

# **Workers Compensation Process and Procedures Manual**

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Bureau of State Risk Management

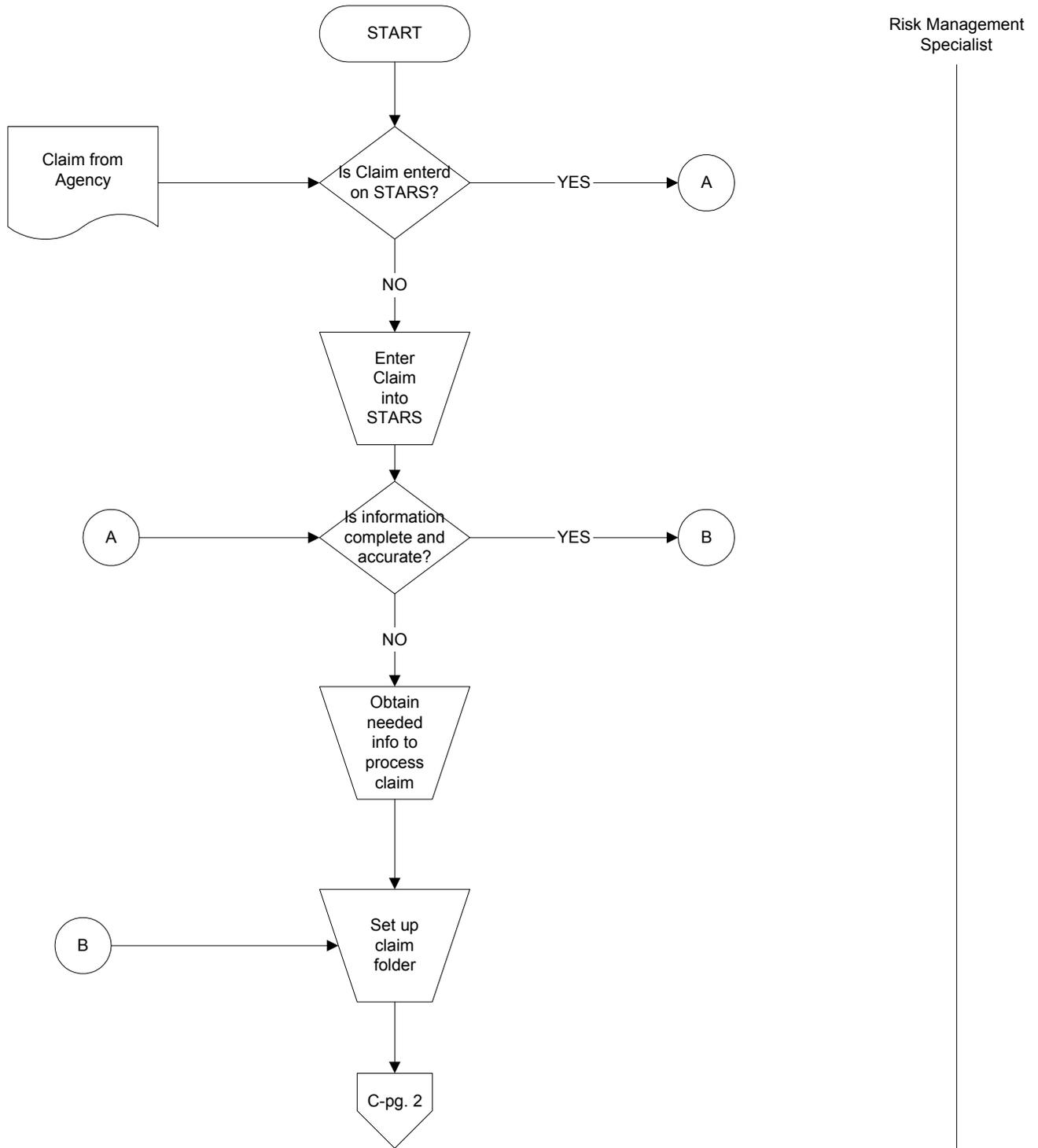
Process Code	W1.1
Process	Worker's Compensation Claims Management
Sub-Process	Basic All Claims Management

Input

Process

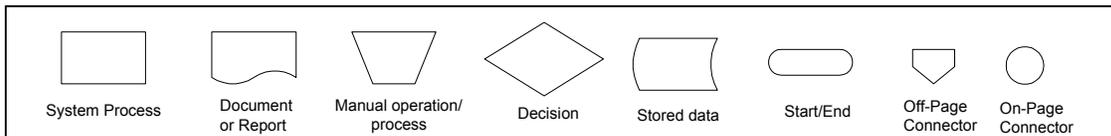
Output

Responsibility



Risk Management Specialist

Legend:

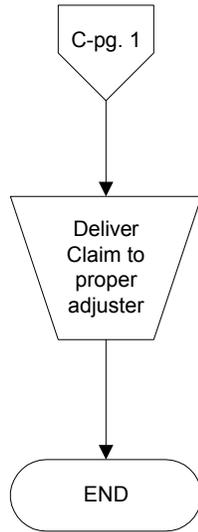




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Management**

<b>Process Code</b>	W1.1
<b>Process</b>	Worker's Compensation Claims Management
<b>Sub-Process</b>	Basic All Claims Management

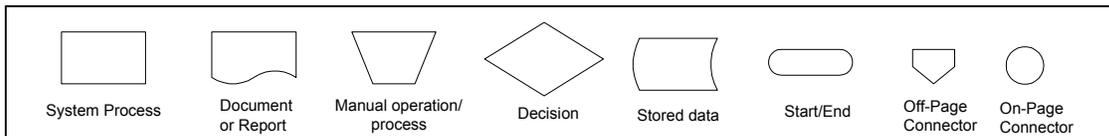
Input	Process	Output	Responsibility
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Risk Management Specialist



**Legend:**





<b>Process Code</b>	W1.1
<b>Process</b>	Worker's Compensation Claims Management
<b>Sub-Process</b>	Basic All Claims Management

**Input****Process****Output****Responsibility****Basic All Claims Management (W1.1)****Claims received**

1. Claims are either entered into STARS by an agency's Worker's Compensation Coordinator using STARSWeb or sent to DOA by FAX, mail, or e-mail. (A "claim" consists of an "employee's First Report of Injury Disease," (WKC12) completed by the injured employee's supervisor.) After receiving a claim from an agency, the Risk Management Specialist searches STARS by claimant name and or/ Social Security Number to determine if the claim has been entered onto the STARS system. If the claim has not been entered into STARS, the Risk Management Specialist enters it.

**Determine if the claim information is complete**

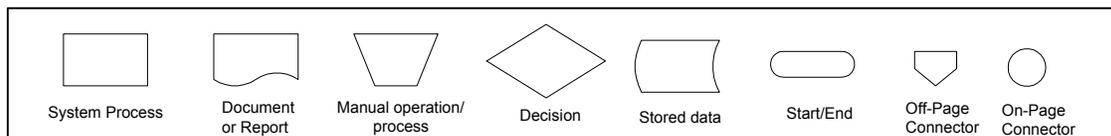
2. After finding the claim or entering the claim into STARS, the Risk Management Specialist must determine if the information entered is complete, accurate, and ready to be distributed to the proper claims adjuster.

**Obtain needed information**

3. If the information is not accurate, the Risk Management Specialist will obtain the needed information by either consulting coding documents, contacting the agency's Worker's Compensation Coordinator, and/or consulting the Bureau's Worker's Compensation staff.

**Set up claim folder**

4. The Risk Management Specialist sets up a claim folder and puts it in the IN box of the proper claims adjuster.

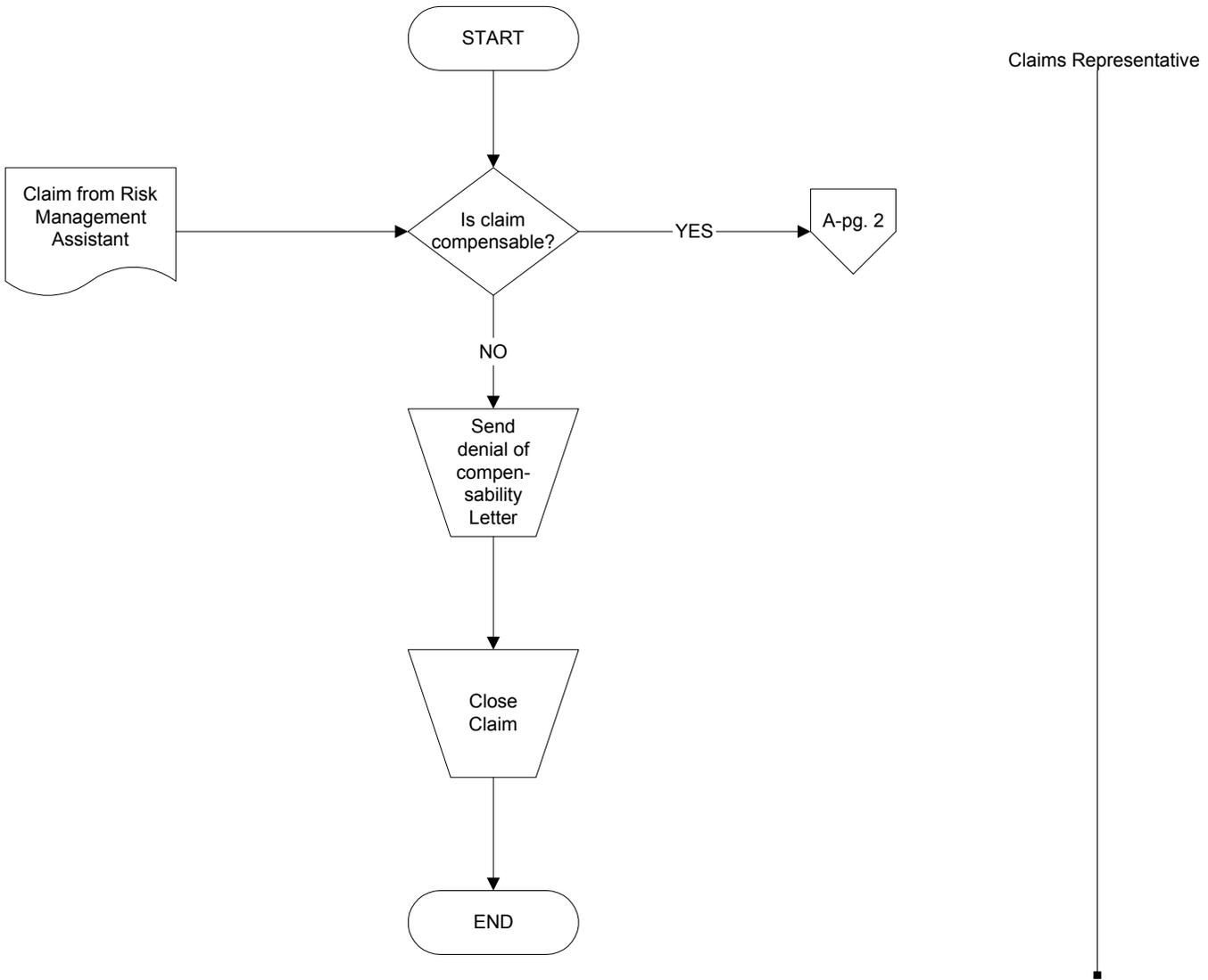
**Legend:**



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Process Code	W1.2
Process	Worker's Compensation Claims Management
Sub-Process	Medical Only Claims Management

Input	Process	Output	Responsibility
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Legend:

System Process	Document or Report	Manual operation/process	Decision	Stored data	Start/End	Off-Page Connector	On-Page Connector



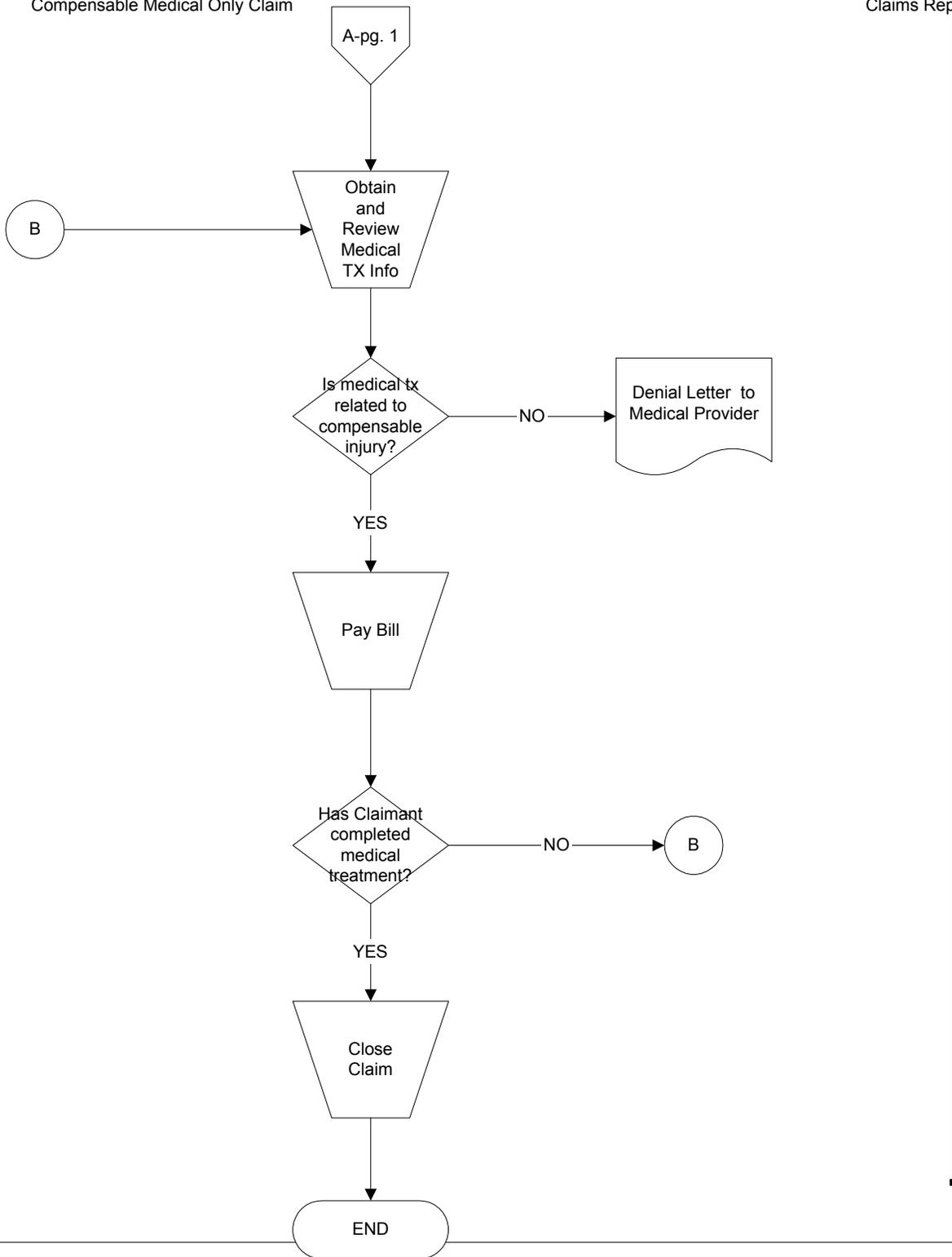
Division of State Agency Services  
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Process Code	W1.2
Process	Worker's Compensation Claims Management
Sub-Process	Medical Only Claims Management

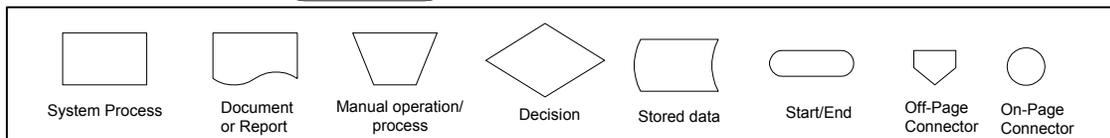
Input	Process	Output	Responsibility
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Compensable Medical Only Claim

Claims Representative



Legend:



## **Medical Only Claims Management (W1.2)**

### **Determine if the claim is compensable**

1. A Risk Management claims representative receives a new claim from the Risk Management Assistant. The claims representative reviews the claim to determine compensability, the claim must arise out of employment, occur in the course of employment, and are causally related to the employment.
  - 1a. If the claim is compensable go to step 2
  - 1b. If the claim is not compensable, the claims representative sends a “denial of compensability” letter to the claimant, carbon the employer, the Department of Workforce Development, and the claim file. The claims representative will set a diary to review the claim for closure.

