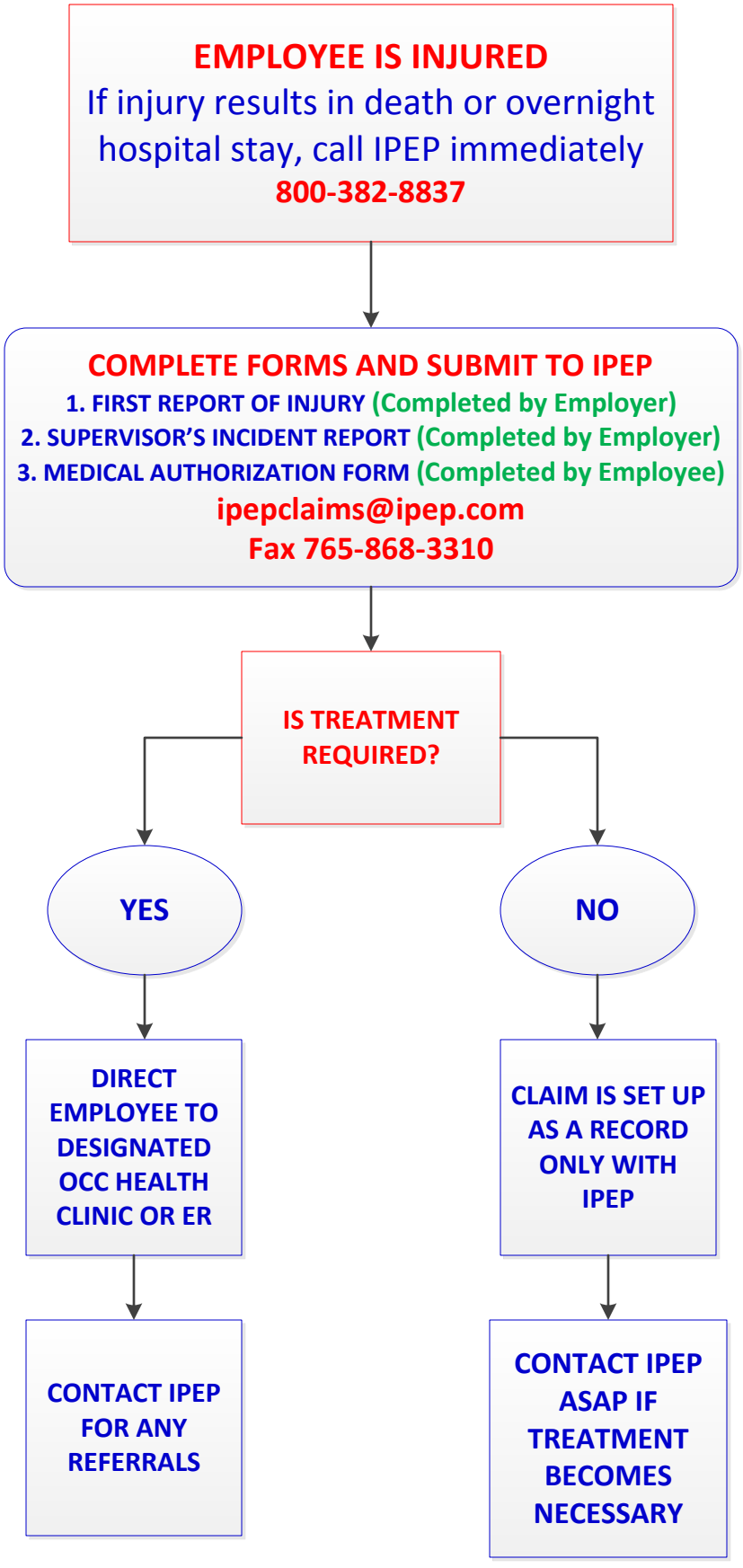
IPEP REPORTING PROCEDURES



1/2022

Fundamentals of Workers Compensation

COMPENSABILITY

INJURY OR ILLNESS

- Arising out of employment
- In the course of employment
- By accident or unforeseen event

THE BURDEN OF PROOF IS ON THE EMPLOYEE

DEFENSES

THE BURDEN OF PROOF IS ON THE EMPLOYER

- Knowingly self inflicts injury
- Intoxication
- Commission of an offense
- Knowing failure to use a safety appliance
- Knowing failure to obey a reasonable written or printed rule of the employer which has been posted in a conspicuous position in the place of work
- Knowing failure to perform any statutory duty

BENEFITS

- TTD – 66 2/3% of AWW up to maximum weekly benefit
- TPD – 66 2/3% of difference from AWW and actual earnings up to maximum wage
- DEATH – 66 2/3% of AWW up to maximum wage for 500 weeks plus burial benefit
- MEDICAL – unlimited amount for authorized care with two year statute of limitation
- PPI – permanent loss of body function

CLAIMS REPORTING AND GENERAL INSTRUCTIONS

CLAIMS REPORTING ADDRESS AND GENERAL INSTRUCTIONS

A. Reporting of an Injury or Occupational Disease

1. In the event of a serious injury, such as severe trauma or spinal injury, please notify Public Risk Underwriters by telephone immediately at 1-800-382-8837.

