Ohio | Bureau of Workers' Compensation

Provider Educational Series

BWC FROI & You

Bliss Dickerson, Director Provider Engagement

Tammie Mihaly, Manager Provider Relations

Series objectives

- Provide workers' compensation overview and information on pertinent topics
- Educate and support providers and their team
- Increase provider knowledge of how the workers' compensation system works

Agenda

1. Work-related accident occurs – what's next?
2. Review enhanced First Report of Injury (FROI) form.
3. Discuss online FROI filing changes.
4. Questions and answers.

Work-related accident occurs

What's next?

- Employee seeks treatment
- Provider determines follow-up care and RTW
- First treating provider is responsible to file FROI within one business day of treatment

Options to file a FROI

- Complete online FROI - preferred method
- Complete paper form and fax to the employer's MCO
  - MCO Directory | Bureau of Workers' Compensation (ohio.gov)
  - If unable to determine the correct MCO, fax to BWC at 1-866-336-8352

Provider work-related accident investigation questions

The provider should get detailed answers to the below questions from the injured worker.

- Was anyone else involved?
- What happened?
- Where did the injury take place?
- When did the injury occur?
- How did the injury happen?

Provider's Opinion - Causality

Causality (causal relationship) is the provider's opinion regarding the correlation between the mechanism of injury and the injury itself.

Causality: Did the slip and fall **cause** the lumbar sprain and fractured left wrist?

New FROI paper form

Ohio | Bureau of Workers' Compensation

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First Report of Injury, Occupational Disease, or Death (FROI)

Submit the form to BWC in one of the following ways. **Online:** www.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 ☐ Male ☐ 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? ☐ Yes ☐ No If yes, name of temp agency	Mark the days of the week you usually work ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ 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	Number of hours scheduled to work the week of this injury
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?** ☐ Yes ☐ No

Injured worker start time _____ ☐ am ☐ pm	Time of injury _____ ☐ am ☐ pm	Date employer notified	Was any part of a workday missed due to the injury? ☐ Yes ☐ No	Date last worked	If the injured worker has returned to work, provide the date.
Was the place of the accident or exposure on employer's premises? ☐ Yes ☐ No If no, give accident location, street address, city, state, and ZIP code.					Was injured worker hospitalized overnight? ☐ Yes ☐ No

Initial treatment date	Health-care office/Facility name	Treating physician/Provider name	Telephone number	Fax 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 ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Decedent's number of dependents

To be completed by the injured worker

New FROI paper form

Ohio | Bureau of Workers' Compensation

To be completed by the injured worker

By signing this form, I:

- **Elect to only receive compensation, benefits, or both provided for in this claim under Ohio's workers' compensation laws.**
- **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.**
- **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.**
- **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.**

Furthermore, I understand that:

- 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.
- 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.
- Information or records maintained in my previous or future claims may affect decisions made in this claim.
- 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 2913.48).

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

New FROI paper form

Ohio | Bureau of Workers' Compensation

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? ☐ Yes ☐ No Are you the physician of record? ☐ Yes ☐ 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.) ☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation

For all employers: ☐ Certification – I certify the facts in this application are correct and valid. ☐ Rejection – I reject the validity of this claim for the reason(s) listed below.

For self-insuring employers only: ☐ Medical only ☐ 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. June 22, 2022)

FROI

ICD's not allowed in claims

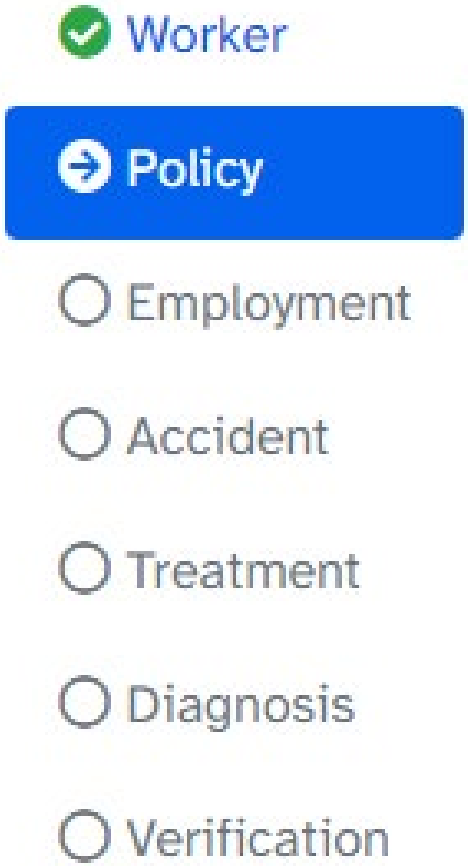
ICDs for conditions

ICDs specific to workers' compensation

Workers' compensation only covers the body part(s) and condition(s) affected by the industrial injury or illness. BWC and self-insuring employers rely on provider diagnoses to determine what conditions to allow. Specific diagnoses, including site and location are needed. The conditions reported on a First Report of Injury (FROI) should include the cause of the injured worker's symptoms and not just the symptoms themselves. Symptom codes cannot be recognized within the workers' compensation system. See the documents below for guidance in reporting injuries and requesting additional conditions.