### **Monitoring claim activity**

2. Upon determining compensability the claims representative will set a diary to review the claim for closure in 90 days if there is no activity. “Activity” is usually the receipt of medical bills and treatment notes. The claims representative will review the treatment notes to ensure the bills that are being paid are related to the date of injury. Also, the claims representative will monitor the treatment to ensure treatment is reasonable and necessary for the current injury. If reasonability and necessity is in question the claims representative may choose to refer the claim to case management vendor or for an Independent Medical Evaluation for a second opinion on necessity of treatment. If a bill is received for treatment that is clearly unrelated to the current injury a denial letter is sent to the medical provider. Bills that are related to the current injury should be paid according to process W1.5.

### **When to close claim**

3. The claims representative will continually be reviewing medical records to monitor for an end of healing status. If end of healing has been reached the claim should be closed. If end of healing has not been reached Step 2 should continue to be followed.

### **Application for Hearing**

4. If an application for hearing is received, the claim should be given to the claims supervisor, who in turn will give it to a claims examiner for continued handling.



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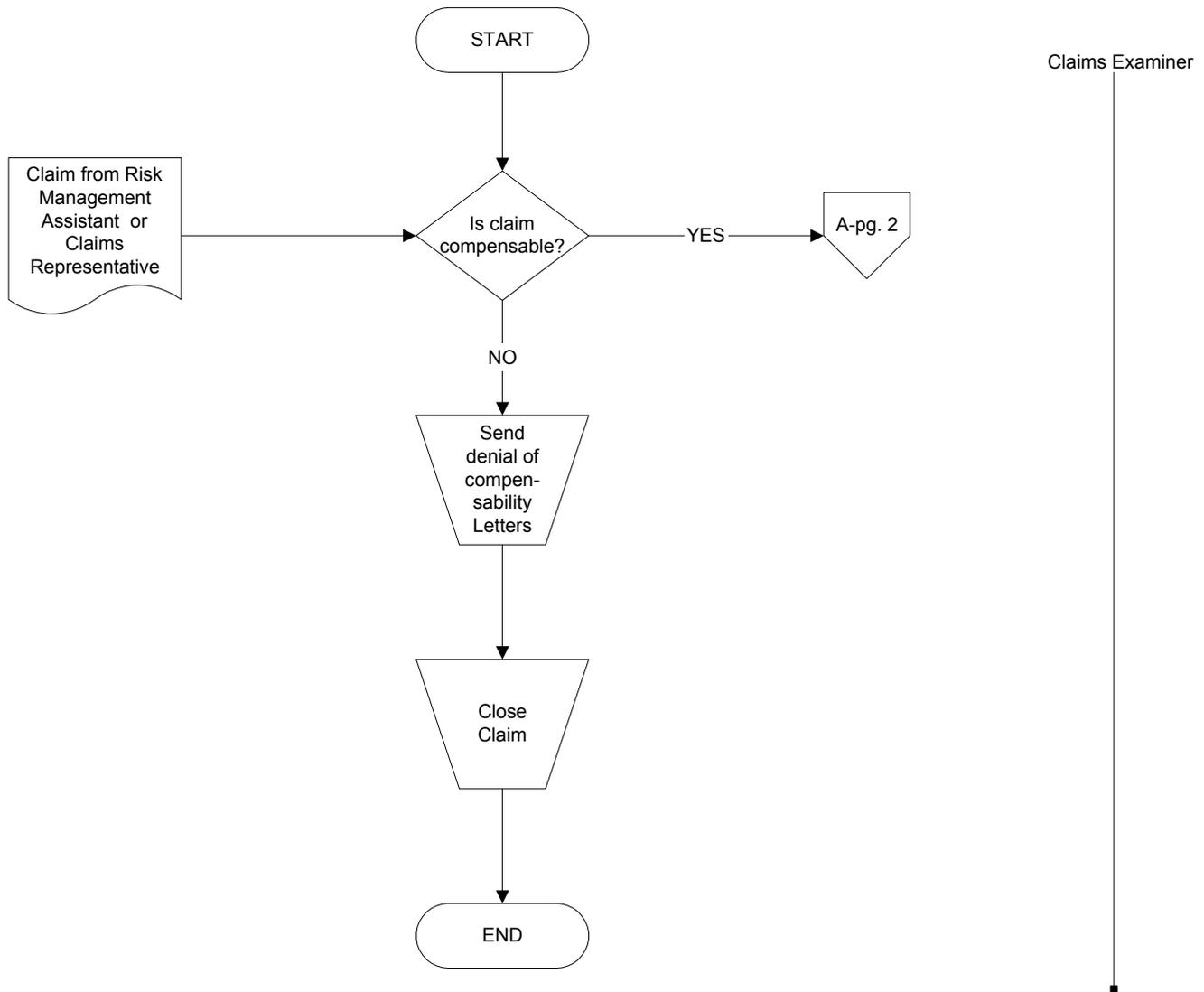
Process Code	W1.3
Process	Worker's Compensation Claims Management
Sub-Process	Lost Time Claims Management

Input

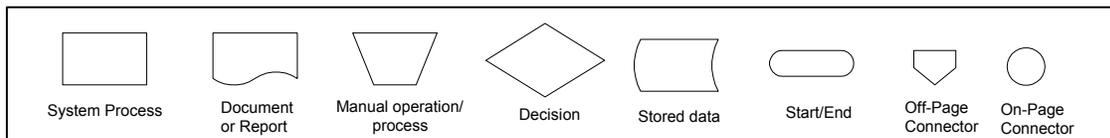
Process

Output

Responsibility



Legend:



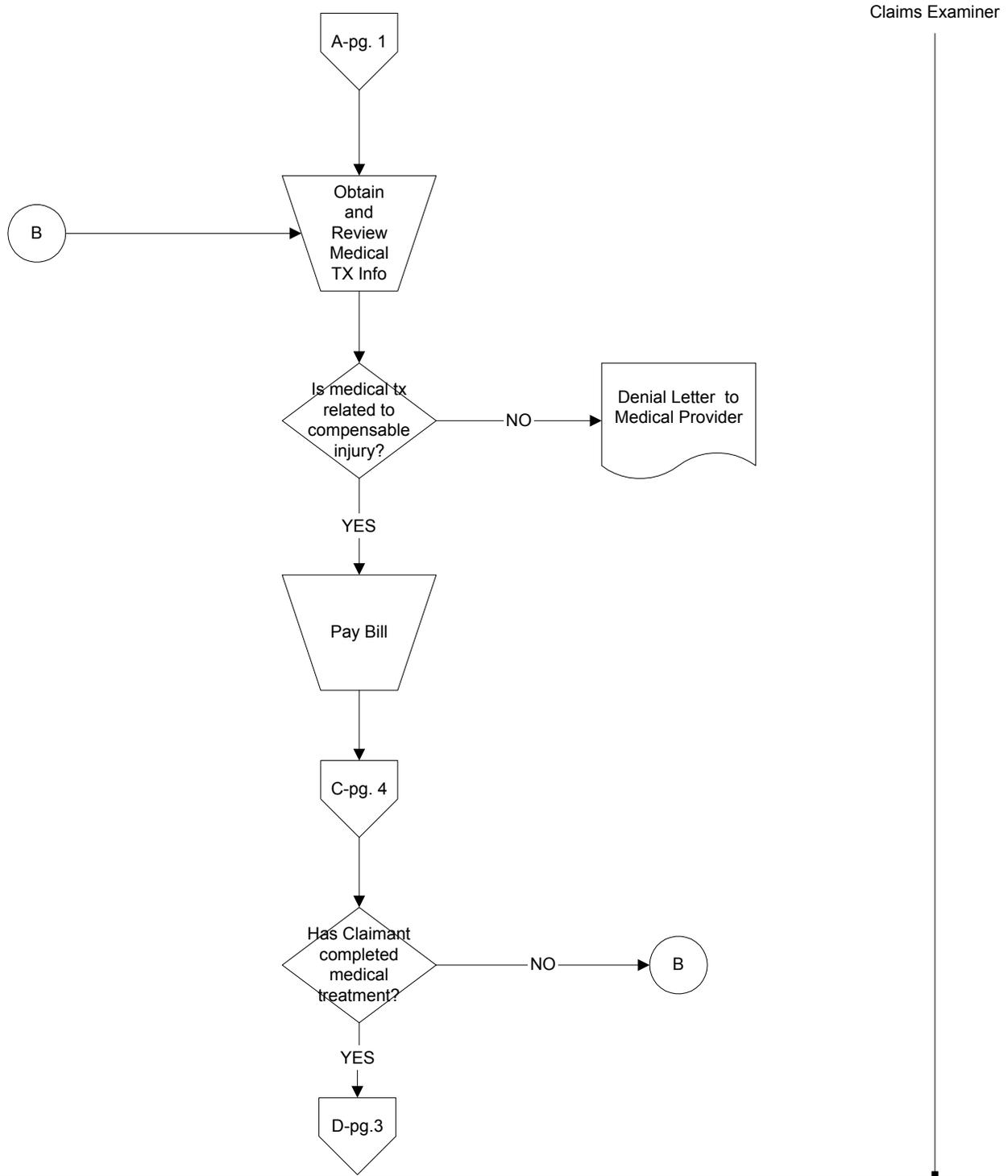


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Management**

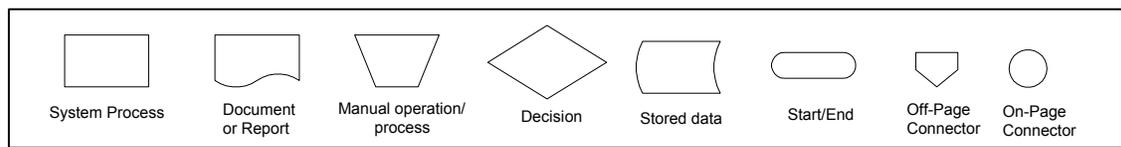
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<b>Process</b>	Worker's Compensation Claims Management
<b>Sub-Process</b>	Lost Time Claims Management

Input	Process	Output	Responsibility
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Compensable Lost Time Claim



**Legend:**





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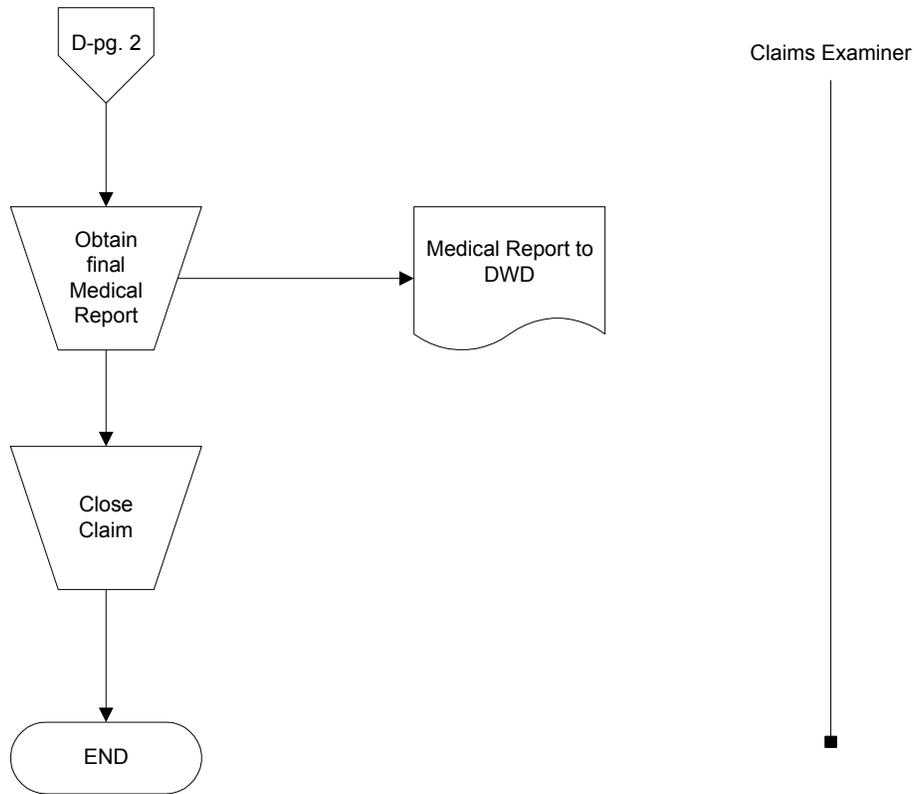
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Process	Worker's Compensation Claims Management
Sub-Process	Lost Time Claims Management

Input

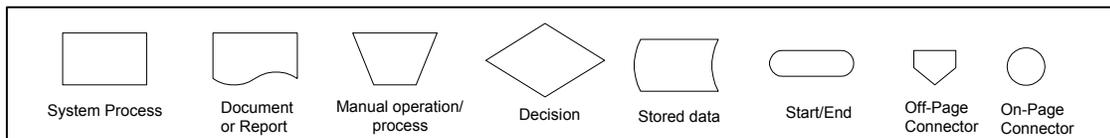
Process

Output

Responsibility



Legend:



## **Lost Time Claims Management (W1.3)**

### **Determine if claim is compensable**

1. Once an agency forwards an initial lost time WKC-12 to DOA, a Risk Management claims examiner will receive this lost time claim in one of two ways, either from the Risk Management Assistant or from a claims representative. The claims examiner will review the claim to determine compensability. A useful tool when determining compensability is the Three-point-contact. This is contact with the injured employee, employer and doctor (or representative, e.g., nurse). This should be done within 24 hours of receipt of the claim. A step by step procedure for the Three-point contact can be found in the [Workers Compensation Manual](#).

To be compensable the claim must arise out of employment, occur in the course of employment and be causally related to the employment.

1a. If the claim is compensable the claims examiner will send the [WKC-12](#), First report of injury (attached), [WKC-13a](#) (attached) to DWD within fourteen days of the date of loss. Go to step 2.

1b. If the claim is not compensable, the claims examiner sends a “denial of compensability” letter to the claimant, carbon the employer, the Department of Workforce Development, and the claim file. Also, a WKC-12, First report of injury, along with a WKC-13 and [WKC-13a](#), must be sent to DWD indicating that we are denying the claim. The claims examiner will set a diary to review the claim for closure.

1c. If the claim needs to be suspended to investigate further the compensability, the claims examiner will send the WKC-12, First report of injury, WKC-13, and WKC-13a to DWD with rationale for investigation within fourteen days of the date of loss.



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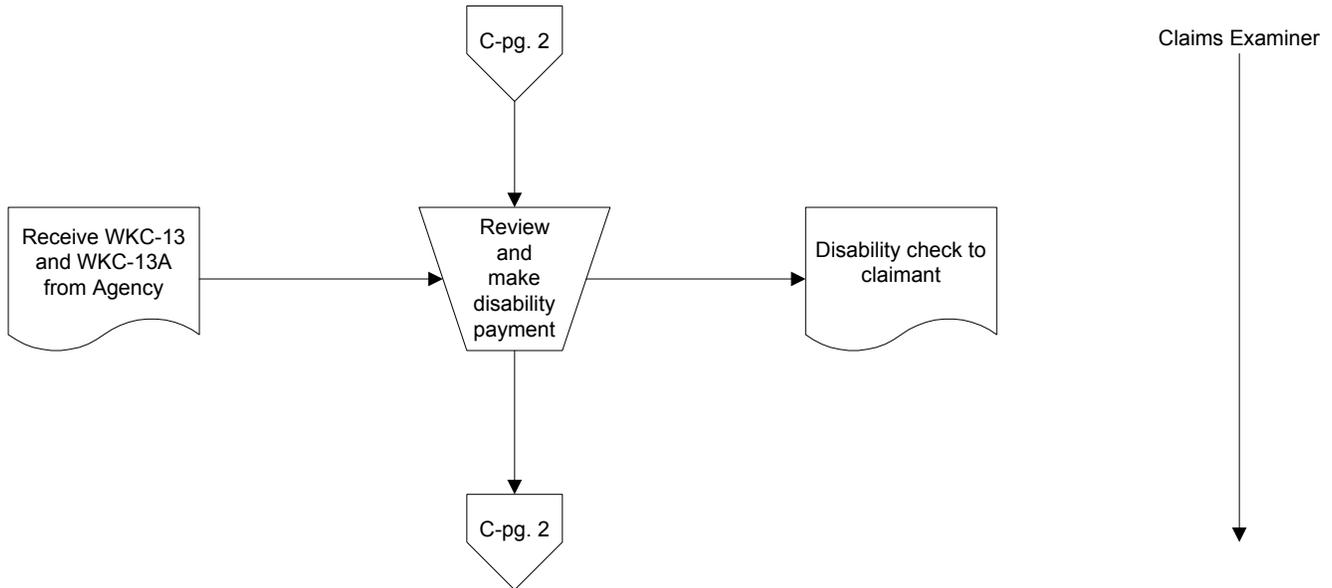
Process Code	W1.3
Process	Worker's Compensation Claims Management
Sub-Process	Lost Time Claims Management

Input

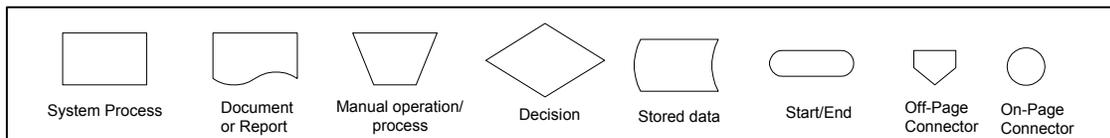
Process

Output

Responsibility



Legend:



### **Monitoring Medical Treatment**

2. The claims examiner will obtain and review medical treatment information and keep in close contact with the injured employee and the employer to assure that all possible return to work efforts are being utilized. See process W1.8 for further return to work information. Also, it is necessary to monitor medical treatment to make sure that all treatment is reasonable and necessary. The claims examiner will forward an authorization and medical provider list to the claimant for signatures. When the claims examiner receives this back all past medical records will be requested and reviewed. When reviewing medical treatment the determination of whether or not to use claims management services must be made. See process W1.6 for further information on claims management services.

