OUR TRANSITIONAL WORK GUIDE

PATHWAY FOR POST INJURY CARE

MUSKINGUM VALLEY EDUCATIONAL SERVICE CENTER

INTEGRATED CARE FROM:

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MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

OUR PROGRAM

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OUR MISSION

We are committed to the support of our employees. Implicit in this support is the requirement that we provide a safe workplace for our people. We recognize workplace accidents may, in spite of our efforts, still occur. Therefore, we have developed our transitional work program to provide the following support to our injured employees:

- Provide a practical guideline that outlines the basic steps of transitional work from point of injury to successful return to work;
- Facilitate a rapid response to insure employees of our concern for their well-being and the desire to provide support during this period;
- Coordinate with our MCO, **GatesMcDonald HealthPlus, Inc.** , and providers to support rehabilitative efforts;
- Provide support for injured workers and supervisors at the worksite;
- Reduce employee frustration following workplace injuries;
- Provide our employee with the best chance to return to full and productive employment;
- Provide suitable support in the event that they cannot return to their pre-injury position;
- Reduce lost time through effective management of the injury support process and lower our Workers' Compensation insurance rates.

DISABILITY MANAGEMENT COUNCIL

We have created a Disability Management Council to assist injured workers, as needed, when working within the Transitional Work process. The Council will meet annually to review the Transitional Work Program and will address issues as they arise with individual cases. In the event that no transitional work has been used then the council will not meet. The Disability Management Council will consist of:

Christine Wagner, Treasurer / Workers' Compensation Coordinator
Richard Murray, Superintendent
Diane Jones, Assistant Superintendent
Judy VanVoorhis, Director, Curriculum, Instruction, & Assessment
Mike Fuller, Director, Data Services
Kathy Spitzer, Director , Early Childhood Services
Lorrinda Saxby, Project Coordinator - Professional Development, Salt Fork RSIT
Jim Khoury, Director, School Psychology Services
Donna Adornetto, Director, Student Services
Lynn Dunn Special Services Coordinator

The Disability Management Council shall also provide support for individual workers and shall include the following persons as a minimum:

- injured worker
- injured worker's supervisor/principal

Support for the Disability Management Council, when required, shall be provided by:

Our Developer: **John P. Goodman, RN, BSN, COHN-S/CM**
Our MCO: **GatesMcDonald HealthPlus, Inc.**
MCO Nurse Case Manager: **Vicki Bechtel, R.N.**
Ohio BWC support as needed.

Role of the Disability Management Council:

- Meet as required to achieve objectives;
- Annually review the program/update as required;
- Coordinate as required with our consultant/developer;
- Respond to concerns of the injured worker when disputes arise;
- Coordinate care with MCO, providers, and/or BWC;
- Coordinate return to work with the Supervisors/Principal;
- Provide other support as required.

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OUR PROFILE

Muskingum Valley Educational Service Center

205 North Seventh Street
Zanesville, Ohio 43701
Phone: 740-452-4518
Fax: 740-455-6702

Christine Wagner
Treasurer /
Workers' Compensation Coordinator
205 North Seventh Street
Zanesville, Ohio 43701
Phone: 740-452-4518
Fax: 740-455-6702

Richard Murray
Superintendent
205 North Seventh Street
Zanesville, Ohio 43701
Phone: 740-452-4518
Fax: 740-455-6702

Diane Jones
Assistant Superintendent
205 North Seventh Street
Zanesville, Ohio 43701
Phone: 740-452-4518
Fax: 740-455-6702

Judy VanVoorhis
Director,
Curriculum, Instruction, & Assessment
205 North Seventh Street
Zanesville, Ohio 43701
Phone: 740-452-4518
Fax: 740-455-6702

Mike Fuller
Director,
Data Services
205 North Seventh Street
Zanesville, Ohio 43701
Phone: 740-452-4518
Fax: 740-455-6702

Kathy Spitzer
Director,
Early Childhood Services
205 North Seventh Street
Zanesville, Ohio 43701
Phone: 740-452-4518
Fax: 740-455-6702

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Lorrinda Saxby
Project Coordinator,
Professional Development, Salt Fork RSIT
205 North Seventh Street
Zanesville, Ohio 43701
Phone: 740-452-4518
Fax: 740-455-6702

Jim Khoury
Director,
School Psychology Services
205 North Seventh Street
Zanesville, Ohio 43701
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Fax: 740-455-6702

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Special Services Coordinator
205 North Seventh Street
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Phone: 740-452-4518
Fax: 740-455-6702

**MUSKINGUM VALLEY
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OUR MANAGED CARE ORGANIZATION (MCO) PROFILE

GatesMcDonald HealthPlus, Inc.

