STATE OF OHIO
DEPARTMENT OF ADMINISTRATIVE SERVICES
GENERAL SERVICES DIVISION
OFFICE OF PROCUREMENT SERVICES
4200 SURFACE ROAD, COLUMBUS, OH 43228-1395

REQUIREMENTS CONTRACT: MEDICAL REPOSITORY DOCUMENT PROCESSING SERVICES

CONTRACT No.: OT902010 EFFECTIVE DATES: 08/01/09 to 07/31/10

The Department of Administrative Services has accepted bids submitted in response to Invitation to Bid No. OT902010 that opened on 07/24/09. The evaluation of the bid response(s) has been completed. The bidder(s) listed herein have been determined to be the lowest responsive and responsible bidder(s) and have been awarded a contract for the items(s) listed. The respective bid response, including the Terms and Conditions for Bidding, Standard Contract Terms and Conditions, and Supplemental Contract Terms and Conditions, special contract terms & conditions, any bid addenda, specifications, pricing schedules and any attachments incorporated by reference and accepted by DAS become a part of this Requirements Contract.

This Requirements Contract is effective beginning and ending on the dates noted above unless, prior to the expiration date, the Contract is renewed, terminated or cancelled in accordance with the Contract Terms and Conditions.

This Requirements Contract is available to Ohio Bureau of Workers' Compensation, 30 West Spring St., Purchasing, L-24, Columbus, OH 43215, as applicable.

Agencies are eligible to make purchases of the listed supplies and/or services in any amount and at any time as determined by the agency. The State makes no representation or guarantee that agencies will purchase the volume of supplies and/or services as advertised in the Invitation to Bid.

SPECIAL NOTE: State agencies may make purchases under this Requirements Contract up to $2500.00 using the state of Ohio payment card. Any purchase that exceeds $2500.00 will be made using the official state of Ohio purchase order (ADM-0523). Any non-state agency, institution of higher education or Cooperative Purchasing member will use forms applicable to their respective agency.

Questions regarding this and/or the Requirements Contract may be directed to:

Jan Jacobs
jan.jacobs@das.state.oh.us

This Requirements Contract and any Amendments thereto are available from the DAS Web site at the following address:

http://www.ohio.gov/procure

Signed: _____
Hugh Quill, Director Date

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SPECIAL CONTRACT TERMS AND CONDITIONS

AMENDMENTS TO CONTRACT TERMS AND CONDITIONS: The following Amendments to the Contract Terms and Conditions do hereby become a part hereof. In the event that an amendment conflicts with the Contract Terms and Conditions, the Amendment will prevail.

MANDATORY/REQUIRED SUBMISSIONS: As specified, mandatory submissions must be submitted with the bid response. Required documentation/materials should be submitted with the bid. If not submitted with the bid, the bidder must provide the said documentation/materials within five (5) business days, after notification, to the Office of Procurement Services. Failure to provide mandatory submissions with the bid response or failure to provide the required documentation/materials, as applicable, within the stated time period will result in the bidder being deemed as not responsive.

For specific submission requirements, bidders should refer to the Bid Submission Check List for a listing of those mandatory submissions due with the bid response and those other submissions that should be submitted with the bid response, but which do not become mandatory until requested during the bid evaluation period.

EVALUATION: Bids will be evaluated in accordance with Article I-17 of the "Instructions to Bidders".

CONTRACT AWARD: The award will be made to the lowest responsive and responsible Bidder based on the lowest Base Price plus the result of applying the percentage of the Base Price for Deleted pages to Base Price and adding them together.

CONTRACT RENEWAL: This Contract may be renewed solely at the discretion of DAS for a period of one month. Any further renewals will be for an appropriate period of time. The cumulative time of all renewals may not exceed forty-eight (48) months unless DAS determines that additional renewal is necessary.

During the term of the resulting Contract, BWC shall be responsible to monitor the Contractor's performance and compliance with the terms and conditions of the Contract. If BWC observes any infraction(s), such shall be documented and conveyed to the Contractor for immediate correction. BWC shall be the sole judge of the adequacy of the services. Continued failures on the Contractor's part to comply with the terms and conditions of the Contract may result in the removal of the Contractor from the Contract by DAS.

The services required under this ITB may be reduced in quantity if technological advances make other means of transmission of documents more common or less expensive or more desirable to BWC.

SPECIAL CHARGES: There shall be no assessment, surcharges, small order charge, broken case charge, minimum order charge, single item charge nor any other unspecified additional charge allowed by the State that is not specifically mentioned in this Bid or in any contract award pursuant to this Bid. The Contractor must provide merchandise/service in unit quantity(ies) as indicated in the Bid/Bid response/contract.

BILLING: Invoices are to be sent monthly, to Ohio Bureau of Workers' Compensation, Accounts Payable, PO Box 15369, Columbus, OH 43215-0369.

INSURANCE DOCUMENTS: Upon the policy renewal date, the Contractor must submit updated insurance documents as required by this Contract. The documents must include a current Workers' Compensation Certificate and an Acord Certificate of Liability Insurance and must include all required endorsements as described in the Supplemental Terms and Conditions of this contract.

Failure to maintain compliant insurance coverage per S-13 of the Supplemental Contract Terms and Conditions will be considered a default and will be cause for cancellation of the Contract under the Standard Contract Terms and Conditions, Section I, Item C, Part 1.

These documents shall be forwarded to the Office of Procurement Services, 4200 Surface Road, Columbus, OH 43228-1395, Attn: Jan Jacobs.

RENEWAL DOCUMENTS: Upon each extension of this Contract agreed to by the State and the Contractor, the following documents must be submitted within five (5) business days prior to the effective renewal date.

A. Current Insurance Acord Certificate with all mandatory clauses as described in the Standard Terms and Conditions of this Bid.

SPECIAL CONTRACT TERMS AND CONDITIONS

B. Current Workers' Compensation Certificate

C. Current signed DMA Form (Declaration of Materials Assistance)

D. Invoices of prior twelve months, including at minimum, name and location of agency, date of service, description of service provided, volume of documents invoiced, dollar amount of service, total invoice amount.

D. Agreement to extension of term stated at the same Terms and Conditions at the time of renewal. This letter shall also include any updates to the Contractor's contact information.

USAGE REPORTS: Every twelve (12) months the Contractor must submit a report (written or on disk) indicating sales generated by this Contract. The report shall list usage by customer, by line item, showing the quantities/dollars generated by this Contract. The report shall be forwarded to the Office of State Purchasing, 4200 Surface Road, Columbus, OH 43228-1395, Attn: Jan Jacobs

USE OF STATE PROPERTY: If given access to state resources to complete work under the resulting contract, Contractor agrees to be held accountable for its employees' use and misuse of state resources, including but not limited to electronic mail ("email"), telecommunications, online and network services, and computer equipment and systems. Contractor agrees to require its employees to keep all passwords confidential; to ensure the appropriateness of the content of all transmissions in order to ensure that the time spent on the system directly benefits work under this Agreement; to make every reasonable effort to avoid the introduction of malicious code into any computer system; to report inappropriate uses of email from internal or external sources and any malicious code encountered to the Bureau's Manager of Computer Security; and to observe and obey all copyright laws. Contractor further agrees to require its employees not to disable anti-virus software; not to bypass any access controls or other security measures; not to download, transmit , and/or store any message or information that is defamatory, abusive, obscene, profane, sexually oriented, threatening, or racially offensive or otherwise inappropriate or unrelated to the work under this Agreement; not to transmit confidential Bureau information to anyone not authorized to receive that information; not to transmit messages that serve as advertising or solicitation; not to transmit chain letters, business solicitations, or global email messages; and not to download executable programs and not to participate in chat rooms, open discussions or forums or interactive messaging without specific authorization from the Bureau's Manager of Computer Security. Contractor acknowledges that the Bureau monitors email, internet, PC and network use and reserves the right to access and to use all material and records of use of its property and agrees to so inform its employees.

LIQUIDATED DAMAGES: In the event that an awarded Contractor fails to provide services or deliver equipment as specified herein, the agency will contact the Contractor to determine when the services and/or equipment will be provided. If the Contractor cannot fulfill the requirements within a timeline acceptable to the agency, the agency may procure like-kind supplies/services from another resource and invoice the contract provider for the full amount charged by the third party provider. Invoices for said liquidated damages must be deducted from subsequent Contractor invoices prior to payment by the agency.

In the event that an awarded Contractor fails to provide accurate invoicing, or corrected invoicing within a reasonable amount of time determined by the Office of Procurement Services, the Contractor may be in default of this Contract and may be subject to cancellation.

Under these damage recovery provisions, the agency may: (1) elect to procure any portion of the services and/or equipment purchase from another source; (2) charge the Contractor for any difference in cost for the merchandise or service procured; and (3) cancel any portion of the original order without Contractor penalty. Also reference Supplemental Contract Terms and Conditions, Article S-9, Time of Delivery, and Standard Contract Terms and Conditions, Section II, Contract Remedies.