- International Classification of Diseases (ICD)-10 codes inappropriate for claim allowances - These are primarily symptom codes, unspecified codes and incomplete (ICD chapter heading) codes. Providers who report codes from this list may receive follow-up communication from the MCO or BWC requesting diagnosis clarification. Reporting injuries with inappropriate diagnoses delays claim allowance, treatment authorizations, and provider reimbursement.

ICDs for conditions | Bureau of Workers' Compensation (ohio.gov)



Online FROI filing

- When employer selected: state fund claims shows MCO contact info, self insured claims, TPA contact info (new)
- Employment screen – describes job title, hours etc.

Online Verification – State Fund

Thank you!

We've received your First Report of Injury.

01/17/2023 03:53 PM

Claim number [redacted] 23-111111

MCO Name
Sedgwick Managed Care Ohio

Number
10005

Phone number
555-555-5555

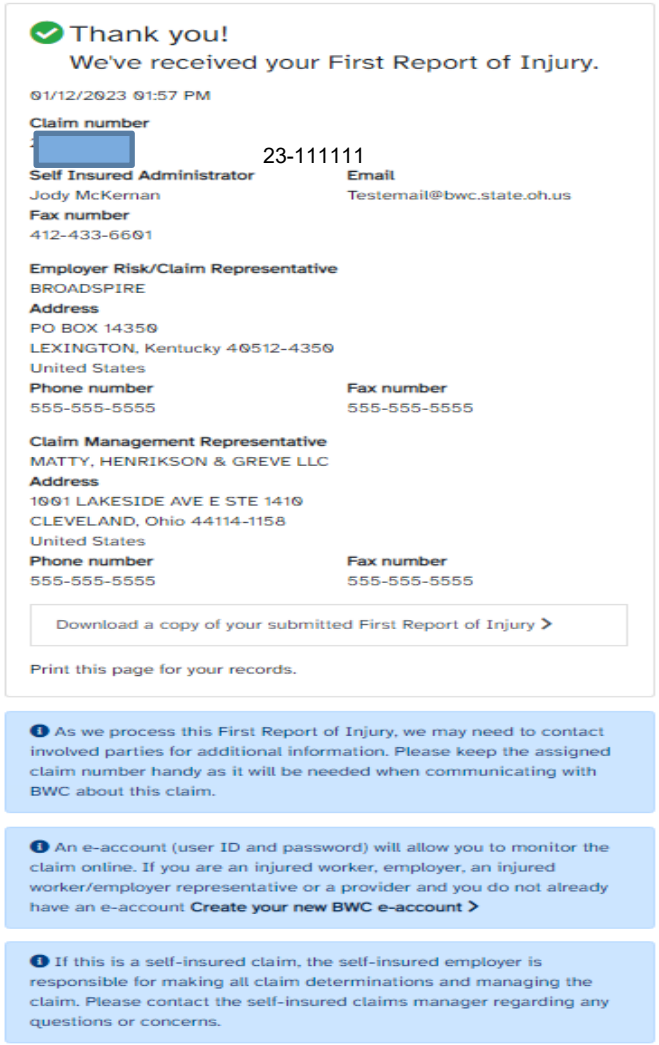
Address
P.O. BOX 1040
DUBLIN, Ohio 43017
United States

Fax number
555-555-5555

Download a copy of your submitted First Report of Injury >

Print this page for your records.

As we process this First Report of Injury, we may need to contact involved parties for additional information. Please keep the assigned claim number handy as it will be needed when communicating with BWC about this claim.


Thank you!
We've received your First Report of Injury.
01/12/2023 01:57 PM
Claim number
[redacted] 23-111111
Self Insured Administrator
Jody McKernan
Email
Testemail@bwc.state.oh.us
Fax number
412-433-6601
Employer Risk/Claim Representative
BROADSPIRE
Address
PO BOX 14350
LEXINGTON, Kentucky 40512-4350
United States
Phone number
555-555-5555
Fax number
555-555-5555
Claim Management Representative
MATTY, HENRIKSON & GREVE LLC
Address
1001 LAKESIDE AVE E STE 1410
CLEVELAND, Ohio 44114-1158
United States
Phone number
555-555-5555
Fax number
555-555-5555
Download a copy of your submitted First Report of Injury >
Print this page for your records.
As we process this First Report of Injury, we may need to contact involved parties for additional information. Please keep the assigned claim number handy as it will be needed when communicating with BWC about this claim.
An e-account (user ID and password) will allow you to monitor the claim online. If you are an injured worker, employer, an injured worker/employer representative or a provider and you do not already have an e-account Create your new BWC e-account >
If this is a self-insured claim, the self-insured employer is responsible for making all claim determinations and managing the claim. Please contact the self-insured claims manager regarding any questions or concerns.