P.O. Box 182720
Columbus, Ohio 43218
www.gmcdhealthplus.com

Vicki Bechtel, R.N.
Nurse Case Manager
P.O. Box 182720
Columbus, Ohio 43218
Phone: 614-677-0570
Fax: 888-329-6261
Email: bechtev@gatesmcdonald.com

Michael Ware
MCO Account Specialist
P.O. Box 182720
Columbus, Ohio 43218
Phone: 614-677-0534
Fax: 877-202-3505
Email: warem3@gatesmcdonald.com

OUR THIRD PARTY ADMINISTRATOR (TPA) PROFILE

GatesMcDonald, Inc.

5525 Park Center Circle
Dublin, Ohio 43017

Melony Bryant
Account Manager
5525 Park Center Circle
Dublin, Ohio 43017
Phone: 614-854-8647
Email: bryantm1@gatesmcdonald.com

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OUR BWC PROFILE

BWC SERVICE OFFICE

Cambridge Service Office
61501 Southgate Road
Cambridge, Ohio 43725
Phone: 800-898-6446
Fax: 866-457-0597
www.ohiobwc.com

Michele Weyrauch

Disability Management Coordinator
Cambridge Service Office
61501 Southgate Road
Cambridge, Ohio 43725
Phone: 740-435-4262
Fax: 866-457-0597

Kimberly St. Clair

Employer Services Representative
Cambridge Service Office
61501 Southgate Road
Cambridge, Ohio 43725
Phone: 740-435-4239
Fax: 740-435-4219
Cell Phone: 614-562-5964
Email: Kimberly.stclair@bwc.state.oh.us

OUR MEDICAL PROVIDER CONTACT LISTINGS

Genesis-Bethesda Hospital

2951 Maple Avenue
Zanesville, Ohio 43701
Phone: 740-454-4000

Genesis-Good Samaritan Hospital

800 Forest Avenue
Zanesville, Ohio 43701
Phone: 740-454-5000

Genesis-Bethesda Physicians Pavilion

***Occupational Health**

945 Bethesda Drive
Zanesville, Ohio 43701
Phone: 740-454-4010

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INTEGRATED SUPPORT SERVICES, INC.
PROFILE

36 Harrison Street
Sunbury, Ohio 43074
Phone: 740-965-9407 or 866-437-4673
Fax: 740-965-9487
www.issids.com

DEDICATED RTW SUPPORT SPECIALISTS

JOHN P. GOODMAN, RN, BSN, COHN-S/CM
Vocational Rehabilitation Nurse Case Manager &
Transitional Work Grant Developer
36 Harrison Street
Sunbury, Ohio 43074
Phone: 740-965-9407
Fax: 740-965-9487
Email: iss1jpg@aol.com

JEANNE HOGG	**Operations Manager / RTW Support Specialist**
JENNY HOLTSBERRY	**Receptionist**
LISA KOESTER	**Transitional Work Grant Coordinator Assistant**

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WORKERS' COMPENSATION COORDINATOR'S GUIDELINES & FORMS

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Workers' Compensation Coordinator's Assessment of Return to Work

Employee Responsibilities:

- Employee reports to supervisor upon return.
- Employee provides copies of all BWC/medical paperwork to Supervisor.