### **Determine if medical treatment is related to the work injury**

3. The claims examiner will carefully review all medical bills and treatment notes to be sure that the provider is only billing us for treatment that is relevant to the work injury. If the bill is related to the work injury then the bill should be paid using process W1.5, Bill Payment. If the bill is not related to the work injury or if the claim has not been accepted yet, a denial or suspension letter is sent to the medical provider.

### **Disability payments**

4. The claims examiner will receive a WKC-13 and WKC-13A from the agency. After reviewing these forms for completeness and accuracy disability (indemnity) payments must be made to the employee as long as they remain off work. This payment is made from calculations on the [DOA-6026](#) (attached). This is done using process W1.5, Bill Payment.

**Determine if medical treatment has been completed**

5. If medical treatment has not been completed return to step 2 and continue the process again. If medical treatment has been completed obtain a final medical report (WKC-16, attached) and send it to DWD along with the final WKC-13. If the treating MD assigns Permanent Partial Disability (PPD), the examiner must calculate the rating into benefits and pay as accrued. The pay in accordance to the state PPD rate. Upon payment of the final PPD and updated WKC-13 should be submitted to DWD and the file is closed. If no PPD is assigned, the claim can be closed when medical treatment has been completed.



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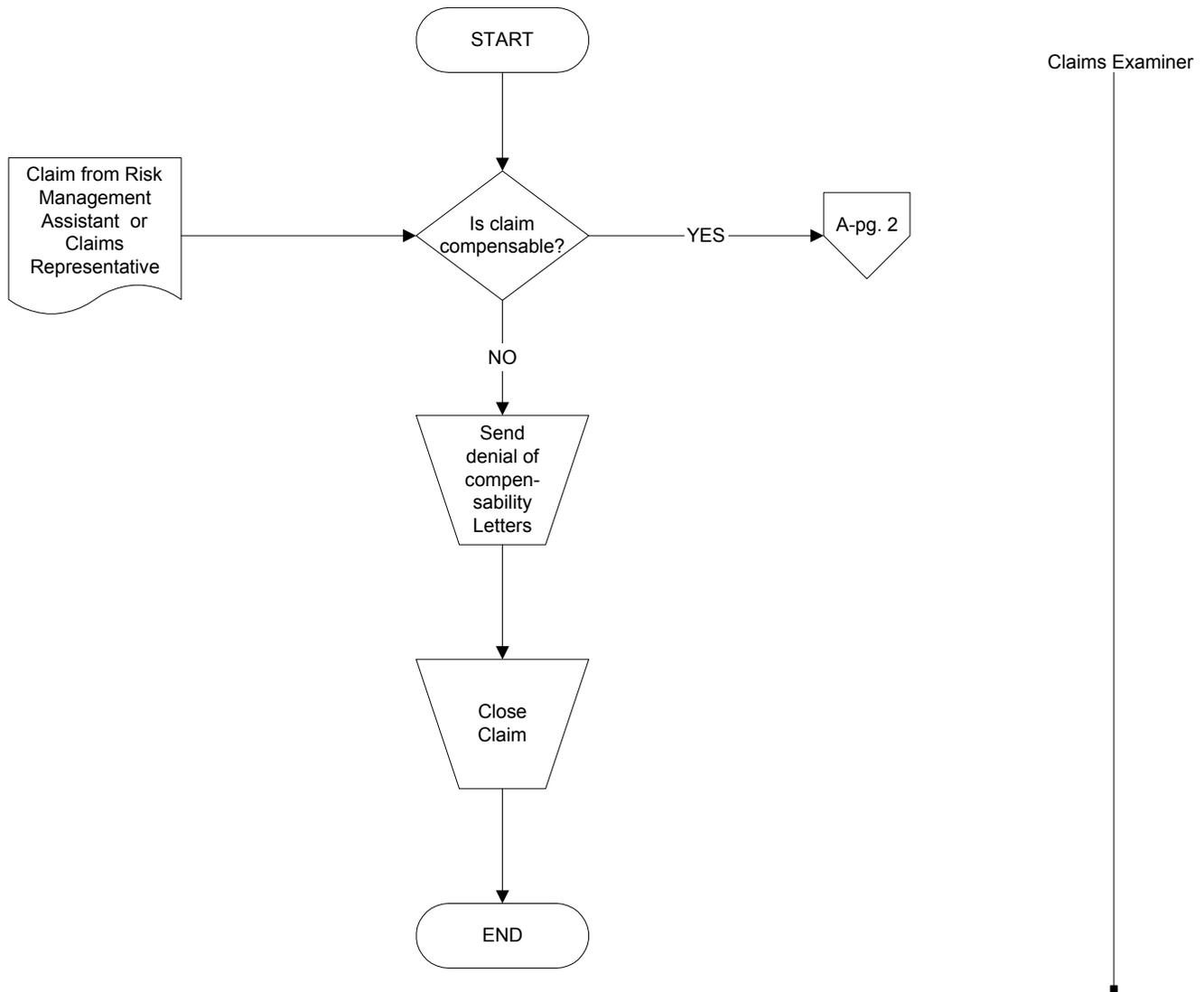
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Process	Worker's Compensation Claims Management
Sub-Process	Hazardous Duty Claims Management

Input

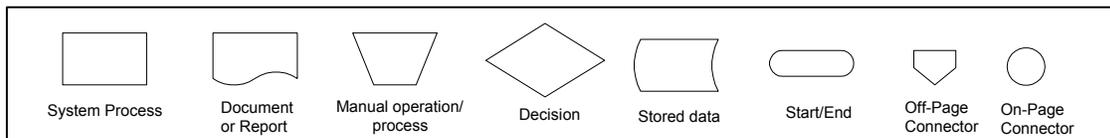
Process

Output

Responsibility



Legend:



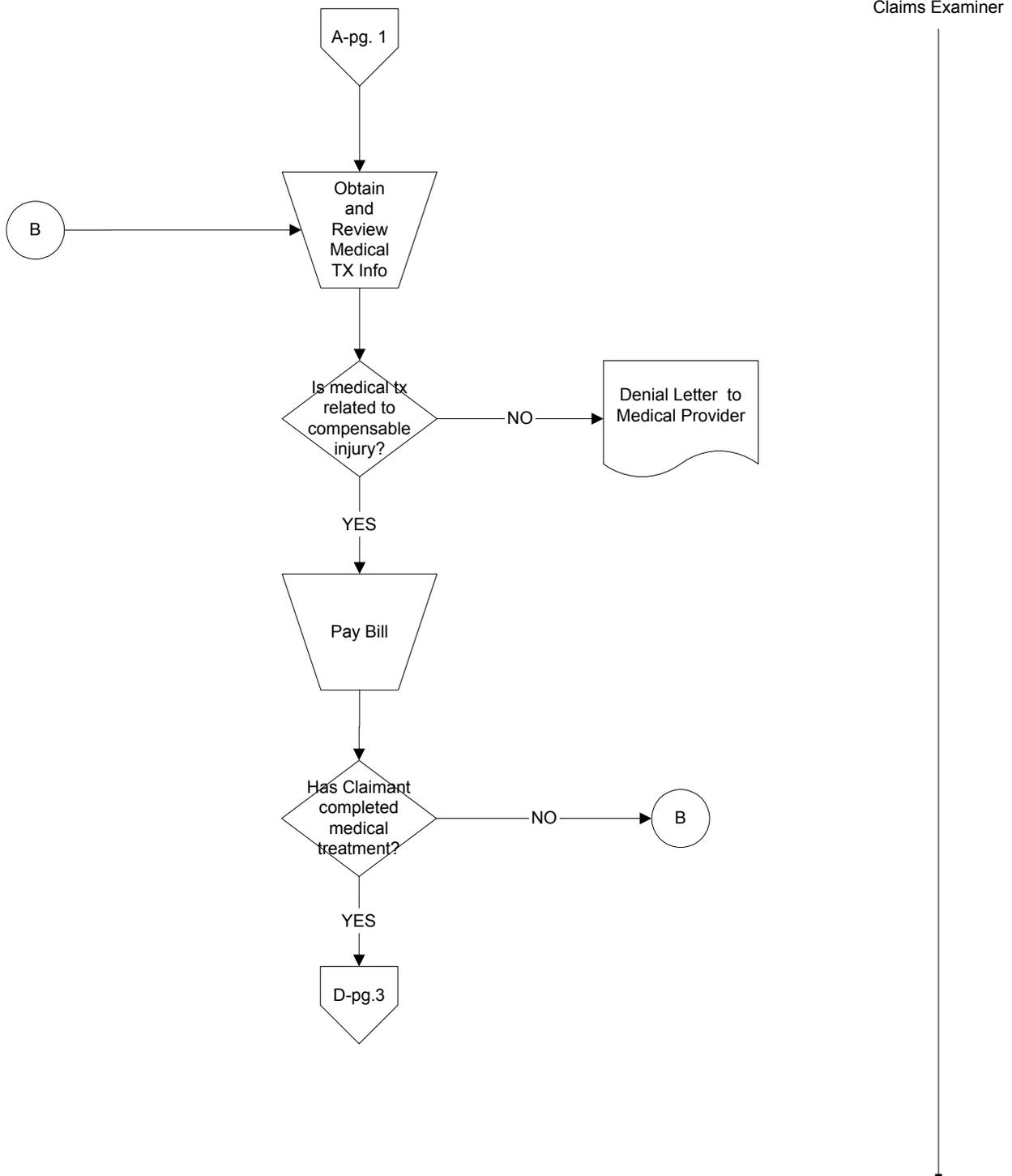


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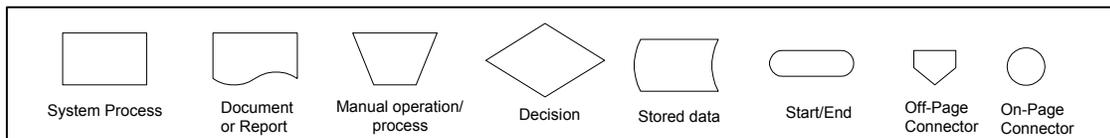
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<b>Process</b>	Worker's Compensation Claims Management
<b>Sub-Process</b>	Hazardous Duty Claims Management

Input	Process	Output	Responsibility
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Compensable Hazardous Duty Claim



**Legend:**





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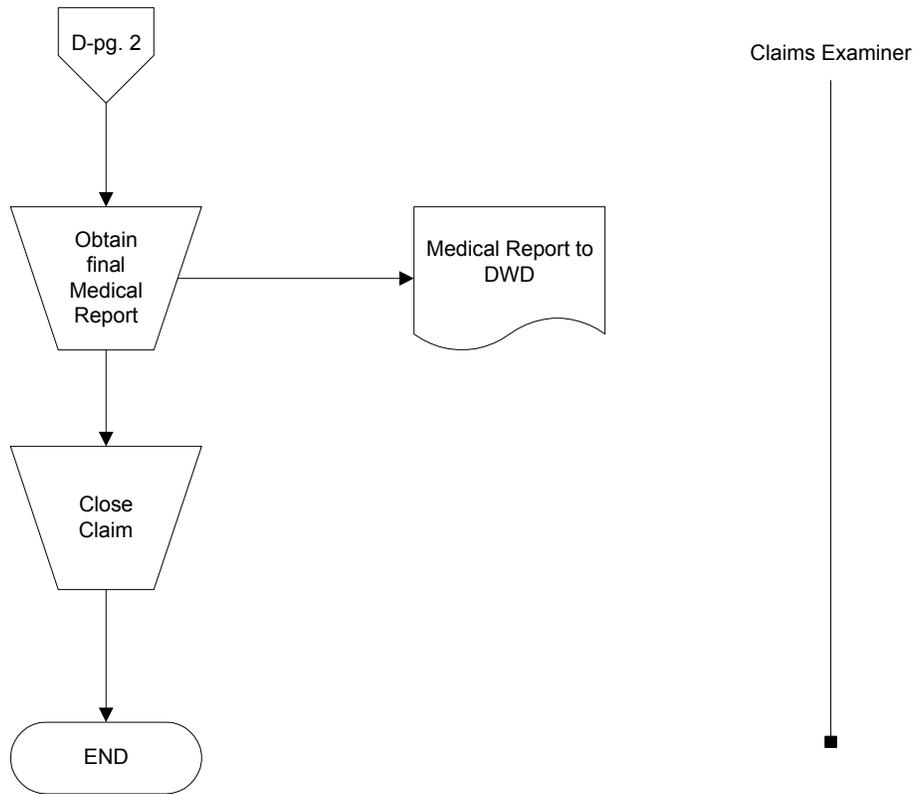
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Process	Worker's Compensation Claims Management
Sub-Process	Hazardous Duty Claims Management

Input

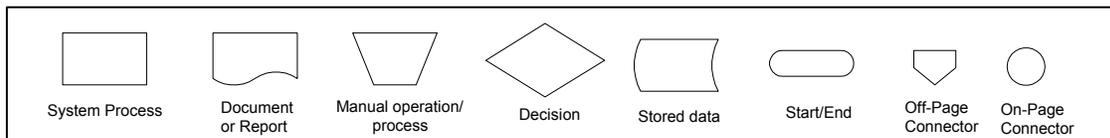
Process

Output

Responsibility



Legend:



### **Hazardous Duty Claims Management (W1.4)**

A hazardous duty claim is a claim where the injury occurs to a protected class employee in the line of duty. Hazardous duty claims are handled in the same manner as Lost Time Claims (W1.3) with one exception. The claimant receives 230.36 benefits, which means the employee gets paid their full wage instead of two-thirds paid under workers compensation benefits. The employing agency determines if the claimant receives the 230.36 benefits and handles all aspects of indemnity. Workers compensation only deals with the medical aspect of the claim.



