

# JACKSON COUNTY - 2016 WORKERS COMPENSATION

## MANAGER/SUPERVISOR INSTRUCTIONS

1. Page 1 - First Report of Injury to be completed and signed by SUPERVISOR
2. Page 2 & 3 - Accident Injury Report must be completed and signed by EMPLOYEE
3. Injuries involving BACK, NECK, KNEES, SHOULDERS AND HEAD – Requiring Medical Treatment– Contact the County Mutual Care Line @ 855-650-6580 and report your injury to the Care Line Nurse (see attached information).
4. Any/all ORIGINAL doctor's slips must be turned in with this report to the Personnel Department. Subsequent doctor slips may be requested until end of healing.

**NOTE: A DOCTOR IS DEFINED IN STATUTE 102.17 - WI WORKERS COMPENSATION ACT SECTION D(1).**

5. If the employee needs to go to the Doctor, send the Return To Work/Medical Status Report with them. This report must be returned to the supervisor as soon as possible.

**6. NO EMPLOYEE IS PERMITTED TO RETURN TO WORK WITHOUT A DOCTOR'S EXCUSE IF HE/SHE IS BEING TREATED FOR A WORK RELATED ILLNESS OR INJURY.**

Jackson County faces penalties if the following are not completed within proper time requirements:

- ❖ LOST TIME INJURY/ILLNESS: must be reported to the insurance company within 3 days of injury/illness.
- ❖ FATALITY: must be reported to the insurance company within 24 hours.

## EMPLOYEE

Retain the stapled packet, "What Jackson County Employees should know about Workers Compensation Benefits" for informational purposes. Call the Personnel Department should you have any questions.

This is not an all-inclusive list of benefits and guidelines under Workers Compensation. For a complete listing, please refer to the State of Wisconsin Department of Workforce Development.

# EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

**Department of Workforce Development  
Worker's Compensation Division**  
201 E. Washington Ave., Rm. C100  
P.O. Box 7901  
Madison, WI 53707-7901  
Imaging Server Fax: (608) 260-2503  
Telephone: (608) 266-1340  
Fax: (608) 267-0394  
http://www.dwd.state.wi.us/wc/  
e-mail: DWD@DWC@dwd.state.wi.us

An employer subject to the provisions of ch. 102, Wis. Stats., shall, within one day after the death of an employee due to a compensable injury, report the death to the Department of Workforce Development (DWD) and to the employer's insurance carrier, if insured. In cases of permanent disability or where temporary disability results beyond the 3-day waiting period, an insured employer shall also notify its insurance carrier of a compensable injury or illness within 7 days after the injury or beginning of a disability from occupational disease related to the employee's compensable injury.  
Insurance carriers and self-insured employers must report all compensable claims to DWD on this form, the EDI system, or the internet format within 14 days of the date of injury.

The provision of your social security number is voluntary. Failure to provide it may result in an information processing delay.  
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)]. **(Please read the instructions on page 2 for completing this form)**

