

**March 13, 2024**



**GREATER CINCINNATI  
SAFETY COUNCIL**



**PRESENTS**

**“Managing Workers’ Compensation Claims”**

# Today's Panelists Introductions



**Tina Mayo,  
Sr. Account  
Manager**

Tina has more than 20 years of experience in Ohio Workers' Compensation. She joined the Sheakley team in 2015 as a Sr. Account Manager. Prior to joining Sheakley, Tina worked as a Case Examiner with a Managed Care Organization and spent 10 years with a Third-Party Administrator. There she gained experience with investigating and managing claims and representing employers at hearings before the Industrial Commission of Ohio. She has experience working with both State Fund and Self-Insured employers. Tina has a complete understanding of both claim and rate issues which helps her guide university and private employers through the complexity of the workers' compensation system.



**Tim Clark, Field  
Safety Services  
Supervisor (BWC)**

Tim is the Regional Field Safety Services Supervisor for the Cincinnati/Dayton region of the Ohio Bureau of Workers' Compensation. In his almost 33 years of public service, Tim has managed claims, field office operations, employer services, and now safety services for the last 8 years. His top priority is working with his staff to prevent workplace injuries and illnesses. The best claim is the one that never happens!



# Today's Panelists Introductions



**Andrew Thaler, Esq.**  
Taft Law

Andrew handles all aspects of workers' compensation claims, from the initial filing of the claim to hearings before the Industrial Commission, to the Courts of Common Pleas, Court of Appeals, and Supreme Court. As a seasoned litigator, Andrew has extensive trial experience successfully defending employers in numerous jury and bench trials. He routinely defends workers' compensation death claims, asbestos and mesothelioma claims, VSSR matters, as well as claims involving additional conditions and requests for disability benefits.



**Melissa Allen, HR**

Melissa is Human Resources for both the Cincinnati Museum Center and the National Underground Railroad Freedom Center. She served a 22-year career as a Paralegal and Bailiff serving both Clermont County Common Pleas and Municipal Courts. After retirement, she served the Country as a Federal Officer at Homeland Security. Following the covid shutdown, she took a position at the museums in HR and handles all Workers' Compensation claims, OSHA recordkeeping, and other HR duties.



# The Bureau of Workers' Compensation



- Began in 1911
- Ohio Constitution 1912 (Article 35)
- Ohio Revised Code (Ohio law)
- Ohio Administrative Code (Rules to carry out Ohio law)
- Two Agencies
- 11 Member Board, Bureau Policy
- 11 Service Offices

# What is Workers' Compensation Insurance?

- **Just Like Most Other Insurance**
- **Premium Collected**
  - **Held in the State Insurance Fund**
- **Pays Indemnity**
- **Pays Medical**
- **No-Fault**
- **Protects both employers and employees**



# What Types of Claims Can Be Filed?



## Medical only:

Seven or fewer days lost from work due to allowed conditions



## Lost time:

Eight or more days lost from work due to the allowed conditions



## Occupational disease:

Continued exposure over time

# Injury Happens, What is Next?

- Injured Worker (IW) notifies employer
- Injured Worker (IW) seeks medical treatment
- Claim filed by Injured Worker (IW), provider, or employer
- BWC receives claim
- Claim Investigation
  - Employer Incident/Accident Report
  - Witness Statements
  - Medical Treatment Documentation



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ENSEMBLE





## Example of my filings for an injury:

Injured worker, “Deno Dinosaur” injured his big toe on his left foot, running down a hallway due to being chased by a Triceratops.

- There were two eye-witnesses, who both provided written statements.
- Deno Dinosaur made a written statement.
- Investigating Officer wrote a Narrative Report.
- Investigating Officer took location photographs and injured body part photographs.
- Investigating Public Safety Officer took detailed injury report.
- Deno declined any treatment on site, but later, decided he needed to be treated, as his foot began to hurt.
- FROI completed by HR Department.
- Claim filed by HR directly with BWC.
- Copy of all materials sent to MCO.***





# What is a “GOOD” Detailed Injury Report?

**I modified our original injury reports to directly correlate to the “FROI” for Workers’ Compensation**

## What you do **NOT** want:

- a lack of **accurate** information
- a lack of **appropriate** information
- a lack of **photographs** or **video footage** of the injury AND the location or cause of said injury
- a lack of an injured party statement, recorded, dictated, or written **SIGNED/DATED**
- A lack of responding staff’s statements and any eye-witness statements, **SIGNED/DATED**
- A lack of **preparedness** and **follow up** with the injured employee!