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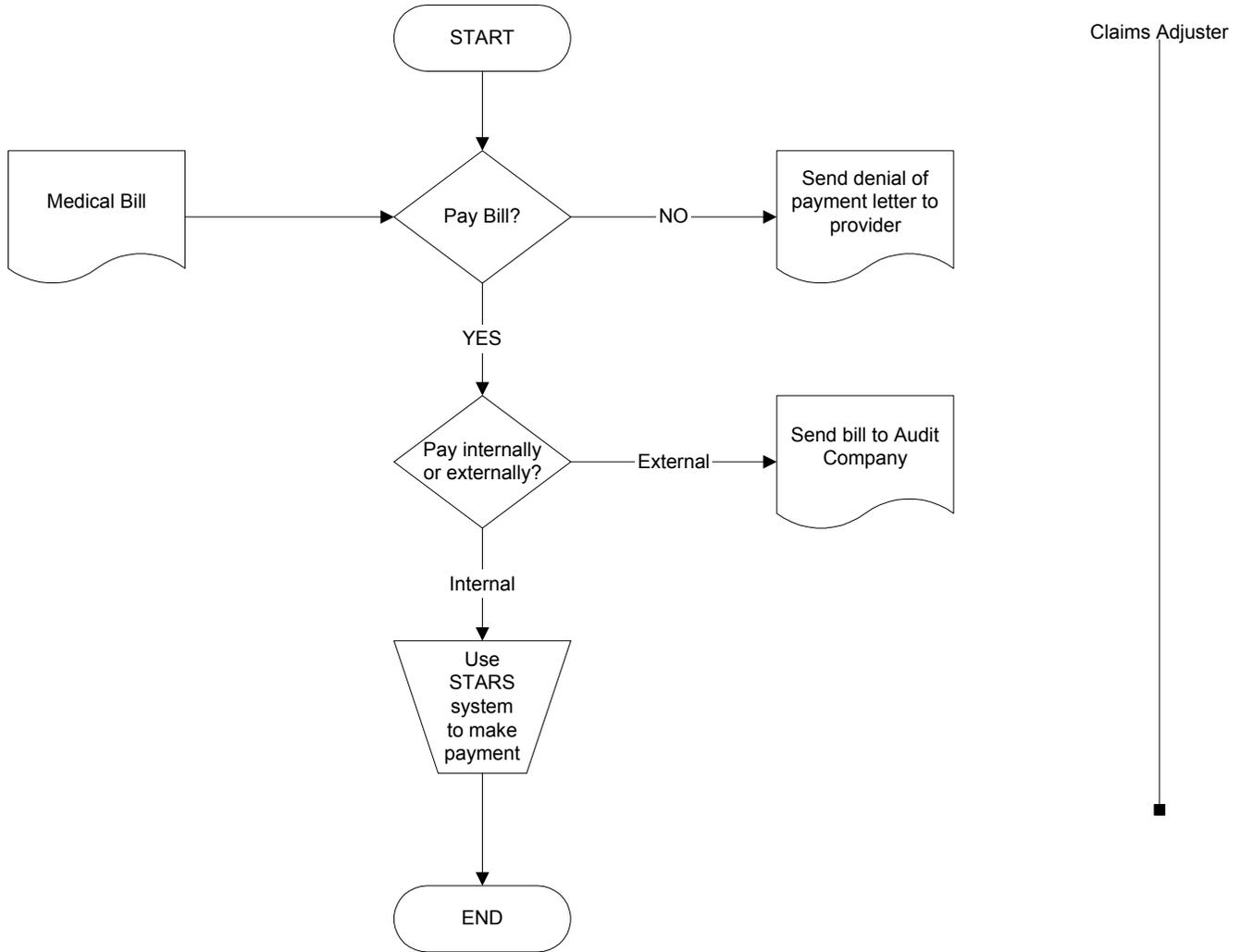
Process Code	W1.5
Process	Worker's Compensation Claims Management
Sub-Process	Bill Payment

Input

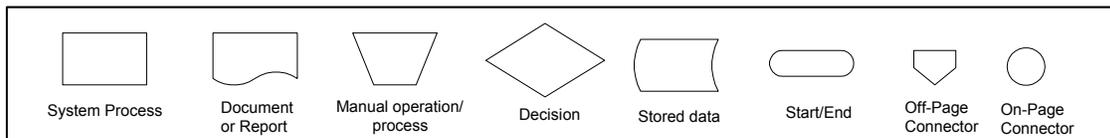
Process

Output

Responsibility



Legend:



## **Bill Payment (W1.5)**

### **Determine if bill should be paid under Worker's Compensation Benefits**

1. When a medical bill is received the claims adjuster determines if the bill should be paid under worker's compensation benefits. If the bill is not covered under worker's compensation benefits the claims adjuster will send a denial of payment letter to the provider, carbon the employer. If the bill is covered under worker's compensation benefits the claims adjuster must determine whether to pay the bill internally or externally.

### **Determine if bill should be paid internally or externally**

2. Bills that are always sent to the Audit Company include outpatient medical provider, chiropractor, physical therapy, hospital outpatient, and hospital inpatient. Bills that should not be sent to the Audit Company include ambulance charges, anesthesia, medical supplies, outpatient emergency room, work hardening, pharmacy charges, mileage, telephonic case management, all indemnity, and all expense charges.

### **External bill payment**

3. Bills that are paid externally are sent to the billing Audit Company to possibly receive a rate reduction. Bills that should be paid externally should be placed in the Audit Company out folder. The Risk Management Specialist picks up these bills daily and mails them to the Audit Company.

### **Audit Company upload to the STARS system**

4. The Audit Company sends a weekly file containing all bills they have processed via the File Transfer Protocol site for uploading onto the STARS system. A worker's compensation claims representative uploads the file, which posts each payment made by the Audit Company to the proper claim in STARS. Procedures for this can be found on the G drive:

G:\Riskmgmt\STAR\Corvel\CorvelUpdateProcedure.doc

### **Internal Bill Payment**

5. When paying bills internally use the STARS system. Refer to the STARS manual for instructions as show below.

### **MAKING A PAYMENT**

The check writing module is not within the claim. This gives you the option of h or processing all of your payments at the same time. Begin by creating the invoice then pay the bill(s) from the invoice you created. Be sure to indicate the status c claim on each payment.

#### **To Create the Invoice:**

- Click on “More” from the left toolbar or Click on “Go” from the top toolbar.
- Click on “Checks” module
- Click on “Check Register/Check Printing” button on the tool bar (only one or other appears on the screen. You are in the one that is not appearing.)
- Click on “New”
- Click on Payee Name “Rolodex” button to search for payee (If payee is a comp check the box beside the payee name field to specify it is a company.
- Tab past “Vendor Id” - Auto filled by the payee tax ID number
- Tab past “Tax ID” – Auto filled with the address line of the payee
- Tab past “Invoice #” - Auto generated field for tracking. Do not edit this field
- Tab past “Account #” - Leave this blank
- Tab past “Check Status” – Auto filled
- Enter “Invoice Date” – Today’s date
- Tab past “Check Number” – leave blank
- Enter short description in “Memo” – This field does not carry over to the claim transaction screen.
- Enter “Adjuster” by using the “Rolodex” search button to locate your adjuster
- Enter “Invoice total” – Total of the complete invoice
- Tab past “Transaction”– Leave blank
- Tab past “Balance” – Leave blank
- Enter “Due Date” – Date you want WiSMART to release the check. If left blank automatically is filled and released from WiSMART the day after you print your proof report.
- Tab past “Check Date” – leave blank
- Click on “Save”

If you get a red bar error across the bottom of the screen it means the Invoice al exists. This will only happen if two people click on creating an invoice at the sam time. Do not save the invoice. Close the invoice and re-enter a new invoice.

## **Create the Payment**

- Click on “Transaction” tab of the invoice screen
- Click on “New” – This opens search screen
- Enter search criteria to locate the claim
- Highlight the claim you are attaching payment to
- Click “Ok”
- Click on the “Financial Bucket” – Payment Type
- Click on “Status”- Indicate if the claim is open or closed
- Select “Transaction Code” from the drop down table of payment types
- Transaction Date – Auto generated with the date payment is entered.
- Enter the “Service From” – Date of 1<sup>st</sup> service
- Enter the “Service to” – Date of last service
- Enter “Paid Amount” – Amount of bill you are paying
- Click on “Additional Info” Tab
- Enter “Single Check” and use drop down to select how the check should be billed in WiSMART (Default is “No”)
- “No” indicates all invoices to the same vendor will be printed on one check at WiSMART.
- “Yes” indicates you do not want this invoice combined with other checks to the same provider.
- Enter “Mail Code” by using the drop down to select how you want the check mailed.
- “KL” indicates the check should be mailed directly out in central mail
- “2L” indicates the check should be returned to you for mailing.
- Enter “Check Stock” – use drop down to select your agency code
- Tab past “Sent to WiSMART” – Leave this field blank – auto populated when you print your proof report
- Tab past “Corvel Control #” – this field is only updated with Corvel payments

## **Notes**

“Reference Number” - is required to be filled in when making multiple payments on a single invoice. If not completed, WiSMART will not recognize multiple lines to print the EOB portion of the check.

If your invoice has multiple payments, save the invoice then create the payments and continue doing this until the invoice is paid in full. Make sure to mark single check flag on each of the payments. Fill in the “Reference Number” field on each.

Make sure you have a \$0 Balance on the Invoice screen after you are done with each invoice.

Make sure to mark status as “Final” when making payments on closed files; otherwise the file will be re-opened

Corvel payments will never increase a reserve on open or closed claims.

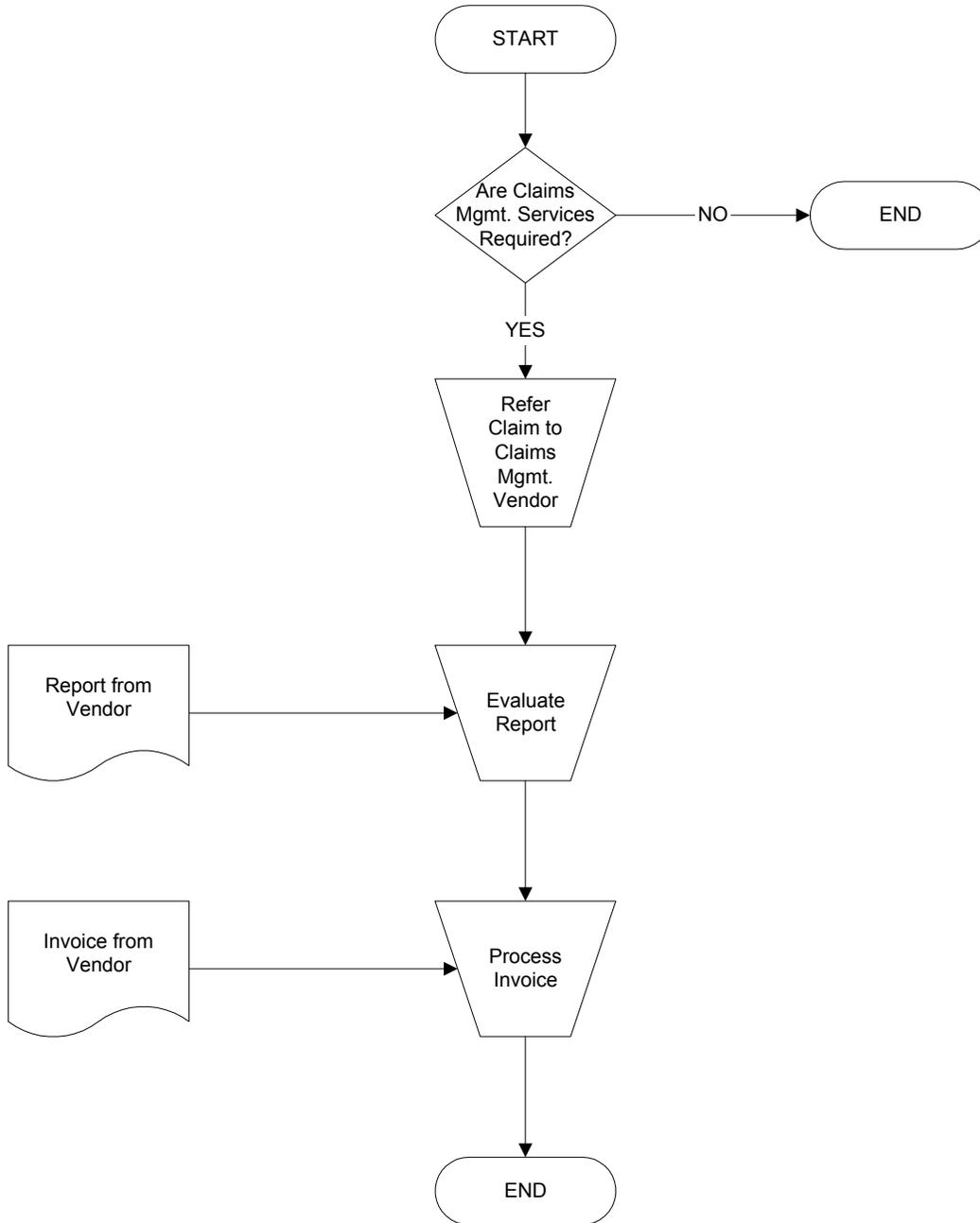


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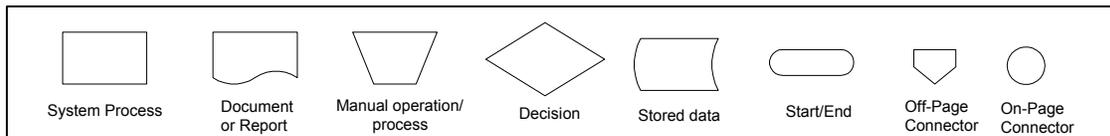
Process Code	W1.6
Process	Worker's Compensation Claims Management
Sub-Process	Claims Management Services

Input	Process	Output	Responsibility
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Claims Adjuster



Legend:



## **Claims Management Services (W1.6)**

Claims Management services consists of Telephonic Case management (TCM), Medical Case Management (MCM), Loss of Earning Capacity Evaluations (LOEC), Independent Medical Evaluations (IME), and Claims Investigations. Contracted vendors provide these services.

### **Determining when to order claims management services**

1. When handling a claim, a determination must be made as to whether or not services are required to manage a claim efficiently. Consulting a list of criterion for using each service makes this determination.

Use **Telephonic Case Management (TCM)** if/when

- The provider renders a vague diagnosis
- Treatment is excessive (generally continuing beyond 6-8 weeks.)
- There is a lapse in treatment
- You see more than 3-4 modalities in one treatment plan
- Repeat diagnostics are scheduled
- There are re-injuries or multiple injuries (If the claimant has several injuries, some of which may be non-work related.)
- Duplicate charges
- Chiropractor treating an unusual injury
- Unknown chiropractor
- Unlimited treatment plans (no end in sight).
- Care beyond 6 months
- Treatment plan suggesting future care long in duration
- Patient has a history of chiropractic treatment
- Treatment is for pre-existing condition
- Failure of the provider to respond to your request for records
- Provider known to over-treat
- Assistance is desired for intervention or explanation of treatment, including area such as diagnostic, surgery, hospitalization, or out of the ordinary conditions.

Use **Medical Case Management (MCM)** if/when

- A claimant has numerous prior claims.
- The injury is serious.
- Treatment appears to be excessive.
- The treating physician is not cooperating with the adjuster.
- Claimant has significant underlying problems.

Obtain an **Independent Medical Evaluation (IME)** to:

Physical Illness:

- Determine if the condition diagnosed is causally related to the work injury.
- Determine if treatment is reasonable and necessary (ex-surgical procedures, pain clinics).
- Determine temporary or permanent work restrictions (determining return to work date).
- Determine a Permanent Partial Disability (PPD) rating.
- Determine End of Healing (EOH).
- Distinguish between a pre-existing condition.

Mental Illness

- Determine if there are enough criteria for meeting psychological diagnosis for DCM-IV (e.g., PTSD).
- Determine if there is extraordinary stress per School District No. 1 vs. ILHR.

Obtain a **Loss of Earning Capacity Evaluation (LOEC)** if/when:

- Attorney names a vocational expert.
- Claimant has an unscheduled injury and can not return to the same job.
- Claimant's physician contends claimant has permanent total disability.

Use **Claims Investigations** if/when:

- There is an identifiable or anonymous tip that the employee may be exaggerating the injury and able to perform beyond capabilities identified by the treating physician.
- There is the indication the employee is working at another job even though medically excused from work. Examples: employee is never home, doesn't return phone calls, or doesn't answer correspondence.
- The employment includes work that exceeds medical restrictions. Documents the employee was earning wages while collecting indemnity payments at the same time.
- An Independent Medical Exam (IME) or attending physician's report indicates few objective findings to support the disability.
- The employee's complaints far outweigh the objective medical findings.
- The Claimant appears to be exaggerating or falsifying information.

\*\*\*Please be aware that the above criteria are simply guidelines. Claims experience intuition and common sense will be the most valuable guide when assessing treatment and the need for claims management services.

### **Referrals to Vendors**

1. Upon determining if claims management services are needed, the claims adjuster will refer the claim to the proper vendor. A list of vendors can be obtained from the Worker's Compensation Manager or the Claims Supervisor. For all of the above claims management services, permission from the Claims Supervisor is not needed with the exception of surveillance when used for Claims Investigations. To obtain surveillance services the claims adjuster MUST consult with the Claims Supervisor.

When referring a claim to a vendor always send a WKC-12, First Report of Injury, along with other documentation specific to the service. For TCM and MCM include medical records and treatment notes. Setting up IME is much more involved: you must select a physician and arrange the appointment; see the section on IME's in the Worker's Compensation Manual which can be viewed on the World Wide Web.

## **Reports from Vendors**

1. The vendor will send the claims adjuster a report providing the information requested. Sometimes there will be several reports until the file is closed with the vendor. The claims adjuster will review this information and keep the file updated.

## **Invoices from Vendors**

2. Invoices will be received from the vendor via e-mail or mail for services rendered. The claims adjuster reviews the invoice for accuracy and appropriate charges. If there is an error the invoice should be forwarded with a note to the Worker's Compensation Manager (WCM). The WCM will contact the vendor for corrections and/or send a disputed charges notice.

For MCM, TCM, LOEC, and IME's the claims adjuster pays the invoice using STARS following the Bill Payment process (W1.5). Send one copy of the paid invoice for TCM, MCM, and LOEC to the WCM. This copy is filed in case of dispute from the vendor in the future.

