Reporting a Work Related Injury

Norfolk State University
Facilities Safety and Risk Management
GROUND RULES

Please ensure you print and sign your name on the Attendance Log.

Bathrooms are located,...

Please raise hand if you have a question.

Please silence all cell phones. Please leave the room if you must take or place a call.

Relax and enjoy!!!!
GOAL

This training is designed to ensure all supervisors and employees are able to investigate and complete the necessary forms for Worker’s Compensation Claims.
Who is covered at Norfolk State by the Virginia Workers’ Compensation Act?

- Faculty Members
- Part-time Faculty Employees
- Classified Employees
- Hourly/Wage Employees (1500 hour employees)
- Student Workers - Must visit Spartan Health immediately
- Temp. Agency Workers are covered by Temp. Agency. Forms must be completed by supervisor or designee and submitted to Risk Management
Emergencies

In a life threatening emergency situation please get the necessary medical treatment at the nearest medical service provider.

Supervisor or designee are not authorized to transport an injured employees for medical treatment. Please call campus police (823-9000).

Campus Police will ask employee if they wish to be transported.

NSU will only pay for transportation for NSU employees.
Accident Investigation

Determine the Facts
- Interview the individuals and witnesses
- Photograph the accident if possible

Determine the Causes
- Lack of employee or supervisor training
- Lack of enforcement of safety regulations or policy.
- Third Party liability - preserve evidence and document

Determine Corrective Action and Review
- Make an effective corrective action
- Review corrective actions
Procedures to follow to report work related injury!!!

Employees should report the work related injury immediately to supervisor or designee on duty.

The **Supervisor** or **designee** must **complete** the Supervisor's "Accident Investigation Report" (Attachment I) and submit report to the Risk Management Office (phone #823-9142).
**Employee’s Instructions for Filing Claim**

The Commonwealth of Virginia selected MANAGED CARE INNOVATIONS (MCI) to manage the Commonwealth’s workers’ compensation program. To the extent granted by the Virginia Workers’ Compensation Act, the MCI team coordinates the medical and disability benefits related to your claim.

To assist in this process, the program uses a Preferred Provider Organization (PPO) medical network (available at www.covwc.com). The coordinated process between the claims management, PPO, and medical management services are designed to provide the Commonwealth’s employees with quality medical care and procedures to facilitate return to work as soon as medically possible.

**The following are steps you should follow if you are injured on the job:**

1. In the event of a medical emergency, seek medical attention immediately.
2. Report all details of the incident or injury to your supervisor. An investigation will be performed for investigation of safety prevention and claim compensability.
3. Complete all required agency forms with your supervisor.
4. Your employer will offer you a panel of physicians. You must select a physician from the list provided.

*Please note, if you choose to go to a physician other than the panel provider, you may be responsible for the cost of the medical services.*

5. This program also provides for the payment of pharmacy prescriptions by your panel physician. Your supervisor can locate the closest pharmacy to you by checking www.covwc.com, page to PPO/Rx Networks, or calling 800/876-EPIC (3742).

The card below provides you with the instructions for filing a workers’ compensation claim and selecting medical care. Show this card to the medical provider you select.

*These procedures are in addition to any internal policies required by your agency.*

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**WORKERS’ COMPENSATION**

If you are injured on the job do the following:

1. Immediately report all details of the incident to your supervisor. Complete all agency forms.
2. Select medical care from the panel offered to you by your Supervisor. If you do not use a panel physician you may be responsible for the cost of the treatment.
3. If you are to be admitted to the hospital, your medical provider should call MCI.
4. For Prescription Drugs, use an EPIC Pharmacy. Call 1/800/867-3742 for pharmacy locations or www.covwc.com, page to PPO/Rx Networks. Question? Call MCI at 804/649-2288

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**Commonwealth of Virginia Workers’ Compensation Injury Management**

Attention Panel Provider:
The holder of this card has reported a Workers’ Compensation claim.

All billing should be sent to:
MANAGED CARE INNOVATIONS
P.O. Box 1140
Richmond, VA 23298-1140
804/649-2288 fax 804/649-2435

Attention EPIC Pharmacy:
Please call 1/800/876-3742 (800/876-EPIC) for authorization.

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**MANAGED CARE INNOVATIONS**

Phone 804/649-2288 Fax 804/649-2435

Form WCIC 7/98
ATTACHMENT I

NORFOLK STATE UNIVERSITY
NORFOLK, VIRGINIA

SUPERVISOR’S ACCIDENT INVESTIGATION REPORT

Investigate All ACCIDENTS: Help stop accidents by discovering how and why this one happened. Determine and correct the basic cause of this accident in your department and help to prevent accidents in the future. Please type or print the information requested below and return to the EHS&RM Office within 24 hours of the accident.

