CLAIMS COORDINATOR
IMPLEMENTATION CHECKLIST:

Factors employers should consider in adopting a *Back on the Job Program*:

- ☐ Appoint a program coordinator
- ☐ Train managers and supervisors
- ☐ Communicate the program to employees
- ☐ Educate employees on return-to-work
- ☐ Require incident report within 24 hours
- ☐ Hold return-to-work team meetings
- ☐ Designate jobs for modified, transitional, and alternative duty
- ☐ Modify work schedules
- ☐ Use vocational, rehabilitation, and/or medical professionals
- ☐ Standardize job descriptions
- ☐ Place returning employees in other departments or locations

EMPLOYEE RESPONSIBILITIES WHEN INJURED ON-THE-JOB

1. Report all accidents or illnesses, no matter how minor, to _____.

2. If you need to see a physician, please contact your supervisor immediately.

3. Written or verbal information regarding the availability of light duty work should be given to the physician at the time of the first visit. In any case, the information will be provided to your attending physician in accordance with _____ Return-to-Work Program.

4. Immediately report to _____ the results of each physician visit. This should be done in person unless other arrangements have been made.

5. Contact should be made with _____ each _____ for updates on your condition and your ability/needs to return-to-work. Any information from the company will be provided to you at this time.

6. All work releases must be reported to _____ immediately so your return-to-work can be scheduled.

7. If _____ is unavailable, you should contact _____.

8. If you have any questions or have concerns about the light duty job, it is your responsibility to consult _____ or _____ immediately to discuss them. If they have any questions or concerns they will discuss them with you.

9. Doctor or physical therapy appointments should be scheduled outside working hours if possible. If not possible, arrangements need to be made with _____.

I have read the above responsibilities information. I have been given the opportunity to ask questions about my responsibilities. I understand that failure to follow them may result in disciplinary action and/or adversely affect my workers' compensation benefits. I have received a copy of this document.

_____ _____

Employee's Signature Date

FOLLOW-UP CHECKLIST FOR JOB RELATED INCIDENTS:

Name of Employee_____ Date of Incident_____

Instructions: The Claims Coordinator *must complete this for every job-related employee injury or illness*

Send the employee to the proper medical facility.

Send the following material with the employee:

Introductory Letter

Drug test authorization (if applicable)

Back – On – The – Job Authorization

Release of Medical Information Form

IN CASE OF EMERGENCY:

DO NOT DELAY TREATMENT WHILE THESE FORMS ARE GATHERED.
FAX FORMS TO DOCTOR WITHIN 24 HOURS OF THE INCIDENT.

Name of Doctor/Clinic/Hospital_____

Disposition:

Unrestricted work

Modified work

Not back to work

Fax or call in First Report of Injury to Insurance Carrier and to us, your insurance agent.

Fax letter to Claims adjuster.

Copy of employee's normal job description.

Additional comments on a separate sheet.

Complete an accident investigation report.

If employee comes back to work:

Meet with the employee to review workers compensation benefits and answer questions.

If employee comes back for modified work:

Meet with the employee to review workers compensation benefits and answer questions.

Explain the modified work limitations to the employee and explain how to get help with tasks that exceed these limitations.

Diary your file weekly from the date of injury to review status.

Continue to get feedback from the employee as to “how things are going.”

If employee did not come back to work:

Continue to the Follow-Up Checklist for Disabling Injuries.

FOLLOW-UP CHECKLIST FOR WHEN EMPLOYEE DOES NOT COME BACK TO WORK:

Name of Employee:_____ Date of Incident_____

Instructions:

Complete the Checklist for job-related incidents first.

The Claims Coordinator must complete this checklist for every job-related employee injury or illness that involves time lost from work.

You have 5 working days from the date of the incident to complete this checklist.

Mail the explanatory letter on workers' compensation benefits to the employee at home.

Telephone the injured employee.

Briefly explain workers' compensation benefits.

Ask about satisfaction with medical care.

Ask when the next doctor's appointment is scheduled.

Date:_____ Time:_____ Doctor:_____

Ask if transportation is needed.

Tell the employee you are anxious to have him/her back to work as soon as possible.

Explain that modified work will be made available as soon as the doctor approves it.

Explain that you expect the employee and his/her doctor to cooperate with the Back-on-the Job Program.

Telephone the treating physician.

Make sure the doctor received the normal and modified work job descriptions.

Discuss the employee's normal job duties.

Discuss any modified work that is available.

Ask when the employee can be cleared for modified work: Date:_____

Prepare a get-well card for management to sign and mail to employee.