**I record **EVERY** injury as if it will end up in a lawsuit, an OIC hearing, or any other legal process**

## What you **DO** want:

- Appropriate details- I do not want an **opinion** written by a responder. *“She appeared to be in a lot of pain.”* Should be recorded as **“She stated she was in a lot of pain.”**
- Accurate information**- I do not want blank areas, write “N/A”. I want writing errors, simple ~~line through~~ with date and initials of who lined through it and the correction as well.
- Narrative reports, eye-witness statements, photographs/footage, and a FULLY COMPLETED INJURY REPORT!**
- Signed and Dated- **EVERYTHING** needs to be signed and dated!

**-BE PROACTIVE, BE PROFESSIONAL, BE READY ALWAYS!**

Company Name Here

INJURY REPORT

Date of Injury: Status: (circle one): EMPLOYEE YOUTH VOLUNTEER GUEST HHC SSA RR CLUB AMTRAK CONTRACTOR Time of Injury: Site: (circle one): UNION TERMINAL NURFC GEIER EDGE Time of clock in this day: MORGAN WEGMAN OFF SITE Date Employer Notified of Injury: If OFF SITE, ADDRESS:

Full Legal Name of Injured Party Age M/F Address of Injured Party

If Employee: Department Name: Job Title: Social Security Number: Marital Status: M S W D. # of Dependents Date of Birth: Email: Phone:

Injured Body Part: Photographs taken: Y or N If so, how many and description of same:

Description of how the injury occurred:

Where did the injury take place: Photographs taken: Y or N If so, how many and description of same

911 OFFERED: Yes, 911 called Yes, Declined If Declined, N/A Signature of Refusal by Injured Party

Medical Attention Provided by PSO: YES NO (If YES, provide description of aide provided)

Witness(es): YES or NO Name: Address: Phone: Name: Address: Phone: Name: Address: Phone:

Public Safety Officer Completing Report: Date Time

Company Name Here

INJURY REPORT

Date of Injury: Injured Party Full Legal Name: Time of Injury:

Table with 3 columns: Inured Wearing, Lighting Conditions, After Accident, Injured Party; Weather Conditions, Medical Treatment; Footwear, Temperature; Accident Scene, Stated accident; SURFACE TYPE, Surface Conditions, Witness(es); At Time of Injury, Individual Was.

Additional Information:

Checklist Completed by PSO: Date: Time:



Company Name Here

Date of Injury: 02/01/2024 Status: (circle one) EMPLOYEE YOUTH VOLUNTEER GUEST  
 HHC SSA RR CLUB AMTRAK CONTRACTOR  
 Time of Injury: 13:05 Site: (circle one) UNION TERMINAL NURFC GEIER EDGE  
 Time of clock in this day: 09:00 MORGAN WEGMAN OFF SITE  
 Date Employer Notified of Injury: 02/01/2024 If OFF SITE, ADDRESS:

Deno Dinosaur 250 Millions M 1361 Western Avenue  
 Full Legal Name of Injured Party Age M/F Cincinnati, Ohio 45203  
 Address of Injured Party

Employee: Department Name: Natural History Dept Job Title: Exhibit Display  
 Social Security Number: 000-00-0000 Marital Status: M S (W) D. # of Dependents 0  
 Date of Birth: ~~02-29-1996~~ 02-29-1996 Email: Denodinosaur@aol.com Phone: 513-721-7000

Injured Body Part: (L) Foot  
 Photographs taken: (Y) or N If so, how many and description of same:  
2 photographs taken of (L) foot  
 Description of how the injury occurred:

Deno states he was being chased by a Triceratops and fell and injured his first toe on his (L) foot

Where did the injury take place: Natural History Museum  
 Photographs taken: (Y) or N If so, how many and description of same 2 photographs of hallway

911 OFFERED: Yes, 911 called Yes, Declined If Declined, Deno Dinosaur N/A  
 Signature of Refusal by Injured Party

Medical Attention Provided by PSO: YES (NO) (If YES, provide description of aide provided)  
he declined and he has big teeth!

Witness(es) (YES) or NO  
 Name: Tina Tyrannosaurus Address: 1361 Western Avenue Phone: 513-721-7000  
 Name: Vinnie Velociraptor Address: Cin, Oh 45203 Phone: 513-721-7000  
 Name: Vinnie Velociraptor Address: 1361 Western Avenue Phone: 513-721-7000  
 Address: Cin, Oh 45203

Public Safety Officer Completing Report: Melissa D. Allen Date 02/01/2024 Time 13:25

# OF PAGES

# OF PAGES

Company Name Here

Date of Injury: \_\_\_\_\_ Injured Party Full Legal Name: Deno Dinosaur  
 Time of Injury: \_\_\_\_\_

