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I. POLICY PURPOSE

This policy ensures that BWC processes initial claim applications in compliance with ORC 4123.511.

II. APPLICABILITY

This policy applies to BWC Claims Services staff.

III. DEFINITIONS

Auto Claims Processing (ACP)
The systematic evaluation and determination of low-risk claims with little or no human intervention. Claims systematically pass through established business rules that either allow

the claim to be accepted with no human intervention or prevent claims from completing the process and require Claims Services staff to conduct further investigation. Terminating rules will prevent claims from being allowed via ACP.

Cause of Loss/E-Codes
Specific codes available in BWC's claims management system (originating from the International Classification of Disease (ICD) code sets), which are assigned to a claim and used to capture how an injury or occupational disease occurred.

Lost-Time Claim
A claim is considered lost-time when:

- There are eight or more days of lost time from work directly caused by a work-related injury; or
- BWC awards compensation, even if the injured worker did not miss eight or more days of work.

Lost-Time Indicators
One type of terminating rule that presupposes an injured worker will, or could, miss eight or more days of work.

Medical-Only Claim
A claim is considered medical-only when:

- There are seven or fewer days of lost time from work directly caused by a work-related injury; or
- BWC does not award compensation.

National Council on Compensation Insurance (NCCI)
An organization that gathers data, analyzes trends, and provides objective insurance rate and loss cost recommendations for the workers' compensation industry. BWC uses NCCI's classification system, however, BWC develops its own rates.

Peace Officer
An individual legally vested with law enforcement rights who generally works for a city, county or state public employer and can be either "traditional" (e.g., police officer) or "non-traditional" (e.g., certain park rangers, tax agents or liquor agents).

Placeholder Policy
An employer policy number that is created when an alleged employer has never established a policy with BWC, BWC no longer has a record of the policy number, or the policy is in a "cancelled" status, and the date of injury occurred after the policy was cancelled.

Quote Number
A temporary number used for tracking purposes in the claims management system when an employer files an *Application for Ohio Workers' Compensation Coverage* (U-3).

Salary Continuation
Regular, full wages paid to the injured worker by the employer of record. This includes any kind of paid leave (e.g., sick leave, paid time off, occupational injury leave, etc.).

Social Security Crossmatch
The electronic receipt of information from the Social Security Administration that provides the name, date of birth, date of death (if applicable), and any Social Security benefits paid to the individual associated with that Social Security number. Used by BWC to validate information in the claim file, and to calculate temporary total compensation, permanent total disability, and Disabled Workers' Relief Fund payment rates.

Terminating Rules
Any systematic red flag that assumes a claim will, or could, be a lost-time claim.

Triage
The systematic or manual review of all claims that evaluates the severity of a claim as identified by International Classification of Diseases (ICD) codes. The review includes indications of lost time, benefit applications and/or claim accident/illness type, and assigns those claims not allowed by Auto Claims Processing to the appropriate claims team for determination.

IV. POLICY

A. Claim Filing
    1. BWC's policy is to process claims that are filed:
        a. Via BWC online;
        b. By calling the BWC contact center;
        c. Electronically by the managed care organization (MCO); or
        d. Via BWC's Application Processing Unit, upon receipt of a *First Report of an Injury, Occupational Disease, or Death* (FROI).
    2. BWC employees are prohibited from filing any claim on behalf of the injured worker (IW) or IW's family unless the IW or IW's family expressly requests BWC to file on their behalf.
    3. Initial Determination Requests for Psychiatric Conditions
        a. BWC will consider a psychiatric condition requested on a FROI signed by the IW:

i. Concurrent with the request for a physical injury; or
ii. As a result of forced sexual conduct without an IW declaration statement.

b. BWC does not require an accompanying IW declaration statement for psychiatric conditions requested as part of an initial claim determination.