SPECIFICATIONS AND REQUIREMENTS

I. BACKGROUND

The Ohio Bureau of Workers' Compensation (BWC) is an agency of the State of Ohio, responsible for administering the workers' compensation insurance program in Ohio. As the third largest provider of workers' compensation insurance in the United States, BWC often is looked to as the model for workers' compensation administration, operations and programs. BWC will endeavor to build on this approval and success as a national leader of workers' compensation. Its slated mission is to provide a quality, customer-focused workers' compensation insurance system for Ohio's employers and employees. BWC intends to be the international leader in workers' compensation insurance.

II. SCOPE OF WORK

The Department of Administrative Services, Procurement Services, on behalf of BWC, is seeking bids for a Contractor to provide document indexing services for incoming Medical Repository faxes. This includes not only the act of indexing, but also quality audits, hiring and training of new indexing personnel, and removal of personnel no longer making specified quality and performance targets. This document indexing services contract will be from August 01, 2009 thru July 31, 2010. Any award made as a result of this Bid will become part of this contract, whose current term runs thru July 31, 2010 and which has a potential of four, twelve (12) month renewals available by mutual agreement of all parties.

BWC currently operates a service known as Medical Repository (MR), the impetus of which is the large number of medical documents faxed from medical providers to Medical Care Organizations (MCOs). These documents can range from the First Report of Injury (FROI) to BWC forms to medical reports. Each MCO implemented a phone number or set of phone numbers that the provider would use to fax to the correct MCO based on the employer involved. Due to deficiencies in communication, some of these documents went to the incorrect MCO, a number of MCOs, or to BWC itself, under the assumption that the document would eventually reach the proper MCO. This resulted in confusion for all involved, and regularly generated multiple contacts with the provider requesting a re-fax of the documents, delaying the overall process.

In addition, many documents moving early in the claims process can reach BWC prior to a claim number being generated. In terms of the Document Imaging System for Claims (DISC) application, these documents cannot be directly "indexed" into the system, as the claim number is a major index field. This resulted in documents waiting for claim numbers to be generated and extra work to retrieve them later in the index process.

In the Fall of 1999, BWC Administration asked IT/Advanced Technology Integration Services (ATIS) if there was a technical method to alleviate these problems. After a great deal of research and discussion, it was determined that BWC could become a "nexus" for these documents. A solution was implemented to automatically forward faxes to the MCO, while process "images" of these documents go into a Repository to be accessed by BWC and MCO personnel, as well as external partners, via a web interface.

This has alleviated confusion regarding which party is in possession of which document (as both BWC and MCOs have it near-simultaneously), as well as provided access to the documents prior to a claim number being created.

A. OVERALL DESIGN

The system can be broken up into four parts:

a. Faxing
b. Indexing and reviewing
c. Web access
d. Integration of documents into Document Imaging System for Claims (DISC)

1. Faxing

It was decided by BWC and the MCOs early on in the design that it would be preferable not to change the numbers used by the providers, so the following process was implemented:

a. Providers fax to the MCOs using the existing numbers provided by the MCOs.
b. The numbers are actually owned by BWC, so the faxes go directly to the agency.
c. BWC's fax server uses the 800 number called to determine which MCO should receive that fax, which is then forwarded to them in an automated manner.

As an example, a provider is faxing a medical report to MCO X. The provider faxes the document using the existing number provided by the MCO, which comes to BWC. BWC receives the fax at their server which determines that the document should be forwarded to MCO X, since it was sent to them using 800-555-9999 (the fax number assigned to MCO X). The server automatically forwards the fax to MCO X using a number provided by them.

2. Indexing and Reviewing

Once documents come in through the fax server, a designated staff indexes them. Documents are indexed by:

a. Social Security Number OR Claim Number (if already assigned)
b. Type of Document

The addition of SSN as a valid index is necessary to allow documents that do not yet have a Claim number to be stored and retrieved. Additional indexes are automatically set up by the system.

3. Web Access

Claims Imaging Documents, including those in the Medical Repository, are accessible to users via a web browser interface. There are three classes of users who currently have access to BWC's website service (www.ohiobwc.com) known as Claims Documents:

a. MCOs (using website security)
b. Other external partners (using website security)
c. BWC personnel (using Windows-based security)

Users are able to search for documents by Claim Number, SSN, type of document, and date range. They are given a list of imaged documents that match their search. By clicking on an item in the list, they are shown the related document on screen, and are able to rotate, zoom, and move through the pages of the document.

4. DISC Integration

An automated process called Auto-Index searches the Medical Repository for documents indexed by SSN, and attempts to match them up with a claim number. If the search is successful, it moves the document into the DISC imaging system, and makes it available to the DISC user as if it had been scanned or faxed to that site and indexed there.

B. MINIMUM QUALIFICATIONS

The vendor must meet the following minimum criteria. The three (3) references provided by the vendor must be able to verify these.

1. The vendor's gross annual revenue for each of the last five (5) years has been $4 million or more.
2. The vendor has been operating in this type of business for the last five years or longer.
3. The vendor has been profitable for each of the last five (5) years. Please include details such as balance sheets, revenue statements and audited financials.
4. The vendor has performed work with a minimum of 3 customers within the past 3 years where ongoing, on-site work has been done with on-site management.
5. For at least one of the customers referenced above, vendor has performed an indexing effort of no less than 6 months.
6. For at least one of the customers referenced above, vendor has managed a minimum of 15 on-site support/management staff.
7. For at least one of the customers referenced above, vendor has indexed a minimum of 30,000 pages daily for a period of 6 months or longer.
8. For at least one of the customers referenced above, vendor has indexed a minimum of 10 document types with minimum of 2 index fields.
9. For at least one of the customers referenced above, vendor has successfully reached a service level agreement (SLA) of 1 business day from document entry to the completion of indexing.
10. For each of the customers referenced above, please list the name of the firm, the main function of that firm, their address and web site, and a contact name with phone number or e-mail address.

III. SPECIFICATIONS AND REQUIREMENTS

A. Staff Structure (All items are required)

1. The ITB is for the acquisition of staffing and management for processing of incoming faxed documents into the Medical Repository (MR) system. The MR system accepts faxed documents on an ongoing, continuous basis. For purposes of this document, and based on current statistical data, it will be assumed that the average incoming flow on a business day is 36,000 pages.

2. In order to efficiently process this much data, it has been determined that at least three classes of personnel, each with their own set of tasks, is required, along with personnel that act as management (see Appendix B, Roles and Responsibilities)

3. All staff will be required to sign a confidentiality agreement with BWC.

4. An independent background investigation, at minimum, to include criminal or police records must be completed on all staff assigned to BWC's account at the cost of the vendor. Verification of the background investigation must be submitted after the award of the Contract and before the staff starts to work at BWC.

B. Working Time (All items are required)

1. Staff and management will report to the William Green Building, 30 W. Spring St., Columbus, OH, 43215 at 7am local time each day from Monday through Friday, unless specified otherwise by the Medical Repository Liaison (MRL). This includes dates normally referred to as "bank" or "state" holidays. Those days include:

   a. Martin Luther King Jr's Birthday – Third Monday in January
   b. President's Day – Third Monday in February
   c. Columbus Day – Second Monday in October
   d. Veterans' Day – Eleventh day of November
   e. If 11th is a Saturday, use preceding Friday
   f. If 11th is a Sunday, use following Monday

2. Staff will work from 7am to 3:45pm each day local time under normal circumstances, unless in the transition of new staff.

3. With the exception of the MR Liaison, all personnel involved in the MR process will be ineligible for BWC events and activities not directly related to MR work held during the times noted above. This includes all-employee meetings, classes, seminars, committees, charity events, etc.

4. Depending on the workload and the amount of documents to be worked in the queue, personnel may be asked to work on occasional Saturdays with 48 hours advance notice.

5. Any policies concerning breaks or leave time outside of the specifications above to be determined by the Contractor.

C. Payment Structure (All items are required)

1. Payment by BWC will be based on the amount of work processed, not hours worked.

2. Bid prices (see Bid Price Page) will be on a "per page" basis, with deleted pages charged at not more than 50% of base cost. Historically, approximately 72-77% of pages are processed normally, 23-25% of pages are deleted, and 1% are sent through review.

3. Pages processed outside of production, such as in the training process, will not count toward Contractor payment.

4. Level of staffing to be determined by Contractor. As a reference, the current staffing is 20-25 indexers and reviewers, along with a Manager. Total onsite personnel may not exceed a total of 30. BWC will provide facilities (cubicle, chair, and computer) for onsite personnel up to this figure.

D. Security, Communications and Sensitive Data (All items are required)

Contractor agrees to follow all procedures listed in Appendix A.

E. Roles & Responsibilities- see Appendix B for more detailed information on each role (All items are required)

1. External staff will be provided by the Contractor to cover the roles and responsibilities of each category listed below at the proper level to meet overall specifications. All staff will be located onsite. The Contractor will replace existing staff according to the transition schedule (see Transition of Staff, pg. 10).

2. MR Manager (MRM) – manages the daily reporting and staffing needs. The awarded Contractor must agree to follow all procedures listed in Appendix B, Roles & Responsibilities.

3. MR Quality Reviewer (MRQR) – review and quality checks the Review queue, the Deletion queue and responsible for training new staff. The awarded Contractor must agree to follow all procedures listed in Appendix B.