Injured Wearing: Glasses: YES (NO) TYPE: Eyeglasses Sunglasses Contact Lenses Tinted Glasses	Lighting Conditions: <u>(Well)</u> Adequate Dark Poor Semi-Dark	After Accident, Injured Party Departed sceng w/o identify Refused: to identify of First Aid
Footwear: YES (NO) TYPE: leather shoes sandals tennis shoes rain boots high heels platforms	Weather Conditions: Temperature: Clear/Sunny Clear/overcast Rain: Light Moderate Heavy Snow: Light Moderate Heavy <u>INDOORS</u> Other: _____	Medical Treatment: Needed additional Refused: _____ Left _____ and released by hospital emergency room Stated intent to see own doctor <u>palaeontologist</u>
Footwear Material: Sole/Heel: Leather Rubber Metal other: <u>NONE</u>	Accident Scene: Photographs Taken (Yes) No How Many: <u>2</u> Describing: <u>location of injury</u>	Stated accident: Caused "no injury" Was "own fault" Caused by Safety Hazard Was not in condition to be questioned at that time
Condition of Footwear: Good Fair <u>N/A</u> Poor Torn Any loose fitting clothing or headgear which MAY have contributed to or aggravated this incident: YES (NO) EXPLAIN: <u>NAKED</u>	Safety Hazards Present: Yes (NO) Describe: <u>N/A</u> Warning Devices Present: Y (N) Describe: _____	Type of Injury Sustained: Abrasion Contusion Puncture Animal Bite Dislocation <u>Sprain</u> Burn Laceration Insect bite/Sting Fracture: Open Closed Suspected: concussion Internal Spinal injury Other known or <u>N/A</u> suspected:
SURFACE TYPE: <u>(Interior)</u> exterior asphalt Brick <u>carpet</u> cement dirt Concrete grass gravel metal Non-skid rubber mat rug Tile/ceramic vinyl wood Other: _____	Surface Conditions: <u>(Dry)</u> Wet Slippery Smooth Rough Torn Loose Muddy Oily Snowy Icy Platform Broken Pot Holes Level Uphill Steps Downhill Other: _____	Witness(es): (YES) NO Interviewed: (YES) NO Written Statement: (YES) NO Could not be found: YES (NO) Refused to cooperate: YES (NO) Departed the area: YES (NO) Refused to Identify Self: YES (NO)
Additional Information: <u>N/A</u>	At Time of Injury, Individual Was: Walking <u>(Running)</u> Playing Jumping Standing Climbing Sitting Carrying In Wheelchair Other Disability Wearing Brace: Neck, Leg, Knee On Meds/under influence/seizure	Accident not witnessed: YES NO
Checklist Completed by PSO: <u>Melissa D. Allen</u> Date: <u>02/01/2024</u> Time: <u>13:25</u>		

ERRORS

WRONG!

NO BLANKS

NO BLANKS

N/A

N/A

N/A

No Blanks

Sign/date

Sign/date

NO BLANK SPOTS!

# FIRST REPORT OF INJURY (“FROI”)

## Alphabet Soup!

“IW”

“FROI”

“BWC”

“MCO”

“TPA”

EE or HR Portion

Doctor’s Portion

Employer/HR Portion



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](http://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 <input type="checkbox"/> Male <input type="checkbox"/> Female		Email address				Home phone number		Cell phone number	
Employer name				Employer address		City		State ZIP code	
Was the injured worker hired through a temp agency? <input type="checkbox"/> Yes <input type="checkbox"/> No						Mark the days of the week you usually work <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> 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	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Injured worker start time <input type="checkbox"/> am <input type="checkbox"/> pm		Time of injury <input type="checkbox"/> am <input type="checkbox"/> pm		Date employer notified		Was any part of a workday missed due to the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date last worked	
Was the place of the accident or exposure on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, give accident location, street address, city, state, and ZIP code.									
Initial treatment date		Health-care office/Facility name			Treating physician/Provider name			Telephone 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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed						Decedent's number of dependents	
To be completed by the injured worker									
By signing this form, I:									
<ul style="list-style-type: none"> <li>Elect to only receive compensation, benefits, or both provided for in this claim under Ohio's workers' compensation laws.</li> <li>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.</li> <li>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.</li> <li>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.</li> </ul>									
Furthermore, I understand that:									
<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>Information or records maintained in my previous or future claims may affect decisions made in this claim.</li> <li>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 2913.45).</li> </ul>									
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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	
Employer policy number		Federal ID number		Injured worker is (Check box, if applicable.) <input type="checkbox"/> Owner/Sole proprietor <input type="checkbox"/> Partner <input type="checkbox"/> Individual incorporated as a corporation					
For all employers: <input type="checkbox"/> Certification - I certify the facts in this application are correct and valid. <input type="checkbox"/> Rejection - I reject the validity of this claim for the reason(s) listed below.									
For self-insuring employers only: <input type="checkbox"/> Medical only <input type="checkbox"/> 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	