Within five days of receipt Claims Investigations and Transcription invoices are forwarded to the WCM with 2 copies attached. The WCM sends the original and a copy to DOA Accounting for disbursement of funds. Again a copy is filed in case of dispute from the vendor in the future.



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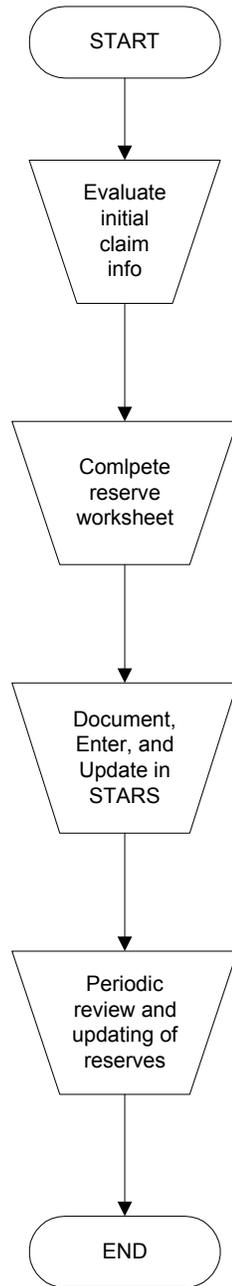
Process Code	W1.7
Process	Worker's Compensation Claims Management
Sub-Process	Reserving

Input

Process

Output

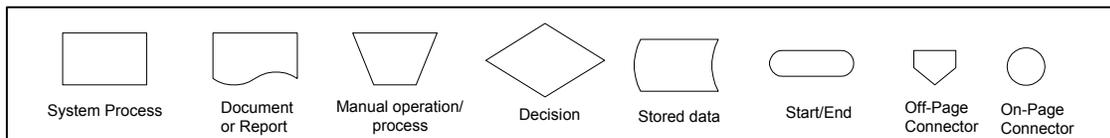
Responsibility



Claims Adjuster



Legend:



## **Reserving (W1.7)**

**Case Reserves** are established separately for indemnity, medical and expense values. The case reserve represents the best current estimate of probable or expected settlement cost associated with a claim. The cost does not include amounts that have already been paid.

**Medical case reserve** is that part of a case value associated with curative and/or therapeutic medical costs necessary to treat employment-related injuries or disease.

**Indemnity case reserve** is that part of a case value associated with statutory benefits as follows:

- Permanent Total Disability
- Permanent Partial Disability
- Temporary Total Disability
- Temporary Partial Disability
- Fatalities
- Retraining (Occupational Vocational rehabilitation Services)

**Expense case reserve** is that part of a case value associated with claim and litigation management such as legal expenses, independent adjuster/experts, special investigation reports, independent medical examinations, medical bill audits, copy charges, and case management services. Expense reserves do not include general claim management expenses not specifically allocated to individual claims.

### **Evaluate Initial Claims info**

1. First aid claims will not carry a medical case reserve. These claims either do not involve medical treatment by a medical provider or the medical treatment is limited to a one-time visit to a medical provider.

Medical-only claims will carry a “standard” or formula medical case reserve of \$500.00 and a “standard” expense case reserve of \$20.00, however reserves can increase if treatment continues for an extended period of time.

Indemnity claims will carry case reserves that properly and adequately reflect statutory wage loss or restraining values in addition to medical and expense claim values.

### **Complete Reserve Worksheet**

1. To get a more accurate reserve value after the initial review and receiving medical notes the claims adjuster will fill out the reserve worksheet, using the initial reserve guidelines shown on the next three pages:

## WORKER'S COMPENSATION RESERVE WORKSHEET

CLAIMANT: \_\_\_\_\_ CLAIM NO. \_\_\_\_\_

DOI: \_\_\_\_\_ CLAIMS EXAMINER/REP/SPEC: \_\_\_\_\_ AGENCY \_\_\_\_\_

### CLAIMANT PROFILE

AWW: \$ \_\_\_\_\_ TTD RATE: \$ \_\_\_\_\_ PPD RATE: \$ \_\_\_\_\_

DOB\AGE \_\_\_\_\_ SEX: M \_\_\_ F \_\_\_ MARITAL STATUS: \_\_\_\_\_

HIGHEST EDUC: <8 \_\_\_ 8 \_\_\_ 12 \_\_\_ 16 \_\_\_ >17 \_\_\_ TRANSFERABLE SKILLS: Y \_\_\_ N \_\_\_

ATTY: \_\_\_\_\_ TARGET RTW DATE: \_\_\_\_\_ RTW MOTIVATED? Y \_\_\_ N \_\_\_

INJURY: \_\_\_\_\_ ANTICIPATED PPD: \_\_\_%

MEDICAL TREATMENT AFTER RTW? Y \_\_\_ N \_\_\_ HOW LONG? \_\_\_\_\_ MONTHS

HOSPITALIZED: Y \_\_\_ N \_\_\_ MED MGMT: Y \_\_\_ N \_\_\_ VOC./DVR: Y \_\_\_ N \_\_\_

MODIFIED DUTY AVAILABLE? Y \_\_\_ N \_\_\_ SPECIAL FACTORS \_\_\_\_\_

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TTD PAID: \$ \_\_\_\_\_ PPD PAID: \$ \_\_\_\_\_ MED PAID: \$ \_\_\_\_\_

ADDITIONAL TTD \_\_\_\_\_ WKS X \_\_\_\_\_ RATE = \$ \_\_\_\_\_

ADDITIONAL PPD \_\_\_\_\_ WKS X \_\_\_\_\_ RATE = \$ \_\_\_\_\_

REHABILITATION \_\_\_\_\_ WKS X \_\_\_\_\_ RATE = \$ \_\_\_\_\_

RECOMMENDED GROSS TTD: \$ \_\_\_\_\_ RECOMMENDED GROSS PPD: \$ \_\_\_\_\_

MEDICAL PAYMENTS TO DATE: \$ \_\_\_\_\_

ADDITIONAL MEDICAL	HOSPITAL/CLINIC	\$ _____
	DOCTOR/SURGEON	\$ _____
	DIAGNOSTIC/X/RAY	\$ _____
	CHIROPRACTIC	\$ _____
	PHYSICAL THERAPY	\$ _____
	RX/TRAVEL	\$ _____
	MISCELLANEOUS	\$ _____
	OTHER	\$ _____
	TOTAL ADDITIONAL MED	\$ _____
	EXPENSE RESERVE	\$ _____
	<b>TOTAL RESERVE</b>	<b>\$ _____</b>

COMMENTS:

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

DATE COMPLETED \_\_\_\_\_ APPROVED \_\_\_\_\_

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## INITIAL RESERVE GUIDELINES

INJURY TYPE	MEDICAL	INDEMNITY	EXPENSE	PPD
Lumbar Strain <sup>1</sup>	\$1,500	6 weeks	\$50	0%
Lumbar Laminectomy	\$20,000	24 weeks	\$1,200	5%
Cervical Strain <sup>2</sup>	\$1,500	3 weeks	\$50	0%
Carpal Tunnel <sup>3</sup> (One wrist; w/numbness & loss of strength)	3,500	4 weeks	\$1,000	2%
Carpal Tunnel <sup>3</sup> (Bi-lateral)	\$6250	7 weeks	\$1,000	4%
Epicondylitis <sup>4</sup> (Tennis Elbow)	\$1,500	2 weeks	\$50	0%
Knee Strain	\$1,000	4 weeks	\$50	0%
Knee Injuries (w/ meniscotomy)	\$6,000	8 weeks	\$100	10%
W/ anterior cruciate repair	\$9,000	12 weeks	\$100	10%
Ankle Strain <sup>5</sup>	\$1,500	2 weeks	\$50	0%
Shoulder Strain <sup>5</sup>	\$2,500	6 weeks	\$50	0%
Fractures (Simple)	\$2,000	8weeks	\$50	0%
Fractures (Compound)	\$7,500	12 weeks	\$100	5%
Burns (w/lost time)	\$10,000	8 weeks	\$100	0%
Occupational Asthma	\$5,000	6 weeks	\$1,000	10%
Occupational Stress	\$7,500	10 weeks	\$2,000	10%

All other lost time claims not listed above should be reserved based on claim handler's experience from similar claims.

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<sup>1</sup> Assumes no surgery and no chiropractic involvement

<sup>2</sup> Assumes no surgery and no chiropractic involvement

<sup>3</sup> Assumes surgery and IME with good results

<sup>4</sup> Assumes IME and no surgery

<sup>5</sup> Assumes conservative treatment, alternate duty, X-rays, ER visit and some PT

### **Document reserves in STARS**

3. The claims adjuster will enter the determined amount of reserves on to the STARS system along with entering notes in STARS as to why the given reserve values were chosen.

### **Periodic Review and update of reserves**

4. Case reserves should be revised as soon as possible after a change in circumstances is brought to light. All information placed in a claim file, especially medical reports, investigative reports, etc., should be evaluated to determine its potential effect on the current case reserve levels. As the case develops from an investigative standpoint, it is equally essential that it be frequently reviewed to determine if case reserves are adequate in terms of reflecting the investigative developments on the case. In making such revisions, it is essential that a review be made of the total payments to date, in order to project a reasonable evaluation of future payments to be incurred, all of which are valuable indications of required reserve levels.

In setting the case reserve, it is essential to take into account the following factors:

- 
- The nature and extent of the injury and the medical treatment required.
  - The type of injury. Back sprains and strains are especially difficult problems, which require careful investigation, evaluation and reserving.
  - The maximum period of temporary total, temporary partial, permanent total and permanent partial disability benefits.
  - The maximum period of disfigurement benefits and schedule of specific loss benefits payments.
  - Whether permanent partial disability benefits are based on wage loss or on loss of earning capacity consideration.
  - Whether disability benefits are deducted from death benefits, or paid in addition to them.
  - The maximum period and amount of hospital and medical treatment payments.
  - Whether a lump sum settlement is anticipated.
  - Whether a return-to-work program is in place in the agency and whether one has been initiated for this case.
  - Whether the injured employee has been referred to the "Injured State Employees Reemployment Program".
  - Whether the case is subject to another state's compensation act.
  - The manner in which the act is administered by the Department of Workforce Development (DWD).
  - The nature of past experiences with DWD on this type of case.
  - The amount of disability likely to be awarded by DWD.

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The likelihood of DWD approval of a compromise settlement.

- Case reserving of very serious injuries, such as brain damage, spinal cord injuries, double amputations, etc. Should take into consideration the effect of the injury on the claimant's normal life expectancy and long-term implication of the required medical care rehabilitation efforts, etc.
- Care should be taken to avoid under reserving serious injury cases
- The claimant's age, family (income) needs, continued (transitional duty) work or return-to-work capabilities, and general injury recovery attitude.
- The conduct and potential cost of medical treatment by the individual physician. What does the physician believe the claim requires in the way of treatment, prosthetic devices and the like? What is the physician's reputation with the commission? Is the treating physician willing to confer and cooperate with other physicians of the same specialty?
- The attitude of the employee. In particular, the employee's attitude of cooperating with the claim handler in providing an appropriate return-to-work environment is very important.
- If the injured employee retained an attorney, who the attorney is and the attorney's attitude regarding case dispositions.

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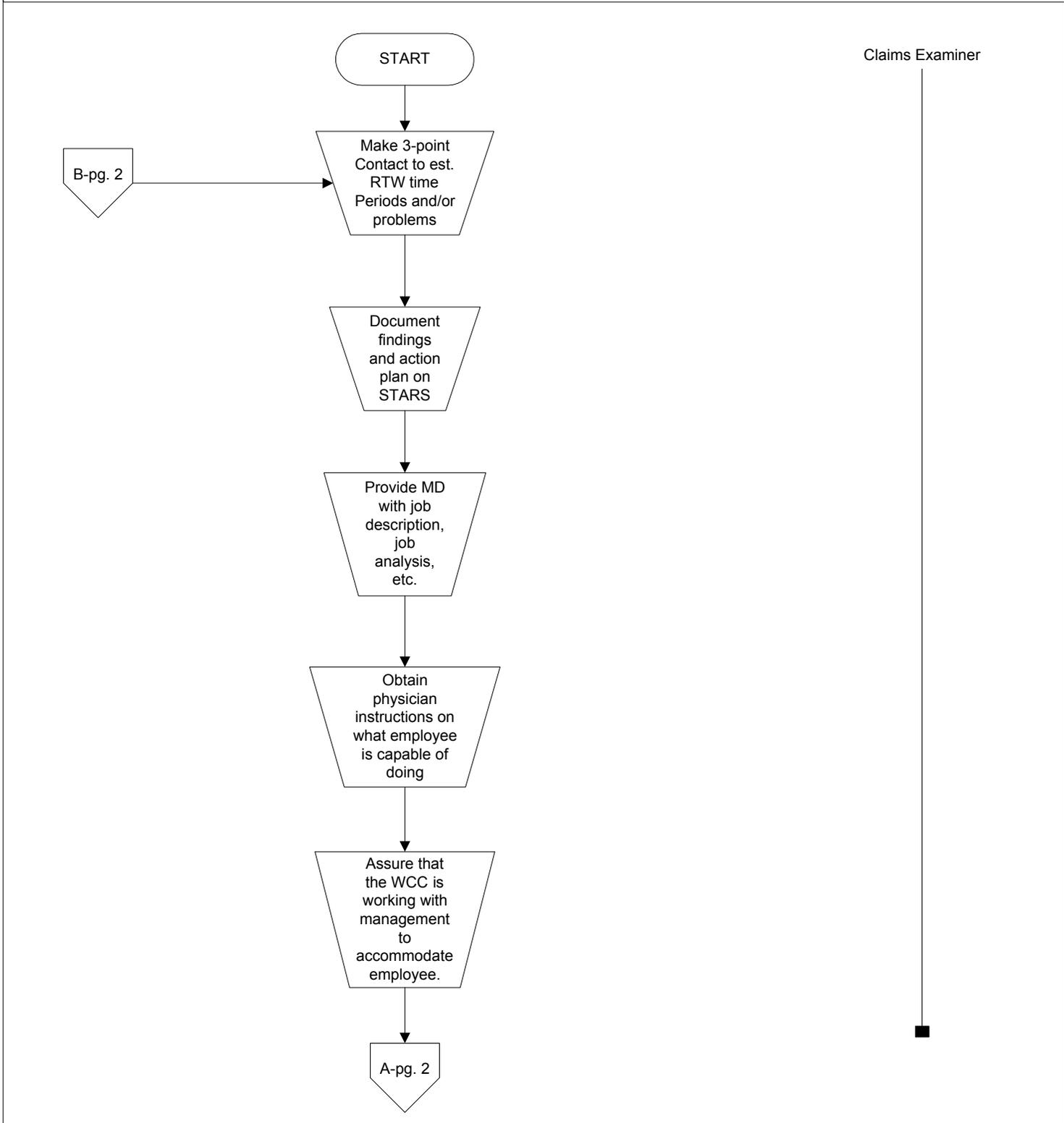
Worker's Compensation case reserves should be revised (revalued up or down) whenever the investigation of the relevant factors indicates a change in circumstances and case value. Worker's Compensation case reserves should not be "discounted" because of anticipated subrogation recoveries.



Division of State Agency Services  
Bureau of State Risk Management

Process Code	W1.8
Process	Worker's Compensation Claims Management
Sub-Process	Return to Work

Input	Process	Output	Responsibility
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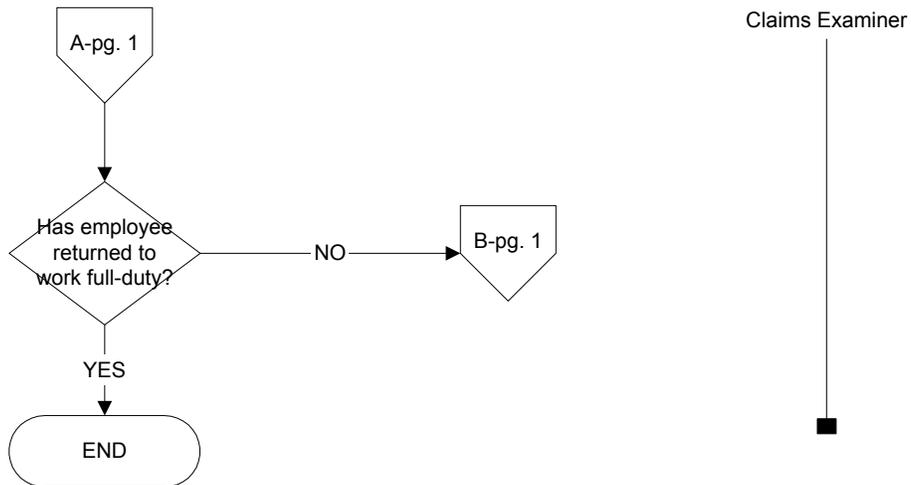
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Division of State Agency Services  
Bureau of State Risk Management

Process Code	W1.8
Process	Worker's Compensation Claims Management
Sub-Process	Return to Work

Input	Process	Output	Responsibility
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**Legend:**

System Process	Document or Report	Manual operation/process	Decision	Stored data	Start/End	Off-Page Connector	On-Page Connector

## **Return to Work (W1.8)**

### **Estimate RTW time periods and/or problems**

1. This information can be attained a number of ways. One way is by making the 3-point contact (see W1.3). Reports from Case Management vendors and return to work slips from the physician can also provide this information. Evaluate the case and newly attained information to develop a plan of action.