Name of injured_________________ Employee ID No._________________ Birth date_________________

___ Telephone # __________________ Home___________________ Work_________________ Cell___________________

Home Address_________________ (Number & Street)_________ (City or Town)_________ (State)_________ (Zip)

Marital Status: Married________ Single________ Widow________ Widower________ Divorced

Employment Date______________ Class Title_________________ Dept.______________

Work shift starts: A.M.________ P.M._______ Work shift ends: A.M.________ P.M.________

Type of Employee: Faculty________ Part-Time Faculty________ Classified________

Hourly/Wage Employee___________ Student Worker_____________

OCCUPATIONAL INJURY OR OCCUPATIONAL ILLNESS

Date Accident Occurred_________________ Time_________ A.M.________ P.M.________

Date Reported to Supervisor_________________ Time_________ A.M.________ P.M.________

Where Did Accident Occur_________ (Building)_________ (Room)_________

Brief description of how the accident occurred (Be specific and name any objects or substances involved and state what the employee was doing when injured).

___________________________________________________________________________

___________________________________________________________________________

Exact location of injury (Indicate the part of the body affected; e.g., right or left, upper or lower, index finger or thumb, etc.).

___________________________________________________________________________

Did injured visit a physician? ________YES ________NO

Name and address of physician __________________________________________________________________

Name and address of Hospital ___________________________________________________________________
Name and address of Hospital ________________________________________________
Name of Health Insurance Plan ____________________________________________
Name and address of Witnesses ____________________________________________
What should be done to prevent repetition? ________________________________
Has it been done ____YES ____NO If not, give reason ________________________
Was employee instructed regarding hazards of job? ______ YES _______ NO
Lost Time ______YES______ NO _______ Probable length of disability _____________
Has injured returned to work? ______________ If so, date and hour ________________
Employee’s Signature ____________________________ Date ______________________
Supervisor’s Comments:

Supervisor’s Signature ____________________________ Date ______________________

The supervisor is responsible for informing the Risk Manager when the employee returns to work (757) 823-9142.

NOTE: In order to complete the report thoroughly, it is suggested that the employee and supervisor complete it together.

DO NOT WRITE BELOW THIS LINE RISK MANAGEMENT OFFICE USE ONLY

Date Received _________________ Length of Disability _________________________
From _________________ To _________________
Date of Follow-up _____________ Number of Days Lost _________________
Comments ________________________________________________________________

(Rev. 04/16)
Employee Instructions for Filing Claim

1. In the event of a medical emergency, seek medical attention immediately.
2. Report all details of the incident or injury to your supervisor. An investigation will be performed for investigation of safety prevention and claim compensability.
3. Complete all required agency forms with your supervisor.
4. Supervisor or designee will offer you a panel of physicians. (Attachment III)

**EMPLOYEE(S): YOU MUST SELECT A PHYSICIAN FROM THE LIST PROVIDED.**
Supervisor(s) or designee must present the Workers’ Compensation Panel Physicians Form to the injured employee.

The Panel Physicians Form and Supervisors’ Accident Investigation Report must be submitted to Risk Management.
Panel of Physicians

ATTACHMENT III

NORFOLK STATE UNIVERSITY
PANEL OF MEDICAL PROVIDERS
FOR WORKERS’ COMPENSATION

GENERAL MEDICINE
You may always use
Id&C
Ghent Family Practice
Urgent Care
Hospital Emergency Room (Sentara Leigh, Sentara Norfolk General)
Walk-in clinics

CHESAPEAKE

Dr. Hal Barnes
Dr. Kenneth Mayer
Dr. Arlene Palting
Dr. Steven Papariello
Dr. Meredith Rose

SHCC - Chesapeake
910 Great Bridge Blvd., Ste 101
Chesapeake, VA 23320

801 Volvo Parkway Ste 111
Chesapeake, Virginia 23320
757-548-0099

5320 Providence Road
Virginia Beach, Va. 23464
757-413-7661

ORTHOPEDICS

Atlantic Orthopedics Specialists

230 Clearfield Ave. Suite 124
Virginia Beach, Va. 23462-1832
757-321-3300

1800 Camelot Drive Ste. 300
Virginia Beach, Virginia 23454

733 Volvo Parkway Suite 300
Chesapeake, Virginia 23320

160 Kingsley Lane
Suite 405
Norfolk, Virginia 23505-4600

1975 Glenn Mitchell Drive Suite 200
Virginia Beach, Virginia 23456

6160 Kempsville Circle Suite 200B
Norfolk, VA 23502-2200
The Virginia Workers’ Compensation law requires your employer to provide to you a Panel of at least three physicians. You must select a physician from this Panel to treat your work-related injury. If you do not use one of these physicians for your work-related injury, you may be responsible for the cost of the medical care.