BWC-1101 (Rev. Sept. 21, 2023)  
FROI





DATE OF REPORT: 02/01/2024

TIME OF REPORT: 13:25

DATE OF INJURY: 02/01/2024

TIME OF INJURY: 13:05

OFFICER: Melissa Allen SUBJECT EMPLOYEE: Deno Dinosaur

On February 1, 2024, I, PSO Melissa Allen, while working the PSOC main desk was approached by employee known as Deno Dinosaur, Exhibit Display Mgr. Mr. Dinosaur reported that he was running in the Natural History Museum due to being chased by a Triceratops and "fell and injured his first toe on his left foot." A full and complete CMC injury report was completed during my interview with Deno Dinosaur and 2 pictures were taken of his injured left foot and first toe on left foot. PSO Officer Allen states that 2 photographs were taken of the area where Deno Dinosaur fell. PSO Allen also acquired a written statement from the injured party as well as eyewitness statements from the two witnesses.

Deno Dinosaur declined 911 medical assistance. He was provided with the Sheakley Workers' Compensation Packet from me. Contact was made with HR as to any action involving Workers' Compensation claim and Deno did not want to see a doctor. HR advised he could stay if he wanted to do so. HR also advised they would follow up with employee the next day.

Witnesses to this interview between Deno and I were PSO Officers Sanders and Box.

The 2-page CMC Injury report, 4 photographs, EE written statement, and two witness statements were sent to HR, PSO Director Matt Spragen and Shift Supervisor Steve Cohn.

No further information to report at this time.

SIGNATURE: Melissa Allen DATE: 02/01/2024 TIME: 13:25

Mark our blank area

Mark our blank area

Mark out blank area

I, Deno Dinosaur, am making this statement as to what happened to the big toe on my left foot today. At about 1:00 p.m. I was running in the Natural History hallway and I fell and hurt the big toe on my left foot.  
Deno Dinosaur  
02/01/2024

I am Vinnie Velociraptor and on February 1, 2024 I was with Tina Tyrannosaurus in the Natural History hallway when I saw Deno Dinosaur being chased by Troy Triceratops and while they were running, Deno fell and looked to me like he hurt his left foot. Me and Tina called Public safety. This all happened at around 1:00 p.m.  
Vinnie Velociraptor  
02/01/2024

I, Tina Tyrannosaurus, was in the Natural History hallway with Vinnie Velociraptor today. About 1:00 I saw Troy Triceratops chasing Deno Dinosaur in the hallway and Deno fell and roared out loud in pain. I saw his left foot turn in an odd way when he fell and his toes were bent apart on that foot. Me and Vinnie Velociraptor called Public Safety to come help him.  
Tina Tyrannosaurus  
02-01-2024



Mark out blank area



# From an HR perspective:

Sheakley is our Managed Care Organization (MCO)

They provided prepared packets for each event that takes place.

• Inside each packet is:

