXPRESS SCRIPTS®

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource
Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare Network
Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

To search for participating pharmacies in your area, please use the "Find a Pharmacy" tool located at: http://www.express-scripts.com/services/workerscompensation/

NOTE: This form is not valid in the state of Ohio. For all other states, liability of a workers' compensation claim is not assumed based on the dispensing of medication(s) to a patient.

EXPRESS SCRIPTS®

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CONCURRENT EMPLOYMENT REVIEW FORM

All injured workers should complete the Concurrent Employment Review Form. The employee must report all earnings and indicate if he/she will continue to work for another employer(s) (public or private) while the workers' compensation claim is being processed and throughout the course of his/her workers' compensation claim.

If the employee is working at the time of the state industrial accident, the salary from that job must be considered by the HRD adjuster when calculating the AWW and the Compensation rate. If the employee continues to work at his/her other employment, he/she would be paid section 35 benefits and not section 34 benefits.

Your review of concurrent employment is separate from the Earnings Report authorized under M.G.L. Chapter 152, s. 11D requiring the reporting of all earnings including wages or salaries earned from self-employment. The purpose of this review is to insure that the employee receives the appropriate compensation, which is based on the loss of **all earnings**. If the employee returns to any of his/her former employer(s), adjustments must be made to the compensation rate and the payment section.

In the event the injured worker states that he/she has no concurrent employment, that should be noted on the form and filed with the HRD Adjuster.

It is essential that the workers' compensation agent incorporate this review into the initial agency level claims investigation process. Please use the attached HRD "CONCURRENT EMPLOYMENT REVIEW FORM", when meeting with the injured worker when a claim is being filed.

Commonwealth of Massachusetts
Human Resources Division

Workers' Compensation Section
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CONCURRENT EMPLOYMENT REVIEW FORM

CLAIMANT'S NAME: _____ SS#_____

STATE AGENCY: _____
DATE OF INJURY: _____

OTHER EMPLOYER NAME: (public or private)_____
EMPLOYER ADDRESS: _____
CONTACT PERSON: _____Telephone #_____

DATES OF OTHER EMPLOYMENT: From_____ To_____
DO YOU EXPECT THIS EMPLOYMENT TO CONTINUE? Yes_____ No_____

JOB DESCRIPTION OF OTHER EMPLOYMENT: _____
_____
_____
_____

Please list all positions both private and public other than the position for which you are claiming workers' compensation. Attach a separate sheet for each position.

Week No.	Year: Week Ending Month Day	Gross Amount Paid including overtime
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		

Week No.	Year: Week Ending Month Day	Gross Amount Paid including overtime
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		
32		
33		
34		

Week No.	Year: Week Ending Month Day	Gross Amount Paid including overtime
35		
36		
37		
38		
39		
40		
41		
42		
43		
44		
45		
46		
47		
48		
49		
50		
51		
52		

I hereby certify that the above information is a complete and accurate statement of income from any other employment. Signed under the pains and penalties of perjury.

_____ _____
Claimant's Signature *Date*

This statement of income is to be utilized to determine the amount of workers' compensation you may receive for the injury for which you have a claim.