2. As of July 1, 2018, the Workers Compensation Board requires a First Report of Injury form within 7 days of an employer's knowledge of the injury, either actual, alleged or reported, for any injury resulting in death or the need for medical care beyond first aid.

3. As of July 1, 1991, the Workers Compensation Board is allowed to assess a $50.00 - $300.00 civil penalty against an employer if the first report of injury is not reported within 7 days. The fine increases incrementally for each infraction. Therefore, if Public Risk Underwriters does not receive the report in a timely manner, there is the possibility that a fine could be assessed. If Public Risk Underwriters has caused the delay, we will pay the fine. However, if the board assesses the penalty and the lateness of the report is due to the member's delay, we will request that the penalty be paid directly by the member.

   Additional penalties may be assessed if TTD is not paid within 14 days after disability begins. Immediate reporting of lost time accidents is imperative to avoid fines.

4. The following forms should be sent to Public Risk Underwriters as the third-party administrator for IPEP:

   a. Employer's Report of Injury Illness of Employee (State Form 34401)
   b. Supervisor's Incident Investigation Report
   c. Wage statement for any lost time accident where disability may exceed seven (7) days.
   d. Medical Authorization Release

Claims Reporting Address and General Instructions
(Cont.)

B. Public Risk Underwriters Claims

1. If you have a serious claim, please call us at 1-800-382-8837.
2. **The most efficient way to report claims is by e-mail to ipepclaims@ipep.com.**
3. You may also fax reports to 765-868-3310. (See Section 2.1 A for reporting times required by the state.)

C. Workers' Compensation Disability Checks

1. Benefit checks will be mailed to the injured worker on a biweekly basis.

D. Medical Benefits

1. Public Risk Underwriters as the Third Party Administrator of IPEP has the right to direct treatment.

The Public Risk Underwriters Claims Department encourages members to use a specific medical facility or physician in their geographic area. If you don't currently utilize a designated physician or clinic for your workers compensation injuries, please contact your claims representative or the Claims Supervisor for assistance. Our claims staff will assist with selecting a designated occupational health physician or facility and developing a workers' compensation protocol.

COMPLETION OF REPORTING FORMS

A. First Report of Employee Injury/Illness (State form 34401)

The **employer** should complete the form in detail. The signature at the bottom should be the person responsible for filing workers compensation claims. **If it appears the employee completed the form, we will request resubmission of the form with the appropriate signature.**

The employee's phone number should always be included. If the employee does not have a phone, please provide an alternate number where the employee may be reached.

The employer information should contain the employer's mailing address. The section "Actual Location" should indicate the specific location where the injury occurred.

Any claim involving more than first aid requires the First Report of Employee Injury/Illness (State Form 34401) to be submitted to the Workers Compensation Board within 7 days of notification of the injury. The first report form must be forwarded to IPEP immediately in order to avoid any fines.

NOTE: The Federal identification number is mandatory.

B. Wage Statement

The wage statement is based on wages 52 weeks prior to the date of injury. Therefore, if the employee was injured on 1/1/17, the wage statement should be completed for 1/1/16 to 1/1/17. This amount should include overtime and bonuses.

Vacation and sick pay is considered earned income and should be included; workers compensation benefits should not be included. If there were compensation benefits paid in the prior year, simply write w/c in those weeks.

If the employee has not worked a full 52-week period prior to the date of accident, complete the wage statement back to the date of hire.

If there is not sufficient information for us to calculate an accurate wage, we will request the employer provide wages from another employee in the same job classification.

A computer printout can be used in lieu of completing the wage statement. We will request this information on all lost time claims to ensure that the employee's benefits are calculated correctly.

C. Medical Authorization

This form should be signed by the employee and submitted on all claims.

D. Supervisor's Incident Investigation Report

The injured employee's immediate supervisor should complete this form. It is helpful in providing additional information for Risk Management and requires the immediate supervisor to review the accident facts to determine if future incidents can be prevented. Section 4.0 – ACCIDENT INVESTIGATION (Red Section) has a copy of this form and instructions.