<b>EMPLOYEE</b>	Employee Name (First, Middle, Last)		Social Security Number		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Employee Home Telephone No. ( ) -	
	Employee Street Address		City	State	Zip Code	Occupation	
	Birthdate	Date of Hire	County and State where accident or exposure occurred				
<b>EMPLOYER</b>	Employer Name Jackson Co. General Courthouse - JK03		WI Unemployment Ins. Acct No. 692025	Self-Insured? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Nature of Business (specific product) County Government	
	Employer Mailing Address 307 Main Street, Personnel Dept., 2 <sup>nd</sup> Floor		City Black River Falls	State WI	Zip Code 54615-	Employer FEIN 39 - 6005703	
	Name of Worker's Compensation Insurance Co. or Self-Insured Employer Jackson County					Insurer FEIN 39 - 1098844	
	Name and Address of Third Party Administrator (TPA) used by the Insurance Company or Self-Insured Employer Aegis Corporation, 18550 West Capitol Drive, Brookfield, WI 53045-1925					TPA FEIN -	
<b>WAGE INFORMATION</b>	Wage at Time of Injury \$	Specify per hr., wk., mo., yr., etc. Per:	In Addition to Wages, Check Box(es) if Employee Received:	<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Tips	No. of Meals/wk. No. of Days/wk. Avg. Weekly Amt. \$		
	Is worker paid for overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, after how many hours of work per week?						
	For the 52 week period prior to the week the injury occurred, report below the number of weeks worked in the same kind of work, and the total wages, salary, commission and bonus or premium earned for such weeks.						
	No. of Weeks:	Gross Amount Excluding Tips: \$		If Piece-Work, No. of Hrs. Excluding Overtime:			
	Employee's Usual Work Schedule When Injured:		Start Time : <input type="checkbox"/> AM <input type="checkbox"/> PM	Hours Per Day	Hours Per Week	Days Per Week	
	Employer's Usual Full-Time Schedule For This Type of Work At Time of Employee's Injury:						
	Part-Time Employment Information:	Are there other part-time workers doing the same work with the same schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many?			Number of <b>full-time</b> employees doing the same type of work:		
Injury Date	Time of Injury : AM : PM	Last Day Worked	Date Employer Notified	<input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return			
Did injury cause death? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Death	Was this a lost time or other compensable injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did injury occur because of: <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Failure to Use Safety Devices <input type="checkbox"/> Failure to Obey Rules			
Was employee treated in an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No Was employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Name and Address of Treating Practitioner and Hospital:							
Case Number from the OSHA Log:							
<b>Injury Description</b> - Describe activities of employee when injury or illness occurred and what tools, machinery, objects, chemicals, etc. were involved.							
What happened to cause this injury or illness? (Describe how the injury occurred)							
What was the injury or illness? (State the part of body affected and how it was affected)							
Report Prepared By		Work Phone Number ( ) -	Position		Date Signed		

## EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

### MANDATORY INFORMATION

**In order to accurately administer claims, each of the following sections of this form must be completed.** The First Report of Injury will be returned to the sender if the mandatory information is not provided.

**Employee Section:** Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

**Employer Section:** Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

**Wage Information Section:** Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

**Injury Information Section:** Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.

JACKSON COUNTY  
**Worker's Compensation**  
**ACCIDENT/INJURY REPORT**

**TO BE FILLED OUT BY EMPLOYEE**

Employee Name \_\_\_\_\_ Dept \_\_\_\_\_ Today's Date \_\_\_\_\_

**ACCIDENT DESCRIPTION AND RELATED INFORMATION**

Describe the following: (add additional sheets if necessary)

1. Location where the injury/incident occurred?  
\_\_\_\_\_
2. Describe what employee was doing at time of injury?  
\_\_\_\_\_
3. What caused the accident/incident?  
\_\_\_\_\_
4. What was the resulting injury?  
\_\_\_\_\_
5. What part of the body was injured?  
\_\_\_\_\_
6. Name of witnesses (statements from witnesses may be attached)?  
\_\_\_\_\_
7. Is this injury an aggravation of an existing injury/condition?  
\_\_\_\_\_
8. Have you had this type of injury before?  
\_\_\_\_\_
9. How do you feel this incident could have been prevented?  
\_\_\_\_\_

**NATURE OF INJURY** (Please check those that apply.)

- Abrasion/Bruise/Contusion/Cut  
 Back/Neck/Shoulder Injury  
 Allergic Reaction  
 Internal Injury  
 Blood/Body Fluid Exposure

**TIME OF INJURY:** \_\_\_\_\_

- Concussion  
 Sprain/Strain/Fracture  
 Skin Irritation  
 Needle Stick  
 Other – please identify: \_\_\_\_\_
- Burn  
 Electric Shock  
 Human Bite  
 No apparent Injury

**SITE CONDITIONS**

What defective or otherwise unsafe condition(s), if any, of tools, equipment, work area, machine, etc., may have contributed to this injury/accident? (i.e. wet floor, faulty machinery, etc.)

\_\_\_\_\_  
 \_\_\_\_\_

**PROPERTY DAMAGE**

Please describe any property damage to any, and all, equipment, property or other item(s). Include name and addresses of person(s), place and/or list items involved. INCLUDE/ATTACH police reports, pictures, witness statements, etc.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PROTECTIVE EQUIPMENT**

Is protective equipment used for the specific task(s) you were working on? \_\_\_\_\_ yes \_\_\_\_\_ no

Were you using each item of protective equipment required for the specific task(s)? \_\_\_\_\_ yes \_\_\_\_\_ no

Please list the protective equipment you were using at the time of injury (i.e. work gloves, hearing aids, lift belt, etc.) \_\_\_\_\_  
\_\_\_\_\_

By signing below I agree that the above statements are true to my knowledge. Note: You may be asked to participate in an injury review as part of this review process.