-My business card

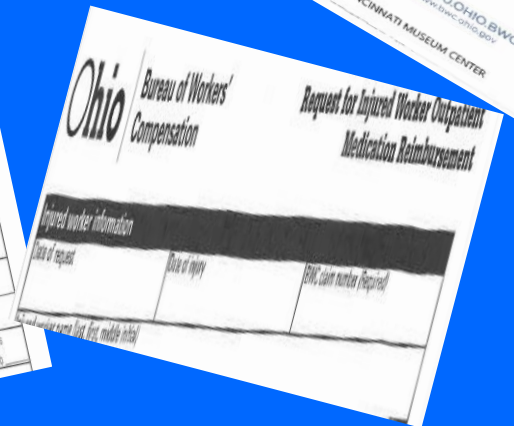
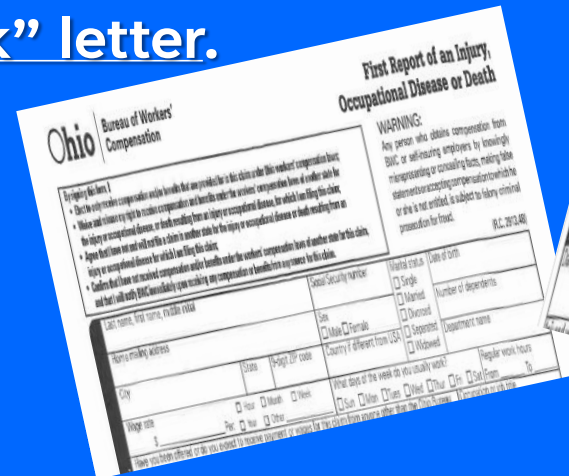
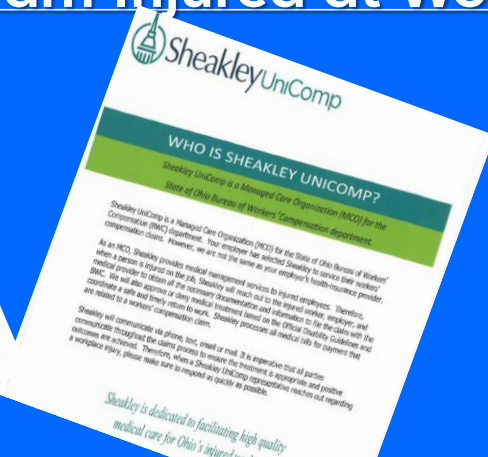
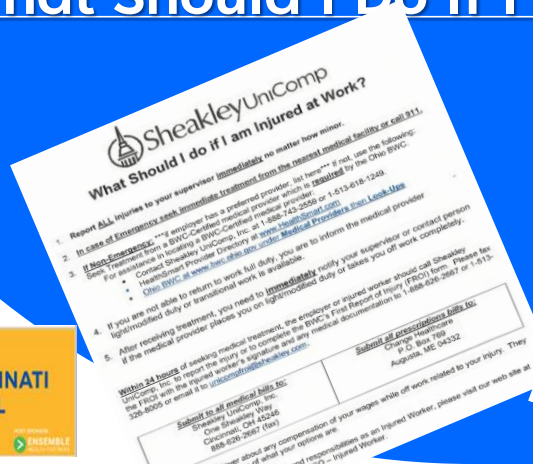
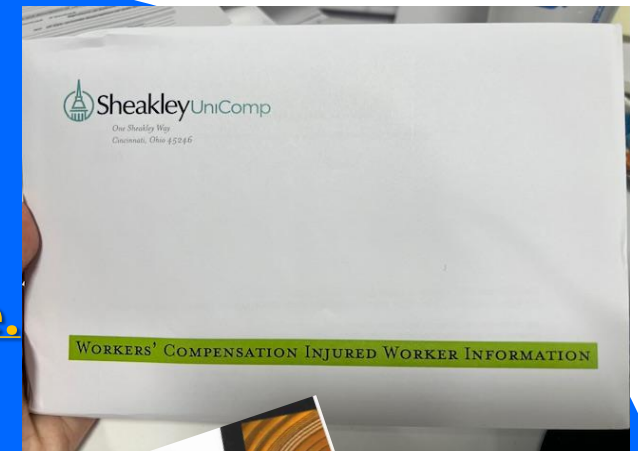
-Sheakley card

-FROI

-C17 form (Request for Injured Worker Outpatient Medication Reimbursement and instructions for completion)

-A letter from Sheakley explaining the partnership with our organization as our MCO, and a

–“What Should I Do If I am Injured at Work” letter.





Document! Document! Document!

“

If it is **not** in writing,  
it **DID NOT** happen!

”

- EVERY Human Resources Staffer!  
(and Attorney 😊)



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As John Quiñones would say...  
what would you? Contest or no?



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Managing Workers' Compensation Claims

# **Injured employee facts:**

- 1) She was on duty at the time**
- 2) She had recently had and completely recovered from shoulder surgery on her left shoulder (about 3 months prior)**
- 3) She injured her left shoulder and her left knee when she fell on the escalator**
- 4) She did seek medical attention the day of the injury, which included a trip back to her surgeon, an MRI, and treatment of shoulder and knee**

Now, we have our injury, we have **completely documented** the injury, what is next?

**A CLAIM IS FILED:**

**Who can file a claim?**



- Medical Provider
- Injured Worker
- Employer
- Authorized Representative
- Any interested party, such as a spouse

**An employer can file through their MCO.**

**They will take claim information:**

- file the claim on your organization's behalf**
- provide a reference # until they obtain the claim #**
- provide you the claim # for your records**

**You will see the packets on your tables of what my MCO, Sheakley, has provided for me. I give them to each injured party to have with any filed claim. VERY HELPFUL!**



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TOGETHER WE  
ENSEMBLE

# Why Would an Employer File Directly With BWC vs. MCO?

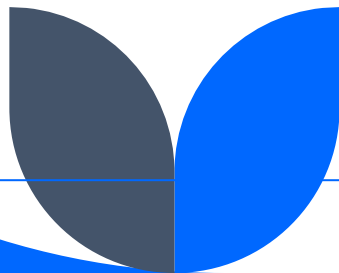
- Claim will be submitted with the correct policy number
- Claim will be submitted with the correct manual number
- Claim will have a complete accident description
- The injured worker will have a claim number at or near the time of the initial treatment
- BWC will know whether or not the employer certifies the facts of the claim



