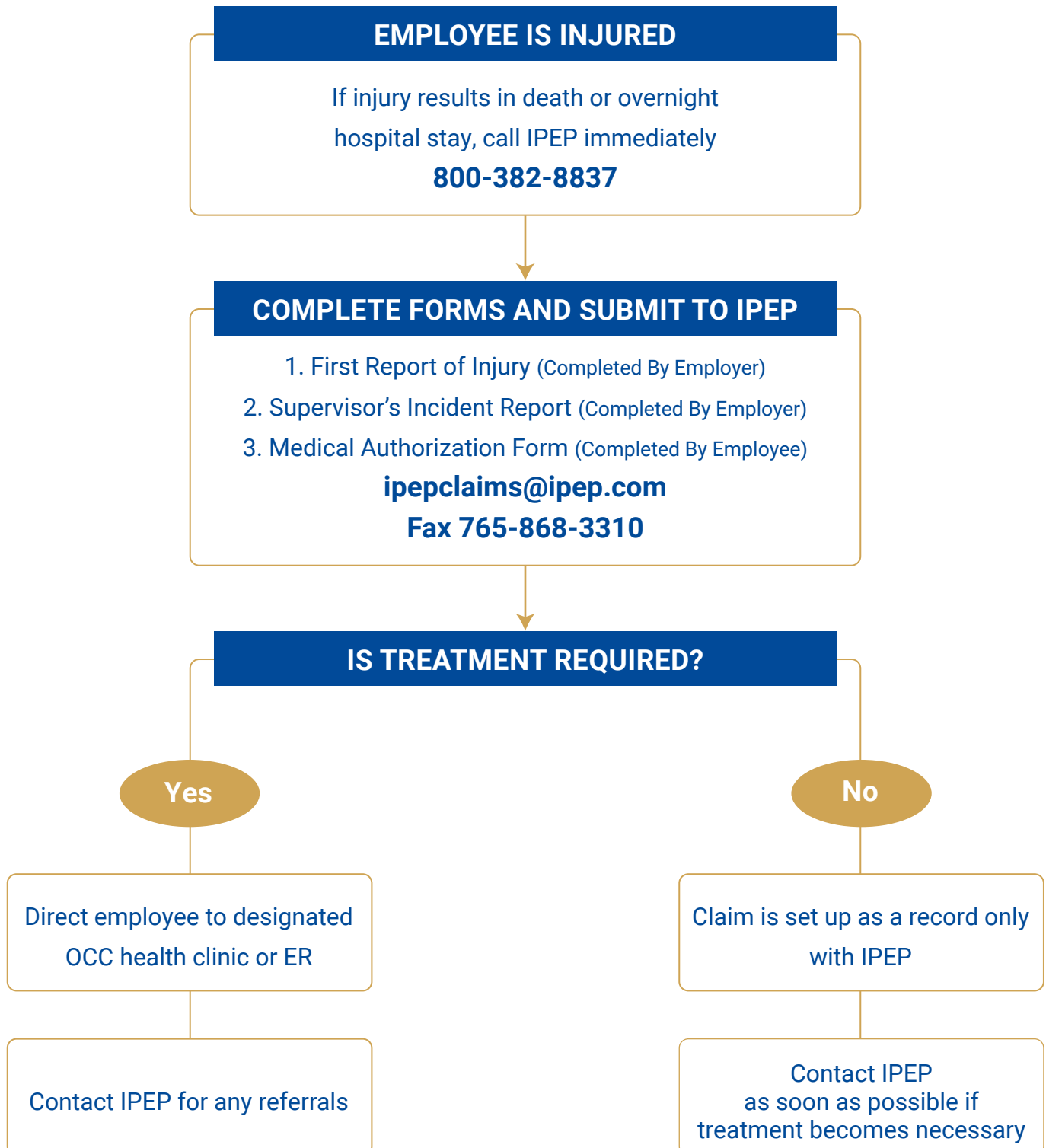




# IPEP REPORTING PROCEDURES





# 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

- 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 that has been posted in a conspicuous position in the place of work
- Knowing failure to perform any statutory duty

**THE BURDEN OF PROOF IS ON THE EMPLOYER**

# 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](mailto: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.



## **Completion of Reporting Forms**

(Cont.)

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 46082  
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

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:

	
<b>BIN:</b>	<b>004336</b>
<b>PCN:</b>	<b>ADV</b>
<b>RxGroup:</b>	<b>RXFFWC237</b>
<b>Member ID:</b>	<b>See below to generate ID</b>

**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:  
**XXXXXXXXMMDDYYYY**

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





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 Male    Female    Unknown			Occupation / Job title			NCCI class code		
Name (last, first, middle)				Marital status  Unmarried Married Separated Unknown		Date hired		State of hire		Employee status
						Hrs / Day	Days / Wk	Avg Wg / Wk		
Address (number and street, city, state, ZIP code)				Wage                      Per		Hour                      Day		Paid Day of Injury Salary Continued		
Telephone number (include area)										Number of dependents
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 Indiana Public Employers Plan (IPEP)				Carrier federal ID number		Check if appropriate  Self Insurance				
Email of Claims Administrator: ipepclaims@ipep.com				Insurance Carrier Third Party Admin.		Policy / Self-insured number				
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)								<b>INITIAL TREATMENT</b> No 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).

## 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 otherwise deemed 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*).



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



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.**





## 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 by 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 email form to:  
ipepclaims@ipep.com

IPEP

Toll-free:  
Claims Fax:  
Local:

1-800-382-8837  
1-765-868-3310  
1-765-457-9161