### **Document findings and action plan on STARS**

2. Make a note in STARS containing all of the information attained in the above step and the plan of action for the claim. Update as necessary.

### **Provide MD with job description/analysis**

3. Make sure the treating physician is aware of what capabilities the employee must have to function in their current job. This will enable the MD to make the proper decision for work restrictions and return to work.

### **Obtain physician instructions for Worker's Compensation**

4. Obtain the physicians instructions as to what the employee is capable of doing so that possible light duty work can be assigned.

### **Assure that WCC is working to accommodate employee**

5. Be sure that the Workers Compensation Coordinator is working with the employee and management to get the employee back to work, including light duty, as soon as possible.

### **Determine if employee has returned to work full duty**

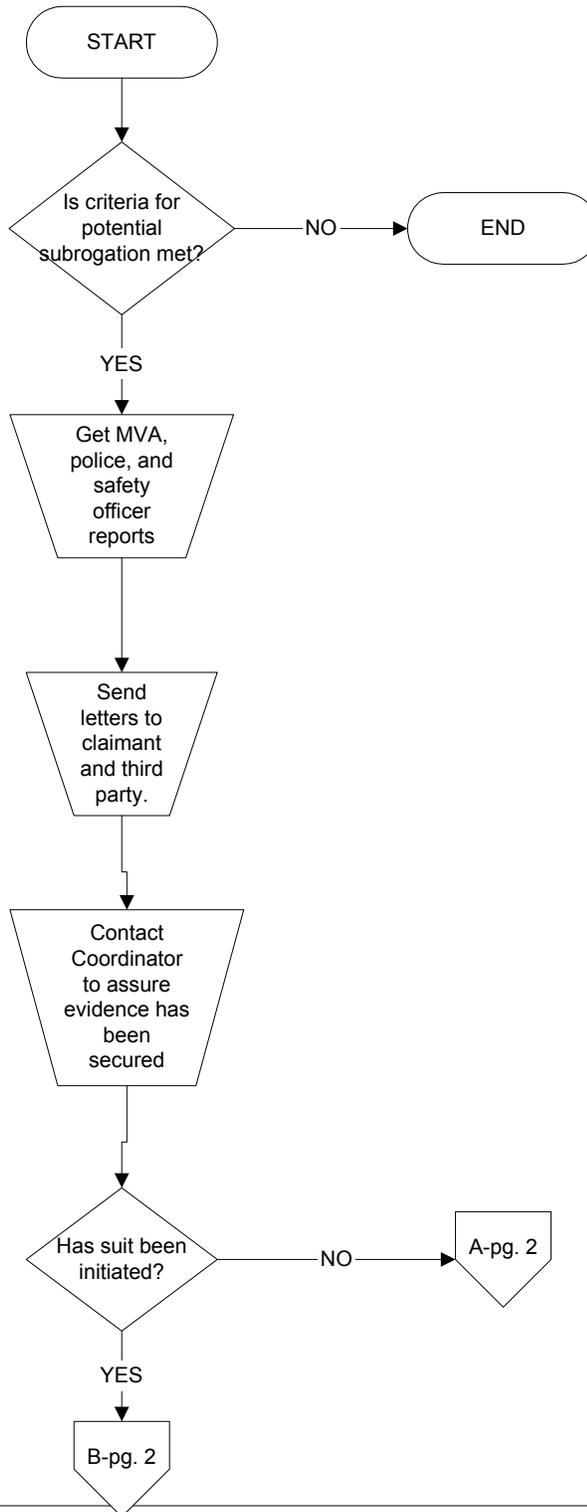
6. If the employee has not returned to full duty return to step one and develop a new action plan. If the employee has returned to full duty this process is complete.



Division of State Agency Services  
Bureau of State Risk Management

Process Code	Worker's Compensation Claims Management
Process	W1.9
Sub-Process	Subrogation

Input	Process	Output	Responsibility
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Claims Adjuster



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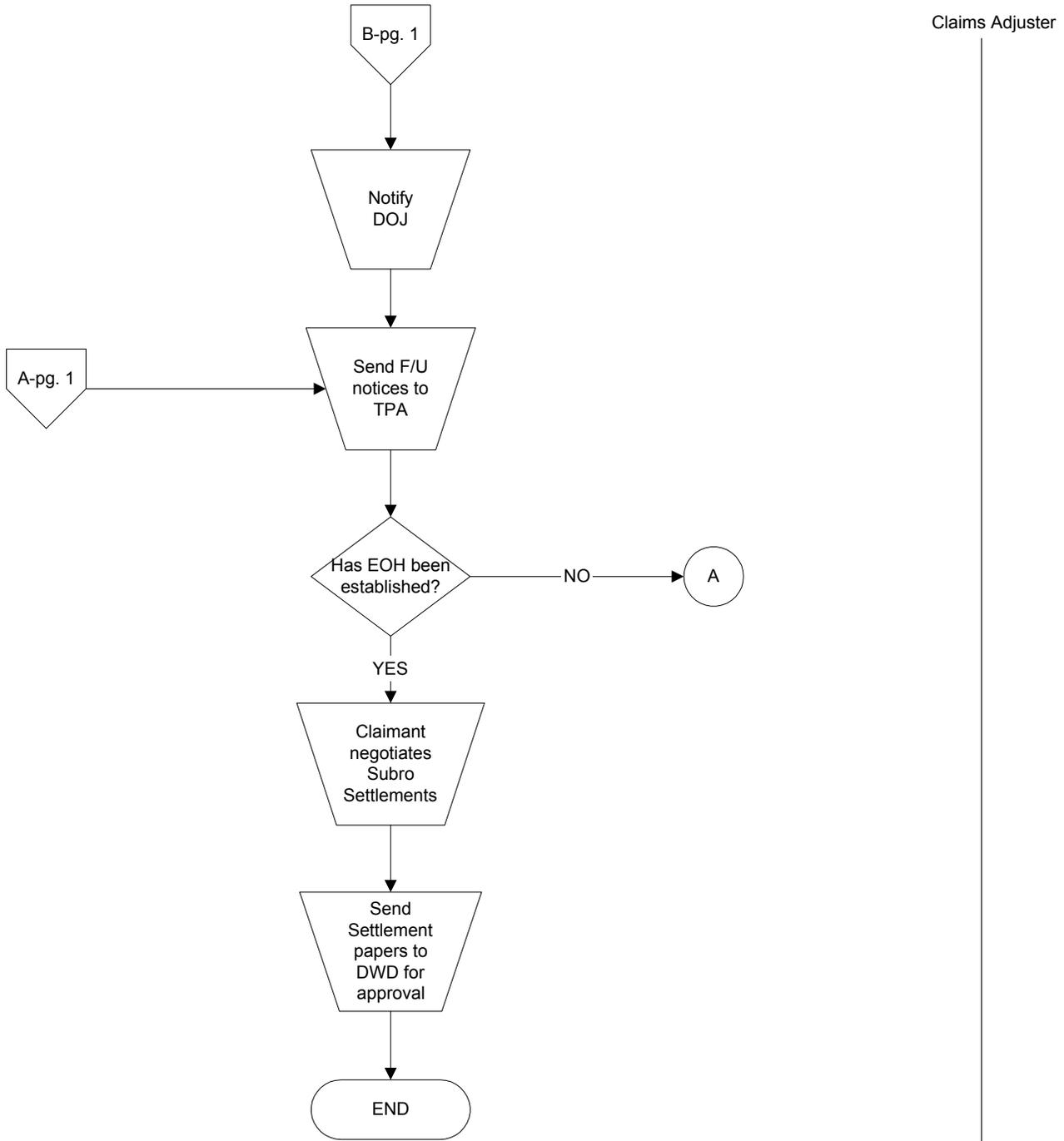
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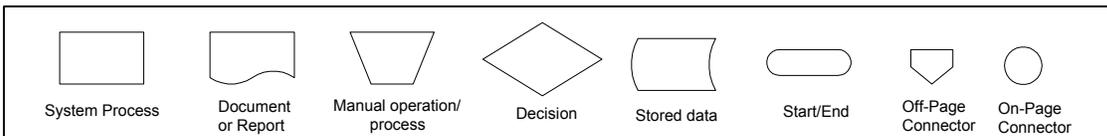
Division of State Agency Services  
Bureau of State Risk Management

Process Code	Worker's Compensation Claims Management
Process	W1.9
Sub-Process	Subrogation

Input	Process	Output	Responsibility
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Legend:



## **Subrogation (W1.9)**

Worker's Compensation subrogation is a process where the State "subrogates," or asserts its rights as a creditor in a third party lawsuit. The State's claim is based on past and future benefits to be paid to the injured employee. The claim is against a portion of proceeds from the lawsuit.

The subrogation procedure is provided in [Section 102.29, Wis.Stats.](#) "third party" is usually a manufacturer of faulty products or an individual causing damage to the employee through their negligence, resulting in the worker's compensation claim. Examples might be a poorly manufactured ladder or an automobile accident. The employee brings the suit with the aid of a private attorney.

### **Determine if criteria for subrogation are met**

1. Determining if the criteria for subrogation are met can be done by referring to the Subrogation potential checklist in the Worker's Compensation Manual.

### **Collect all information needed to pursue subrogation**

2. Contact the Workers Compensation coordinator to get the motor vehicle accident report, police report, and safety officer report. Review these reports to obtain third party information including insurance company name, address, and telephone number. Also, contact the employee to determine if an attorney has been secured. Obtain the name, address, and phone number of the attorney.

### **Send letters to claimant and third party**

3. The claimant must be notified that the state has an interest in any settlement that is made. Also, the claimant should be sent a copy of Statutes 102.29 (attached to this procedure) explaining their subrogation rights under Workers Compensation Law. If the claimant has an attorney, the attorney must also be notified. In addition, the third party/parties should be put on notice (via letter) as well as the third party carrier. If the claimant and/or the third party have obtained an attorney they must also receive a copy of the notification letter.

### **Assure that evidence has been secured**

4. Contact the Workers Compensation Coordinator and any other parties involved to make sure all evidence necessary to pursue out interest has been secured.

### **Determine if a lawsuit has been initiated**

5. If a lawsuit has been initiated you must notify the Department of Justice, subrogation unit. Also, obtain an accounting of all benefits paid out on the claim.

**Keep TPA and attorney informed**

6. Send follow up notices of all benefits paid out on the claim to the attorney and the TPA periodically as the claim matures.

**Determine End of Healing**

7. Continue step six until end of healing has been reached. Once end of healing has been reached the claimant will negotiate a settlement.

**Prepare settlement papers and send to DWD**

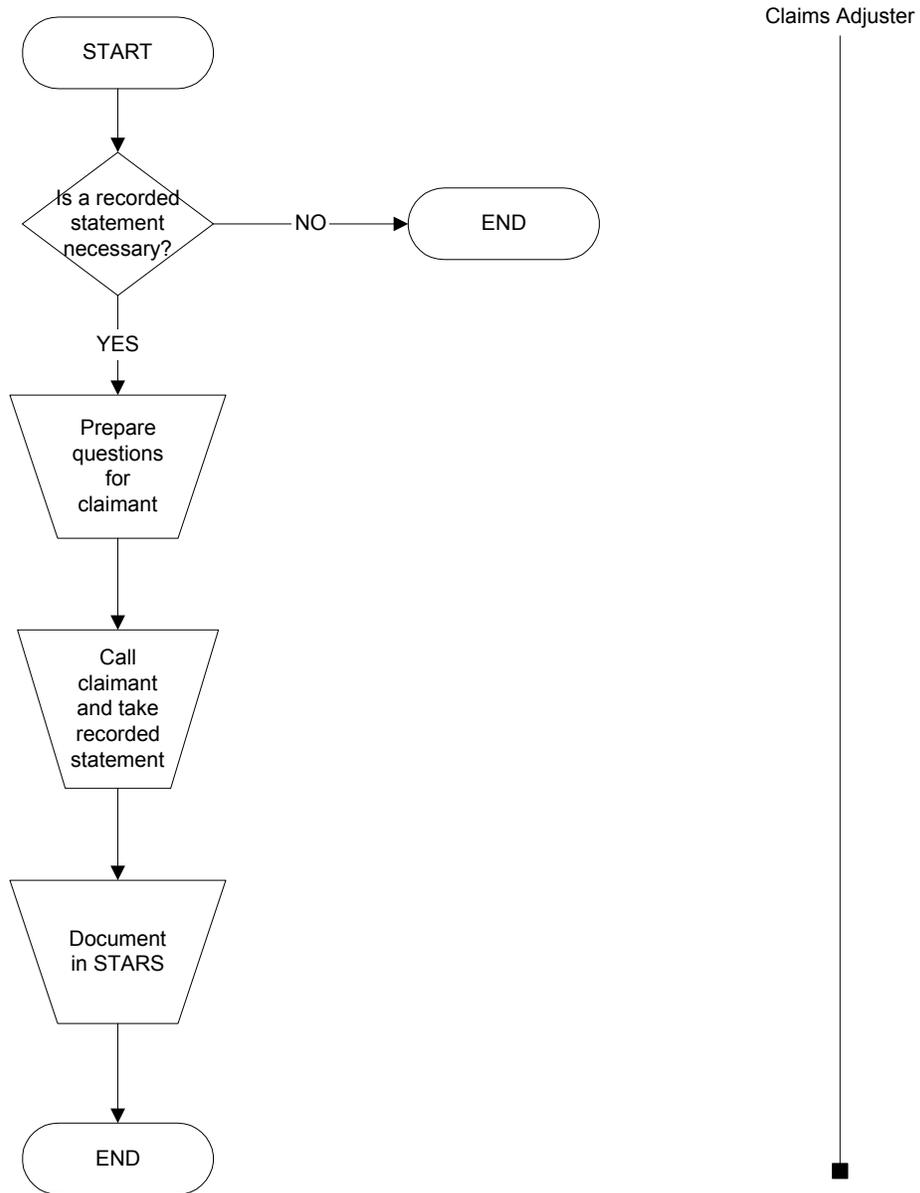
8. Prepare the Third Party Proceeds Distribution Agreement, attached, [WKC-170](#) after the settlement has been made and send it to DWD for approval. Once payment is received the subrogation process has ended.



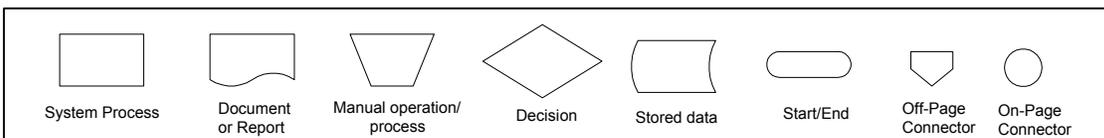
Division of State Agency Services  
Bureau of State Risk Management

Process Code	W1.10
Process	Worker's Compensation Claims Management
Sub-Process	Recorded Statements

Input	Process	Output	Responsibility
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Legend:



## **Recorded Statements (W1.10)**

### **Determine if a recorded statement is necessary**

1. Recorded statements are used as an effective means to verify facts and determine the legitimacy of a claim. Recorded statements can also be a helpful tool in determining the appropriate course of action to be taken on a claim (i.e. medical case management, utilization review, IME, etc.). To determine if a recorded statement is necessary refer to the criteria below:
  - The injury was unwitnessed.
  - The injury occurs just prior to a strike, a job termination, a retirement, a layoff. The end of seasonal work, the end of a probation period or just after a worker has returned to work from a leave of absence.
  - The injury occurs in an area where the employee normally should not be working.
  - The injury involves an activity that the worker normally should not be doing.
  - The injury is not reported promptly.
  - The details of the injury are vague or contradictory.
  - The employee is disgruntled, a poor performer or has unexplained absences shortly before the injury.
  - The employee is new to the company or job, has a history of frequent job changes, or is in financial difficulty.
  - The employee has several other family members also receiving workers compensation benefits or other “social insurance” benefits, e.g., unemployment.
  - The employee earns extra money by moonlighting or is in college, is known to participate in contact sports or physically demanding hobbies such as horseback riding or mountain climbing.
  - The employee has a history of frequently sustaining injuries of a subjective nature.