**Employee's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Supervisor Comments/Recommendations: _____ _____ _____
---

**Supervisor's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Department Head Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

<p><b>THIS FORM IS TO BE FILLED OUT IN ADDITION TO THE FIRST REPORT OF INJURY</b></p> <p><b>ROUTE IMMEDIATELY TO THE FOLLOWING:</b></p> <p><b>County Agencies:</b> Forward the original First Report of Injury and Investigative Report to the County Personnel Office.</p>
---

# 2016 WORKERS COMPENSATION BENEFITS

## JACKSON COUNTY EMPLOYEES Informational Brochure

For information not contained in this brochure, contact the Jackson County Personnel Department, at 715-284-0216 or email to [susie.meinerz@co.jackson.wi.us](mailto:susie.meinerz@co.jackson.wi.us). You may also contact Jackson County's third party administrator, workers compensation company, at: Aegis Corporation, 18550 West Capitol Drive, Brookfield, WI 53045-1925- Toll Free: 1-800-236-6885 - Fax: 1-262-252-6579.

This is not an all-inclusive list of benefits and guidelines under Workers Compensation. For a complete listing, please refer to the State of Wisconsin Department of Workforce Development.

## TABLE OF CONTENTS

I.	WHAT IS WORKERS COMPENSATION?.....	3
II.	WHAT SHOULD I DO WHEN INJURED ON THE JOB? .....	3
III.	WHAT ABOUT ON-GOING MEDICAL CARE? .....	3
IV.	HOW AM I PAID FOR LOST WAGES? .....	3
	A. What do I need to do when I am completely off work?.....	3
	B. If I lose more than three calendar days from work? .....	4
	C. What do I do if I am losing hours do to my injury restrictions? .....	4
	D. How do I notify the Workman’s Compensation Company of lost wages when I am working partial shifts?.....	4
	E. How do I get reimbursed when I have doctor appointments? .....	4
V.	REIMBURSEMENTS.....	5
VI.	WHAT ARE MY RIGHTS UNDER WORKERS COMPENSATION?.....	5
VII.	WHAT ARE MY RESPONSIBILITIES UNDER WORKERS COMPENSATION? .....	5
VIII.	WHAT ARE JACKSON COUNTY’S RESPONSIBILITIES? .....	6
IX.	WHAT ARE THE GOALS FOR RETURN TO WORK? .....	6
X.	WHOM DO I CALL FOR MORE INFORMATION? .....	6
XI.	WHAT IF MY CLAIM IS DENIED? .....	6

## I. WHAT IS WORKERS COMPENSATION

If you have an injury or an illness resulting from your employment you may be entitled to workers compensation benefits. Jackson County's goal is to help you return to your job as soon as possible.

Workers Compensation pays partial wage replacement benefits and reasonable and necessary medical and rehabilitation costs when you are injured at work.

If your injury or illness results in permanent disability, as defined in the Workers Compensation Statute, additional benefits will be paid according to your disability rating. This additional benefit occurs after you have reached Maximum Medical Improvement (MMI) as certified by a treating physician.

Your dependents are entitled to benefits should your death occur as a result of a work related injury or illness, once dependency is proven.

All Wisconsin employees are covered by workers compensation. Your employer pays for this benefit.

## II. WHAT SHOULD I DO WHEN INJURED ON THE JOB?

1. IMMEDIATELY report to your supervisor. Failure to do so may result in disciplinary action.
2. If emergent, obtain medical attention as soon as possible. If medical attention isn't necessary or not emergent you must complete the required paperwork immediately.
3. Complete the Workers Compensation Accident/Injury Report.
4. Your supervisor/department personnel will complete the First Report of Injury Form.
5. If you are treated for a work related injury or illness, you ARE REQUIRED to have your medical provider fill out the Jackson County Return To Work/Medical Status Report. You must inform your medical provider that only treatments for the Worker's Compensation Injury should be submitted to Jackson County's Workers Compensation company

NOTE: Throughout the recovery of your injury/incident you are to report regularly to your supervisor as to your current condition. **The Jackson County "Return To Work/Medical Status Report" will be used throughout recovery to keep your supervisor updated on your injury/illness. This form will be REQUIRED prior to your return to work.**

## III. WHAT ABOUT ON-GOING MEDICAL CARE?

You have a right to choose your certified medical provider.