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Online SI verification

- Self insured employer's contact information – more now viewable
- Print this page!

Claim Number: [redacted] 23-111111

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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
John E. Doe III	1/17/2023	[redacted]	9/1/2000

Mailing address; add apartment number or P.O. Box, if applicable	City	State	ZIP code
30 W Spring St	Columbus	OH	432152216

Sex	Email address	Home phone number	Cell phone number
☒ Male ☐ Female	Jdoe@gmail.com		614-000-0000

Employer name	Employer address	City	State	ZIP code
state of ohio	30 E Broad St	columbus	OH	43215

Was the injured worker hired through a temp agency? If yes, name of temp agency	Mark the days of the week you usually work	Regular work hours (include a.m. p.m.)
☐ Yes ☒ No	☐ Sun ☒ Mon ☒ Tues ☒ Wed ☒ Thurs ☒ Fri ☐ Sat	From 08:00 AM To 04:30 PM

Date hired	Job title	State where hired	State where supervised	Wage rate; $ per hour	Number of hours scheduled to work the week of this injury
1/25/2022	laborer	OH	OH	17.00	40.00

Work number for call-offs (Number injured worker calls to reach supervisor)	Part(s) of body affected (For example: Left knee, right index finger)
614-000-0000	Right Shoulder strain/contusion

Accident description (Describe the sequence of events that directly caused the injury or death.)
Fell from first step of ladder putting up stock in cupboard, hit right shoulder on ledge, landed on feet. "Shoulder hurting."

Will the incident cause the injured worker to miss 8 or more days from work? ☐ Yes ☒ No

Injured worker start time	Time of injury	Date employer notified	Was any part of a workday missed due to the injury?	Date last worked	If the injured worker has returned to work, provide the date.
08:00 AM	09:15 AM	1/17/2023	☐ Yes ☒ No	1/17/2023	1/17/2023

Was the place of the accident or exposure on employer's premises? ☒ Yes ☐ No If no, give accident location, street address, city, state, and ZIP code.

Was injured worker hospitalized overnight? ☐ Yes ☒ No

Initial treatment date	Health-care office/Facility name	Treating physician/Provider name	Telephone number	Fax number
1/17/2023	Main Urgent Care	John Smith, MD	888-488-3210	888-488-3211

Health-care office/Facility street address	City	State	ZIP code
32 W Spring St	Columbus	OH	43215

If the injury resulted in death, answer the following.
Date of death Decedent's marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Decedent's number of dependents

To be completed by the injured worker

By signing this form, I:
- **Elect to only receive compensation, benefits, or both provided for in this claim under Ohio's workers' compensation laws.**
- **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.**
- **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.**
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Furthermore, I understand that:
- 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.
- 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.
- Information or records maintained in my previous or future claims may affect decisions made in this claim.
- 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 2913.48).

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".

S46.911A shoulder strain

Initial treatment date	Are the medical conditions you have listed above causally related to the reported work-related accident or occupational disease? ☒ Yes ☐ No Are you the physician of record? ☐ Yes ☒ No		
1/17/2023			
Treating physician/Provider's name (Print)	**Treating physician/Provider's signature**	**BWC provider number**	**Date**
	[redacted] JS [Electronic Signature]	10016830001	1/17/2023

To be completed by the employer

Employer name	Employer county	Phone number	Fax number	Email address
SECRETARY OF STATE OF OHIO	Franklin	(555) 555-5555	(555) 555-5555	

Employer policy number	Federal ID number	Injured worker is (Check box, if applicable.)
10003109-0	31-1334820	☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation

For all employers: ☐ Certification – I certify the facts in this application are correct and valid. ☐ Rejection – I reject the validity of this claim for the reason(s) listed below.
For self-insuring employers only: ☐ Medical only ☐ Lost time
Clarification – I clarify and allow the claim for the condition(s) below.

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Completed online FROI

- Immediate claim number (top center)
- Information you entered shows
- Option to print form

Online FROI key reminders

Completing online FROI as a POR provider type

- Causal relationship (required)
- Are you POR?
- ICD code/description (required)

Completing online FROI as a guest

- Above 3 questions are not required
- Must designate role and include signature

Online FROI key reminders

- Please complete optional information fields as much as possible.
- Answering question of missing 8 or more days of work allows appropriate internal team assignment.

Questions

Ohio | Bureau of Workers' Compensation

Bliss Dickerson, RN, BSN, COHN/CM

(330) 312-8220

Bliss.D.1@bwc.state.oh.us

Tammie Mihaly, RN, MSM-HCA, CCM

(614) 728-5726

Tammie.M.1@bwc.state.oh.us

Thank you for attending!

Looking for reminders, updates, tips and breaking news on workers' compensation?

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twitter.com/ohiobwcfraud

ohiobwcblog.wordpress.com
ohiobwcfraud.wordpress.com