4. See the *Psychiatric Conditions* policy and procedure for additional information for medical review information.

B. Claim Assignment and Reassignment

1. Upon receipt, BWC will assign a claim number to each initial application for benefits and will provide the claim number to the claimant and employer.
2. BWC will use Auto Claims Processing (ACP) until claim determination is complete, unless one of the terminating rules removes it and redirects the claim to the appropriate claims team for processing.
3. BWC will assign the claim to the appropriate claims team or specialized unit. Claims will be assigned to a specific team based on:
   a. Benefit type (medical-only or lost-time);
   b. Accident type (e.g., injury, death);
   c. Severity of injury (e.g., minor, catastrophic);
   d. Multiple claim event; or
   e. Requested condition.

C. Initial Claim Review and Research

1. BWC will complete a systematic evaluation of every claim entered into the claims management system to determine if the claim is eligible to be considered for immediate determination.
2. Claims that meet all the required eligibility rules will be immediately determined.
3. Claims that may meet the eligibility requirements will continue to be systematically reviewed for three days before being assigned to Claims Services staff.
4. Claims that fail to meet the eligibility requirements are assigned to Claims Services staff for review and processing.
5. BWC will review all documentation, claim notes, and demographic information in the claims management system.
6. BWC will not release the residential and familial information of peace officers as defined in ORC 109.71 and ORC 149.43(A)(1)(p).
7. In compliance with federal law, BWC does not require an individual to have a Social Security number (SSN) to obtain workers' compensation benefits.
8. BWC's policy is to pursue missing evidence to support decisions made in the claim.

D. Date of Injury (DOI)
   1. The DOI assigned to a claim is the date the injury occurred, regardless of when the IW's shift began or ended.
   2. Occupational disease (OD) claims are assigned a date of disease, not a DOI. See *Occupational Disease Claims* policy and procedure for additional information.

E. Employer Certification and Retention of Appeal Rights
   1. BWC's policy is to attempt to obtain certification or rejection of the claim from the employer.
      a. When the claim is certified, the employer has only acknowledged that the IW's work-related injury occurred.
      b. An employer's certification of a claim does not automatically mean that BWC will allow the claim.
   2. Certification may be written or verbal.
      a. State-fund and public employers can only certify or reject the claim.
      b. Self-insuring employers can certify, reject, or clarify their certification.
   3. Only a sole proprietor who has elected coverage for themselves can certify their own claim.
   4. Employers who have certified the claim retain the right to appeal a decision.

F. Claim Determination and Issuing and Order
   1. BWC must issue the most complete order possible:
      a. No later than 28 calendar days after BWC received notice of the claim and provided notification to the IW and employer; or
      b. No more than 28 calendar days after receiving the report for a medical examination in OD claims in which examination is required by statute.
   2. At a minimum, the order must contain the:
      a. Description of the condition or conditions for which the claim is being allowed, and parts of the body affected; and
      b. Basis of the decision.
   3. BWC will not allow or deny a symptom on an order.

G. Dismissal of a FROI
   1. BWC will dismiss a claim prior to issuance of an Initial Allowance order, or during the appeal period when an IW/IW representative requests dismissal of a claim either verbally or in writing.
   2. BWC may dismiss a claim at any time during the 28-day determination period when:
      a. The investigation of the claim is complete, the claim allowance is not supported, and there is no signed FROI on file;

b. The investigation of the claim is complete, the claim does not meet the minor injury guidelines outlined in the *Medical Evidence for Diagnosis Determinations* policy, and no medical documentation was submitted;
c. An employer is an elective coverage person who did not elect coverage for themselves; or
d. An employer cannot be identified after a thorough investigation.

3. BWC will not dismiss an initial claim application if the appeal period has expired. Requests to dismiss after the appeal period has expired must be referred to the Ohio Industrial Commission for hearing.
4. Once a claim is dismissed, BWC can take no further action in the claim, except updating claim notes, unless a party refiles the claim application.
5. The dismissal and subsequent refiling of a claim application will not change the statute of limitations for filing the claim.