4. MR Reviewer (MRR) –review and indexes from the Review queue; assist with the training of new staff. The awarded Contractor must agree to follow all procedures listed in Appendix B.

5. MR Indexer (MRI) – indexes from the main Fax queue. The awarded Contractor must agree to follow all procedures listed in Appendix B.

6. A member of the BWC staff will act as the MR Liaison (MRL) – performs audit checks and handling of any business issues.

F. Service Level Agreements (All items are required)

1. The following Service Level Agreements (SLAs) for the MR system are in place: A maximum of one full business day from the time a document is faxed to the point it has been indexed and made available through the MR web site.

2. A maximum of seven (7) business days from the time a document is sent to the Auto-Index process to be matched with a claim number and sent to the Review queue.

3. A maximum of one full business day from the time a document is sent to the review queue before it is processed.

4. Unless otherwise indicated, access to the MR indexing application will be available between 7:00am and 7:00pm Monday-Friday local time on business days. This is limited based on the accessibility of the underlying applications.

5. All SLAs subject to change based on agreement between BWC and the Contractor.

6. In order to ensure the SLAs listed above, both the Index and Review queues must be kept to a manageable size. Threshold figures are measured at 7:00am and 3:00pm local time. See Appendix C for Threshold Figures.

7. MRM shall inform MRL in the event that any of these conditions are not met. MRM will also inform their staff as soon as is feasible that overtime may be necessary.

G. Fluctuations in Throughput (All items are required)

1. As in any production environment involving ongoing, continual input from multiple external parties, MR throughput will fluctuate on a daily basis.

2. MRM will be fully responsible to ensure that the SLAs are met by adjusting staffing as required. To do so the following rules will be in place:

   a. MRM will have the right to send MRI, MRR, or MRQR personnel home early on a daily basis as long as SLA is met.
   b. In this situation, MRM shall advise MRL that this step has been taken.
   c. MRL will have the right of refusal if it is clear that SLA will not be met based on conditions at that time.

H. Quality Assurance (All items are required)

1. MRL shall, on a monthly basis, perform a quality audit of the documents processed through the MR system, based on a statistically meaningful random sampling as reasonably determined by BWC of the volume total. Example of a random quality audit would be based on the following:

   a. Index Queue –350 pages
   b. Review Queue – 50 pages
   c. Deletion Queue –350 pages
   d. FROI – 30 pages

   Effective date of the quality audits will be three months from the award date. Based on the results of this audit, payment to the Contractor shall be reduced as follows:

2. Index Queue Processing – total payment for that month will be reduced if the error rate goes above 2% at a rate of $2,000 for each partial or full percentage point up to 5% and $4,000 for each partial or full percentage point above 5%.

   Errors to be defined as:
   a. Date of Injury (DOI) on document was incorrect, and was not cross-checked against Injured Worker name, address, or birth date
   b. Social Security Number (SSN) on document was incorrect, and was not cross-checked against Injured worker's name.
   c. Claim Number on document was incorrect, and was not cross-checked against Injured Worker name or SSN
   d. Incorrect selection of document type
   e. Multiple documents indexed as single document

3. Review Queue Processing – total payment for that month will be reduced if the error rate goes above 2% at a rate of $2,000 for each partial or full percentage point up to 5% and $4,000 for each partial or full percentage point above 5%

   Errors to be defined as:
   a. SSN on document was incorrect and was indexed as such, and was not cross-checked against injured Worker name
   b. Multiple documents indexed as single document
   c. A claim number that matched the SSN and DOI is not found
   d. Claim number missed on document
   e. In addition, any First Report of Injury (FROI) in the Review queue older than 8 business days, or any other type of document in the Review queue older than 15 business days, will be charged at a rate of $2,000 each. This is in line with procedures and SLAs.

4. First Report of Injury (FROI) Processing –due to the critical nature of this document type, and the fact that the MRR class was designed specifically for this document, total payment for that month will be reduced by $2,000 for each occurrence of the following:

   a. DOI is not cross-checked with Injured Worker name, SSN
   b. SSN is not cross-matched with Injured Worker name or is entered incorrectly
   c. Claim number that matches DOI and SSN was available but not indexed as such

5. Deleted Queue – total payment for that month will be reduced if the error rate goes above 1% at a rate of $2,000 for each partial or full percentage point up to 3% and at $4,000 for each partial or full percentage point above 3%. Errors to be defined as documents found in Delete queue that are:

   a. Included in defined document type list AND
   b. Have legible index data (SSN, Claim Number) OR
   c. Index data could be found via crosscheck with Injured Worker name and DOI.

6. MRL shall provide a copy of the monthly audit report to MRM as a form of evidence for any reductions and as a tool for the MRM to avoid future reductions.

7. Monthly Audit report is to be made available to the MRM no later than close of business on the fifth business day of the next month. If not provided by that time, no quality-based reductions for the previous month will be allowed.

8. MRL shall also perform more limited “spot audits” of the system on an ongoing basis. The results of the spot checks shall be made available to the MRM as tool to increase performance and quality; however, they shall not be used in order to determine payment reductions.

I. Default Conditions (All items are required)

At BWC’s discretion, the following conditions shall constitute a state of Default and shall initiate conditions listed under Section C, #1g. of the Terms and Conditions,

a. Index queue reaching a level of 50,000 pages, assuming normal availability of the system to process documents for a period of two business days prior to that point OR
b. Quality-based payment reductions (see Quality Assurance, pg. 8) that equal or exceed 50% of the total monthly payment.

J. Transition of Staff (All items are required)

1. Within 30 days of the opening of the bids the new staff would be prepared to start to be transitioned into the process. Each staff member assigned to BWC’s account must have a criminal background check completed and passed before the start date. Each staff member assigned to BWC’s account must sign the BWC confidentiality agreement before the start date.

   As each new staff member becomes productive (1500 pages indexed per day) and doesn’t impact quality, a current staff member at BWC would be cycled off the project. Regardless of the transition timeframe, new staff will not replace existing staff until these conditions are met.

2. The transition process of replacing staff is expected to complete in 120 days. The vendor cannot terminate contract before the 120 day transition period to ensure continuity of service.

   a. Vendor to make first new staff available (maximum of 3) for training at the site within 30 days of contract signature and execution.
   b. Vendor to provide a maximum of 3 personnel each week (or as requested by BWC) after that point for training and assignment until current staff is fully replaced.
   c. MRL has final authority to replace any and all staff during the transition process.

3. The training process normally will take up to 4 days. The training schedule is listed in Appendix D, Training Schedule.

4. As pages processed during training will not be counted toward vendor payment (see Payment Structure, pg. 7), it will benefit all concerned that the personnel brought in have appropriate aptitude for the task, and that those who do not perform well in training be removed promptly by the vendor.

5. In addition, the vendor agrees that, as of the expiration of the Contract described in the ITB, a transition process identical to that listed above shall be implemented to accommodate replacement staff.

BID PRICE PAGE

All details pertaining to costs of Medical Repository Document Processing Services are covered in this paragraph, broken out by the following details. This paragraph should be used as a worksheet with the final per page and annual bid price to be listed on the bid page. Notice: Cost shall not exceed three (3) digits after the decimal point. Reference the Instructions, Terms and Conditions for Bidding, Article I-18, Unit Costs.

ITEM NUMBER	ITEM DESCRIPTION	*COST PER PAGE (Estimated figure of 36,000 pages per day)
16501 (index per page) 16503 (index per deleted page)	The Contractor shall state the base price to index a single page through the MR system, as specified above, and then complete the calculations. The base price will include all costs involving all vendor roles specified in the ITB, and including all vendor personnel involved in the process. There will be no additional cost above the base price. BWC is not liable for any costs not identified in the Contractor's response, costs incurred in the preparation of any response to this ITB, any costs incurred prior to the issuance of a valid purchase order by BWC, or for any costs incurred after the Contract expires.	Base Price: $ _.11____Page % of Base Price for Deleted Pages: ___50____%

The annual usage should be considered an estimate only and the actual number may be greater or smaller.

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IV. BID SUBMITTAL

A. Mandatory: These items shall be included at the time of the Bid. Failure to provide these items with the Bid or by the Bid Opening date and time as stated on Page 1 of this Bid may deem the Bid as not responsive and no further consideration will be given to the Bid. A list of these Mandatory items can be found on the last page of this Bid.

B. Required: These items shall be included at the request of Office of Procurement Services. Failure to provide these items within the specified timeframe stated on the last page of this Bid may deem the Bid as not responsive and no further consideration will be given to the Bid. A list of these required items can be found on the last page of this Bid.

V. REFERENCES

Bidder must provide with their Bid at least three (3) positive references for jobs of similar scope which may include government agencies and private industries. The reference must provide the name and address of the company, the name and telephone number(s) of the contact person, a brief description of services provided and the length of service for that company. The references must include the annual dollar amount of the contract, and the type(s) of services performed.

Upon request from Office of Procurement Services, the Bidder will provide additional references if needed. Failure to provide references that are able and available to answer questions pertinent to the Bidder's performance and job satisfaction may deem the Bidder as not responsive and their Bid may be disqualified.

