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

- 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 <u>detailed</u> 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?
- o 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 <u>cause</u> the lumbar sprain and fractured left wrist?



New FROI paper form





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 in	itial, last name				Date of inj	ury/disease	Social Security number			Date of birth	
Maillian address and		D 16					O'h			Otata	71D d .
Mailing address; add	apartment number or P.O.	BOX, IT	applicable				City			State	ZIP code
		Em	ail address				Home phone number			Cell phone num	hor
Sex ☐ Male ☐ Fe	male		all address				Home phone number			Cell priorie riuri	ibei
Employer name		Em	ployer address				City			State	ZIP code
Was the injured wor	ker hired through a temp ag	encv?	☐ Yes ☐ No		Mark the d	days of the week you usually	work	R	egular wo	ork hours (include	a.m. p.m.)
If yes, name of temp						☐ Mon ☐ Tues ☐ Wed ☐			rom	Т	
Date hired	Job title			State where	hired	State where supervised	Wage rate; \$ per hour	Numbe	r of hours	of hours scheduled to work the week of this	
Work number for cal	l-offs (Number injured work	er calls t	to reach supervisor)	Part(s) of bo	dy affected (For example: Left knee, right	t index finger)				
Accident description	(Describe the sequence of	events t	that directly caused the	injury or death	ı.)					Will the incide	nt cause the injured
											s 8 or more days
										from work?	☐ Yes ☐ No
Injured worker start t			Date employer notifie			workday missed due to	Date last worked		njured wo	rker has returned	to work, provide the
🗆 am 🗆					njury? 🗆 Ye			date.			
Was the place of the	accident or exposure on e	nployer'	's premises? 🛘 Yes I	☐ No If no, giv	e accident lo	cation, street address, city, s	state, and ZIP code.				talized overnight?
							I = 1 - 1 1		☐ Yes		
Initial treatment date	Health-care office/	acility r	name	Treating phys	ician/Provide	r name	Telephone number			Fax number	
Health-care office/Facility street address						City		Ctata	ZIP code		
Health-care office/Fa	icility street address						City			State	ZIP code
If the injury regulte	d in death, answer the fol	owina								l	
Date of death		_	ot's marital status 🗖 (Single D Marr	ind Dive	rced Separated Wide	owed Decedents	number e	f donor de	anta	
	al less than indicated second	Jecede	int a maritar status 🗀 S	ongle Li Man	ieu 🗀 DIVOI	ced in Separated in Wild	owed Decedent's	number 0	i depende	ento	

New FROI paper form

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 filling 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



							I .
To be completed by the treating	<u> </u>						
Diagnosis(es)-narrative description includir right knee" not "pain right knee", "toxic effe				injury, list the	condition or disease	, not the symp	toms or exposure. For example, "sprain
		,					
Initial treatment date	Are the medical condi	tions you have listed abo	ve causally related to the reported wo	ork-related acc	ident or occupation	al disease?] Yes □ No
	Are you the physician	of record? ☐ Yes ☐ N	No.				
Treating physician/Provider's name (Print)		Treating physician/Pro	vider's signature		BWC provider nur	nber	Date
To be completed by the employe	or .						
Employer name		Employer county	Phone number	Fax number	•	Email addre	55
		•					
Employer policy number	Federal ID number		Injured worker is (Check box, if ap	plicable.) 🗆 (Owner/Sole proprieto	r 🗆 Partner	☐ Individual incorporated as a corporation
For all employers: Certification – I cer	rtify the facts in this applica	ition are correct and valid	. Rejection – I reject th	e validity of th	is claim for the reason	on(s) listed bel	ow.
For self-insuring employers only: Me	edical only \(\subseteq \text{Lost time}						
Clarification - I clarify and allow the claim							
-							
Employer signature and title							Date
To be completed by the submitte	er if the form is comp	pleted by someone	other than the injured worke	r, treating	physician, or er	nployer	
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)

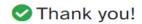


- Policy
- O Employment
- O Accident
- O Treatment
- O Diagnosis
- Verification

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



We've received your First Report of Injury.

01/17/2023 03:53 PM

Claim number

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.

(1) 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.



We've received your First Report of Injury.

01/12/2023 01:57 PM

Claim number

23-111111

Self Insured Administrator

Email

Jody McKernan

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.
- ① 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.



Online SI verification

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



23-111111 First Report of Injury, Occupational Disease, or Death (FROI)

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First name, middle initial, la John E. Doe III	ast name			Date of inj 1/17/20			Security number		9/1/2000	
Mailing address; add apart	ment number or P.O. Bo	x, if applicable		1/1//20	123	City			State	ZIP code
30 W Spring St		Email address				Columb			OH Cell phone	432152216
Sex Male Female	Jdoe@gmail.com					Home phone number			614-000-0000	
Employer name tate of ohio	Employer address 30 E Broad St	955				City			ZIP code 43215	
Was the injured worker him If yes, name of temp agent		y? Yes No		Mark the d	ays of the week you us Mon Tues W	sually work	Teri ∏ Sat	Regular w From 08:		lude a.m. p.m.) To 04:30 PM
Date hired Job t			State where		State where supervis					work the week of this in
1/25/2022 labo			OH		ОН	17.00		40.00		
Work number for call-offs (614-000-0000	Number injured worker of	alls to reach supervisor)	Part(s) of bo		For example: Left knee	, right index fine	jer)			
Accident description (Desc	ribe the sequence of eve	ents that directly caused the	ne injury or death	1.)					Will the in	cident cause the injure
Fell from first step	of ladder putting	up stock in cupb	oard, hit rig	ht should	ler on ledge, lar	nded on fee	et. "Shoulder	hurting."	worker to	miss 8 or more days
Injured worker start time 08:00 AM	Time of injury 09:15 AM	Date employer not 1/17/2023		any part of a	workday missed due to	o Date las		If the injured wo		med to work, provide the
Was the place of the accid								Was in		ospitalized overnight?
Initial treatment date 1/17/2023	Health-care office/Fac Main Urgent Care	lity name	Treating phys John Smit		r name		ne number 188-3210		Fax numbe 888-488-	
Health-care office/Facility s	street address					City			State	ZIP code
32 W Spring St If the injury resulted in de	eath answer the follow	ina				Colum	DUS		OH	43215
By signing this form, I: Elect to only Understand, an injury or o Confirm I hav or benefits fr	receive compensation, waive, and release my occupational disease for re not received comper om any source for this	benefits, or both provid- right to receive compen r which I am filing this of sation and benefits und claim.	sation and bene laim. Ier the workers'	efits under the compensation	e workers' compensa on laws of another st	ation laws of a	m, and I will notif	BWC immedi	ately upon re	ceiving any compens
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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



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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