- The employee receives income from workers compensation benefits and collateral sources that meet or exceeds regular wages.
- The employee is difficult to reach at home or return calls that have incongruous background noises.
- The employee frequently changes physicians, medical providers or attorney.
- The employee recently purchased one or more disability policies.
- The employee demands quick settlement on decisions or commitments.
- The employee is unusually familiar with workers compensation claims handling procedures and laws.
- The employee is consistently uncooperative.
- The injuries are subjective, i.e., pain, headaches, nausea, inability to eat or sleep, etc.
- The accident report is inconsistent with the diagnosis or the diagnosis is inconsistent with the treatment.
- Extensive treatments, testing and procedures are performed for relatively minor or subjective injuries.
- The treating physician is known for handling suspect claims.
- The injured worker refuses a diagnostic procedure to confirm the injury
- A lab or separate facility in which the referring physician has financial interest performs the treatment or testing.
- The treatments extend for lengthy time periods without any bills being issued.
- The treatment dates occur on Sundays, holidays or other unusual times.
- The employee does obvious doctor shopping.
- The employee had a family trauma immediately prior to the accident.

\*\*\*Please be aware that the above criteria are simply guidelines. Claims experience, intuition, and common sense will be the most valuable guide when assessing the need to take a recorded statement.

### **Prepare questions**

2. The claims adjuster will decide which questions to ask the claimant in the interview to obtain the needed information. Some general questions to use as a guide follow:

- Address/telephone number?
- Social security number?
- Age? Birth date?
- Height? Weight?
- Married? Spouses name?
- Current employer? Length of employment? Title? Specific duties?
- Confirm injury date. When reported. Who reported to (coworker, supervisor).
- Witness? Name/Address/phone number.
- Injury events?
- Current physical complaints?
- Current treatment?
- Prior work comp claims?
- Preexisting conditions related to current condition?
- Recent auto/home injuries?
- Hobbies/non work-related activities?
- Address any red flags not previously discussed

### **Call claimant and take recorded statement**

3. Using a tape recorder hooked up to the phone, the claims adjuster calls the claimant and uses the following introduction addressed what ever questions they have prepared and closes with the following closing:

**Introduction**

“This is \_\_\_\_\_ and I am speaking with \_\_\_\_\_ by telephone at \_\_\_\_\_ on \_\_/\_\_/\_\_\_\_. Please state your full name and spell your last name. Before we begin this interview, are you aware I am recording this conversation? Do I have your permission to do so? Are you currently on any medication that may interfere with your understanding of my questions?”

**Closing**

“I do not have any further questions at this time. Is there anything you would like to add to this interview? To end the interview, were you aware I recorded this conversation? Did I have your consent to do so? This is \_\_\_\_\_ completing this interview with \_\_\_\_\_ at \_\_\_\_\_ on \_\_/\_\_/\_\_\_\_.”

**Document in STARS**

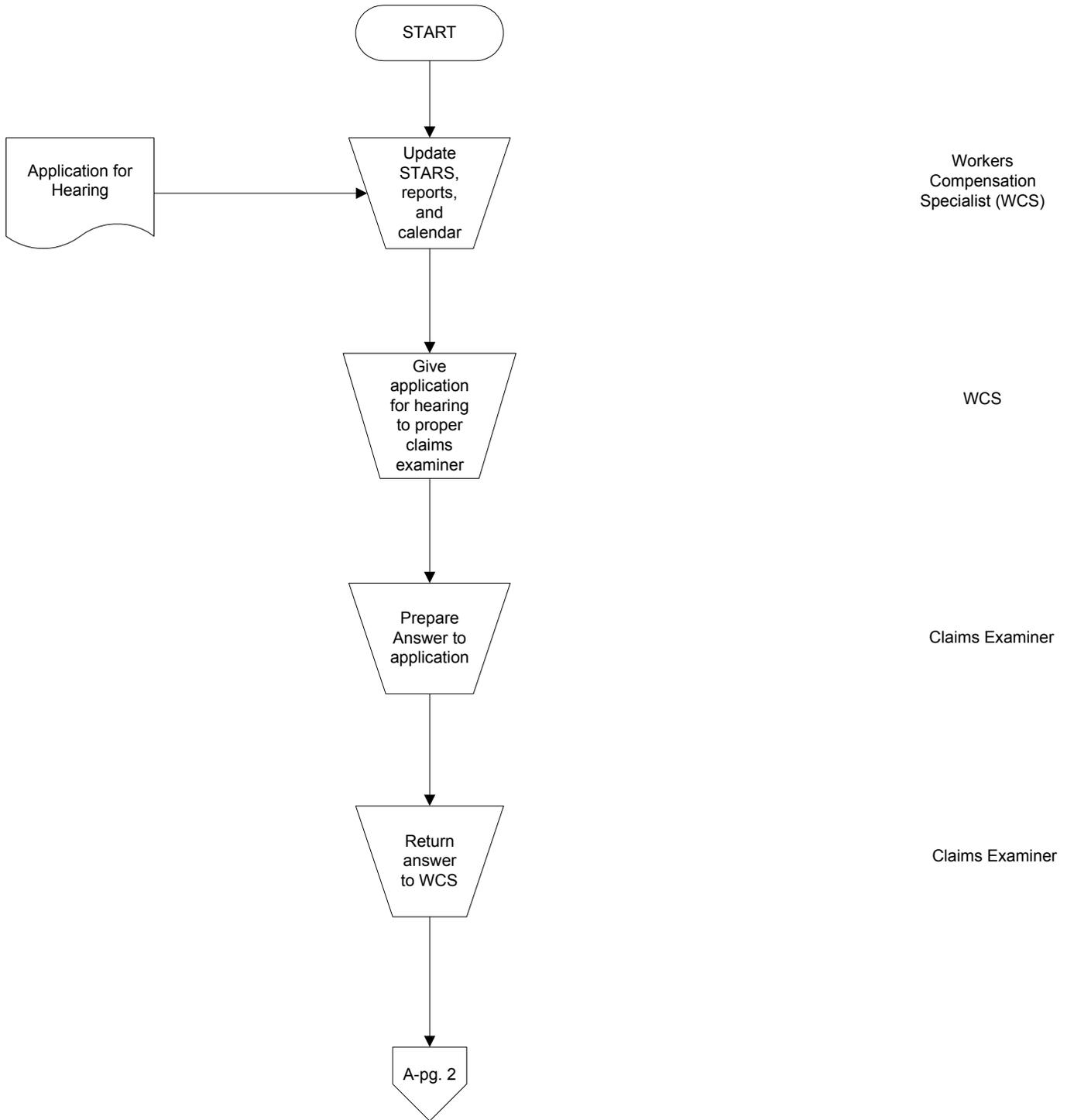
4. Listen to the recording and make notes in STARS to include any information obtained from the recorded statement and the action plan for the claim.



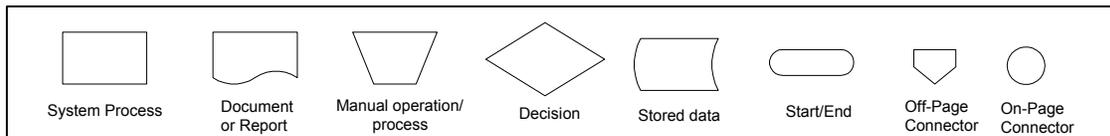
**Division of State Agency Services  
Bureau of State Risk  
Management**

<b>Process Code</b>	W1.11
<b>Process</b>	Worker's Compensation Claims Management
<b>Sub-Process</b>	Litigation

Input	Process	Output	Responsibility
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**Legend:**

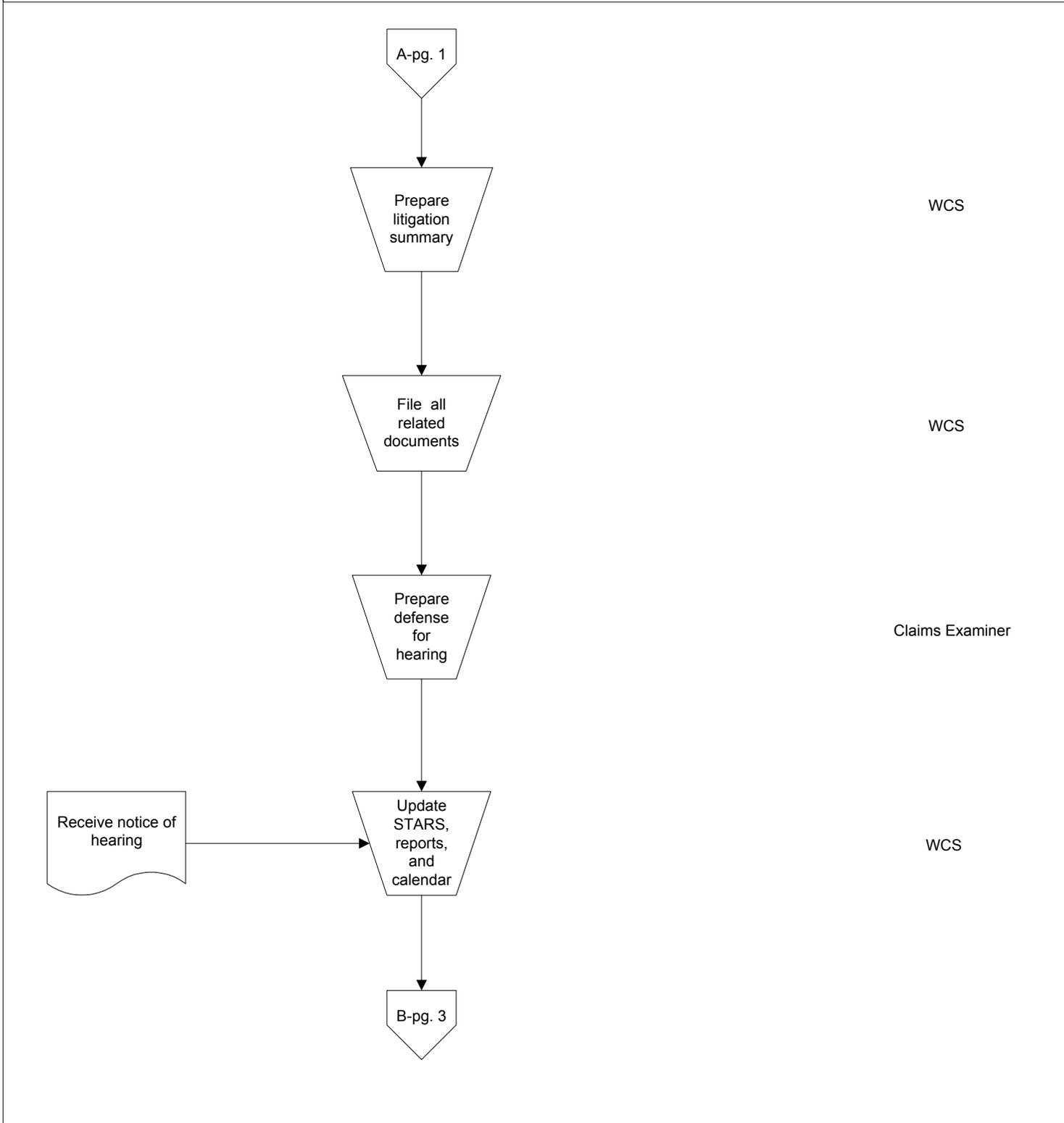




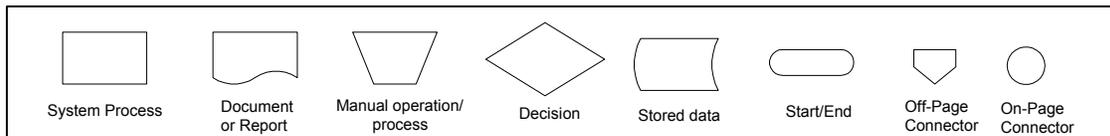
Division of State Agency Services  
Bureau of State Risk  
Management

Process Code	W1.11
Process	Worker's Compensation Claims Management
Sub-Process	Litigation

Input	Process	Output	Responsibility
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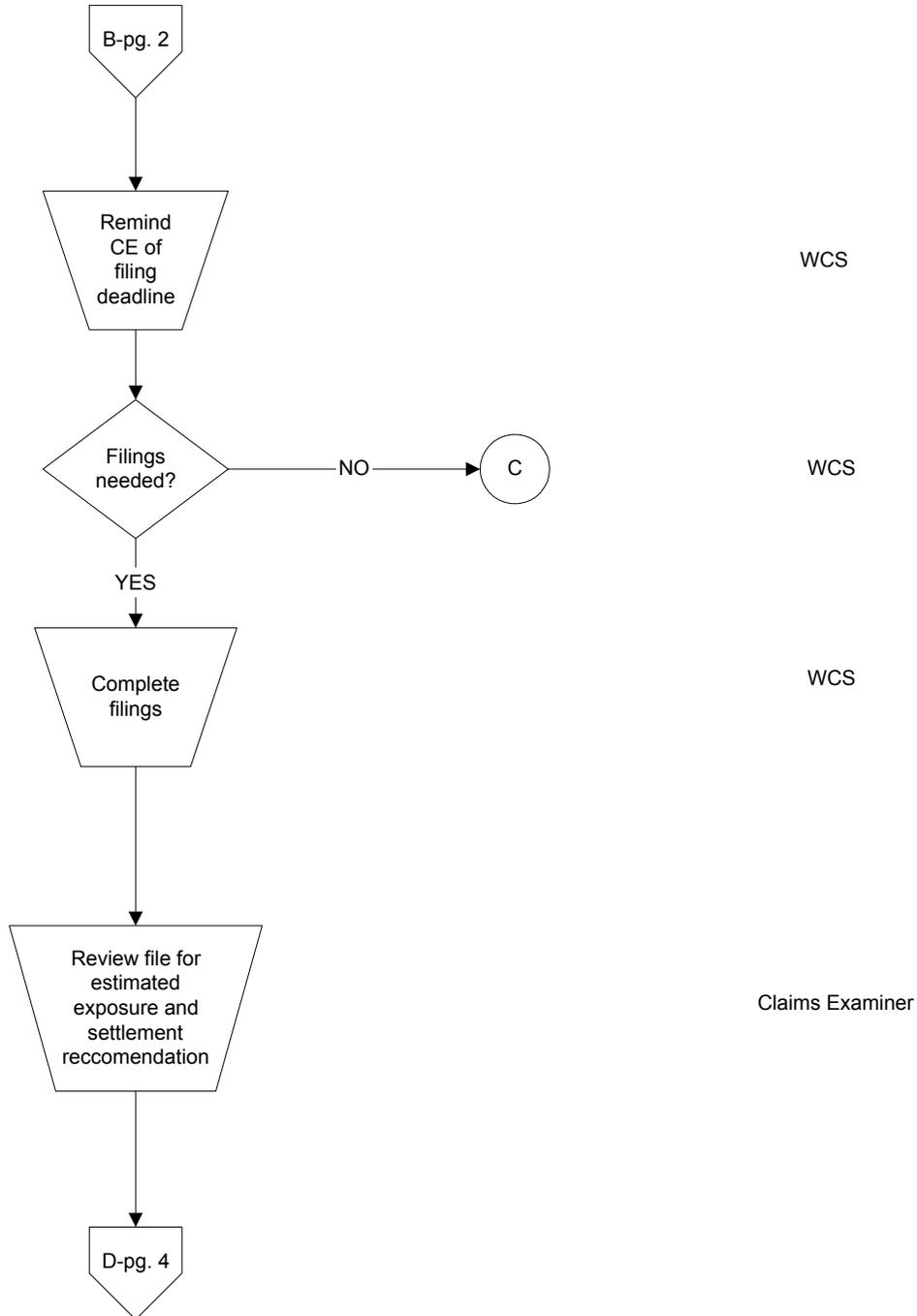




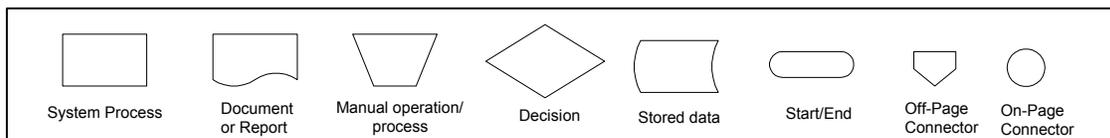
**Division of State Agency Services  
Bureau of State Risk  
Management**

<b>Process Code</b>	W1.11
<b>Process</b>	Worker's Compensation Claims Management
<b>Sub-Process</b>	Litigation