CONTRACTOR INDEX

CONTRACTOR, TERMS, AND SHIPMENT:

BID CONTRACT NO.: OT902010 (07/31/10)

CONTRACT NO: OT902010-1

0000086104
The Data Entry Company
4920 Elm Street, Suite 200
Bethesda, MD 20814

TERMS: 2%, 10 Days

CONTRACTOR'S CONTACT: John R. DuFour

Telephone: (301) 718-0703
Fax: (301) 718-1615
E-mail: jdufour@tdec.com

OAKS ITEM NO.: 16501 – price per page
16503 – price per deleted page

PREFERED METHOD OF RECEIVING PO: E-Mail

0000101061
US Bank

OT902010-2 (07/31/10)

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Appendix A – Security, Communications and Sensitive Data

Security

Personnel will be required to fill out forms 2 business days prior to their start date in order for BWC to provide them with proper physical (cardkey) and computer (login) security.

Any personnel leaving the project will be required to return cardkeys and all other BWC materials to Medical Repository Liaison (MRL) before leaving.

Personnel, while onsite, will remain on floors and areas indicated by the MRL.

Communications

All communication between staff and BWC will be done through the Medical Repository Manager (MRM), the Medical Repository Quality Reviewer (MRQR), and the Medical Repository Reviewer (MRR) who will work directly with the Medical Repository Liaison (MRL). Onsite E-mail and phone service will be provided for the MRM, MRQR, and MRR for this purpose.

Confidentiality

Contractor acknowledges that some of the information, documents, data, records, or other material to which it may be exposed in the performance of the Agreement is of a confidential nature. The Contractor shall assume that all aspects of information, documents, data, records or other material are confidential unless otherwise indicated by BWC.

The Contractor promises not to copy, disclose, publish, or communicate BWC's confidential information and the Contractor promises to maintain the security and confidentiality of BWC information as follows:

Contractor, its officers, agents, employees, representatives, subcontractors and assigns shall keep confidential all information, in whatever form obtained or accessed, in the performance of this Agreement, including but not limited to knowledge of the contents of confidential records of the Bureau. Any information subject to the confidentiality laws of this state, including but not limited to employer premium data subject to Ohio Revised Code Sections 4123.26 and 4123.27 and claim file data subject to Ohio Revised Code Section 4123.88, shall not be released to any person other than authorized representatives of the Bureau, unless the Bureau directs its release.

Contractor shall comply with, and shall assist the Bureau in complying with, all disclosure, notification or other requirements contained in Sections 1347.12, 1349.19, 1349.191, and 1349.192 of the Ohio Revised Code, as may be applicable, in the event computerized data that includes personal information, obtained or accessed by Contractor in the performance of this Agreement, is or reasonably is believed to have been accessed and acquired by an unauthorized person and the access and acquisition by the unauthorized person causes, or reasonably is believed will cause a material risk of identity theft or other fraud.

All Contractor staff performing services under this Agreement will be required to sign a confidentiality agreement, in the format set forth in Appendix A of this Agreement, with BWC.

Sensitive Data

The faxes received in the medical repository area are all considered as sensitive data due to the information located within the fax documents. The following are the Contractor's responsibilities with regard to the handling of BWC sensitive data:

a. Paper records with sensitive information shall be stored in a secure environment. They shall not be left unattended without adequate safeguards such as placement in desk drawers, filing cabinets or other secured environments. Records shall not be removed from BWC premises..
b. Never leave paper records that may contain BWC sensitive information lying on your desk or in an open area that is out of your control.
c. Never throw sensitive paper records in the trash. The paper record must be kept in a secured environment until it is shredded or placed in a lockable recycle bin.
d. Immediately notify MRL if sensitive and/or personal data is or reasonably is believed to have been accessed and acquired by an unauthorized person and the access and acquisition by the unauthorized person causes, or reasonably is believed will cause a material risk of identity theft or other fraud.

The restrictions herein shall survive termination of this Agreement.

Contractor and its employees must, at all times, exercise utmost caution when handling BWC sensitive information especially when transmitting and/or mailing any type of sensitive data. BWC sensitive information is any information that, if made public, would:

a. be unlawful;
b. compromise BWC's ability to carry out its functions;
c. expose BWC customer(s) or employee(s) confidential information (e.g. social security numbers, medical records, employer financial data, banking information, driver's license numbers, confidential internal communications, etc.); or
d. jeopardize the safety of BWC's employees.

Contractor may refer to the Sensitive Data Charts below for additional information; however, be advised the charts are not meant to be all-inclusive. If there is any uncertainty regarding whether or not information is considered sensitive, Contractor will treat the information as sensitive and will protect it accordingly.

Sensitive Data Chart

Injured Worker Sensitive Data Chart

Data Element	Sensitive or Non-sensitive	Data Element	Sensitive or Non-Sensitive	Data Element	Sensitive or Non-Sensitive
Name	Sensitive	Name and Any Banking Information/Credit Card Information	Sensitive	Claim Number and Any Banking Information/Credit Card Information	Sensitive
Name and SSN	Sensitive	SSN and ANY data element	Sensitive	Phone Number and ANY data element	Sensitive
Name and Claim Number	Sensitive	Claim Number	Sensitive	Address and ANY data element	Sensitive
Name and Address	Sensitive	Claim Number and Address	Sensitive	Claim Status and ANY data element	Sensitive
Name and Phone Number	Sensitive	Claim Number and Phone Number	Sensitive	ICD-9 Codes and ANY data element	Sensitive
Name and Claim Status	Sensitive	Claim Number and Claim Status	Sensitive	Medical Records Created in the Course Of Treatment and ANY data element	Sensitive
Name and ICD-9 Codes	Sensitive	Claim Number and ICD-9 Codes	Sensitive	Medical Records created to establish entitlement to benefits and ANY data element	Sensitive
Name and Medical Records Created in the Course Of Treatment	Sensitive	Claim Number and Medical Records Created in the Course Of Treatment	Sensitive	Payments and ANY data element	Sensitive
Name and Medical Records created to establish entitlement to benefits	Sensitive	Claim Number and Medical Records created to establish entitlement to benefits	Sensitive	HIV and ANY data element	Sensitive
Name and Payment	Sensitive	Claim Number and Payment	Sensitive	Psych Conditions and ANY data element	Sensitive
Name and HIV	Sensitive	Claim Number and HIV	Sensitive	Drivers License and ANY data element	Sensitive
Name and Psychiatric Conditions	Sensitive	Claim Number and Psychiatric Conditions	Sensitive	Banking Information/Credit Card Information and ANY data element	Sensitive
Name and Drivers License	Sensitive	Claim Number and Drivers License	Sensitive	IW Name, Employer Name, Accident Information	Sensitive

Employer Sensitive Data Chart

Data Element	Sensitive or Non-sensitive	Data Element	Sensitive or Non-Sensitive	Data Element	Sensitive or Non-Sensitive
Coverage Status	Non-Sensitive	Manual Numbers	Non-Sensitive	Rating Plan and Premium Amounts	Sensitive
Coverage Status and Payroll Reported	Sensitive	Manual Numbers and Payroll Reported	Sensitive	Rating Plan and Security Deposit	Sensitive
Coverage Status and Premium Amounts	Sensitive	Manual Numbers and Premium Amounts	Sensitive	Rating Plan and Reserves	Non-Sensitive
Coverage Status and Manual Number	Non-Sensitive	Manual Numbers and Security Deposit	Sensitive	Rating Plan and Banking/Credit Card Information	Sensitive
Coverage Status and Security Deposit	Sensitive	Manual Numbers and Rating Plan	Non-Sensitive	Reserves	Non-Sensitive
Coverage Status and Rating Plan	Non-Sensitive	Manual Numbers and Reserves	Non-Sensitive	Reserves and Payroll Reported	Sensitive
Coverage Status and Reserves	Non-Sensitive	Manual Numbers and Banking/Credit Card Information	Sensitive	Reserves and Premium Amounts	Sensitive
Coverage Status and Banking/Credit Card Information	Sensitive	Security Deposit and ANY data element	Sensitive	Reserves and Security Deposit	Sensitive
Payroll Reported and ANY data element	Sensitive	Rating Plan	Non-Sensitive	Reserves and Banking/Credit Card Information	Sensitive
Premium Amounts and ANY data element	Sensitive	Rating Plan and Payroll Reported	Sensitive	Banking/Credit Card Information and ANY data element	Sensitive
Number of Employees and ANY data element	Sensitive	Federal Tax ID and ANY data element	Sensitive	Employer Policy Number	Non-sensitive

Provider Sensitive Data Chart

Data Element	Sensitive and Non-Sensitive
Provider Number	Sensitive
DEA Provider Number	Sensitive

Appendix B Roles & Responsibilities

Medical Repository Manager (MRM)

Onsite Responsibilities

- Oversee the day to day staff operations of the unit onsite.
- Generate status and statistical reports to the MRL as required.