A certified medical provider is defined by the US Dept of Labor as: a doctor of medicine or any other person determined by the secretary of state to be capable of providing health care services within the scope of their practice as defined by state law.

## IV. HOW AM I PAID FOR WAGES LOST?

Records received from your treating physician must coincide with any lost work time you have reported before payment can be issued. When eligible for Workers Compensation benefits, you will receive a separate check for reimbursement of lost time from our Workers Compensation carrier. This will equal approximately 2/3rds of your gross weekly wage, subject to maximums and minimums set annually by the legislature.

### A. What do I need to do when I am completely off work?

1. Obtain certification for lost time from your Health Care Provider. Certification for lost work time must be obtained as soon as reasonably possible.

2. Report information immediately to your supervisor.
3. While on Workers Compensation you are required to submit a time sheet. If you are off work, you or your supervisor should note on your time card that your lost time is work related. The time card/sheet should reflect the code WC for Workers' Compensation. If certification is not received you will be required to use your accrued benefits. If you have no accrued benefits available, please see your department head immediately.

**B. If you lose more than three calendar days from work:**

1. There is a mandatory three day waiting period before wage replacement benefits begin from the Workers Compensation company, meaning you will be reimbursed for lost time beginning the 4<sup>th</sup> calendar day of authorized lost time. You may use accrued benefits for the 1<sup>st</sup> through 3<sup>rd</sup> day according to Jackson County policy. If you are off eight calendar days, Workers Compensation will go back to the first three days.
2. If eligible, you will receive a separate check from our Workers Compensation Company for TEMPORARY TOTAL DISABILITY BENEFITS (TTD) equal to approximately 2/3rds of your average gross weekly wage at the time of injury. (For example: If you earn \$300.00 per week, you would receive a check for \$200.00).
3. Our Workers Compensation carrier will be requesting wage information from the Payroll Department to determine your average weekly wage. Your compensation rate is based on this information.
4. You can expect to receive your first check approximately 14 days after your first day of lost time and every two weeks thereafter while you are completely off work. Your initial check may be an estimate of your earnings and any difference will be made up after your wage history has been reviewed.
5. The amount of time that you can receive TTD benefits is subject to limitations determined by State Workers Compensation laws in effect at your date of injury.
6. While you are receiving benefits from the Workers Compensation Company, you may ***not*** also receive payment for accrued benefits from Jackson County. If you use accrued benefits for the first three days, and then later are reimbursed by the Workers Compensation Company, you must "pay back" those three days by payroll deduction.

**C. What do I do when I am losing hours because of my injury restrictions?**

1. This gets a little more complicated, but in general, you may be reimbursed the percentage lost in wages times your Temporary Total Disability rate (TTD). This is called TEMPORARY PARTIAL DISABILITY BENEFITS (TPD). For example: if you were earning \$300.00 per week before your injury, and now you're earning \$150.00 per week, you will receive a check for \$100.00 per week). So you can expect a regular payroll check from your employer plus a benefit check from our Workers Compensation Company approximately seven working days after you have notified the Workers Compensation Company.
2. The amount of time you can receive TPD benefits is subject to limitations determined by State Workers Compensation laws in effect at your date of injury.

**D. How do I notify the Workers Compensation company of lost wages when I'm working partial shifts?**

1. ***All*** lost hours must be certified by your medical provider and/or authorized by your employer. You must turn in your medical slips to your supervisor and indicate on your time sheets any lost time due to your work injury/incident.

**E. How do I get reimbursed for lost hours when I have doctor appointments?**

1. You should schedule appointments outside of work when possible. When you must lose time for medical appointments, your lost wages are reimbursable. You should report this the same way you report TPD (see above), but you need to send along a note explaining why

you lost time (i.e., 4/1/97, 4:30 p.m., Dr. appt. with Dr. Johnson, 2 hour appt., etc.) Your time card/sheet must reflect "WC" for lost time due to Worker's Compensation.