H. Refile of a Previously Dismissed Claim
1. BWC will consider refiled claims within one year of the DOI.
2. BWC will accept notice of refile:
a. Verbally; or
b. In writing. Written notice of refile may be in the form of a written statement, but any written indication of the intent to refile is also acceptable (e.g., writing "Refile" at the top of newly submitted medical evidence).

I. Reconsidering a Previously Denied Claim (Greene Case)
1. It is BWC's policy is to reconsider a previously denied claim if the original claim was denied due to a lack of specific information that was requested but never received.
2. BWC will only reconsider the claim if:
a. The previously requested missing information has been submitted;
b. The IW or IW's representative requests that BWC reconsider the claim in writing; and
c. BWC receives the request within the statute of limitations.

V. PROCEDURE

A. General Claim Note and Documentation Requirements
1. BWC staff will refer to the *Claim File Contents and Documentation* policy and procedure for claim note and documentation requirements; and
2. Must follow any other specific instructions for claim notes and documentation included in this procedure.

B. Systematic Claim Review and Evaluation
    1. Upon receipt, all claims filed are systematically evaluated to determine if they can be allowed by automated processing. If the claim does not meet the ACP eligibility rules:
        a. The claims management system will generate a “new claim-ineligible for ACP” work item;
        b. The claim will be assigned to the appropriate team (e.g. medical-only, lost-time, special claims); and
        c. Claims Services staff from the appropriate team will process the claim per sections V.C. and V.D. below.
    2. All claims that meet ACP eligibility rules will be systematically evaluated for determination.
        a. If, upon initial evaluation, the claim meets all required ACP eligibility rules, the claims management system generates an Initial Allowance order.
            i. If the claim meets the Fast Response requirements, both the claim and International Classification of Diseases (ICD) statuses will be updated to “Accepted.”
            ii. If the employer certifies the claim, both the claim and ICD statuses are updated to “Accepted.”
            iii. If the employer does not certify the claim, the claim status is updated to “Accepted”, but the ICD status is placed in “Accepted/Appeal.” The ICD status will remain in “Accepted/Appeal” and will be updated to:
                a) “Accepted” status at the end of the appeal period; or
                b) “Hearing” status if an appeal is filed.
        b. Claims that do not initially meet all the required ACP eligibility rules will continue to be systematically evaluated for three days. During the three days:
            i. If information is received that causes the claim to be ineligible for the ACP process, the claim is automatically reassigned to the appropriate area for manual processing (e.g., information is received that indicates the claim is lost-time).
            ii. If information is received that causes the claim to meet all the required ACP eligibility rules, the claims management system will generate an Initial Allowance order and assign the claim to the ACP group. See Section V.B.3.a.i-iii above for further status update information.
        c. If additional information is still needed to determine if the claim meets the ACP eligibility rules, the claim will be assigned to Claims Services staff for processing.
            i. Claims Services staff will receive a “new claim pending ACP” work item.

ii. Within two business days of receiving the work item, Claims Services staff must review and verify all available information has been entered into the claims management system correctly.
    a) Claims Services staff must ensure the claim is assigned appropriate ICD codes, in accordance with the narrative description of the injury or OD.
    b) If the information is available in claim documents or notes, Claims Services staff will enter or correct it in the claims management system and:
        i) Allow the claim to go through ACP; or
        ii) Pull the claim from the ACP process if the claim does not meet the ACP criteria.
iii. If the information is not on file, Claims Services staff will contact the MCO for missing medical documentation (e.g., supporting documentation, statement of causality), or the appropriate party to obtain the missing evidence.
    a) If, after three calendar days, the information is still not on file, Claims Services staff will make one more attempt to obtain it.
    b) After 14 calendar days, the system will generate a "no claim decision" work item if the claim is still undetermined. Claims Services staff will continue to investigate the claim, and the claims management system will continue to evaluate the claim using ACP eligibility rules.

