

ACCIDENT / INJURY REPORTING PROCEDURES
FOR
GEORGIA STATE UNIVERSITY

FOR ANY LIFE THREATENING EMERGENCY**

SEEK TREATMENT IMMEDIATELY

THEN FOLLOW THE PROCEDURES THAT FOLLOW

() LIFE THREATENING* EMERGENCIES** - Could possibly include: probable damage to major blood vessels or nerves, profuse bleeding that cannot be stopped, amputated body part, broken bone, cut to bone, eye injury, head trauma and/or automobile accident.)

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INTRODUCTION:

Workers' compensation is a benefits program created by State Law that provides medical, rehabilitation, income, death and other benefits to employees and dependents due to injury, illness and death resulting from a compensable work-related claim covered by the law.

Workers' compensation coverage begins the first day of employment.

Workers' compensation coverage covers all employees (persons who maybe part-time, temporary, full time, limited term and etc.) who are doing work for Georgia State University and getting paid by Georgia State University, via the payroll system for that work.

Any injury, illness or death arising out of and in the course of employment is by definition a compensable work-related claim. This means if employees are injured while performing assigned job duties during assigned work hours, they are usually covered under the workers' compensation program. Injuries sustained while engaging in unassigned duties, during lunch and breaks, are not usually covered. In addition, injuries that occur during an employee's normal commute to and from work are usually not covered.

When an employee is injured while working for Georgia State University and wants medical treatment under the provisions of the Workers' Compensation Insurance Program, a claim must be filed so that the injured employee's medical bills can be paid.

The supervisor of the injured employee, or their designated representative, is responsible for reporting the employee's injury correctly, **to the Georgia State University, Department of Safety and Risk Management**, so that a claim may be filed.

Georgia State University's Workers' Compensation Insurance program is managed by a third party administrator. Georgia State University's Department of Safety and Risk Management coordinates the Workers' Compensation Insurance claims process.

GENERAL INSTRUCTIONS:

EMERGENCY CARE:

If an employee requires immediate medical attention, as in a life threatening emergency situation,

(LIFE THREATENING* EMERGENCIES** Could possibly include: probable damage to major blood vessels or nerves, profuse bleeding that cannot be stopped, amputated body part, broken bone, cut to bone, eye injury, head trauma and/or automobile accident.)

the employee should seek immediate attention first. then following an employee's emergency admission, service or procedure, the employee, or the employee's designated representative, must notify the employee's supervisor, who will complete the paperwork for their employee's accident. The supervisor then must submit the required paperwork to the Department of Safety and Risk Management so the employee can obtain a claim number and continue medical care under the provisions of the Workers' Compensation Insurance Program.

INJURED EMPLOYEES AND / OR SUPERVISORS ARE NOT TO CALL IN ACCIDENT CLAIMS

After receiving a Workers' Compensation Claim Number, from the Department of Safety and Risk Management, the injured employee must call AMERISYS, INC., Managed Care – Triage, by calling the number listed under Contact Information on page 8 of this document, to get set up for post-emergency room treatment.

Note #1: The employee will be allowed to choose an authorized treating physician who will then evaluate the employee's treatment plan and make further recommendations.

Note #2: The injured employee cannot go to any physician, for additional care unless specifically authorized by AMERISYS, INC., Managed Care - Triage, if they want Workers' Compensation to pay their bills.

NON EMERGENCY CARE:

If an employee is injured, their supervisor or the supervisor's designee should be immediately notified (but no later than 24 hours), by the injured employee.

At Georgia State University, the injured employee's supervisor, or the supervisor's designee, is responsible for correctly reporting the injured employee's accident to the Department of Safety and Risk Management, at Georgia State University. **Refer to specific instructions on pages 5-6 of this document.**

The injured employee is responsible for providing the Department of Safety and Risk Management and their supervisor with medical status slips, every time they have a medical visit, until they are fully dismissed from a Workers' Compensation Authorized Physician, if they choose to receive benefits under the Workers' Compensation Insurance Program at Georgia State University. **Refer to specific instructions on pages 7 of this document.**

SPECIFIC INSTRUCTIONS

SUPERVISOR'S RESPONSIBILITIES:

1. Supervisor obtains fully completed items A, B, C and D, below so as to initiate the process of reporting an accident and/or filing a Workers' Compensation Claim:

- A. Fully Filled out **First Report of Injury Form** (page 10 of this document). All blank spaces (non-highlighted) on this Form must be filled in.