#### V. REIMBURSEMENTS

1. Mileage is reimbursable when traveling to and from approved medical appointments. Mileage reimbursement can be submitted to the Workers Compensation Company with documentation of date and round trip mileage calculation.
2. Parking costs incurred while attending medical appointments. You must submit parking receipts for reimbursement to the Personnel Department.
3. Pharmacy bills for drugs and approved medical equipment to your injury/illness are reimbursable. Please submit receipts your supervisor to the Personnel Department.

REMINDER: Please keep copies of any reimbursement requests and receipts for your own records.

#### VI. WHAT ARE MY RIGHTS UNDER WORKERS COMPENSATION?

1. The right to reasonable and necessary medical or chiropractic treatment to cure or relieve the effects of your work injury.
2. A right to confidential individualized treatment. Medical providers will only discuss with your supervisor or rehabilitation specialist, medical information related to your injury and job demands.
3. A right to choose a medical provider. Providers are required to follow state medical treatment guidelines.
4. A right to ask questions and get answers regarding your treatment plan and expectations for recovery. It is important that you understand your medical condition and treatment plan. An Occupational Health Nurse or other Occupational Health Medical Providers may work collaboratively with you to insure that you are receiving the best possible medical care.
5. Modified (transitional) work. Jackson County does not normally have light duty positions although an Occupational Health Professional, or the Personnel Department will work with you and your medical provider to assure that you can work in a temporary transitional position, if available, and also to assure you can fulfill the primary/essential functions of your job upon your return to work.
6. A right to consideration of permanent job accommodations and an ergonomic assessment of your work site when necessary.
7. A right to a Rehabilitation Consultation by a Qualified Rehabilitation Consultant (QRC) should you be unable to permanently return to work with your current employer.

#### VII. WHAT ARE MY RESPONSIBILITIES UNDER WORKERS COMPENSATION?

1. To promptly report an injury and any lost time from work to my direct supervisor.
2. To cooperate with reasonable and necessary medical examinations and treatment plans to cure or relieve the effects of your injury.
3. To follow through with your medical treatment. Failure to follow through may result in suspension or termination of Workers Compensation wages, up to loss of benefits.
4. To keep your supervisor and the personnel department notified of your status even if you are treating with an outside provider. If you are off work, you will NOT be allowed to return to work until the Employee Workers Compensation Medical Provider has cleared you to do so.
5. To follow through and maintain any recommended restrictions at all times whether at work or not. You are responsible for following safe practices.

VIII. WHAT ARE JACKSON COUNTY'S RESPONSIBILITIES TO ADMINISTER WORKERS COMPENSATION BENEFITS?

1. To notify the Workers Compensation carrier (our Third Party Administrator) of all Workers Compensation claims immediately. Our Workers Compensation Carrier (Third Party Administrator) has the following responsibilities:
  - A. To file a FIRST REPORT OF INJURY with the State of Wisconsin if you are off work for more than three calendar days.
  - B. To investigate the claim to determine if it is work related/compensable under the State Statute.
  - C. To obtain medical reports relevant to the reported injury.
  - D. To determine in a timely manner whether the claim is work related/compensable. The Workers Compensation Company has 14 calendar days from the last day worked to start paying weekly benefits or to deny the claim.
  - E. To administer benefits due you in a timely manner.
  - F. To pay reasonable and necessary medical bills in accordance with a state certified database and guidelines.

IX. WHAT ARE THE GOALS FOR YOUR RETURN TO WORK?

1. Same job: The primary goal is to return you to work to your pre-injury job. This is what occurs most often.
2. Transitional Position: Jackson County does not normally have light duty positions. If you are not immediately able to return to your same job, every effort will be made to place you in your same department or in another department, if necessary, and if a transitional position is available.
3. New Employer: The last option is for you to locate employment outside of Jackson County.

X. WHO DO I CALL FOR MORE INFORMATION? For questions specific to your claim: (Wage replacement, mileage reimbursement, and medical bills)

Contact the Personnel Director, Jackson County Personnel Department, at 715-284-0215 or email to [diane.peterson@co.jackson.wi.us](mailto:diane.peterson@co.jackson.wi.us) or the workers compensation company at: Aegis Corporation, 18550 West Capitol Drive, Brookfield, WI 53045-1925- Toll Free: 1-800-236-6885 - Fax: 1-262-252-6579.