If the Employee does not come back to work within *one week* of the incident:

Notify management that the employee is still off work.

Establish a plan to maintain weekly contact with the employee, the treating physician, the insurance company claim adjuster, and management.

If the Employee does not come back to work within *one month* of the incident:

Notify management that the employee is still off work.

Develop a custom-tailored return-to-work plan in cooperation with appropriate personnel inside and outside the company.

WORKER'S COMPENSATION FRAUD RED FLAG CHECKLIST:

Claimant's Name: _____ Date of Injury: _____
Mark applicable red flag indicators. Describe red flag indicators on reverse.

Note: *Red flags are indicators that indicate the need for further investigation of a claim to determine its legitimacy. Therefore, the applicability of one or even several "red flag" indicators is not necessarily indicative of the existence of worker's compensation fraud.*

	Unexplainable delay in reporting
	No witnesses to the alleged injury-producing incident
	Insufficient detail was provided surrounding the injury-producing incident
	Alleged injury seems inconceivable considering the work which the claimant performs
	Injury is not visible (e.g., soft tissue injury)
	Degree of injury is not likely to result from alleged injury-producing incident
	Allegations or rumors of fraud and/or the claimant has been observed working elsewhere.
	Incident was reported on a Monday morning (or after one or two days off of work)
	Claimant has recently purchased disability insurance
	Claimant is a new employee
	Claimant has no health insurance coverage
	Claimant has used all available sick & vacation days
	Claimant is known to have personal financial problems
	Claimant is physically active outside
	Claimant has submitted workers compensation claims in the past Inconsistencies revealed from the claimant's initial description of the incident
	Claimant is unusually familiar with workers compensation system
	Claimant is uncooperative and/or objects to administrative controls intended to address workers compensation fraud
	Claimant does not provide a street address for a residence
	Employer is frequently unable to contact the claimant while off work due to an alleged injury
	Claimant obtained legal representation soon after the alleged incident and/or has obtained legal counsel with a questionable reputation
	Claimant has indemnity checks mailed to his/her residence
	Subsequent medical evaluations apparently contradict the initial evaluation
	Employee has missed scheduled physician visits or rehabilitation appointments
	Treatment being provided seems more extensive than the injury warrants
	Claimant has changed medical providers more than once after the initial treatment
	Claimant has been referred to a medical provider close in proximity to the referring medical partner

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Making Workmans Comp Work

RETURN TO WORK AUTHORIZATION FORM

Our company has a light duty and transitional work program that provides temporary jobs that injured employees should be able to safely perform during their recovery periods. Completion of this form will allow us to identify an appropriate assignment for this employee. Thank you for your cooperation and prompt response.

Date _____ Employee

_____

Employer _____

Employer Contact Person _____Phone_____

Diagnosis _____

_____

Work Related; Submit Claim to: _____

Non-Work Related; Submit Claim to: _____

Treatment: _____

_____

Disposition:

Return to work date (no limitations for current job)

Return to work date (with limitations for modified duty)

Unable to work From _____ To _____

Return to Clinic on _____

Prognosis: _____

Referral:

Doctor _____

Physical therapy _____

Please fax to: _____
(fax number)

or e-mail to: _____
(e-mail address)

this form to _____ so our employee may return to work.
(name of Back-on-the-Job Coordinator)

WORK RESTRICTIONS

Restrictions apply to: Work Home Leisure

During the applicable workday, this employee can:

Sit _____ hours
Stand _____ hours
Walk _____ hours

In terms of an applicable work day, "occasionally" equals 1-33%. "frequently" equals 34-66%, and "continuously" equals 67-100%.

Employee Can	Never	Occasionally	Frequently	Continuously
Lift and carry				
Up to 10 pounds				
11- 25 pounds				
26- 35 pounds				
36- 50 pounds				
51- 75 pounds				
76-100 pounds				
Reach above shoulder level				
Push/Pull				
Climb				
Squat/Kneel				
Bend/Stoop/Crouch				
Balance				
Twist upper body				
Use hands dexterously				

Physician's Comments:

Physician _____ Date _____

SAMPLE: RELEASE OF MEDICAL INFORMATION

AUTHORITY TO RELEASE MEDICAL INFORMATION

(Employee Name)
(Employee Address)
(Date of Birth)

I authorize (name of treating doctor) to release medical information to my employer, (name and address of employer), regarding my on the job injury that occurred on
(Date of injury).

This information may facilitate my return to medically appropriate productive work.

(Print employee name)_____

(Employee signature)_____Date: _____