INJURED EMPLOYEES AND / OR SUPERVISORS ARE NOT TO CALL IN ACCIDENT CLAIMS

Note #1: An employee may either fill out the **First Report of Injury Form** for their supervisor, but may not sign or date it, or they may provide their supervisor with information the supervisor may not readily have available.

Note #2: The supervisor of the injured employee, or supervisor's designee, must sign, date the form and provide both an office telephone number and E-mail address in the spaces provided on the **First Report of Injury Form**.

- B. **Employee Leave Election Form** (page 11 of this document), signed and dated by the injured employee.

Note #3: The Supervisor obtains an original, fully filled out, signed and dated **Leave Election Form** from the injured employee, **before they leave campus**.

Note #4: The Leave Election Form must be filled out when the First Report of Injury Form is filled out.

Note #5: The Leave Election Form tells the Workers' Compensation and Georgia State University Human Resources how the injured employee wants to be paid for any time they have to be away from work.

Note # 6: Even if no time is expected to be missed from work, the First Report must be filled out, signed and dated by the injured employee.

- C. **Employee Acceptance / Declination of Workers' Compensation Benefits** (page 12 of this document), initialed, signed and dated by the injured employee

Note # 7: The Acceptance / Declination of Medical Treatment Form must be filled out when the First Report of Injury Form is filled out. The Acceptance / Declination of Medical Treatment Form tells the Department of Safety and Risk Management that a Workers' Compensation Claim needs to be filed, or not filed with the Claims Service.

Note #8: Even if the injured employee declines medical treatment the Acceptance / Declination of Medical Treatment Form must be fully filled out, signed and dated.

- D. **Witness Form** (page 13 of this document) – Filled out either by Witness or Employee
If no person witnessed the accident, then the injured employee must fully fill out the Form, sign and date it, putting "NO WITNESS" at the bottom of the form.

Note #9: On the **Witness Form**, the accident should be fully described, including specific causal elements for the accident/injury, specific location where the accident occurred and time the accident occurred. The Supervisor assures that the Witness Form is signed and dated by both the person filling out the Form AND by a supervisor.

2. The supervisor faxes, or scans (and then E-mails), all 4 (A, B, C and D) of the above fully completed documents to the "CONTACT INFORMATION" numbers listed on page 8, under item #1: **Filing a Workers' Compensation Claim at Georgia State University, within two (2) hours of an employee's reported injury.**

Note #10: A claim cannot be filed, by the Department of Safety and Risk Management, until all information and all the required forms are provided.

3. The Supervisor then sends (or hand delivers) the **ORIGINAL** fully filled out, signed and dated:

- A. Fully Filled out First Report of Injury Form
- B. Employee Leave Election Form
- C. The Acceptance / Declination of Medical Treatment Form
- D. Witness Form – Filled out either by Witness or Employee

to the address listed below, under "CONTACT INFORMATION" numbers listed on page 8, under item #1: **Filing a Workers' Compensation Claim at Georgia State University making sure that it will arrive within 2 business days of completion of the forms.**

4. Supervisor Gives The Injured Employee:

- A. **myMATRIX Prescription First Fill Form** (page 14 of this document), before employee leaves campus for the day, but after all paperwork is completed.

Note #11: All paperwork should be completed quickly after an accident occurs and BEFORE the employee leaves campus for the day, so that the accident is timely reported and the employee has the option of obtaining medical care for their injury without having to return to campus to fill out the required forms.

- B. The office telephone number for the Georgia State University, Department of Safety and Risk Management (**404-413-9549**), if the employee wishes medical care for their injuries, so that the employee can obtain their claim number.

Note #12: A Workers' Compensation claim number is required for an injured employee to be able to obtain an appointment for medical care.

Note #13: Workers' Compensation Claims will **NOT** be filed with the Claims service, unless the injured employee elects to accept medical treatment via the Workers' Compensation insurance, using the **Employee Acceptance / Declination of Workers' Compensation Benefits Form.**

Note #14: Workers' Compensation Claims will be filed for injured employees only during regular business hours by the Department of Safety and Risk Management (8:30am – 4pm, Monday through Friday).

Note # 15: The supervisor may assist the employee in choosing a doctor, but cannot choose a doctor or facility for the employee. Nor may a supervisor **send / take an injured employee** to any facility without the employee having a claim filed and the employee has a pre-set medical appointment.