Input	Process	Output	Responsibility
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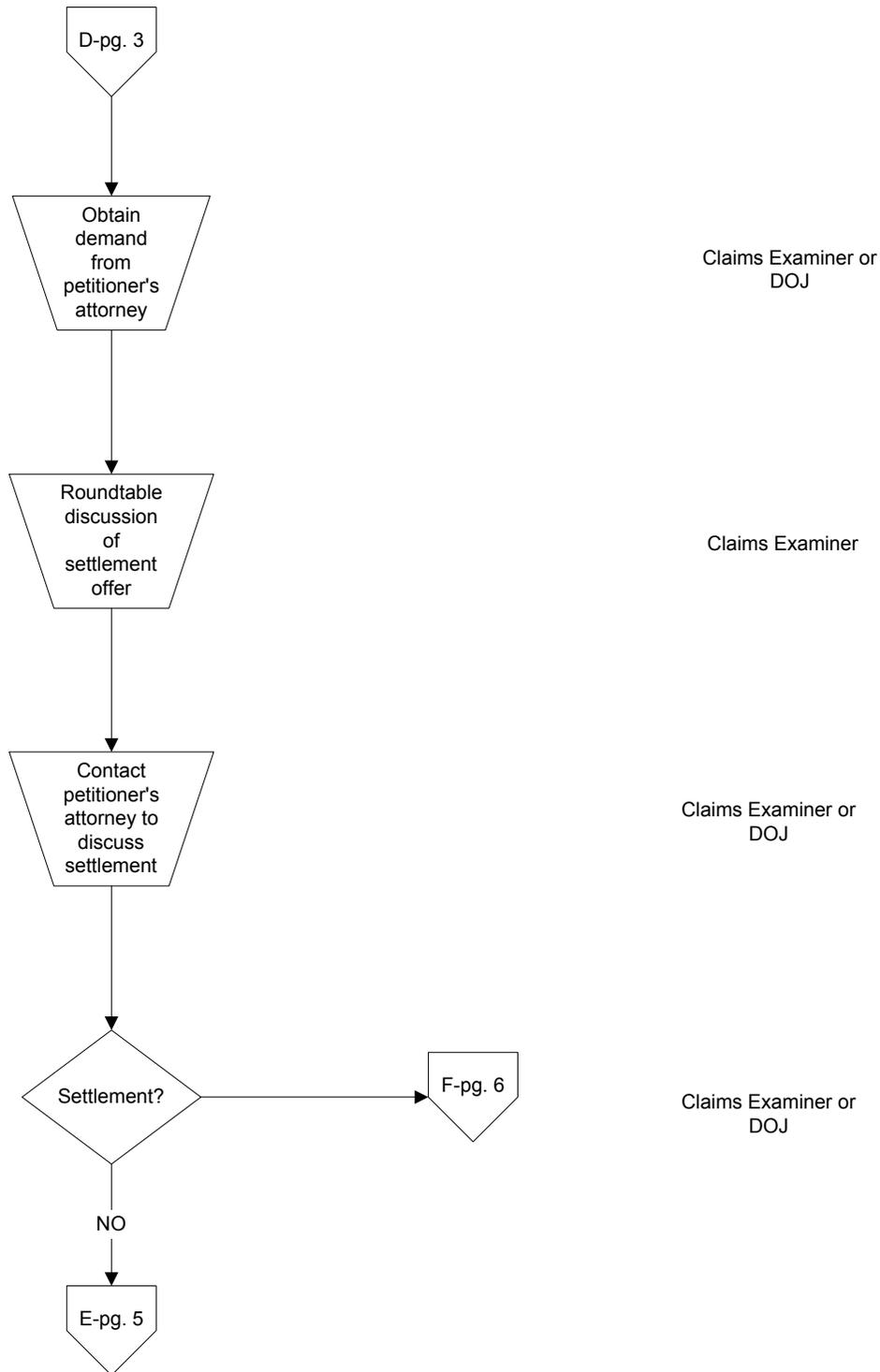




**Division of State Agency Services  
Bureau of State Risk  
Management**

<b>Process Code</b>	W1.11
<b>Process</b>	Worker's Compensation Claims Management
<b>Sub-Process</b>	Litigation

Input	Process	Output	Responsibility
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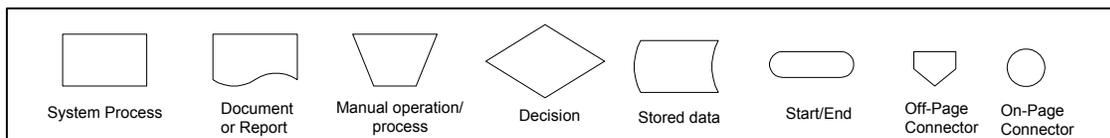
Claims Examiner or DOJ

Claims Examiner

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Claims Examiner or DOJ

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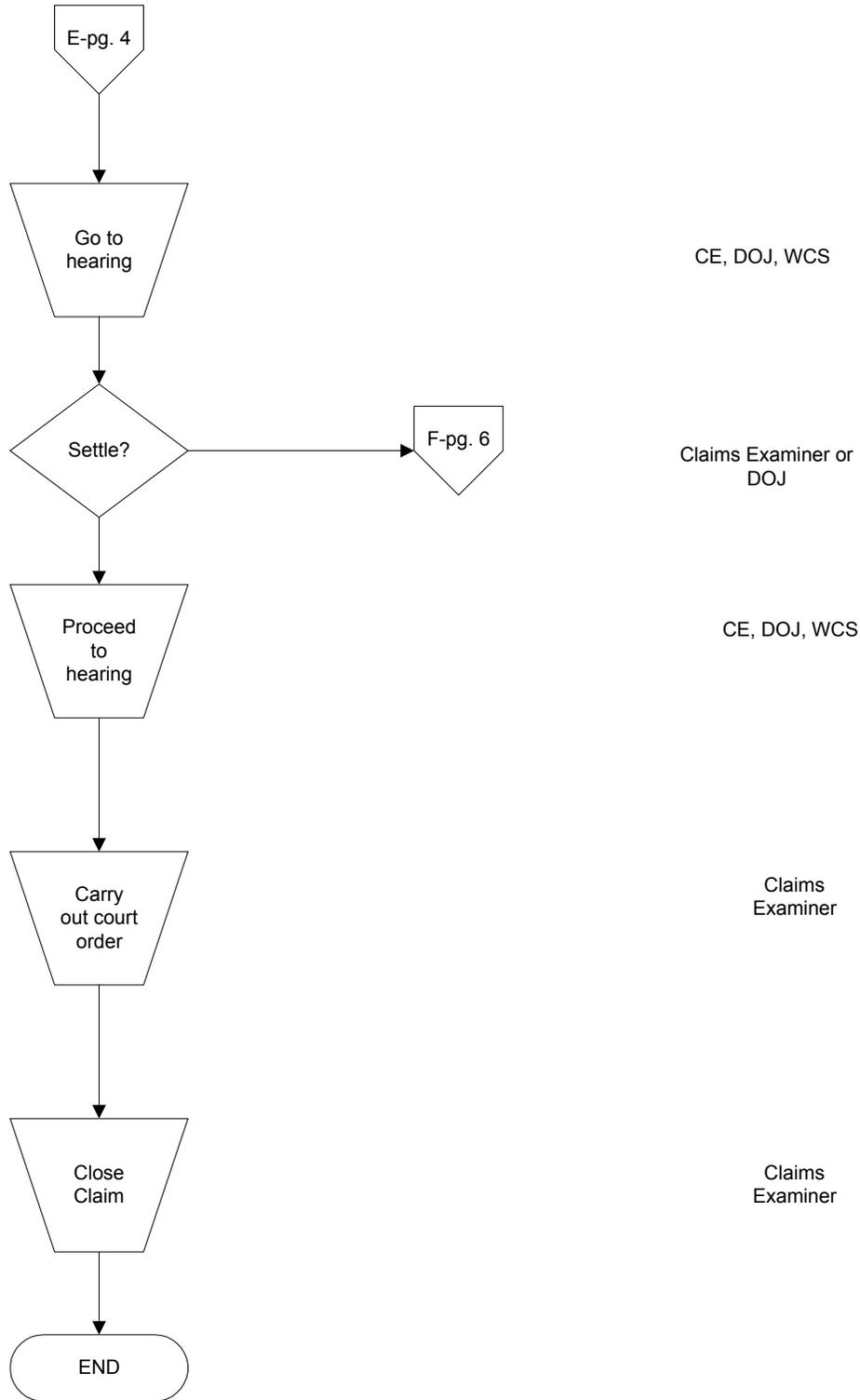




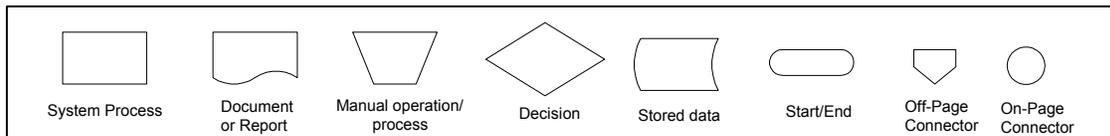
**Division of State Agency Services  
Bureau of State Risk  
Management**

<b>Process Code</b>	W1.11
<b>Process</b>	Worker's Compensation Claims Management
<b>Sub-Process</b>	Litigation

Input	Process	Output	Responsibility
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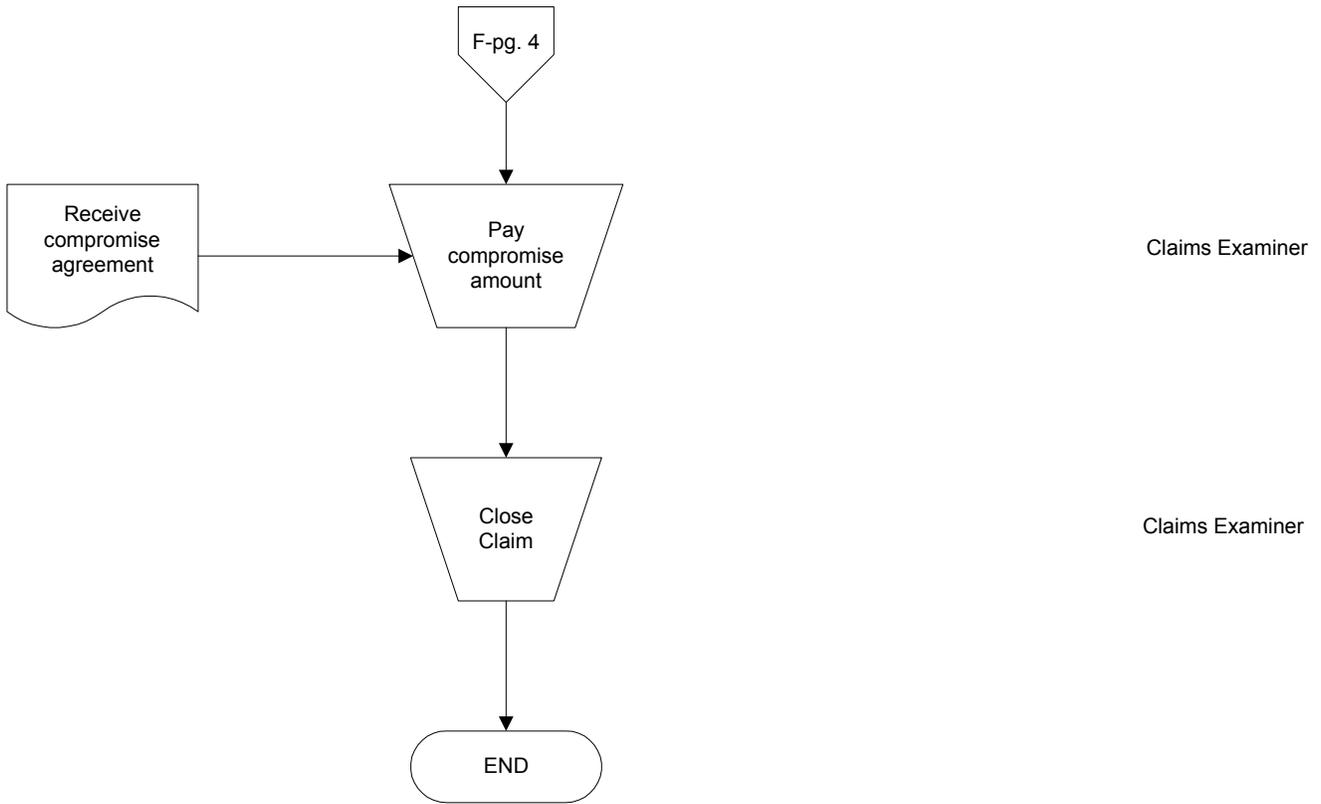




Division of State Agency Services  
Bureau of State Risk  
Management

Process Code	W1.11
Process	Worker's Compensation Claims Management
Sub-Process	Litigation

Input	Process	Output	Responsibility
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**Legend:**

System Process	Document or Report	Manual operation/process	Decision	Stored data	Start/End	Off-Page Connector	On-Page Connector

## **Litigation (W1.11)**

1. Application for hearing is received by the Workers Compensation Specialist (WCS). The WCS enters all pertinent litigation information into STARS. The claims examiner then prepares an answer to the application for hearing and returns it to the WCS. The WCS files the application and all pertinent information with the Department of Justice (DOJ) and the Department of Workforce Development (DWD). Also, as needed the WCS will update litigation reports and the hearing calendar with the filing deadlines and hearing dates.

### **Prepare litigation summary**

2. The WCS will prepare a litigation summary to be used by the claims examiner and DOJ. This will be a detailed file history, including medical history, the petitioner attorney's demand and what we have paid on the file.

### **File all related documents**

3. The claims examiner and WCS will make sure that all related documents, WKC-12, WKC-13, WKC-13a, IME reports, medical records, LOEC reports, etc are filed with DOJ and DWD with copies to the petitioner's attorney. Any additional correspondence received after the initial filing must also be filed.

### **Prepare defense for hearing**

4. The claims examiner will review the file and prepare a defense to be used in hearing. This may include updating IME's, medical records, LOEC's, or obtaining surveillance if warranted (see W1.6 for criteria for obtaining surveillance). This must all be done in time to be filed with DOJ and DWD.

### **Notice for hearing**

5. When the notice of hearing date is received the WCS will update STARS the litigation reports and the calendar. Also, the WCS will notify the claims examiner of the filing deadline. If needed additional filings will be completed in the same manner as above. The claims examiner will review the file for estimated exposure and settlement recommendations. The claims examiner will either obtain a demand from the petitioner's attorney or give DOJ the authority to obtain the demand. If necessary, for instance if the claims examiner is unsure or there is a large dollar amount at stake, there will be a roundtable discussion about the settlement offer. The claims supervisor, claims manager and appropriate claims examiner will discuss the exposure and proper settlement amount.

### **Settlement Attempt and hearing proceedings**

6. The claims examiner will either contact the petitioner's attorney or give the authority to DOJ to contact and discuss a settlement. If a settlement is reached the claims examiner will wait to receive the compromise agreement, pay it and close the claim. If a settlement is not reached the case goes to hearing. Once at the hearing the claims examiner and/or DOJ will again try to settle the case before going before the judge. If a settlement agreement is reached again the claims examiner will wait for the compromise agreement pay it and close the file. If a settlement cannot be reached the case will go before the judge. After hearing the claims examiner will carry out the court order and close the claim.

### **Notice for hearing**

When the notice of hearing date is received the WCS will update STARS, the litigation reports and the calendar. Also, the WCS will notify the claims examiner of the filing deadline. If needed additional filings will be completed in the same manner as above.

the petitioner's attorney or give DOJ the authority to obtain the demand. If necessary, for instance if the claims examiner is unsure of there is a large dollar amount at stake, there will be a roundtable discussion about the settlement offer. The claims supervisor, claims manager and appropriate claims examiner will discuss the exposure and a proper settlement amount.

6. The claims examiner will either contact the petitioner's attorney or give the authority to DOJ to contact and discuss a settlement. If a settlement is reached the claims examiner will wait to receive the compromise agreement, pay it and close the claim. If a settlement is not reached the case goes to hearing. Once at the hearing the claims examiner and/or DOJ will again try to settle the case before going before the judge. If a settlement agreement is reached again the claims examiner will wait for the compromise agreement pay it and close the file. If a settlement can not be reached the case will go before the judge. After hearing the claims examiner will carry out the court order and close the claim.



**Division of State Agency Services  
Bureau of State Risk  
Management**

<b>Process Code</b>	W1.2
<b>Process</b>	Worker's Compensation Claims Management
<b>Sub-Process</b>	Medical Only Claims Management

**Input**

**Process**

**Output**

**Responsibility**

**Legend:**