Job Duties

- Approves leave and schedules for MRI, MRR, and MRQR.
- Assigns duties & tasks for same.
- Evaluates performance of same.
  Interviews & recommends hire of potential staff, as well as firing of existing staff based on their performance and efficiency.
- Reports business/procedural issues to MRL, technical nature issues to BWC Service Desk.

MRM Recommended Minimum Qualifications

- Completion of undergraduate core program in social or behavioral science, or public or business administration or
- accounting.
- 6 mos. exp. in management.
- 12 mos. exp. in supervisory principles/ techniques. OR completion of graduate core program in social or behavioral science.
- 6 mos. exp. in image, document, or mail processing.

Medical Repository Quality Reviewer (MRQR)

Onsite Responsibilities

- Q & A the review queue.
- Q & A the deletion queue.
- Assist with any questions/issues/problems.
- Research all one/two page documents in the review queue for FROI's.
- Verify that the document is of readable quality.
- Confirm SSN using V3 lookup that could require multiple lookup attempts.
- Confirm Injured Worker's name or address or date of injury (DOI) or birth date using V3 lookup that could require multiple lookup attempts.
- Confirm that no claim number is available matching DOI (including name and SSN lookups) using V3 lookup that could require multiple lookup attempts, print for processing, and delete.
- Complete research by using Claims Management on documents when duplications are found in V3 or the Injured Worker cannot be located by SSN.

Job Duties

- Works directly with MRL.
- Trains staff in proper procedures of MR system.
- Assists staff with problems of highly complex or policy nature.
- Perform productivity and quality audits.
- Generate monthly quality reports.
- Assist MRR.
- Assists MRM with interviews & recommends hire of potential staff, as well as firing of existing staff based on their performance and efficiency.
- Works under minimum supervision.
- Requires considerable knowledge of clerical systems and procedures in order to perform specialized clerical tasks (i.e. cross referencing data or variety of other procedures where absolute accuracy is required).
- Serve as lead worker (i.e., provide work direction and training).

MRQR Recommended Minimum Qualifications

- Must have 1 course or 3 months experience in typing.
- Ability to key 10,000 keystrokes per hour.

Appendix B Roles & Responsibilities (Cont'd)

Medical Repository Reviewer (MRR)

Onsite Responsibilities

- Works directly with MRL.
- Assist with any questions/issues/problems.
- Research all multiple page documents in the review queue.
- Verify that the document is of readable quality.
- Verify Social Security Number (SSN) using V3 lookup that could require multiple lookup attempts.
- Confirm Injured Worker's name or address or DOI or birth date using V3 lookup that could require multiple lookup attempts.
- If not enough information is available to locate the correct Injured Worker, delete.
- If no DOI is located on any of the medical, use Injured Worker Profile to locate the ICD – 9 codes.
- Medical - confirm date of receipt - if less than 14 business days, index back by SSN to run for 7 more business days.
- Confirm that no claim number is available that matches DOI (including name and SSN lookups), delete document .

Job Duties

- Trains staff in proper procedures of MR system.
- Assists staff with problems of highly complex or policy nature.
- Assists MRQR.
- Works under minimum supervision.
- Requires considerable knowledge of data processing in order to make changes, deletions and/or corrections to documents for data entry.
- Ability to retrieve information necessary to correct computer-rejected documents.

MRR Recommended Minimum Qualifications

- Typing skill of 45 words per minute.

Medical Repository Indexer (MRI)

Onsite Responsibilities

- Identify each fax by type of document being faxed in - BWC forms are 'stand alone' forms, no other pages should be connected but only the fax cover sheet. (See Appendix F – Document Type Guide)
- Index documents by either claim number or SSN.
- Verify document is of readable quality.
- Check for Injured Workers' name or address or (DOI) or birth date via V3 lookup.
- Verify there are not multiple claims within one fax.
- If multiple images are on one page then delete.
- Verify the Injured Worker name at the bottom of the screen and compare with the name on the pages to be indexed.

Job Duties

- Works under immediate supervision of MRQR.
- Requires knowledge of clerical systems and procedures in order to perform basic repetitive clerical tasks involving few variables.
- Must follow a written set of procedures without variance.
- Able to index 1500 pages per day.

MRI Recommended Minimum Qualifications

- Typing skill of 45 words per minute required.
- Able to index 1500 pages per day.

THIS IS INCLUDED AS REFERENCE ONLY—NOT PART OF BID

Medical Repository Liaison (MRL)

Responsibilities

- Explain processes (logical, technical) in the Medical Repository.
- Resolve issues or modifications in the workflow as they arise.
- Coordinate Medical Repository personnel (security badges, logins, equipment, supplies, etc…)
- Coordinate technical issues with BWC Service Desk.
- Resolve quality issues.
- Monitor queues.
- Perform productivity and quality audits.
- Modifies the vendors invoice based on quality issues found during the month.
- Recommends hire of potential staff, as well as firing of existing staff based on their quality.

Job Duties

- Thoroughly understanding of the workflow.
- Modifies the workflow.
- Mentors personnel through training process.
- Resolves quality issues.
- Assists MRM, MRQR, and MRR with problems of highly complex or policy nature.
- Perform the final quality check before placing new hires into production.

Appendix C -- Threshold Figures and Example of Random Quality Audit

Threshold Figures

Based on the performance of the system to this point, as well as the productivity of the staff involved, the following decision points have been made to determine the need for additional work outside of the times stated.

- At 7am, a reading shall be taken by the MRM or MRQR of the Index and Review queues

    1. If the Index queue at that point is at or over **20,000** pages or **5,300** documents
       MRM shall plan for additional work for MRI outside of the times stated on page 7, Working Time.

    2. If the review queue at that point is at or over **3,300** pages or **1,245** documents
       MRM shall plan for additional work for MRR and MRQR outside of the normal times.

- At 3pm, a reading shall be taken by the MRM or MRQR of the index and Review queues

    3. If the Index queue at that point is at or over **10,000** pages or **3,000** documents
       MRM shall plan for additional work for MRI outside of the normal times, or up until 7pm,
       whichever comes first.

    4. If the Review queue at that point is at or over **500** pages or **250** documents
       MRM shall plan for additional work for MRR and MRQR outside of the normal times when needed.

Appendix D – Training Schedule

Sample Only

			TRAINING DAY ONE		
TASK	**OBJECTIVE**	**TIME**	**ACTUAL TIME**	**TRAINEE INTIALS**	**COMMENTS**
REVIEW MANUAL	Trainee will read the training manual and become familiar with each form/document	1 hour			
REVIEW MANUAL	Trainer will review the manual with trainee and provide more detailed information	1 hour			
INDEXING	Trainer indexes while trainee observes the indexing process	6 hours			
			TRAINING DAY TWO		
INDEXING	Trainee index on their own.	all day			All work is reviewed for quality and accuracy
			TRAINING DAY THREE		
INDEXING	Trainee index on their own.	all day			All work is reviewed for quality and accuracy, if any issues are found - indexer will not go for final check but be terminated
			TRAINING DAY FOUR		
INDEXING	Trainee index on their own.	all day			Final check by BWC before being placed into Production

Appendix F – Glossary and Document Type Guide

Glossary

Claims Management – main application used at BWC, also known as “Version 3” or “V3”

DOI – Date of Injury

Injured Worker Profile – screen listing details

MR – Medical Repository

MRI - Medical Repository Indexer who works the daily fax in queue

MRL - Medical Repository Liaison is the main BWC contact

MRM - Medical Repository Manager oversees the onsite daily operation

MRQR - Medical Repository Quality Reviewer does the training and Q & A indexers

MRR - Medical Repository Reviewer works the Review Queue

SSN – Social Security Number

Document Type Guide

(Samples are shown in Exhibits A-J)

TYPE - DOCUMENT TYPE DESCRIPTION

C140 - WAGE LOSS APPLICATION
C84- PHYSICIAN’S SUPPLEMENTAL REPORT
C86 - MOTION
C9 – PHYSICIAN’S REQUEST FOR MEDICAL SERVICES
C92 – DETERMINATI OF % OF PP DISBLTY
C92EXA - C921C92A EXAMS
FRI - FIRST REPORT OF INJURY
MED - MEDICAL DOCUMENTS
MEDCO14 – PHYSICIAN’S REPORT OF WORK ABILITY
MEDCO2I- PHYSICIAN REVIEW

- FAX COVER SHEETS ATTACHED TO DOCUMENT BECOME SAME DOC TYPE

Appendix G – CONTRACTOR AGREEMENT

I understand that in the course of my employer's assignment with the Bureau of Workers' Compensation ("BWC") I may have access to confidential information, including but not limited to the confidential information or trade secret information of BWC or the confidential or trade secret information of another entity in the possession or control of BWC. I understand that I may also have access to state property and equipment in the course of my employer's assignment with BWC.

I agree to maintain the confidentiality of this confidential or trade secret information in the manner instructed by my supervisor(s) or any BWC official at the time access is granted to me. I agree not to disclose this confidential or trade secret information to any individual or entity, directly or indirectly during the term of my assignment or thereafter, except as requested by my supervisor(s) or by a BWC official. I agree not to use such confidential or trade secret information for any purpose than to complete the assignment.