Note #16: Injured employees must go through the AMERISYS medical approval system, before attempting to seek medical attention ***unless the employee has a life threatening injury. Then emergency medical transport maybe summoned or the employee can get to the nearest emergency care facility. Then a claim must be filed, for the medical bills to be paid by the Workers' Compensation insurance.***

SUPERVISORS OR INJURED EMPLOYEES ARE NOT TO CALL IN ACCIDENT CLAIMS

INJURED EMPLOYEE'S RESPONSIBILITIES:

Injured Employees are to provide their supervisor with:

- A. A verbal, or written, report of their injury within 24 hours of the injury/accident occurring.
- B. Enough information so that their supervisor can fully complete a **First Report of Injury Form**.
- C. Employee **Leave Election Form**, fully filled out, signed and dated, before leaving campus for the day and/or before scheduling any doctor's appointments.
- A. The Acceptance / **Declination of Medical Treatment Form**, fully filled out, signed and dated. The Acceptance / Declination of Medical Treatment Form tells the Department of Safety and Risk Management that a Workers' Compensation Claim needs to be filed, or not filed with the Claims Service.
- E. **Witness Form** – fully filled out, signed and dated by both the witness (or injured employee) and a supervisor, before leaving campus for the day and/or before scheduling any doctor's appointments.

Note #17: Injured Employees should receive a copy of the **myMATRIXX Prescription First Fill Form** (page 14), before leaving campus for the day, and /or scheduling any doctor's appointments but only after all other paperwork is completed, by the supervisor. The **myMATRIXX Prescription First Fill Form** (page 14) allows the injured employee to fill a needed prescription without having to pay out of pocket, until their claim is properly processed.

Note #18: For Injured Employee's Specific Rights and Responsibilities, please refer to **GEORGIA STATE BOARD OF WORKERS' COMPENSATION – BILL OF RIGHTS FOR THE INJURED WORKER** posted in your work area.

SUPERVISORS OR INJURED EMPLOYEES ARE NOT TO CALL IN ACCIDENT CLAIMS

PROCESS FOR INJURED EMPLOYEES TO RECEIVE "NON-EMERGENCY" MEDICAL CARE

After an employee is injured, requires, **AND WANTS** Worker's Compensation medical attention, outside of regular first aid treatment, a claim must be called into the claims service, by **THE DEPARTMENT OF SAFETY AND RISK MANAGEMENT**. **A claim cannot be filed, by the Department of Safety and Risk Management, until all information and the required forms are provided.**

The injured employee then must call the AMERISYS Managed Care at 800-900-1582, selecting option #2, to obtain assistance with selecting an authorized treating physician and to schedule the first medical appointment, **after receiving an assigned claim number**. The injured employee must do this **before seeking any medical treatment unless the injury requires immediate medical attention, or is life threatening.**

Note #19: The supervisor may assist the employee in choosing a doctor, or facility, but cannot choose for the employee or send an employee to any facility without the employee going through the AMERISYS approval.

Note #20: The injured employee is responsible for keeping all scheduled doctor's appointments and continuing the regular prescribed care, until they are fully dismissed from care.

Note #21: The injured employee is responsible for obtaining and providing the Department of Safety and Risk Management and their supervisor with a doctor's status report, each and every time the employee is seen by a Workers' Compensation Physician.

CONTACT INFORMATION

1. Filing a Workers' Compensation Claim at Georgia State University, contact:

Workers' Compensation Administrator
Department of Safety and Risk Management
P.O. Box 3961
Georgia State University
Atlanta, GA 30302-3961
Phone: (404) 413-9548
FAX: (404) 413-9550
E-Mail: SAFBHP@langate.gsu.edu
In Person: 75 Piedmont Ave., Suite 506

2. Obtaining information about Workers' Compensation and/or how to file a Claim at Georgia State University:

Go to Georgia State University's Department of Safety and Risk Management's webpage - <http://www.gsu.edu/auxiliary/safety.html> - and look under the tab marked **Occupational Health and Safety**, then under the tab marked **Worker's Compensation**.

3. Medical care arrangements for injured employees, under the provisions of Georgia State University's Workers' Compensation Insurance Program:

Injured employees are to call:

Department of Administrative Services (DOAS)
AMERISYS Manage Care
Triage Unit
Phone: 1-800-900-1582, **then select Option # 2**

Note #22: Employees will need an assigned Workers' Compensation Claim number before calling the number above.