Employee Returns to their Supervisor with a Release From Physician:

Step 1: The Supervisor will evaluate the return to work slip from the doctor to see if the employee has been fully released to duty. If yes, the Supervisor and the injured worker will fill out the "Injured Worker Report of Return to Work" and send the employee back to work. The Supervisor will notify the Workers' Compensation Coordinator that the return to work can be reported to the MCO. If no, then go to Step 2.
Step 2: The Supervisor will determine if he/she can accommodate the injured workers' restrictions within their normal job classification/position? If yes, the Supervisor and the injured worker will complete the "Injured Worker Report of Return to Work" form, develop the "Return to Work Plan" and send the employee back to work. The Supervisor will notify the Workers' Compensation Coordinator that the return to work can be reported to the MCO. If no, then go to Step 3.
Step 3: The Supervisor will determine if there is an alternative duty outside of the injured worker's job classification/position? If yes, the Supervisor and the injured worker will complete the "Injured Worker Report of Return to Work" form and develop the "Return to Work Plan". The injured worker will return to work. The Supervisor will notify the Workers' Compensation Coordinator of the return to work and he/she will notify the MCO. If no, then go to Step 4.
Step 4: If there is no work available, the Supervisor will coordinate with the Workers' Compensation Coordinator and brainstorm return to work ideas with the MCO and ISS as needed.

Supervisor Coordinates with Workers' Compensation Coordinator:

Step 1: Call the MCO or ISS to coordinate a return to work and verify status.
Step 2: Identify extent of injuries and likeliness of immediate return to work with the MCO or ISS.
Step 3: If needed ask the MCO to describe likely restrictions or to contact physician to get proposed restrictions.
Step 4: Review restrictions and identify suitable work, if assistance needed contact the MCO or ISS.
Step 5: Contact MCO or ISS to coordinate release to work.
Step 6: If barriers exist go to "Barrier Response".

Barrier Response:

Step 1: The Workers' Compensation Coordinator will call the MCO or ISS and jointly identify barriers to return to work for the injured worker.
Step 2: The Workers' Compensation Coordinator will determine if the identified internal barriers can likely be resolved within the employer's resources and capability, within 7-days of the injury/event? If yes, the Workers' Compensation Coordinator will coordinate with the Supervisor to resolve the barriers and return the employee to work following the steps identified, above. If no, go to Step 3.
Step 3: The Workers' Compensation Coordinate will ask the MCO if the identified barriers are likely to be solved by telephonic case management within 7-days of the injury/event? If yes, he/she will ask the MCO to promptly resolve the barriers. The Workers' Compensation Coordinator will work with the Supervisor to return the injured worker back to work following the steps identified, above. If no, go to Step 4.
Step 4: The Workers' Compensation Coordinator will coordinate a game plan with the MCO to aggressively manage the injury for optimized return to work, consider vocational rehabilitation referral without delay if barriers exist, and maintain frequent contact with the MCO. Notify ISS for assistance in management at this time.
Step 5: If lost time is probable then the Workers' Compensation Coordinator will verify wage status (sick leave, wage continuation, temporary total). Have employees indicate which method they intend to select.
Step 6: The Workers' Compensation Coordinator and the Supervisor will monitor progress towards return to work very closely. ISS can also assist with monitoring of case if needed.

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Desired Event Timing:

Timing	Well Managed Event	Caution	High Concern
Day of injury	✓ Injured worker reports event ✓ Scene is safe ✓ Investigation is started ✓ Check back with supervisor – outcome of medical care	✓ Informal report only ✓ Scene is not controlled ✓ Investigation not started ✓ MCO awaiting notification	✓ No report made ✓ Scene unsafe ✓ No investigation planned ✓ MCO not notified
1st – 3rd lost day/1-3 days following event	✓ Basic medical information available ✓ Immediate return to work assessment complete ✓ MCO provides updates/claim is being managed effectively	✓ Medical info is sketchy and prognosis is unclear ✓ Return to work release status is unclear	✓ MCO has not received medical info ✓ Supervisor rejects return to work ✓ Injured worker rejects return to work
3rd – 5th lost day/3-5 days following event	✓ Return to work likelihood verified ✓ Pay status verified ✓ Return to work scheduled	✓ Return to work uncertain ✓ Physician support for return uncertain ✓ MCO not actively pursuing return to work plan	✓ No return to work planned ✓ Injured worker out of sick leave
5th – 7th lost day/5-7 days following event	✓ Clear return to work status/long-term prognosis ✓ Game plan in place for long-term care as needed ✓ Remain at work outcomes are known	✓ Outcomes of return to work uncertain ✓ Known or perceived barriers present	✓ Injured worker refuses work ✓ Failure of return to work expected
Day 8+ lost day/8th + day following event	✓ Tracking process established ✓ MCO game plan in place to facilitate rapid return to work ✓ Vocational rehabilitation when medically feasible or with barriers	✓ Game plan for return is unclear ✓ Long term care may be needed	✓ There is no game plan for return ✓ Long term care required ✓ Worker psycho-social barriers present