I acknowledge receipt of a copy of the BWC Code of Ethics and I agree to follow them to the extent they pertain to my employer's assignment with BWC.

If given access to state resources to complete work in the course of my employer's assignment with BWC, including but not limited to electronic mail ("email"), telecommunications, online and network services, and computer equipment and systems, I agree to keep all passwords confidential; to ensure the appropriateness of the content of all transmissions in order to ensure that the time spent on the system directly benefits work for my employer's assignment with BWC, to make every reasonable effort to avoid the introduction of malicious code into any computer system; to report inappropriate uses of email from internal or external sources and any malicious code encountered to the Bureau's Manager of Computer Security; and to observe and obey all copyright laws and to be responsible for respecting any other intellectual property rights of others.

I agree not to disable anti-virus software; not to bypass any access controls or other security measures; not to download, transmit, and/or store any message or information that is defamatory, abusive, obscene, profane, sexually oriented, threatening, or racially offensive or otherwise inappropriate or unrelated to my employer's assignment with BWC; not to transmit confidential Bureau information to anyone not authorized to receive that information; not to transmit messages that serve as advertising or solicitation; not to transmit chain letters, business solicitations, or global email messages; and not to download executable programs and not to participate in chat rooms, open discussions or forums or interactive messaging without specific authorization from the Bureau's Manager of Computer Security.

I acknowledge that the Bureau monitors email, internet, PC and network use and reserves the right to access and to use all material and records of use of its property. I understand that unauthorized access to any BWC system is prohibited. I also understand that if I misuse any data or access granted it could result in access restrictions and possible criminal and civil penalties.

_____ _____

DATE SIGNATURE

_____

Print Name

_____

Print Employer's Name

Exhibit A

Ohio | Bureau of Workers' Compensation

Initial Application for Wage Loss Compensation

Instructions
File this application when requesting an **initial** payment of wage loss compensation.

- Complete the form in its entirety.
- Provide your physician completing this form with a copy of the functional job description at the time of injury and have him or her complete the medical report.
- Provide your employer at the time of injury with all copies and attachments.
- Return the completed form to your local customer service specialist or your self-insuring employer.

You must attach the following when requesting working wage loss (WWL):
- Written proof that employment has been sought with your employer of record;
- Copies of current pay stubs with gross earnings or a completed C-94-A Wage Statement notarized if completed by the injured worker.

You must attach the following when requesting non-working wage loss (NWWL):
- Written proof that employment has been sought with your employer of record.
- Proof of registration with the Ohio Department of Job and Family Services;
- Completed wage loss statement(s) for job search (C-141).

Injured worker name		Date of birth		Claim number
Address	City		State	Nine-digit ZIP code
Occupation or job title at time of injury			Injured worker telephone number	
Employer name at time of injury			Employer telephone number	
Address	City		State	Nine-digit ZIP code

☐ I am requesting WWL benefits from _____ to _____

☐ I am requesting NWWL benefits from _____ to _____

Previous work history
This is required for initial applications of WWL and NWWL. Please provide your employment history for each position that contributed to your income at a minimum of the last 10 years. (Please attach additional sheets with this information if necessary.)
BWC may use this information to determine possible referral for vocational rehabilitation and to evaluate job search efforts.

Employer	Dates of employment	Job title	Reason for leaving	Earnings
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Warning
I have answered the foregoing questions truthfully and completely. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or self-insuring employers, or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

I hereby request payment of wage loss benefits for the period listed and certify that the information listed on this Application for Wage Loss Compensation is correct to the best of my knowledge. I have also given a copy of this application with supporting documentation to my employer at the time of injury.

Injured worker signature	Date

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C-140

Exhibit A – Cont'd

Ohio | **Bureau of Workers' Compensation**

Medical Report

Instructions for the physician
- BWC will use this medical report as part of an application for wage loss compensation.
- Please complete this report in its entirety.
- Attach additional information that you feel will substantiate this request.
- The attending physician must complete and submit this report every 90 days if restrictions are temporary or every 180 days if restrictions are permanent.

Injured worker name		Claim number	
Name of physician completing this report	Telephone number	Fax number	
Address	City	State	Nine-digit ZIP code
Date of this report	Date of last medical examination		
List the allowed conditions in the claim that are causing the restrictions listed below			

Indicate only the restrictions caused by any impairment resulting from the allowed conditions.
For psychiatric/psychological conditions – attach narrative report outlining restrictions.
For physical capacity – denote below.

Total hours during an eight-hour day injured worker can:

	0	1	2	3	4	5	6	7	8
Sit	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐	☐	☐	☐	☐

Injured worker can: (% of eight-hour day)

	Never 0%	Occasionally 1%-33%	Frequently 34%-66%	Continuously 67%-100%
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Reach	☐	☐	☐	☐

Injured worker can lift: (% of eight-hour day)

	Never 0%	Occasionally 1%-33%	Frequently 34%-66%	Continuously 67%-100%
Up to 5 lbs	☐	☐	☐	☐
6-10 lbs	☐	☐	☐	☐
11-20 lbs	☐	☐	☐	☐
21-25 lbs	☐	☐	☐	☐
26-50 lbs	☐	☐	☐	☐
51-100 lbs	☐	☐	☐	☐

Injured worker can carry: (% of eight-hour day)

	Never 0%	Occasionally 1%-33%	Frequently 34%-66%	Continuously 67%-100%
Up to 5 lbs	☐	☐	☐	☐
6-10 lbs	☐	☐	☐	☐
11-20 lbs	☐	☐	☐	☐
21-25 lbs	☐	☐	☐	☐
26-50 lbs	☐	☐	☐	☐
51-100 lbs	☐	☐	☐	☐

Use of hands in repetitive action such as:

	Simple grasping		Pushing and pulling arm controls		Fine manipulation	
Right	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Left	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

Use of feet in repetitive movements of leg controls

Right	☐ Yes	☐ No
Left	☐ Yes	☐ No
Both	☐ Yes	☐ No

Based on the allowed conditions of this claim, please list any additional restrictions not specified in the physical capacity section. _____

_____

Are the restrictions ☐ temporary ☐ permanent

If temporary give an opinion as to the expected duration of the restrictions: from _____ to _____

Due to the restrictions noted above, how many total hours per day and per week can the injured worker work? _____ Hours _____ Days

Physician signature (Mandatory)

I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Physician name (Please print)	Physician signature (**Mandatory**)	Date

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C-140 Pg. 2

Exhibit B

Ohio | **Bureau of Workers' Compensation**

Request for Temporary Total Compensation

Claim number

Instructions for Injured Worker
- Please print or type and complete items 1 - 6 on this form.
- Give this form to your physician of record to complete items 7 - 13 on the reverse side of the form.
- When both your portion and the physician's portion are completed, send this form to the local BWC customer service office or self-insuring employer.
- If you have any questions on completing this form, please call the local BWC customer service office or self-insuring employer.

To Be Completed By Injured Worker

1
- Name
- Date of injury
- Telephone number ( )
- Address
- City
- State
- Nine-digit ZIP code

2 Last date worked due to current period of work related disability: Return-to-work date:

3 Employer name (where injury/disease happened) | Is modified or light-duty work available with this employer? ☐ Yes ☐ No ☐ Don't know

4 Have you worked, in any capacity, (include full-time, part-time, self-employment or commission work) during the disability period shown above? ☐ Yes ☐ No If yes, provide employer name:
- Employer name (self, if self-employed)
- Telephone number ( )
- Address
- City
- State
- Nine-digit ZIP code

5 Have you received or filed for any of the following benefits since your injury?
- Unemployment compensation ☐ Yes ☐ No OBES claim number _____
- Social Security retirement ☐ Yes ☐ No Social Security claim number _____
- Sick leave ☐ Yes ☐ No From _____ to _____
- Public assistance ☐ Yes ☐ No Human services case number _____
- Wage continuation ☐ Yes ☐ No From _____ to _____

Have you applied for or are you receiving other benefits from any other source regarding this injury? ☐ Yes ☐ No

If yes, give Agency/Company name _____ Claim number _____

Injured Worker Signature

6 I understand I am not permitted to work while receiving temporary total compensation. I have answered the foregoing questions truthfully and completely. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

- Signature (if unable to sign, mark before two witnesses)
- Date
- Witness
- Witness

Failure to complete this form, as instructed, may delay or suspend compensation payment.

BWC-1205 (Rev. 7/31/2008)
C-84

Exhibit B – Con'td

Instructions to physician
- Please complete items 7 - 13, injured worker name and claim number on this form.
- You may attach additional medical documentation such as diagnostic test results and current treatment plan to support this request.
- Failure to provide complete information may delay or suspend compensation payments to the injured worker.

Injured worker name	
Claim number	

To Be Completed By Physician of Record

7 What was the injured worker's position of employment at the time of injury?

Can the injured worker return to this position of employment? ☐ Yes ☐ No

Can the injured worker return to other employment, including light-duty work, alternative work, modified work or transitional work? ☐ Yes ☐ No

Please explain, listing any restrictions that may apply. Attach additional sheet if necessary.

8 List diagnosis(es) for allowed conditions being treated, which prevent return to work.

List diagnosis(es) for other allowed conditions being treated.