XI. WHAT IF MY CLAIM IS DENIED?

- If you disagree with the denial and wish to appeal the decision, you must take action IMMEDIATELY.
- First, contact Aegis Corporation at 1-800-236-6885 to discuss the reason for the denial.
- Second, submit in writing to Aegis Corporation any additional information you believe has not been considered in the denial.
- You may also contact a Workers Compensation Specialist at the Department of Workforce Development at 1-608-266-1340 for other available options. State of Wisconsin Dept. of Workforce Development - Workers Compensation Division - Room 161 - 201 E. Washington Avenue - Madison, WI 53707.

This is not an all-inclusive list of benefits and guidelines under Workers Compensation. For a complete listing, please refer to the State of Wisconsin Department of Workforce Development.

Updated: 01/12/2015



# COUNTY MUTUAL CARE LINE<sup>SM</sup>

POWERED BY ALARIS<sup>®</sup>

## 24/7 CAPABILITIES

### REDUCTION IN WORKER'S COMPENSATION COSTS

The Care Line Nurse will walk the employee through the facts of the injury including when it happened, when symptoms were noticed, first treatment, and prior history. In some instances, the employee's medical concern isn't worker's compensation related, but sustained on personal time. After speaking with the Care Line Nurse about causation and determining that the injury was sustained on personal time, the employee's often pursue treatment on their own, through their health insurance. We have found that employee's appreciate speaking with the nurse as a 'feel good' experience for them. This can be effective in limiting the number of legitimate worker's compensation claims.

### SITE SPECIFIC MEDICAL PLANS

The Care Line Nurses will identify, in advance, various occupational health clinics, post-accident drug testing facilities, orthopedic specialists, and emergency departments in order to be able to assist instantly. We will contact these clinics to lay out a specific groundwork for the handling of your occupational health needs, including your policy on return-to-work.

### REDUCTION IN EXPERIENCE MODIFICATION FACTOR

Due to the early intervention and immediate contact with the provider's office, the Care Line Nurse will coordinate an early return-to-work, reducing or eliminating lost time claims. The claim will remain a medical only, which in Wisconsin, qualifies for a 70% reduction in overall claims costs. This means your organization's Experience Modification Factor (or, Mod) will be directly impacted by avoiding lost time claims through our approach. This will have a direct impact on your annual worker's compensation premium, as the Mod is a weighted factor in calculating premium.

### MITIGATION OF OVERALL WORKER'S COMPENSATION CLAIMS COST

With the Care Line Nurse being the first point of contact following a work-related injury, we are able to institute early intervention in order to mitigate overall worker's compensation costs. The nurse will work with the employee to confirm causation, diagnosis, treatment, appropriate diagnostics, and proper providers. The nurse will also immediately contact the provider's office to discuss the employee who is on their way and lay out an immediate return-to-work. The employee no longer has to try and navigate through the complex health system on their own.

### AREA PROVIDERS NETWORK

Prior to the specific Care Line program effective date, quality providers in the area are identified. In Wisconsin, we cannot direct treatment, however, if we can suggest or recommend an employee to a provider within the area, we will do so.

### OSHA RECORDABILITY IMPACT

The Care Line Nurses are trained to contact the provider's office prior to the employee's initial visit in order to set the stage for the OSHA impact. Our Care Line Nurses are trained on what constitutes an OSHA recordable. Therefore, based upon the facts of the injury, if there is any opportunity for the nurse to speak with the provider's office and request, for example, a butterfly bandage instead of sutures, we will proceed accordingly. All OSHA impact opportunities are recorded and presented to the employer on a quarterly basis. This initiative has proven to be hugely successful for Care Line participants thus far.

### ELIMINATES UNNECESSARY EMERGENCY ROOM VISITS

The Care Line Nurse will speak with the employee regarding the injury, whether occupational or non-occupational, and discuss appropriate treatment options. If treatment with a physician is warranted, the Care Line Nurse will guide the employee to an occupational health clinic or general health clinic and only use an emergency room when it's absolutely necessary for emergent needs. Eliminating emergency room visits that are unnecessary is a major cost savings initiative for both worker's compensation and health insurance.