SUBROGATION

Under the Indiana Workers Compensation Act, the employer has the right of recovery against any third party responsible for the accident and injury.

Any money Public Risk Underwriters is able to recover on behalf of IPEP is put back into the general pool fund to help keep the costs of coverage down for all members.

We will investigate all claims for potential recovery. As a member and a governmental entity, you can help us expedite our investigation by including a copy of the police report when available.

If charges are brought against a third party who injures a police officer, we will send the prosecuting attorney documentation of payments made and request reimbursement as part of any probation agreement. Although recovery in these types of cases may not always be successful, we make every effort to recover expenses made on behalf of IPEP.

WORKERS COMPENSATION NOTICE

Your employer is required to provide for payment of benefits under the Workers Compensation and Occupational Diseases Acts of the State of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

Your employer is self-insured through participation in the Indiana Public Employers' Plan, a risk sharing association of Indiana governmental employers. The Plan's address is:

INDIANA PUBLIC EMPLOYERS' PLAN
PO Box 629, Carmel, IN 46032
Phone: 765-457-9161
1-800-382-8837
Attn: Claims Department

For more information about rights or procedures under the Indiana Workers Compensation system, call or write:

Workers Compensation Board of Indiana
Ombudsmen Division
402 West Washington Street, Room W196
Indianapolis, IN 46204
317-232-3808
1-800-824-2667

Injured Worker's First Fill Prescription Form

EFFECTIVE 01-01-22

Employee Name: _____

Date of Injury:_____ SSN: _____

Injured Worker Instructions

On your first Pharmacy visit, please give this notice to any pharmacy listed on this insert. This will expedite the processing of your approved workers' compensation prescriptions, based on the parameters established by **Indiana Public Employers' Plan (IPEP).** With the CorVel pharmacy program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Form to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a 14-day supply of most medications.

Notice to Injured Worker and Pharmacy

This temporary First Fill card is only valid if used within 30 days of the reported date of injury. Temporary eligibility through this program allows for a one-time fill of prescription medications. For assistance with processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.**

Pharmacy Instructions

For assistance processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.** Please use the BIN, PCN, and RxGroup number below to process an online/electronic claim to CorVel:

BIN:	**004336**
PCN:	**ADV**
RxGroup:	**RXFFWC237**
Member ID:	**See below to generate ID**

To generate member ID: The Injured Worker's 9 digit social security number plus 8 digit date of injury will be used as their 17 digit **member identification number** when processing their First Fill Prescription: **XXXXXXXXXMMDDYYYY**

Below is a sample listing of some of the over 67,000 Participating Pharmacies in the CorVel Network. Please call **(800)563-8438** for a participating pharmacy near you.

CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Duane Reade	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite Aid Pharmacy	Wal-Mart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy

Opioid Safety: What you need to know

Opioid misuse and abuse is a growing concern in our country. You may be taking (or have taken) a prescribed opioid such as oxycodone or hydrocodone to help relieve pain. Drugs like these are generally safe when taken exactly as directed for a limited period, but can become harmful—even fatal—if misused. It's important to be informed about the risks and benefits of opioid medication use should your doctor prescribe them to manage your pain.

Prescription opioids can help to manage short-term pain that may occur after a surgery or recent injury. But they may not work as well to manage chronic pain long-term. In addition, you're more likely to overdose or become addicted when using opioids for a long time. An overdose can cause serious health problems or even death. There may be other treatments available with less serious risks. Work with your doctor to find the safest, most appropriate ways to manage your condition.

As many as

taking prescription opioids struggle with addiction when opioids are used long-term.[1]

Safety tips to consider when you are prescribed opioid medication:

- Always take your medication exactly as instructed by your doctor.
- Never share your opioids with others.
- Avoid alcohol and certain medications that may interact with your opioids.
- Review your medication list with your doctor or pharmacist.
- Follow up regularly with your doctor.
- Store opioids in a secure place, ideally a locked location.
- Dispose of unused opioids properly. Check with your pharmacy regarding safe disposal methods.

Please note: Some insurance plans may allow opioid fills with a limited day supply. Please call **CorVel Pharmacy Solutions at 800-563-8438** with any questions regarding your plan.

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1. Prescription opioid overdose data. U.S. Centers for Disease Control and Prevention. Last updated August 1, 2017. https://www.cdc.gov/drugoverdose/data/overdose.html. Accessed January 10, 2018.

INSTRUCTIONS

General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.