3. Fast Response Claims
    a. When the diagnosis code is one that can be allowed through Fast Response, but the claim does not meet ACP eligibility criteria, Claims Services staff must:
        i. Verify all other compensability tests under Section V.C.2. below;
        ii. Update all available claim information in the claims management system;
        iii. Enter a claim note to indicate a Fast Response claim;
        iv. Issue an order;
        v. Immediately update the claim and ICD statuses to accepted in the claims management system; and
        vi. Place the claim in "Hearing" status if an appeal is filed to the order.
    b. See Appendix A to OAC 4123-3-36 for a list of acceptable codes.

C. Initial Claim Review and Investigation of Claims Not Eligible for ACP
    1. Claims Services staff will review the claim in totality to determine what information has already been received and what additional information is necessary for claim processing. The medical claims specialist (MCS)/claims services specialist (CSS) must:
        a. Review and confirm demographics submitted with the claim, FROI, job description, MCO and other notes, mechanism of injury, DOI, and compare the

medical documentation on file to what the Medical Evidence for Diagnosis Determination (MEDD) guidelines or other medical evidence resources (e.g., WebMD) state should be present to make an appropriate determination.

i. If medical documentation (e.g., supporting documentation, statement of causality) or clarification of medical information is required, Claims Services staff must contact the MCO to request the specific information needed.
ii. If the MCO does not respond to the request after three business days, Claims Services staff must make a second request for the information.
iii. If the MCO fails to respond to the second request, Claims Services staff must report the issue to their supervisor. The BWC supervisor must call the MCO supervisor to discuss the issue.
iv. Claims Services staff must contact the MCO after three days if additional information is needed to make the claim determination but will not contact the MCO solely to validate the information in claim notes. Claims Services staff may only contact the MCO to clarify an MCO note when conflicting information is on file or received.
v. Claims Services staff will email the BWC MCO Business Unit Referral email box for assistance when:
    a) The BWC supervisor and MCO supervisor have discussed the issue, and the MCO fails to provide the required data elements and/or necessary medical documentation to make a determination on the claim without good cause; or
    b) The MCO has shown a pattern of not providing the required data elements or obtaining the required documentation.

b. Confirm the IW's SSN is entered into the claims management system correctly, and there are no duplicate claims or customer records by searching the customer's name and address.
    i. The claims management system will systematically verify SSNs with the Social Security Administration (SSA).
    ii. When the correct SSN is entered, it will generally verify upon entry into the claims management system. Once the SSA has verified the SSN, staff do not need to take further action.
    iii. Claims Services staff will promptly investigate an issue regarding an SSN when:
        a) Verification of the SSN through the SSA fails; or
        b) They are notified of a conflict or error with a customer's SSN.
    iv. If an IW does not have an SSN or visa number, Claims Services staff will check the "Tax ID unavailable" box in the claims management system so that compensation may be released to the IW when appropriate.

v. For additional instructions regarding an unverified SSN, see the *Social Security Numbers* policy.

c. Enter a customer information block, if applicable. See *Claim Confidentiality and Information Requests* policy and procedure for further detail.

d. Verify that the employer policy number listed in the claims management system matches the employer information documented in the file, and that the evidence supports that there is an employee/employer relationship.
   i. If the employer identity and an employer/employee relationship have not been verified, Claims Services staff will:
      a) Gather additional information from the IW; and
      b) Staff with a supervisor and BWC Legal, if necessary.
   ii. If the employer identity and an employer/employee relationship have been verified, Claims Services staff will:
      a) Confirm that the employer has active coverage;
      b) Check that the NCCI code in the claims management system matches the job description; and
      c) Identify the correct employer policy number by completing a thorough investigation, and documenting in claim notes all attempts to locate the correct identifier.
         i) If, after investigation, the policy number cannot be identified, the CSS will initiate an EM Referral using the EM Referral Tracker and copy their team leader.
         ii) The referral will be assigned to the Employer Compliance Department (ECD) for further review by inserting ECD Rush in the "EM Referral Office" field of the referral.
         iii) If the correct policy number is identified, ECD will notify the CSS by email, and the referral will be complete.
         iv) If the correct policy number is not identified, ECD will create a quote number in the claims management system.
         v) ECD will email the quote number to the BWC RTS Manual Classification Unit and request the quote number be transitioned to a placeholder policy number. ECD will copy the CSS on the email.
         vi) The BWC RTS Manual Classification Unit will transition the quote to a placeholder policy number and notify the CSS and ECD via email upon completion of the process.
         vii) If the correct policy number is not identified and a placeholder policy is not appropriate, the CSS will staff the claim with a supervisor and dismiss it against a no insured found risk.