9

Date of last exam or treatment	Next appointment date

Disability dates due to the work related injury/disease

From: To:

Return to work date

____ /____ /____ ☐ Actual ☐ Estimated ☐ Released

10 The following clinical findings are the basis for my recommendations:

Objective Subjective

11 Has the work-related injury(s) or disease reached a treatment plateau at which no fundamental functional or physiological change can be expected despite continuing medical or rehabilitative intervention (maximum medical improvement)? ☐ Yes ☐ No If yes give date _____

If no, indicate any barriers preventing normal recovery, or maximum medical improvement. Attach an additional sheet if necessary.

12 Is the injured worker a candidate for vocational rehabilitation services focusing on return to work? ☐ Yes ☐ No Please explain:

Physician of Record Signature - Mandatory

I certify that the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

13

Physician of record name			BWC provider number - **mandatory**	
Address	City	State	Nine-digit ZIP code	Telephone number ( )
Physician of record signature				Date

Exhibit C

Ohio | **Bureau of Workers' Compensation**

Motion

Instructions

- Parties to the claim requesting a decision by BWC or the Industrial Commission of Ohio must use this form if any other form or application does not apply. Parties to the claim include the injured worker, employer and/or their authorized representatives and BWC. For a complete list of injured worker and employer forms visit **ohiobwc.com**, or call BWC at **1-800-OHIOBWC**.
- **Health-care providers or managed care organizations (MCOs) do not use this form.** Health-care providers or MCOs must use the *Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease* (C-9).
- You must submit proof with this form to support the requested action. When requesting an additional condition, please include medical documentation, such as medical reports that include a physician statement addressing causal relationship between the requested condition and the industrial injury, diagnostic test results, radiology exam results, operative reports, etc. When requesting full or average weekly wage adjustments, include earning statements, such as pay stubs, C-96A wage statement form, payroll report, W2, tax forms, etc.
- The applicant must mail a copy of the *Motion* to all parties and/or their authorized representatives to the claim and will indicate a copy has been mailed by signing Certificate of Service below.

Section I

Injured worker name		Claim number	
Street address	City	State	Nine-digit ZIP code

This *Motion* is a request to consider the following:

Section II

In support of this *Motion*, the following evidence is included: (Please indicate the evidence included to support the request, such as medical reports that include a physician statement addressing causal relationship between the requested condition and the industrial injury, earning statements or any other evidence to support the requested action as outlined in the instructions.)

Section III

Certificate of Service: I certify I have served a copy of this *Motion* on all parties and representatives to the claim.

Signed _____ Date signed _____

☐ Injured worker ☐ Employer ☐ Authorized representative ☐ Administrator of the Ohio Bureau of Workers' Compensation

BWC-1208 (Rev. 9/08/2008) *Distribution: Original – Claim File Copies – as needed*

C-86

Exhibit D

Ohio | **Bureau of Workers' Compensation**

Physician's Request for Medical Service or Recommendation for Additional Conditions for Industrial Injury or Occupational Disease

• Instructions for completing C-9 on reverse side.

Fax note:	
To	From
Toll-free phone number	Phone number
Toll-free fax number	Fax number

I. IW

❶ Injured worker name	Claim number	SSN if claim number unknown	Date of injury / /

II. Requested services

❷ Treating diagnosis ICD-9 code(s)	❸ Date service begins / /	Date service ends / /	Date of last exam or treatment / /

❹ Requested Services	Frequency	Duration
1.		
2.		
3.		
4.		

III. Additional conditions

If you are recommending additional conditions to the claim, supporting documentation is required.

❺ Provide diagnosis and ICD-9 code(s), and location and site for conditions you are requesting.

❻ In your opinion, based on the history from the injured worker, your clinical evaluation and expertise, is the diagnosis or condition causally related, either directly or proximately, to the alleged industrial accident or exposure? ☐ Yes, please explain ☐ No, please explain

IV. Physician info.

❼ CHECK ☐ if Physician of Record

I certify that the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment, or both.

❽ Physician/provider name and address (please print, type, or stamp)	❾ Physician/provider/authorized signature (mandatory)	
	BWC Provider number (mandatory)	Date (M/D/Y) (mandatory)

V. MCO/SI Employer decision

MCO If this page is not faxed or mailed back to the submitting physician within three business days of receipt or within five business days of receipt of information requested on the C-9-A, the authorization for treatment shall be deemed granted subject to BWC policy, excluding retroactive requests.

☐ ***APPROVED WITH DISCLAIMER*** *- This medical payment authorization is based upon a claim or additional condition that is currently being considered by BWC/IC as of the date of the MCO's signature. If the claim or additional condition is ultimately disallowed, the services/supplies to which this medical payment authorization applies may not be covered by BWC and may be the responsibility of the injured worker.*

☐ Approved Date service begins ____/____/____ Date service ends ____/____/____

☐ Amended approval _____

☐ Denied explanation: _____

Disputes to the decision may be filed in writing with supporting documents to the MCO.

☐ **Pending:** The documentation requested must be submitted to the MCO case manager within 10 business days to allow for a treatment decision. Failure to respond may result in denial.

☐ **Dismissed (Claim inactive – no supporting evidence):** The issue will be reconsidered upon resubmission of C-9 with current supporting medical evidence. This dismissal cannot be appealed.

☐ **Claim inactive (MCO cannot make a decision on this request, further investigation required):** A decision will be issued in writing by BWC within 28 days.

☐ Withdrawn ☐ Dismissed _____

BWC claim status: ☐ Allowed ☐ Denied ☐ Pending	List allowed ICD-9-code(s)

MCO company/SI Employer name (please print, type or stamp)	MCO name and signature (print, type or stamp and sign)		
	MCO number	Telephone number ( )	Date / /

SI Employer

Self-insuring employer use only Fax or mail this page to the submitting physician within 10 days of receipt or the authorization for treatment shall be deemed granted per OAC 4123-19-03 (K)(5).

Self-insuring employer signature	Date / /

BWC-1113 (rev. 4/29/2008)
C-9 (Combines C-1-A & C-161)

Ohio | Bureau of Workers' Compensation

Application for Determination of Percentage of Permanent Partial Disability or Increase of Permanent Partial Disability

Instructions
- Please use a typewriter or ballpoint pen and press firmly to complete this form.
- You or your representative must sign this form before submission.
- You must submit one copy and retain one copy for your records.
- If assistance is needed you may contact your local BWC customer service office.

Claim number

Application for:

☐ Determination of the initial percentage of permanent partial disability (%PPD);

☐ Determination in the %PPD for a newly allowed condition in this claim (no new medical required);

☐ Increase in the %PPD – **I believe the percentage of permanent partial disability has increased over the percentage previously determined. I have attached three copies of the medical report from my doctor to support this application. Medical reports attached are accompanied by evidence of new and changed circumstances.**

Part A – Injured Worker Information

Injured worker name	Social Security number	Date of injury
Address		
City	State	Nine-digit ZIP code
County	Work telephone number ( )	Home telephone number ( )

Part B – Application Information

Employer at the time of injury	Telephone number ( )
Address	
City	State / Nine-digit ZIP code

Describe the disability you now consider to be permanent as a result of your injury or occupational disease. How does this injury or occupational disease affect your activities of daily living? (specify parts of the body affected)

Other workers' compensation claim numbers and the nature of each injury or occupational disease are listed below.

Claim Number	Allowed Condition	Claim Number	Allowed Condition
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Part C – Authorization

Name of injured worker representative (if represented) (please print or type)	REP I.D. number
Signature of injured worker / injured worker representative (if represented)	Date

I hereby authorize the BWC/employer to forward any monetary award generated by this application to the attorney indicated above for disbursement to me.

Signature of injured worker	Date

BWC Use Only

Copy mailed to: ☐ Employer ☐ Employer representative	Date mailed

Distribution: Original-Claim file Copies-as needed

BWC-1214 (C-92 and C-92-A combined) (Rev. 12/4/2001)
C-92

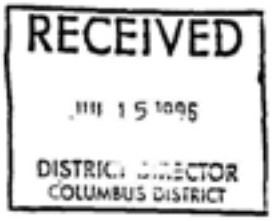
MEDICAL TRANSMITTAL

CLAIM NUMBER:

TYPE OF EXAM:ROUTINE
DATE OF INJURY:
COUNTY: UNION

N/A

N/A



INJURED WORKER'S PHONE NUMBER:

SOCIAL SECURITY NUMBER:

CONDITION(S) ALLOWED IN CLAIM: SPRAIN THORACIC & LUMBAR THORACIC MYOFASCITIS

CONDITION(S) DIS-ALLOWED IN CLAIM: N/A

IF OTHER CLAIMS ARE ALLOWED FOR THE SAME CONDITION AS INDICATED ABOVE AND A PERCENTAGE HAS BEEN GRANTED, LIST THE CLAIM NUMBERS; SPECIFY CONDITION(S) ALLOWED; AND THE PERCENTAGE FIGURE GRANTED.