2. Enter all dates in MM/DD/YY format.

3. Please return completed form electronically by an approved EDI process.

4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME AND CODE NUMBER: Enter the name of your insurance agent and his / her code number if known. This information can be found on your insurance policy.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (*e.g. Acetylene cutting torch, metal plate, etc.*).

AVG WG/WK: Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc.*) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

CONTACT NAME / TELEPHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor, HR Person, Nurse, etc.*)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwised deigned by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (*e.g. Maintenance, Client's Office, Cafeteria, etc.*).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-time, Apprentice Full-time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as: (*FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE, or UK*).

HOW INJURY / ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (*e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall*).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION / JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury / illness (*e.g. Right forearm, Low Back, etc.*)

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

RTW DATE (*Return to Work Date*): Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (*e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting*).

TYPE OF INJURY / ILLNESS: Briefly describe the nature of the injury or illness (*e.g. Contusion, Laceration, Fracture, etc.*)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (*e.g. Building maintenance*).

State Form 34401 (R10 / 1-02)
Please return completed form electronically by an approved EDI process.

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION

Social Security number	Date of birth	Sex	Occupation / Job title	NCCI class code
		Male Female Unknown		

Name (*last, first, middle*)	Marital status	Date hired	State of hire	Employee status
	Unmarried Married Separated Unknown			

Address (*number and street, city, state, ZIP code)*	Hrs / Day	Days / Wk	Avg Wg / Wk	Paid Day of Injury Salary Continued

Telephone number (include area)	Number of dependents	Wage	Per
		$	Hour Day Week Mont

EMPLOYER INFORMATION

Name of employer	Employer ID#	SIC code	Insured report number

Address of employer (*number and street, city, state, ZIP code*)	Location number	Employer's location address (*if different)*
	Telephone number	
	Carrier / Administrator claim number	OSHA log number / Report purpose code

Actual location of accident / exposure (*if not on employer's premises*)

CARRIER / CLAIMS ADMINISTRATOR INFORMATION

Name of claims administrator	Carrier federal ID number	Check if appropriate
Indiana Public Employers Plan (IPEP)		X Self Insurance

Email of Claims Administrator:		Policy / Self-insured number
ipepclaims@ipep.com	Insurance Carrier X Third Party Admin.	
Telephone number 800-382-8837 765-868-3310 FAX		Policy period From To

Name of agent	Code number

OCCURRENCE / TREATMENT INFORMATION

Date of Inj./ Exp.	Time of occurrence AM PM Cannot be determined	Date employer notified	Type of injury / exposure	Type code

Last work date	Time workday began	Date disability began	Part of body	Part code

RTW date	Date of death	Injury / Exposure occurred on employer's premises? Yes No	Name of contact	Telephone number

Department or location where accident / exposure occurred	All equipment, materials, or chemicals involved in accident

Specific activity engaged in during accident / exposure	Work process employee engaged in during accident / exposure

How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.

Cause of injury code

Name of physician / health care provider

Hospital or offsite treatment (*name and address*)

INITIAL TREATMENT
_ Medical Treatment
_ Minor: By Employer
_ Minor: Clinic / Hospital
_ Emergency Care
_ Hospitalized > 24 Hours
_ Future Major Medical /
_ Lost Time Anticipated

Name of witness	Telephone number	Date administrator notified

Date prepared	Name of preparer	Title	Telephone number

An employer's failure to report an occupational injury or illness may result in a $50 fine (IC 22-3-4-13).

INDIANA PUBLIC EMPLOYERS' PLAN, INC.

SUPERVISOR'S INCIDENT INVESTIGATION REPORT

(Please Complete All Sections)

1. Company or Location | 2. Department | 3. Date of Incident/Day of Week

4. Exact Location of Incident | 5. Time of Occurrence (am/pm) | 6. Date Reported

7. Name of Injured | 8. Occupation | 9. Body Part Affected (See Back)

10. Nature of Injury or Illness (See Back) | 11. Item Inflicting Injury/Illness | 12. Type of Accident (See Back)

13. Person With Most Control of Item 11.

14. Description of the Incident

15. Direct Causes of Incident | 16. Why Each Cause Exists

17. Actions Taken or Needed to Prevent Recurrence | 18. Date Completed

19. Investigated By | 20. Date | 21. Reviewed By | 22. Date

Please mail form to:
ipep@ipepclaims.com

Toll free: l-800-382-8837
Claims Fax: l-765-868-3310
Local: l-765-457-9161

Type of Accident

Bite by Animal
Bite by Human
Bite by Insect/Sting
Body Reaction
Burn
Caught In/Between/On
Contacted Harmful Substance
Contagious Disease Exposure
Electrical Contact
Fall From
Fall Level
Fell Through
Foreign Body
Gunshot
Motor Vehicle
Other
Overexertion
Pierced/Punctured By
Public Transportation
Repetitive Action/Motion
Slipped (Not Fall)
Smoke Inhalation
Stepped In/On
Stress
Struck Against
Struck By
Struggle/Resistive Subject