Wisconsin County Mutual Insurance Corporation

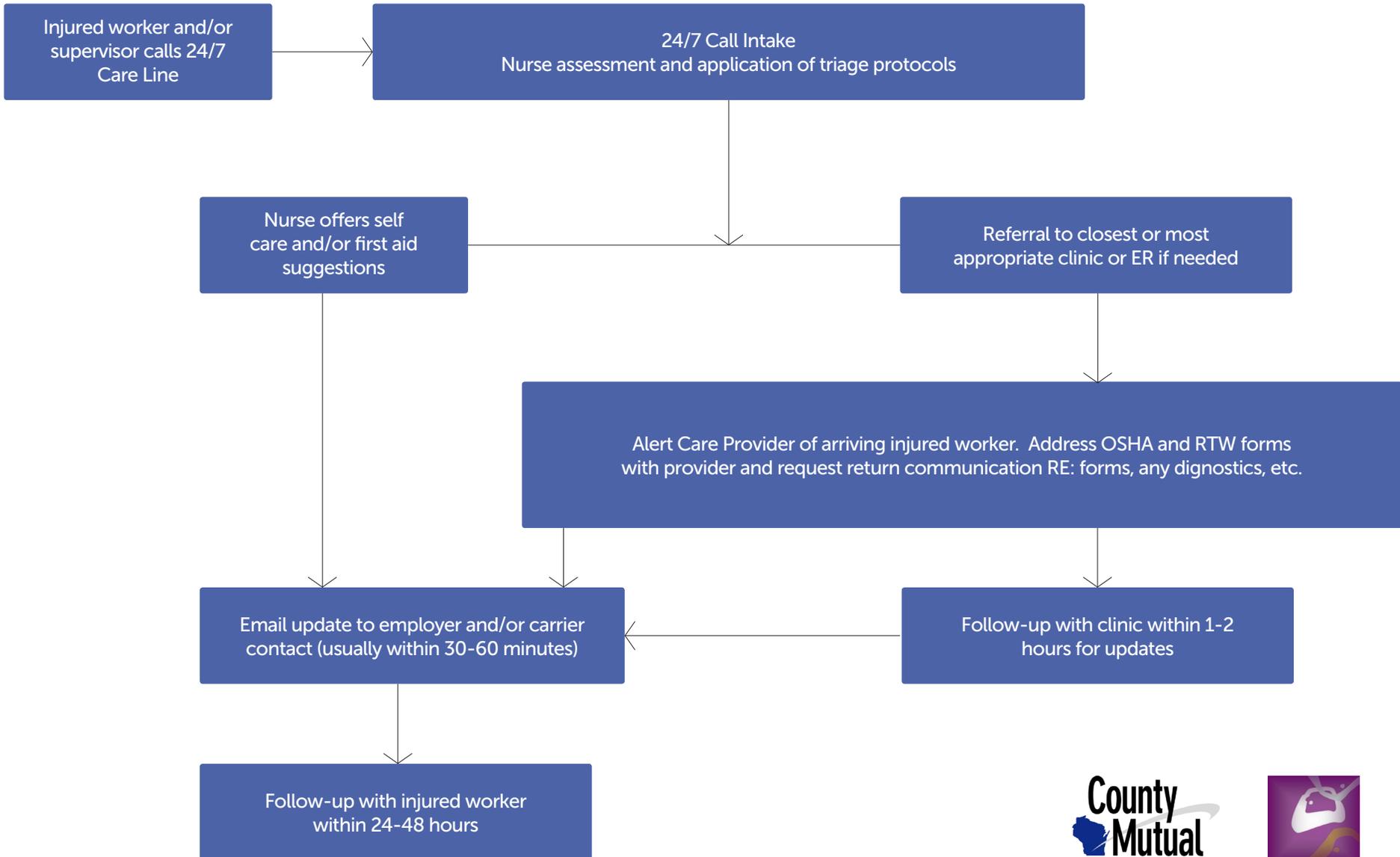


ALARIS<sup>®</sup>

# COUNTY MUTUAL CARE LINE<sup>SM</sup>

POWERED BY ALARIS<sup>®</sup>

## WORKFLOW



Wisconsin County Mutual Insurance Corporation



ALARIS<sup>®</sup>

This is a general workflow of the 24/7 Care Line program. However, we can alter accordingly to accommodate specific customer needs.