e. Search the claims management system to determine if a quote number is listed for the employer. A quote number indicates that the employer recently applied

for coverage, and the Manual Classification Unit will transition it to a policy number when the policy goes into effect.

f. Verify each element of jurisdiction, coverage, and compensability by investigating all facts of the accident. Staff must:
    i. Ensure that:
        a) The claim is within Ohio's jurisdiction;
        b) The claim was timely filed;
        c) An employer/employee relationship exists;
        d) The injury was accidental (unexpected);
        e) The accident/injury occurred while in the course of and arising out of employment;
    ii. Review the evidence for possible coverage issues (e.g., trucking industry owner/operator issue, subcontractors with no coverage, construction, etc.); and
    iii. Staff with a supervisor and BWC Legal, if necessary.
g. Review the claim for subrogation and determine if a referral should be made to the Subrogation Unit. See the *Subrogation* policy and procedure for additional information.
h. Determine if a referral to EM is needed. If a referral is:
    i. Appropriate, send the referral through the existing tracker and enter a corresponding note in the claims management system.
    ii. Not appropriate, enter a note with the reason why.
i. Ensure the claim is assigned the appropriate ICD codes, in accordance with the narrative description of the injury or OD.
    i. Request modification of the narrative description, if necessary; and
    ii. Wait to create the order until the narrative modification is complete.

2. Claims Services staff will make initial contacts to all parties within three business days of the assignment of the claim, regardless of whether the claim is lost-time or medical-only.
    a. The CSS must make the contact by phone unless the employer has specifically requested contact to be made via email.
    b. The MCS will make contact via letter, however, the MCS is expected to make contact by phone when necessary.
    c. During these contacts, Claims Services staff will:
        i. Document the responses to the three-point contact questions;
        ii. Request new or missing information that is necessary for the determination of the claim;
        iii. Set expectations for IWs and employers during the claim process; and
        iv. If necessary, leave a detailed message asking the customer to return the call and leave a call-back number.

d. Claims Services staff must enter a detailed note in the claims management system after each contact or attempt to contact any party to the claim.
e. If the initial contact attempt was unsuccessful, Claims Services staff must make a second contact attempt. A successful contact is when Claims Services staff has:
    i. Spoken with the necessary party and verified claim details;
    ii. Sent an email with no bounce back;
    iii. Left a detailed message for the correct person; or
    iv. Sent the *Request for Information*.

3. When contacting the employer, the CSS must:
    a. Verify the IW is their employee;
    b. Verify the policy number and NCCI classification code or job description;
    c. Verify the accident description and request claim certification or rejection. If the CSS is unable to obtain this over the phone and the MCO has not already secured the information, the CSS must send the *Employer Certification Request* letter;
    d. Request any missing information;
    e. Ask if the employer intends to pay salary continuation or make disability payments. See the *Salary Continuation* policy and procedure for additional information.
    f. Discuss availability of modified/light-duty work; and
    g. Request the IW's wages for the 52 weeks prior to the DOI. Refer to the *Wages* policy and procedure for additional information.
4. When contacting the IW, the CSS must:
    a. Clarify all conflicting demographic information (e.g., date of birth, SSN, address, etc.);
    b. Verify conflicting accident description and parts of body injured;
    c. Verify the name and address of the employer, if the information on file needs to be clarified;
    d. Request that the IW provide a verbal description of their job duties to aid in the selection of the correct NCCI classification code, if necessary;
    e. Explain what specific evidence the IW needs to provide for BWC to determine the claim;
    f. Make the IW aware of any missing medical documentation BWC has asked the MCO to obtain from the treating physician;
    g. Request wages for **all employers** for the 52 weeks prior to the DOI. See the *Wages* policy and procedure for additional information.
    h. Confirm whether the IW is working anywhere (e.g., a second job);
    i. Verify if the IW is receiving any type of wage replacement from another source (e.g., SSR, salary continuation, disability, etc.);