Please select a physician from this Panel, complete and sign this form and return it to your supervisor. The supervisor should immediately return this form to MANAGED CARE INNOVATIONS (MCI).

Please choose from the following list by writing the physician’s name and signing this form. Return the form to your supervisor for filing with the claim application.

1) __________________________  2) __________________________  3) __________________________
   Name                        Name                        Name
   __________________________  __________________________  __________________________
   address                     address                     address
   __________________________  __________________________  __________________________
   Phone                       Phone                       Phone

Employee

By signing this form, I release all medical information to Managed Care Innovations. All information will be considered confidential and used only in the matter of the workers’ compensation claim.

I have been presented with a panel of at least three physicians and have selected __________________________

Dr. __________________________ to provide me with medical care for my work-related injury.

Signed: __________________________  Date ________________

Printed: __________________________  Date of Injury ________________

Employee ID Number ________________
The employee must select (3) Physicians from the Panel of Physicians and sign form upon completion.

Employee refusal to use a Physician from the Panel may jeopardize Compensation Benefit(s).

Employee must inform Physician to submit all claims to MCI

Please Note: Employees must receive a referral (example-Urgent Care) to visit a specialist.
Expense Reimbursement Form
(Attachment V)

Employee may use this form to receive reimbursement for medication, mileage, or parking expenses related to the injury.

Supervisor or designee must ensure employee receives form.
Expense Reimbursement Form

EXPENSE REIMBURSEMENT FORM

NAME_________________________________________ CLAIM NO. ______________

ADDRESS____________________________________ EMPLOYEE ID NUMBER ______

CITY________ STATE________ ZIP_______ DOI ______

( ) PLEASE REIMBURSE ME FOR THE COST OF MEDICATION, SUPPORTED BY THE
ATTACHED ORIGINAL RECEIPTS.
( ) PLEASE REIMBURSE ME FOR TRAVEL EXPENSE AT 27 CENTS PER MILE, AS LISTED
BELOW.
( ) PLEASE REIMBURSE ME FOR PARKING EXPENSE AT THE PHYSICIAN’S OFFICE,
RECEIPTS ATTACHED.

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TOTAL

MANAGED CARE
INNOVATIONS LLC
P.O. Box 1140
Richmond, VA 23298-1121
phone: 804-640-3388 fax: 804-640-2435

I CERTIFY THAT THE INFORMATION GIVEN IS ACCURATE, THAT ALL
MEDICATIONS FOR WHICH I AM REQUESTING REIMBURSEMENT
DIRECTLY RELATE TO MY WORKERS’ COMPENSATION CLAIM AND
THAT I HAVE NOT BEEN REIMBURSED BY ANY OTHER SOURCE FOR
ANY OF THE AMOUNTS CLAIMED.

SIGNATURE ____________________________
Injured employee must use the Expense Reimbursement Form or use EPIC Pharmacy which will not require an out of pocket expense.

Supervisor or designee must ensure the employee receives the Epic Pharmacy List for work related injuries.
Leave Reporting

**Supervisor or designee** must report any **time missed** due to the work related injury on the **Leave Activity Reporting Form (WC)**.

**Employees must clock out** when leaving campus for any issue. Example: Doctor visit, therapy, rehabilitation, x-rays, etc.

**Injured employee** must **submit medical statements** to verify time missed was due to the work related injury.

**If medical documentation cannot be provided by employee,** **supervisor report leave as personal sick leave (SP) or annual leave (AT).**
Leave Reporting cont.

**Supervisor** must report time missed for wage employees on the hourly/wage time sheet.

Part Time employees and student workers should submit any time missed on the Supervisor’s Accident Investigation Report.

Original injury and return to work certification must be forwarded to Risk Management Office.

**PLEASE NOTE:** Workers comp. will not compensate for time lost under 7 days.
Light Duty

Light Duty will be offered.

Examples of Light Duty: Filing papers, engraving equipment, light dusting, cleaning equipment, cleaning door knobs, working within another department, greeter, etc.

Employee refusing light duty could have Worker’s Comp claim denied.
Medical Doctors are the only authority authorized to send an employee home for a work related injury. Light duty will be offered if applicable.

All work related injuries must be reported immediately even if you do not seek medical attention.

Supervisors must ensure all forms are completed and submitted to Risk Management.

If applicable, light duty will be offered.
THANK YOU, For Your Attention!

“BEHOLD THE GREEN AND GOLD!!!”