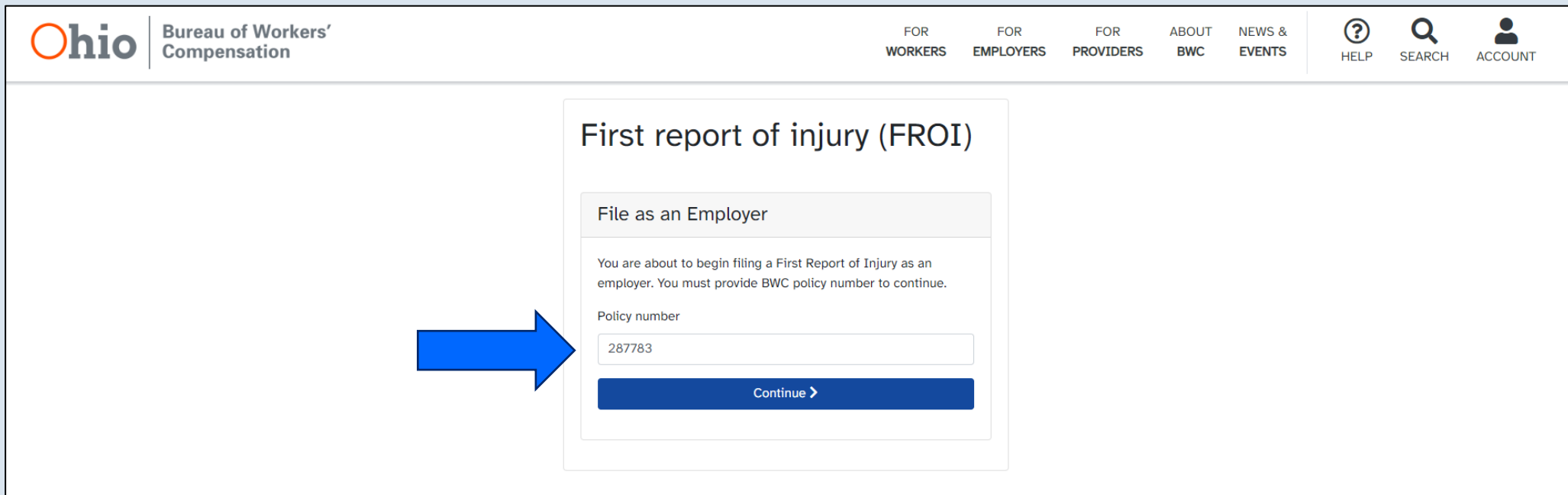
# Employer, Medical Provider, Injured Worker, or Other Interested Party can file **DIRECTLY** with BWC:

- **Online:** Complete the [First Report of Injury, Occupational Disease or Death \(FROI\)](#).
- **Mail or Fax:** You can also [print the FROI \(PDF\)](#), complete it, and then submit it to BWC by mail or fax to 866-336-8352. Be aware that mailing a claim form can slow down the processing time.
- **Phone:** Call BWC at 800-644-6292 from 7:30 a.m. to 5:30 p.m. (EST) or a local BWC customer service office. The customer service representative will ask the questions needed to complete the form and will submit it.

**Important:** *There is **not** a 24-hour time limit for a worker or third party as there is with a doctor to file the claim.*



# To file a claim directly, you will need your policy number to start!



Ohio Bureau of Workers' Compensation

FOR WORKERS FOR EMPLOYERS FOR PROVIDERS ABOUT BWC NEWS & EVENTS HELP SEARCH ACCOUNT

### First report of injury (FROI)

File as an Employer

You are about to begin filing a First Report of Injury as an employer. You must provide BWC policy number to continue.

Policy number

Continue >

# Bureau of Workers' Compensation Website for **EMPLOYER** to file a claim directly:

<https://www.bwc.ohio.gov/Bwc.injury.report.UI>

The screenshot shows the login interface for the Bureau of Workers' Compensation website. At the top left is the Ohio logo and the text "Bureau of Workers' Compensation". The top right navigation bar includes links for "FOR WORKERS", "FOR EMPLOYERS", "FOR PROVIDERS", "ABOUT BWC", "NEWS & EVENTS", "HELP", "SEARCH", and "ACCOUNT". A blue banner at the top contains a notice: "BWC is in the process of transitioning e-accounts to OHID. Learn more about the BWC transition to OHID and how it benefits you. If you are new to BWC, select 'Log in with OHID' to log in or create your OHID." Below this are three login options: "OHID login" with a lock icon, "BWC e-account login" with a person icon, and "Employee login" with a building icon. The "BWC e-account login" section is highlighted with two blue arrows. It includes a "Note" about merged accounts, input fields for "Username" (containing "cincymuseum") and "Password" (masked with dots), and links for "Forgot username?" and "Forgot password?". A "Log in with BWC e-account" button is at the bottom. A disclaimer at the bottom states: "This website is intended for official state use only. Access may be logged and monitored. Anyone using this site shall have no expectation of personal privacy unless explicitly stated in writing on this site. Illegal or unauthorized attempts to access any system or information could lead to criminal and civil liability."