j. Discuss return-to-work goals and expectations (e.g., participating in light/modified-duty work, if available); and
k. Review the Better You, Better Ohio program.

D. Cause of Loss/ E-Codes
1. For every new claim, Claims Services staff must enter a cause of loss code into the claims management system.
2. If the MCO or provider have identified a cause of loss code, Claims Services staff will verify the code for appropriateness based on the accident description.
   a. If the cause of loss code provided by the MCO or provider is appropriate, Claims Services staff will enter it into the claims management system.
   b. If the cause of loss code is not appropriate, or if the MCO or provider did not provide one, Claims Services staff must determine the appropriate code and enter it into the claims management system.
3. If multiple events occurred simultaneously resulting in a claim, Claims Services staff will code the event that caused the most serious diagnosis.
4. Claims Services staff must not enter new cause of loss codes or change cause of loss codes after the claim is initially allowed.
5. If Claims Services staff is unsure of the appropriate cause of loss code, they must staff the claim with their supervisor.

E. Claim Determination
1. Claims Services staff must review the FROI, MCO & BWC claim notes, MEDD guidelines, and all available documentation to make a determination on the requested conditions.
   a. Claims Services staff must follow the *ICD Modification* policy and procedure if any conditions cannot be accurately coded, or if clarification is necessary.
   b. When Claims Services staff is otherwise unable to obtain the correct ICD code, they may use the encoder, or the online ICD-10 look up and enter the ICD code in the diagnosis window in the claims management system.
   c. Claims Services staff must attempt to obtain all medical documentation including exam results or diagnostic tests and a statement of causality from the MCO prior to sending the issue for medical review.
      i. Claims Services staff must send the claim to the MSS for medical review if:
         a) The claim falls outside the MEDD guidelines; or
         b) Claims Services staff are unable to interpret the medical documentation or determine the accuracy of the requested conditions.
      ii. Conditions listed on an unsigned FROI or in the claim file must have supporting medical documentation and a statement of causality on file prior to sending the claim to the MSS for medical review. The conditions will

not be sent for physician file review if supporting medical documentation and a statement of causality for the conditions are not on file.

d. If all jurisdiction, coverage, and compensability elements are met and the claim appears to be non-controversial, but the only diagnosis provided is a symptom, Claims Services staff may refer the claim to the MSS for medical review once all attempts to secure a condition have been exhausted.
e. If necessary, the MSS will obtain a physician file review or schedule an independent medical exam, but an exam does not extend the 28-day time frame to issue a decision as required by law, except for OD claims that statutorily require an exam prior to determination. Claims Services staff may refer to the *Occupational Disease Claims* policy and procedure for additional information.
f. The MSS will enter notes in the claims management system detailing the findings of the physician reviewer, and listing the documentation used to form that opinion.
g. Claims Services staff must address all conditions listed on the FROI signed by the IW. If a condition listed on the FROI signed by the IW cannot be allowed or denied, Claims Services staff must:
    i. Explain in the "add text" section of the order if additional documentation is needed to make a determination; or
    ii. Indicate that the requested condition cannot be allowed or denied under BWC guidelines.
h. Claims Services staff must never allow or deny a symptom on an order. Instead, Claims Services staff must:
    i. Remain silent on all symptoms listed on a FROI or within the medical; or
    ii. If compelled to address a symptom on the order, use the following language: "Your treating physician diagnosed you with (insert symptom). This diagnosis is one that BWC does not allow, either because it is a symptom, or it is a condition BWC does not recognize. If your physician submits either a diagnosis of a condition causing the symptoms, or a diagnosis BWC recognizes, we will review further."
i. Claims Services staff must deny the claim when only one condition that cannot be allowed is listed on a signed FROI, and the supporting medical evidence does not include any other allowable conditions.
j. Claims Services staff must deny the claim for the "no injury" code A00.00 when there are no codes listed on a signed FROI, and the supporting medical evidence does not include any other allowable conditions.
k. For the initial determination only, Claims Services staff may allow a condition that is identified in medical documentation but not specifically requested by the IW. Staff will not deny any conditions that were not specifically requested.