4. For other specific questions concerning Workers' Compensation issues at Georgia State University, contact:

Brenda Hinds Pool, MSPH, CIH
Occupational Health and Safety Officer
Workers' Compensation Administrator
Right to Know Coordinator
Georgia State University
Department of Safety and Risk Management
P.O. Box 3961
Atlanta, GA 30302-3961
Phone: (404) 413-9545
FAX: (404) 413-9550
E-Mail: SAFBHP@langate.gsu.edu
In Person: 75 Piedmont Ave., Suite 506

GEORGIA STATE UNIVERSITY MODIFIED WC-1

**EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE
GEORGIA STATE BOARD OF WORKERS' COMPENSATION**

Assigned Workers Compensation Claim No.: WC	
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NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY

IDENTIFYING INFORMATION					
<u>EMPLOYEE</u>	<u>Last Name</u>	<u>First Name</u>	<u>M.I.</u>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<u>Date of Birth</u>
<u>Address Street</u>			<u>Home Phone Number</u>		<u>Social Security Number</u>
<u>City State Zip Code</u>			<u>Employee E-mail</u>		
<u>EMPLOYER</u>		<u>Nature of Business</u>		<u>EMPLOYEE'S DEPARTMENT NAME:</u>	
Georgia State University		University			
<u>Address</u>			<u>Employer's Workers' Compensation Contact Phone Number</u>		<u>Employer's Workers' Compensation Contact FAX Number</u>
Department of Safety and Risk Management 33 Gilmer St., P. O. Box 3961 Atlanta, GA 30302 - 3961			(404) 413-9545		(404) 413-9550
			<u>Employer Contact E-mail</u> SAFBHP@langate.gsu.edu		
<u>INSURER/ SELF-INSURER</u>	<u>Name</u>		<u>Claims Office Address</u>		
	Department of Administrative Services		200 Piedmont Ave., SE, Suite 1208 West, ATLANTA, GA 30334 404-656-6245		
<u>CLAIMS OFFICE</u>	<u>Name</u>				
	Risk Management Services / Workers' Compensation Unit				

Claims Reporting: Contact Department of Safety and Risk Management – 404-413- 9549 for assistance.	<u>SPECIFIC location where employee was injured or accident occurred:</u>
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	<u>EXACT Date Hired by Employer</u>	<u>Number of Days Worked Per Week</u>	<u>Wage rate at time of injury or Disease:</u>
	Month Day Year		<input type="checkbox"/> per Hour <input type="checkbox"/> per Day <input type="checkbox"/> per Week <input type="checkbox"/> per Month <input type="checkbox"/> per Year
<u>List Normally Scheduled Days Off</u>	<u>Time Employee Workday Started:</u>	<u>Employee's Job Title</u>	

<u>INJURY/ILLNESS & MEDICAL</u>	<u>Date of Injury</u>	<u>EXACT Time of Injury</u> <input type="checkbox"/> am <input type="checkbox"/> pm	<u>County of Injury</u>	<u>Date Employer Notified</u>	<u>Enter First Date Employee Failed to Work Full Day</u>
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<u>Did Employee Receive Full Pay on Date of Injury?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Did Injury/Illness Occur on Employer's premises?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Type of injury/illness</u>	<u>Body Part(s) Affected</u>
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<u>If Returned to Work, Give Date:</u>	<u>Returned at what wage:</u> per Week	<u>If Fatal, Enter Date of Death</u>	<u>How Injury or Illness / Abnormal Health Condition Occurred:</u>
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<u>Treating Physician (Name and Address)</u>	<u>Initial Treatment Given:</u> <input type="checkbox"/> None <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: By Clinical/Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalized > 24hrs	<u>Hospital / Treating Facility (Name and Address)</u>
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<u>Report Prepared By (Injured Employee's Supervisor or designee), (Print or Type Signature)</u>	<u>Office Telephone Number</u>	<u>Date Report Signed</u>
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<u>E-Mail Address Of Person Preparing Report:</u>		
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IF YOU HAVE QUESTIONS PLEASE CONTACT ONE OF THE FOLLOWING: THE DEPARTMENT OF SAFETY AND RISK MANGEMENT, OCCUPATIONAL HEALTH AND SAFETY OFFICER, AT GEORGIA STATE UNIVERSITY (404-413-9545),

REVISION 03/01/11

GEORGIA STATE UNIVERSITY LEAVE ELECTION MEMORANDUM

Date: _____

To: Department of Administrative Services, Workers' Compensation Unit

Co: Benefits Office of Human Resources, Georgia State University

From: Georgia State University, Department of Safety and Risk Management,

Re: **Selection of Workers' Compensation Pay Options for Injured Employee**

On the Date of _____, I, _____ was injured on the job while working for the Department of _____ at Georgia State University. If I lose any time because of this injury, I request that I be paid in the following manner:

() From my accumulated sick leave, and () from my accumulated vacation leave before receiving Workers' Compensation benefits for loss of wages.