# COUNTY MUTUAL CARE LINE<sup>SM</sup>

POWERED BY ALARIS<sup>®</sup>

## CARE LINE INSTRUCTIONS

# 1-855-650-6580

### **MANDATORY FOR USE ON WORKER'S COMPENSATION INJURIES**

The Care Line<sup>®</sup> must be utilized on all work-related injuries **REQUIRING TREATMENT** for the following:

- » Back
- » Neck
- » Knees
- » Shoulders
- » Head

This includes all muscle strains, sprains, fractures, contusions, and cuts to the body part above.

Please **DO NOT** call the Care Line<sup>®</sup> if you do not intend to seek treatment for your injury. You will need to report the incident to your supervisor or the individual designated to receive worker's compensation claims to note the event.

All serious injuries should be treated immediately and reported as soon as possible. All other claims meeting the above criteria should utilize the Care Line<sup>®</sup> Nurse to assess the injuries and provide helpful instructions.

**IN CASE OF EMERGENCY, DIAL 911**

**JACKSON COUNTY**  
**RETURN TO WORK AND/OR MEDICAL STATUS REPORT**

Employee Name \_\_\_\_\_  
Position/Job Title \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_

**TO BE COMPLETED BY ATTENDING MEDICAL PROVIDER**

**(Medical Provider is defined in 102.17 d(1) in the Wisconsin Worker's Compensation Act)**

I saw this patient on: \_\_\_\_/\_\_\_\_/\_\_\_\_      Work Related     yes     no     unknown at this time

**Diagnosis:**

Employee is partially disabled at this time     yes     no      Employee is totally disabled     yes     no

**CHECK ALL THAT APPLY**

Condition:     Improved     Unchanged     Worsened     Not Applicable

Prescription medication prescribed     Medications may affect work performance

Employee is totally disabled because \_\_\_\_\_

Employee will be able to return to work on \_\_\_\_/\_\_\_\_/\_\_\_\_ subject to the following restrictions until \_\_\_\_/\_\_\_\_/\_\_\_\_

Are restrictions permanent     yes     no

Employee will be re-evaluated on \_\_\_\_/\_\_\_\_/\_\_\_\_

Employee will be able to return to work on \_\_\_\_/\_\_\_\_/\_\_\_\_ with no restrictions

Physical therapy recommended     x per day     x per week     weeks

Physical Demands (as described by US Dept of Labor):      Work: Hours/day \_\_\_\_\_      Days/week \_\_\_\_\_

Sedentary: Lifting 10 pounds or less occasionally and frequently lifting and/or carrying small articles (<2lbs.)

Light: Lifting 20 pounds occasionally and frequent lifting and/or carrying of objects weighting up to 10 pounds

Medium: Lifting 50 pounds occasionally, frequent lifting/carrying up to 25 pounds, and constant up to 10 pounds

Medium-Heavy: Lifting 75 pounds occasionally, frequent lifting/carrying up to 40 pounds, and constant up to 15 pounds

Heavy: Lifting 100 pounds occasionally, frequent lifting/carrying up to 50 pounds, and constant of up to 20 pounds

Very Heavy: Lifting >100 pounds occasionally, >50 pounds frequently, and >20 pounds constantly

Should change positions every \_\_\_\_\_

**Push/Pull**

Occasional = 0-33% of work day

Frequent = 34-66% of work day

Constant = 67-100% of work day

May drive     yes     no

May sit     yes     no

May stand     yes     no

Other Recommendations/Comments: \_\_\_\_\_

**Medical Provider Signature (Not to be filled out by PA or APNP)**

Medical Provider's Signature \_\_\_\_\_ Date: \_\_\_\_\_

CLINIC/HOSPITAL NAME: \_\_\_\_\_

Below: Medical Provider's Printed or Stamped Name/Address/City/State/Zip \_\_\_\_\_ Phone \_\_\_\_\_

**Employee Signature and Authorization to Release Information**

1. I hereby authorize my attending Medical Provider and/or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified above to my employer or employer's representative.
2. **I was informed of the above restrictions/instructions and understand that these restrictions apply to my activities both at work and during non-work hours.**
3. **I understand that I need to return a copy of this report to my employer immediately or before next scheduled work shift.**

**Employee Signature :** \_\_\_\_\_ **Date:** \_\_\_\_\_