l. If an additional allowance has been requested on a properly signed *Motion* (C-86) and BWC has not published an initial claim decision yet, Claims Services staff must include the newly requested allowance in the initial decision, even though it is not listed on the FROI, because the C-86 is a formal request.
m. If an additional allowance has been recommended on a *Request for Medical Service Reimbursement or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9) and BWC has not published an initial claim decision yet, the condition is treated as a condition found in the medical evidence (e.g., the condition can be allowed, but cannot be denied because it was not requested by the IW). C-9 recommendations received prior to initial determination are not treated as an additional allowance request.
n. If a subsequently requested condition is filed during the appeal period of the initial decision, Claims Services staff will pend the request. Claims Services staff may refer to the *Additional Allowance* policy and procedure.
o. Claims Services staff must issue an order to accept or deny the claim based on the claim investigation and the evidence in the file. Claims Services staff will note the documentation and rationale used to make the claim determination in the "add text" section of the order.
    i. If a FROI is not signed by the IW, the claim may be allowed, but staff cannot deny a claim solely because the FROI is not signed. If the claim would otherwise be denied, but a signed FROI is not on file and cannot be obtained at the end of the 28-day determination period, Claims Services staff must dismiss the claim by Miscellaneous order.
    ii. Claims Services staff may allow a claim for a minor injury without supporting medical documentation if the injury is "self-evident" or a "common knowledge" injury.
        a) Self-evident or common knowledge injury examples include, but are not limited to:
            i) First degree burns to less than 10% of the body;
            ii) Superficial lacerations (e.g., cut, open wound);
            iii) Superficial contusions (e.g., bruise, hematoma);
            iv) Insect stings;
            v) Minor animal or human bites;
            vi) Superficial foreign body in the eye;
            vii) Corneal abrasions;
            viii) Conjunctivitis (also known as pink eye);
            ix) Dermatitis;
            x) Blisters; and
            xi) Superficial injuries/abrasions.

b) The claim is compensable even if the IW did not seek treatment for the injury.
    i) When allowing a claim, Claims Services staff must update the claim to an “Allowed” status when the appeal period has expired and no appeal has been filed. Benefits are then payable, and the claims management system will update the claim status.
    ii) When denying a claim, Claims Services staff must update the claim to a “Denied” status when the appeal period has expired and no appeal has been filed.
    iii) If the IW or employer appeals the order during the appeal period, Claims Services staff must check that the appeal was filed with the IC and place the claim in “Hearing” status so no benefits are paid.
    iv) If an appeal is filed after the appeal period expires, Claims Services staff must refer the claim to the IC and keep the claim in “Accepted” status so benefits will continue. Once the notice of hearing is received, Claims Services staff must update the claim status to “Hearing”.

p. Claims Services staff will send a modified Initial Allowance order if the correct employer information is discovered prior to expiration of the initial appeal if no appeal has been filed.