# First Report of Injury (FROI)

The screenshot shows the 'First report of injury' form on the Ohio Bureau of Workers' Compensation website. The form is titled 'First report of injury' and has a sidebar with navigation options: Worker (selected), Policy, Employment, Accident, Treatment, Certification, and Verification. The main form area is titled 'Injured worker' and contains the following fields:

- Prefix (optional): First name (with a dropdown menu)
- M.I. (optional)
- Last name (with a dropdown menu for Suffix (optional))
- SSN
- Birth date (mm/dd/yyyy)
- Sex (dropdown menu)
- Country (dropdown menu, currently set to United States)
- Mailing address
- Additional address information (optional)
- City, State (dropdown menu), and ZIP code

This is where you will need employee/employer specific information to complete all the steps:

- Worker Info
- Policy Info
- Employment Info
- Accident Info
- Treatment Info
- Certification – Filer will certify as to accuracy
- Verification – Verification of claim being filed



# Who are the Parties in a Claim?

- **BWC**
- **Injured Worker**
- **Employer**
- **Managed Care Organization (MCO)**
- **Medical Providers**
- **Attorney**
- **Third Party Administrator**
- **Industrial Commission of Ohio (IC)**



# The Who, What, When, Where, Why, How of it all...

- Jurisdiction

- Employer/Employee relationship

- Legal

- Compensability

- Accidental in character
- In course and arising out of employment
- Injury is physical in nature
- Statute of Limitations

- Medical

- Documentation

- Issue a BWC Order



# What Does Each Party In The Process Do Exactly?



## Injured workers are responsible for:

- Reporting a workplace injury to their employer.
- Notifying their employer if a workers' compensation claim has been filed.
- Providing BWC and/or the managed care organization (MCO) with all requested information related to their claim. To release medical information, the injured worker completes the Authorization to Release Medical Information (C-101) (PDF).

# In Summary, What Does Each Party In The Process Do Exactly?

## Employers are responsible for:

- Reporting all workplace injuries to their MCO.
- Investigating all workplace accidents promptly.
- Informing BWC of their decision to certify (confirm an injury has occurred) or reject the workers' compensation claim. Employers can notify BWC of their decision by:
  - Completing a First Report of Injury, Occupational Disease or Death (FROI).
  - Entering that information using their online OHID account.
  - Contacting their MCO or BWC claims service specialist (CSS).
- Monitoring the status of the injured worker, including during any time when the employee is not working.
- Coordinating remain-at-work /return-to-work strategies with the injured worker, MCO, medical providers and BWC.



## The BWC:

### BWC is responsible for:

- Investigating reported work-related injuries.
- Making work-related injury claim determinations.
- Determining allowed conditions, which means BWC issues a claim decision based on the injury's diagnosis.
- Managing and paying workers' compensation benefits.
- Determining eligibility for rehabilitation services.
- Assisting with bringing a claim to resolution.
- MCO Oversight.



# Managed Care Organization (MCO) vs. Third Party Administrator (TPA)

## What is the difference?

Many employers are confused about the different responsibilities between Third Party Administrators (TPAs) and Managed Care Organizations (MCOs). Both play a vital role in mitigating cost and returning injured workers to work as soon as medically possible.



# The MCO

## MCOs are responsible for:

- Managing the medical aspects of the workers' compensation claim.
- Approving or denying treatment requests.
- Treatment/service dispute resolution
- Paying the injury-related medical bills.
- Working closely with the employer and BWC to return the injured employee to work as quickly and safely as possible.



# Explanation of An “MCO”:

Ohio Bureau of Worker’s Compensation (BWC) requires that all employers have an MCO and there is no direct cost to the employer for their services. MCOs are impartial parties to the claim focusing on medical management. MCO’s are responsible for:

- 1) Managing and monitoring the medical portion of workers compensation claims
- 2) Including maintaining a medical provider network:
  - a) submitting First Reports of Injury documentation to BWC
  - b) monitoring medical costs and medical bill payment
  - c) ensuring proper utilization of medical services and monitoring medical needs and level of care.
- 3) Helping to ensure injured workers return to work as soon as medically possible
  - a) by helping to facilitate return-to-work programs and vocational services in coordination with your “TPA”





## TPA and OIC

Third-party administrators (TPAs) are responsible for:  
Assisting an employer in managing their claims.

The Ohio Industrial Commission (IC) is responsible for:  
Resolving appeals filed by an injured worker or  
employer who disagrees with a claim decision.

# What to expect from your TPA

TPA's responsibilities are specifically focused on reducing the administrative and financial burden of the workers' compensation system on the employer community.

- Employers rely on their TPA primarily when they are disputing a claim.
- The best way to get what you need from your TPA is to communicate with them immediately and directly.
- If you are disputing a claim, it is important to be realistic about the ability to have a claim denied. Example; hearsay and gossip an injury occurred outside of work will not be enough evidence.