CLAIM NUMBER(S): N/A

CONDITION(S): N/A

%PP GRANTED: N/A

CLAIM'S REPRESENTATIVE: VW/sim.
DATE TYPED: APRIL 12, 1996

DISTRICT LOCATION: Columbus Service Office C-92 Sectic

C92 EXAM

To be completed by Examining Phy

EXAMINING PHYSICIAN: [illegible] DA

PERCENTAGE FOUND AT THIS EXAM: 19%

IF A PREVIOUS PERCENTAGE WAS GRANTED, THIS IS A

C92EXA

Tear off this sheet and return the completed form to your employer's managed care organization (MCO) or to your local BWC customer service office.

Ohio | Bureau of Workers' Compensation

First Report of an Injury, Occupational Disease or Death

By signing this form, I:
- Elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;
- Waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;
- Agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;
- Confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.

WARNING:
Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.
(R.C. 2913.48)

Injured worker and injury/disease/death info.

Last name, first name, middle initial | Social Security number | Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Date of birth

Home mailing address | Sex: ☐ Male ☐ Female | Number of dependents

City | State | 9-digit ZIP code | Country if different from USA | Department name

Wage rate: $ _____ Per: ☐ Hour ☐ Month ☐ Week ☐ Year ☐ Other _____ | What days of the week do you usually work? ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat | Regular work hours: From _____ To _____

Have you been offered or do you expect to receive payment or wages for this claim from anyone other than the Ohio Bureau of Workers' Compensation? ☐ Yes ☐ No. If yes, please explain. | Occupation or job title

Employer name

Mailing address (number and street, city or town, state, ZIP code and country)

Location, if different from mailing address

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

Date of injury/disease | Time of injury: _____ ☐ a.m. ☐ p.m. | If fatal, give date of death | Time employee began work: _____ ☐ a.m. ☐ p.m. | Date last worked | Date returned to work

Date hired | State where hired | Date employer notified | State where supervised

Description of accident (Describe the sequence of events that directly injured the employee, or caused the disease or death.) | Type of injury/disease and part(s) of body affected (For example: sprain of lower left back)

Benefit application/medical release – I am applying for a claim under the Ohio Workers' Compensation Act for work related injuries that I did not purposely inflict. I affirm that I elect to receive compensation and benefits under the Ohio workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim. I request payment for compensation and/or medical benefits as allowable, and authorize direct payment to my medical providers. I permit and authorize any provider who attends, treats or examines me, and the Ohio Rehabilitation Services Commission (where relevant) to release medical, psychological, prosthetic, vocational or social information that is causally or historically related to my physical or mental injuries relevant to issues necessary for the administration of my claim to BWC, the Industrial Commission of Ohio, the employer in this claim, the employer's BWC MCO and any authorized representatives.

Injured worker signature | Date | E-mail address | Telephone number ( ) | Work number ( )

Treatment info.

Health-care provider name | Telephone number ( ) | Fax number ( ) | Initial treatment date

Street address | City | State | 9-digit ZIP code

Diagnosis(es). Include ICD code(s).

Will the incident cause the injured worker to miss eight or more days of work? ☐ Yes ☐ No | Is the injury causally related to the industrial incident? ☐ Yes ☐ No

Health-care provider signature | 11-digit BWC provider number | Date

Employer info.

Employer policy number | Check if: ☐ Employer is self-insuring ☐ Injured worker is owner/partner/member of firm

Telephone number ( ) | Fax number ( ) | E-mail address | Federal ID number | Manual number

Was employee treated in an emergency room? ☐ Yes ☐ No | Was employee hospitalized overnight as an inpatient? ☐ Yes ☐ No

If treatment was given away from work site, provide the facility name, street address, city, state and ZIP code

☐ **Certification** - The employer certifies that the facts in this application are correct and valid.

☐ **Rejection** - The employer rejects the validity of this claim for the reason(s) listed below:

For self-insuring employers only
☐ **Clarification** - The employer clarifies and allows the claim for the condition(s) below:
☐ **Medical only** ☐ **Lost time**

Employer signature and title | Date | OSHA case number

BWC-1101 (Rev. 3/26/2009) This form meets **OSHA 301** requirements.

FROI-1 (Combines C-1, C-2, C-3, C-6, C-50, OD-1, OD-1-22)

ORTHOPAEDIC SURGERY
SPORTS MEDICINE

SUITE 412
RIVERSIDE MEDICAL BUILDING
3545 OLENTANGY RIVER RD
COLUMBUS OHIO 43214 3457

Bureau of Workers' Compensation

27 September 1995

Via Fax: ( )

ATTENTION:

RE:
CL#

96 MAY -7 PM 2:21
CLAIMS

To Whom It May Concern:

I have advised that a stationary bicycle would be helpful in her post-operative recovery after right knee arthroscopy.

She has attempted to find a facility to rent a stationary bicycle for a month or two and has been unable to find one. Our office has also tried to find a place to rent a stationary bicycle, but we have been unsuccessful.

The patient has notified us she has purchased an Schwinn AirDyne. The use of a stationary bicycle has been part of our suggestion to the patient in her post-operative rehabilitation.

If you have any further questions, please free to contact this office.

Sincerely yours,

MEDICAL

DBR:pt

copy: file

[03\wp60\csmith01.pat]

(MED)

Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

Instructions
- Physician must complete this form when the injured worker is under work restrictions or is temporarily totally disabled.
- You must send or fax a copy of the completed form to the managed care organization (MCO) and a copy given to the injured worker at time of exam.
- You may use any other physician-generated document provided that the substitute document contains, at a minimum, the data elements on the MEDCO-14.
- If injured worker is employed by a self-insuring employer complete this form and mail or fax it to the self-insuring employer.

Fax Note:

To	From
Toll-free phone number	Phone number
Toll-free fax number	Fax number

Injured worker name	Claim number	SSN if claim number unknown	Date of injury
			/ /
Injured worker occupation	**Employer name**		

WORK ACTIVITY

☐ May return to work (RTW) with no restrictions on _____

☐ May RTW with restrictions due to work-related injury/disease from _____ to _____ (complete work/non-work capabilities on the right). Work restrictions apply to work and non-work activity. If restrictions cannot be met at work, then injured worker is recommended to be off work.

The restrictions are ☐ permanent ☐ temporary? If temporary, how long? _____

☐ Is totally disabled from work from _____ to _____.

Please explain in the space provided below why the injured worker is unable to work, due to work-related injury/disease. List ICD-9 codes for the allowed conditions being treated which prevent return to work. _____

Estimated RTW date _____

Work/Non-Work Capabilities

% of Workday (8 hr) / Repetitions per hr	None at all 0%	Occasional 1-33% 4-6	Frequent 34-66% 6-12	Continuous 67-100% >12
Lift/Carry				
Up to 10 lbs	☐	☐	☐	☐
11-20 lbs	☐	☐	☐	☐
21-50 lbs	☐	☐	☐	☐
51-100 lbs	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Twist/turn	☐	☐	☐	☐
Reach below knee	☐	☐	☐	☐
Push/pull	☐	☐	☐	☐
Squat/kneel	☐	☐	☐	☐
Stand/walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
No lifting above shoulders	☐	☐	☐	☐

Hand restrictions ☐ Left ☐ Right
- ☐ Must wear splint
- ☐ No lifting greater than _____ lbs
- ☐ No repetitive activities
- ☐ No work with hot or cold substances

No use of ☐ Left ☐ Right
- ☐ Arm
- ☐ Hand
- ☐ Finger _____
- ☐ Other

☐ Change positions every _____ ☐ Work activity as splint/bandage permits
☐ Avoid driving ☐ Keep wound clean/dry ☐ Limit working to _____ Hrs./Day

Physician's further explanation of work abilities or why the injured worker is unable to perform any work: _____

MMI

Has the work-related injury(s) or occupational disease reached a treatment plateau at which no fundamental functional or physiological change can be expected despite continuing medical or rehabilitative intervention (maximum medical improvement)? ☐ Yes ☐ No

▶ ***Note: Periodic medical treatment may still be requested and provided.***

IF YES, give date _____ IF NO, please explain (attach additional sheet if necessary)

REHAB

☐ **Check if vocational rehabilitation return to work services are indicated.**

Physician name and address *(please print, type or stamp)*

Date of this exam	Follow-up appointment Date	Time
/ /	/ /	

I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment, or both.

Physician signature (mandatory) **Date** / /

Distribution: White-Physician Fax a copy to MCO Yellow-Injured worker

BWC-3914 (Rev. 7/30/2008)
MEDCO-14

Exhibit J

PHYSICIAN REVIEW

Service Office Medical Claims		Claim number
Injured worker's name	Social Security Number	Date of Injury
Allowed conditions:		
The attached claim is being referred to you on by (phone:).		
Question(s) to be addressed: ☐ Does medical information and/or MOI support initial or allowance requested? ☐ If the foregoing answer is 'no', then what diagnosis does the medical documentation support, if any? ☐ Other		

PHYSICIAN'S NARRATIVE

Analysis:		
Conclusion:		
Physician's Name (Typed)	Date	Time
Physician's Signature		

BWC-3921 (Rev. 12/92)
MEDCO-21

PHYSICIAN REVIEW