2. If claim dismissal is appropriate, Claims Services staff must:
    a. Update all ICD codes in the claims management system to “Dismissed” before the Miscellaneous order is created;
    b. Issue a Miscellaneous order if BWC dismisses the claim application before an Initial Determination order has been issued, or within the appeal period of the Initial Determination order;
    c. Include the following language in the order: “This claim is dismissed. The required evidence to determine if this is a compensable claim was not received. Should a verbal request or documentation be received that indicates a request to refile, additional information may be requested, and a full investigation will be completed to determine the claim’s compensability. Please contact your assigned CSS to see what information is needed.”
    d. Complete any correspondence before updating the claim status;
    e. Enter a claim note indicating that the claim is dismissed and cite the specific reason why; and
    f. Update the claim status to “Expired occurrence,” and choose the claim status reason of “Dismissed.”
    g. For lost-time claims, also reassign the claim to the Remain at Work team when the appeal period has expired.

3. Once a claim is dismissed, Claims Services staff can take no further action in the claim, except updating claim notes, until the claim is refiled.
4. If the IW requests dismissal of the claim after expiration of the initial determination appeal period, and the claim is in a final "Accepted" or "Denied" status, Claims Services staff must:
    a. Refer the claim to the IC; and
    b. Place a stop payment on indemnity in the claim management system to prevent any indemnity payments from being issued.

F. Processing a Refiled Claim
1. Upon receipt of any information that indicates or implies that it is the intention of the IW to refile the claim, the assigned claim owner will:
    a. Review all claims documents, correspondence, and notes to determine why the claim was originally dismissed; and
    b. Determine if new or missing evidence has been submitted.
2. Once the review and assessment are complete, Claims Services staff will:
    a. Look for an explicit statement that the claim is being refiled, either on the FROI or accompanying documents.
        i. If a clear statement that the intention is to refile the claim is present, document this in notes and continue to process the claim. The assigned Claims Services Specialist does not need to contact the IW to confirm the intent is to refile the claim.
        ii. If there is no explicit indication the IW is refiling the claim, contact the IW or their representative to confirm that their intent is to refile the claim and document this in notes.
            a) If the IW or their representative states their intent is to refile, staff will reassign the claim to Intake and continue to process the claim.
            b) If Claims Services staff cannot reach the IW or their representative, the claim will remain dismissed until it is confirmed, and no further action is needed.
    b. Review the evidence on file and ensure the previously missing information has been submitted; and
    c. Change the status of the claim in the claims management system.
3. After a thorough investigation, Claims Services staff will publish an order to allow, deny, or dismiss the claim.
4. If the intent is to refile the claim and new information was not submitted to BWC, Claims Services Staff will deny the claim.

G. Reconsidering a Previously Denied Claim (Greene Case)
    1. Upon receipt of an IW's written request to have their previously denied claim reconsidered:
        a. Claims Services staff will ensure that:
            i. The request is submitted via a:
                a) C-86 with or without a new claim application;
                b) New claim application; or
                c) Copy of the original claim application with written documentation of the IW's intent for BWC to reconsider the claim.
            ii. The evidence that was previously requested but never received has been submitted; and
            iii. The request was submitted within the applicable statute of limitations.
        b. Claims Services staff must enter a claim note to acknowledge the IW's intent for BWC to reconsider the claim.
        c. Claims Services staff will then staff with BWC Legal to determine whether there is sufficient evidence to reconsider the claim.
        d. Following staffing, Claims Services staff will vacate the previous order and either:
            i. Allow, if sufficient evidence in support of the allowance was submitted within the applicable statute of limitations;
            ii. Deny, if sufficient evidence was not submitted to justify allowing the reconsidered claim; or
            iii. Dismiss. If sufficient evidence was not submitted to justify allowing the reconsidered claim, Claims Services staff must deny or dismiss the claim consistent with this policy and procedure.
    2. Example:
        a. A claim was previously filed for allowance of a broken tibia and an x-ray report to support allowance of the claim was requested but not submitted; therefore, the claim was denied.
        b. Six months later, the IW files a letter stating their intent for BWC to reconsider the claim. The IW includes x-ray results from the DOI showing they suffered a broken tibia.
        c. The claim will be reconsidered because the specific information that caused denial of the initial claim was submitted with the IW's intent for BWC to reconsider the claim.