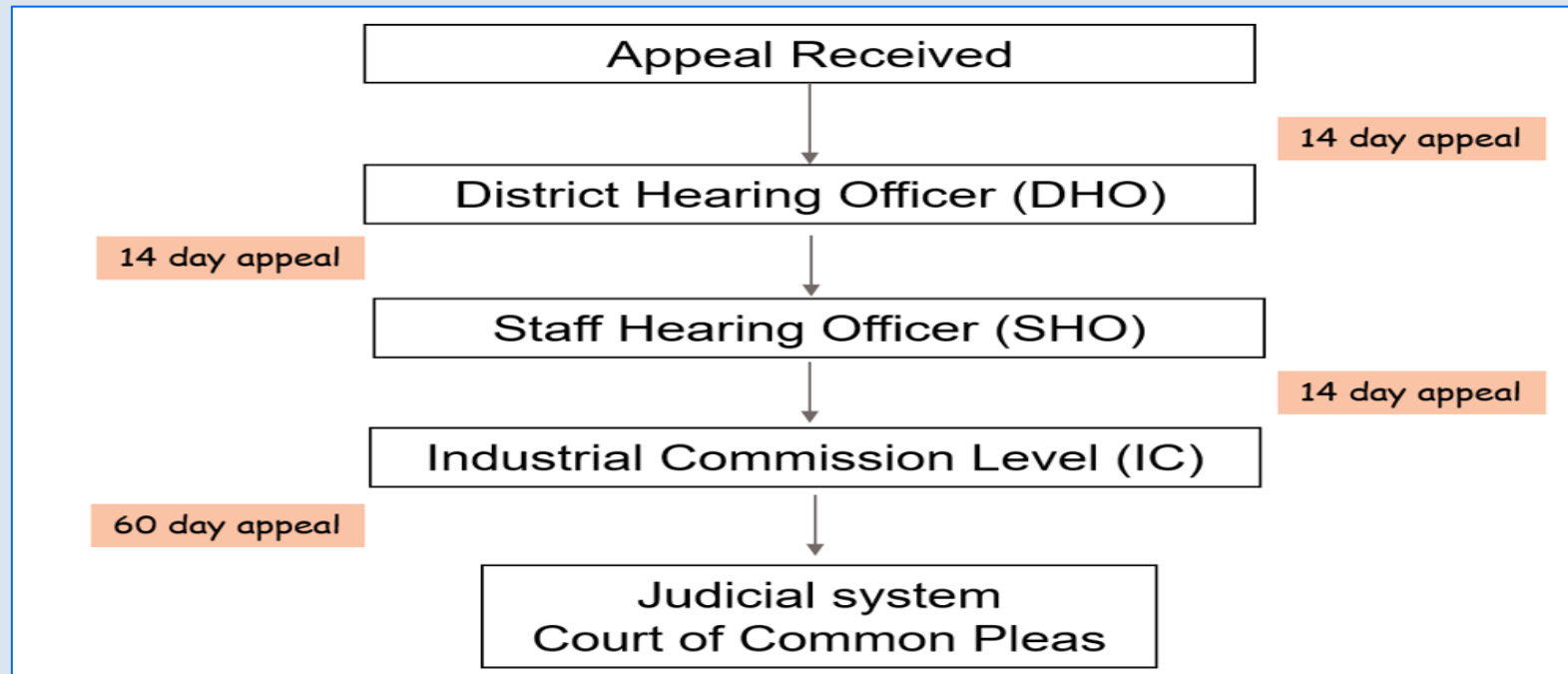
- With your permission your TPA should be sending a medical release on most claims for the neck, shoulder, back and knees. Even if you are not disputing a claim there can be critical predate of injury medical that could help with crediting claims cost.
- Your TPA should advise you on what direction to take with a claim such as; hiring an attorney, sending your employee for an exam or hiring a PI as some options.
- The BWC, MCO and TPA will always ask if you can accommodate restrictions. Light duty is critical to premium savings. Studies show the longer a person is off work the harder it is to bring them back to work. Light duty is always available if we think outside the box. Nonprofit work is also an option.

- **You should be able to rely on your TPA for advice on best ways to manage a claims cost which in turn will help reduce or maintain your premium impact.**
- **The TPA will advise you on potential premium impact for the injuries occurred. We should also be advising you on the best program choice to fit your needs and ideally your budget.**
- **The TPA should always be looking at potential settlements to stop the ongoing claims cost and help with the premium impact. Handicap reimbursement is also critical in helping with cost savings.**





# BWC Order, OIC Hearings, Lawsuits, Any Other Legal Matters



Civil actions are filed in a Common Pleas Court. “Lawsuits” are handled on both sides by an attorney.

**(ANDREW THALER, ESQ. (STEERING COMMITTEE MEMBER) TO SPEAK REGARDING THESE)**

Thank you for your time.

We are happy to take questions.



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