() Workers' Compensation benefits from the State of Georgia for loss of wages instead of full pay from accumulated sick and vacation leave from my employer, Georgia State University.

Note: If this selection is made, the employee must initial all of the statements below.

____ I understand that I will be compensated at no more than 66 2/3% of my weekly wage (max. of \$500/week).

____ I understand that I will not be paid for the first five workdays that I am out of work, unless I am out of work, due to my injury/illness for 21 consecutive days.

____ I understand that I will need to contact Georgia State University, Human Resources – Benefits, and make arrangements to keep my employee benefits current while I am out of work.

() From my accumulated sick leave, and if necessary, from my accumulated vacation leave from the date of _____ until the date of _____ after which time I wish to be paid Workers' Compensation benefits instead of full, regular pay.

____ I understand that I may change my Leave Election at any time, by filling out another Form and submitting the original to the Department of Safety and Risk Management.

Note: Employee must initial above statement before signing.

Signature of Employee (as shown on payroll)

Date Signed

GSU Human Resources to complete this section.

The GSU Employee, _____,

SSN: _____ has a balance of _____ vacation hrs and _____ sick leave hrs.

Leave will end as of _____.

Weekly Wage Rate\$ _____

Short Term Disability Enrollment _____

Verified by: _____ Date _____

(Name of Human Resources Employee)

**GEORGIA STATE UNIVERSITY ACCEPTANCE / DECLINATION
OF
WORKERS' COMPENSATION BENEFITS FOR AN ON THE JOB INJURY / ILLNESS**

Date: _____

To: Department of Administrative Services, Workers' Compensation Unit

Co: Benefits Office of Human Resources, Georgia State University

From: Georgia State University, Department of Safety and Risk Management,

Re: **Employee Acceptance / Declination of Workers' Compensation Benefits**

On the Date of _____, I, _____, was injured on the job while working for the Department of _____ at Georgia State University.

_____ **Employee Initial Here**

I do not want medical treatment for my injuries at this time. I understand that I may change my mind at anytime within 30 days of my reported accident date, by contacting the Department of Safety and Risk Management.

_____ **Employee Initial Here**

I do want medical treatment for my injuries at this time. I am requesting that a Workers' Compensation Claim be filed so that I may select a physician to treat my injuries.

_____ **Employee Initial Here**

Once my Workers' Compensation Claim is filed I understand that I must:

- Schedule a doctor's appointment before returning to work.
- Keep all scheduled doctor's appointments, or reschedule them.
- Provide my Supervisor AND the Department of Safety and Risk Management with a doctor's status slip **every time** I see a medical professional, for my injuries. If I am not offered a status slip, I understand I must ask for one.

Signature of Employee (as shown on payroll)

Date Signed



State of Georgia DOAS Workers' Compensation Temporary (first fill) Prescription Information

Injured Worker:

State of Georgia Department of Administrative Services, has partnered with **myMatrixx** to make filling workers' compensation prescriptions easy!

This document serves as a temporary (first fill) prescription card. Prescription fills of injury-specific medications up to a three-day supply will be honored. After your claim is accepted, you may have the remainder of the prescription filled. A permanent prescription card specific to your injury will be forwarded directly to you within the next three to five business days.

Please take this letter and your prescription to a pharmacy near you. The **myMatrixx** pharmacy network consists of more than 50,000 pharmacies nationwide. If you would like to know if a specific pharmacy is in our network, please call (877) 804-4900.

If the pharmacy denies your medication, please call (877) 804-4900.

Pharmacist:

Please use this information when processing prescriptions for this patient's workers' compensation injury:

Patient Name: _____

Group #: 20012105

Member ID (SSN): _____

Date of Injury: _____

Processor: Matrixhcs

Bin#: 011073

Day supply is limited to three days for a new injury.

myMatrixx Help Desk: 877-804-4900

For questions or rejections, please call (877) 804-4900. Please do not send the patient home or have the patient pay for medication(s) before calling myMatrixx.

*Employer Authorized Signature and Phone #:

Brenda Hinds Pool – 404-413-9545

NOTE: State of Georgia DOAS has pre-approved certain medications for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS CALL: (877) 804-4900