Nature of Injury

Abrasion
Amputation
Asphyxia
Avulsion
Bruise, Contusion
Burn Caused by Chem.
Burn Caused by Heat
Carpal Tunnel Syndrome
Concussion
Cut, Laceration
Crush
Death
Dermatitis
Dislocation
Electrical Shock
Fracture
Frostbite/Freezing
Hearing Loss
Heart Attack
Heat Stroke
Hernia
Infection
Inflammation/Swelling
Multiple Injuries
Other
No Injuries
Poisoning
Puncture
Radiation
Soreness/Pain
Sprain/Strain
Stress
Tendonitis

Part of Body

Abdomen
Arm - Lower
Arm - Upper
Back/Spinal, Back/Non-spinal
Buttocks
Chest
Ears, External
Ears, Internal
Elbow
Eyes
Face
Fingers
Foot
Groin
Hand
Head
Hips
Jaw
Knee
Leg - Lower
Leg - Upper
Mouth
Multiple Parts
Neck/Spinal, Neck/Non-spinal
Nervous System
Nose
Other
Respiratory System
Shoulder
Teeth
Thigh
Thumb
Toes
Trunk/Non-spinal
Wrist

Indiana Public Employers' Plan, Inc.
Please email to:
ipep@ipepclaims.com

Toll free: 1-800-382-8837
Local: 1-765-457-9161
Claims fax: 1-765-868-3310

Adjuster: Claim No:

AUTHORIZATION FOR RELEASE OF MEDICAL, MILITARY, EDUCATION AND WAGE INFORMATION

To any physician, dentist, hospital, health care practitioner, military authority, education authority, employer or insurance carrier:

The requested information is needed to accurately evaluate, adjust and pay the patient's insurance claim.

I hereby authorize any health care professional (including health care physicians, medical practitioners or other health care providers, hospitals, medical attendants, nurses, x-ray technicians, or any other person), military authority, education authority, employer or insurance carrier, to furnish to the insurance company named above or its authorized vendors and representatives, wage loss and individually identifiable health information regarding my injuries, payment, treatment rendered, or health care received or provided. I understand that this authorization is voluntary.

I agree that a photocopy or fax of the original authorization shall have the same force and effect as the original.

I understand that my health care records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

I understand that I may revoke this authorization at any time by notifying the health care professional(s) in writing, but if I do it will not have any affect on any actions taken before receipt of the revocation.

I understand that once disclosed, the information and documentation released may be re-disclosed and may no longer be subject to the HIPAA Privacy Rule.

This disclosure is made at the request of the individual named below for the purposes of evaluation, adjusting and paying an insurance claim.

Unless otherwise required by law, this authorization shall expire upon the final resolution of the insurance claim.

By signing below, the patient acknowledges that he /she has read the fraud statement printed below.

PATIENT OR REP SIGNATURE

PATIENT ADDRESS

PATIENT NAME OR REP (PLEASE PRINT)

CITY, STATE, ZIP

REPRESENTATIVE'S RELATIONSHIP TO PATIENT

PATIENT PHONE NUMBER

DATE

SOC SEC NUMBER

DATE OF BIRTH

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD AN INSURER, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION COMMITS A FELONY.

12103

WAGE STATEMENT

DATE _____ CLAIM NUMBER _____

EMPLOYEE _____ EMPLOYER _____

I have examined our payroll records and the following table shows the weeks worked and the wages earned b the above-named employee during the period stated therein (including bonus and overtime pay).

I have examined our payroll records and find that the above-named employee did not work for said employer for a sufficient period to determine a proper average weekly wage. Therefore, the following table shows the weeks worked and wages earned by _____ a fellow employee of the same class who was similarly engaged by the same employer and who did work a substantial part of the year prior to _____.
(Date of alleged injury)

Position: _____ Signed By: _____

	Week Ending			Days Worked	Amount Paid		Week Ending			Days Worked	Amount Paid
	Month	Day	Year				Month	Day	Year		
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					
				Total						**Total $**	
					Entire Total						

Please mail form to: IPEP
ipep@ipepclaims.com

Toll-free: 1-800-382-8837
Claims Fax: 1-765-868-3310
Local: 1-765-457-9161