Barriers/Responses:

Barrier to Return to Work	Possible Response by Employer
Physician will not release employee	✓ Ask MCO to identify specific reasons ✓ Contact ISS for assistance ✓ Contact physician directly ✓ Contact employee directly
Employee will not return (does not want to)	✓ Contact employee directly ✓ Ask MCO to contact employee directly ✓ Write a certified letter requesting RTW
Too restrictive limitations	✓ Ask MCO to verify restrictions ✓ Ask MCO to send JDA to doctor ✓ Contact ISS for assistance
MCO unable to get cooperation with parties	✓ Contact BWC representative ✓ Contact ISS for assistance
MCO unable to verify return to work status	✓ Contact physician directly ✓ Contact employee directly
Supervisor cannot/would not provide accommodated work	✓ Clarify need for effort ✓ Contact ISS for assistance
Physician requires additional information about job	✓ Ask MCO to send JDA to doctor ✓ Contact ISS for assistance
Injury seems minor but system is not moving quickly enough	✓ Ask MCO to promptly respond/get info ✓ Contact ISS for assistance
Physician disagrees with the need for on-site support	✓ Ask MCO to promptly respond ✓ Contact ISS for assistance

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Bureau of Workers' Compensation Claim Instructions

When initially injured on the job or at least the following day:

Complete required form "Employee Incident/Accident Report, which is available from your supervisor/principal. Return the form to your supervisor/principal immediately.

Your Workers' Compensation Coordinator at your employer will call GatesMcDonald HealthPlus, Inc. , the BWC certified Managed Care Organization, to report your injury if medical treatment is necessary.

Follow-up procedures:

Be sure to let your healthcare provider/emergency room know the name of the Managed Care Organization for your employer (if you do not the medical bills will be sent to you and payment will be delayed).

Call human resources to report whether you have missed any days of work due to the injury. Please keep in mind the following:

If you have not returned to work by the third day <u>you must</u> contact Christine Wagner, Treasurer to clarify pay issues. If you have not returned to work and you have not called Christine Wagner, Treasurer , we will assume your absence has nothing to do with your accident.

If you receive any medical bills related to your claim call the medical provider that billed you and tell them to re-bill:

GatesMcDonald HealthPlus, Inc.
P.O. Box 182720
Columbus, Ohio 43218
Website: www.gmcdhealthplus.com

Keep Christine Wagner, Treasurer informed of further problems, medical treatment, or additional missed days due to the injury/claim.

Muskingum Valley Educational Service Center
Christine Wagner, Treasurer , Workers' Compensation Coordinator
Phone: 740-452-4518 * Fax: 740-455-6702

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CLAIM TRACKING CHECKLIST

Demographic Information:

Injured Worker: ______________________ Title/Position: __________________________

Department: ________________________ Date of Injury: __________________________

Claim #: ___________________________ Injury: _______________________________

Tracking Items:

►ACCIDENT REPORTING FORMS:

Employee Incident/Accident Report Completed: ☐ Yes ☐ No Date:__________

Back Injury Incident/Accident Report Completed: ☐ Yes ☐ No Date:__________

Supervisor's Investigation Report Completed: ☐ Yes ☐ No Date:__________

Witness Statement Form Completed: ☐ Yes ☐ No Date:__________

First Report of Injury (FROI) Form Received: ☐ Yes ☐ No Date:__________

Managed Care Organization (MCO) Notified: ☐ Yes ☐ No Date:__________

Third Party Administrator (TPA) Notified: ☐ Yes ☐ No Date:__________

Claim Certified or Denied: ☐ Certified ☐ Denied Date:__________

Scheduled Return to Work Date: Date: ________________

Actual Return to Work Date: Date: ________________

Supervisor Report of Return to Work Received: ☐ Yes ☐ No Date:__________

Return to Work Plan Developed and Received: ☐ Yes ☐ No Date:__________

►Preliminary Outcome:

- **Full Return to Work with No Restrictions:** ☐ Yes ☐ No Date:__________
- **Return to Work with Restrictions:** ☐ Yes ☐ No Date:__________

►Final Outcome:

- **Full Return to Work:** ☐ Yes ☐ No Date:__________
- **Accommodated in Position:** ☐ Yes ☐ No Date:__________
- **New Position:** ☐ Yes ☐ No Date:__________
- **New Outside Job:** ☐ Yes ☐ No Date:__________
- **Medical Discharge:** ☐ Yes ☐ No Date:__________

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EMPLOYEE INCIDENT/ACCIDENT REPORT

To Be Completed by Injured Employee * OSHA 301 Info in BOLD

Name: ____ Social Sec. No. XXX-XX-__________ (Last 4-digits only)

Home Address: ________________________________ **Date of Birth:** _______ **Sex:** ☐ Male ☐ Female

City/State/Zip: ________________________________ Telephone: ( ) ____________________

Title/Position: ________________________________ Department: ______________________________

Accident Location: ____

Date of Injury or onset of symptoms: ______________________________ Time: ________ ☐ am ☐ pm

Described what caused the injury/symptoms, what you were doing just before the incident, and what you did after the incident (if you need more space, write on the back of this form). Be specific-name any objects or substances involved:

Were you performing regular duties at the time of accident? ☐ Yes ☐ No

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who? ______________________________

Did you report this incident to anyone? ☐ Yes ☐ No If no, why not? ______________________________

If yes, to whom did you report it?:____________________ Title/Position:____________________ When: __________

What time did you start work today? ________ am/pm. **What time was the injury?**________am/pm ☐ Unknown

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger**):**

____

____

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull): __________

____

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe: ______________________________

____

Provided by: ____

Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?: ______________________________

Where?: ______________________ If treatment was not sought immediately, explain why?: __________

____

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury?: ______________________ By whom or where?:______________________

Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury: ____________________

Medical Release **– Under current Workers' Compensation Law, the employer is entitled to a signed medical release.** I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name (print): ______________________ **Employee Signature:** ______________________

Date (required): ________________

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EMPLOYEE INCIDENT / ACCIDENT REPORT
BACK INJURY REPORT

*** To Be Completed When a Back Injury is Reported by the Injured Employee***

Name: ____________________ Social Sec. No. XXX-XX-______ (Last 4-digits only)

Home Address: ____________________ Date of Birth: ________ Sex: ☐ Male ☐ Female

City/State/Zip: ____________________ Telephone: ( ) ____________________

Title/Position: ____________________ Department: ____________________

What part of your back hurts now? ____________________

When did you first notice this back pain? Date: ____________ Time: ________ ☐ am ☐ pm

What were you doing at that time (explain in detail)? ____________________

____

____

If you were lifting an object, what was it and how heavy? ____________________

____

____

What did you feel? ____________________

What was the length of time between the injury and your disability, if any? ____________________

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who? ____________________

Did you report or mention this injury to anyone? ☐ Yes ☐ No If yes, who? ____________ When? ________

Did you ever have a back injury before? ☐ Yes ☐ No If yes, when? ____________________

What part of your back? ____________________

Were you ever treated by a doctor? ☐ Yes ☐ No If so, when? ____________________

Has it given you further trouble since then? ____________________

Have you ever received or filed for compensation because of a back injury? ☐ Yes ☐ No

Any other injury? ☐ Yes ☐ No If yes, list Bureau of Workers' Compensation claim number(s): ____________

____

Medical Release **- Under current Workers' Compensation Law, the employer is entitled to a signed medical release.** I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name (print): ____________________

Employee Signature: ____________________ **Date (required):** ____________________

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SUPERVISOR'S INVESTIGATION REPORT

Employee Name: ________________________**Date of Injury:** ________________**OSHA Log #**____________

OSHA 301 Info in Bold

Was the employee killed as a result of the accident? If yes, indicate date of death:_________________________

Were there any witnesses to this injury? ☐ **Yes** ☐ **No**

If yes, witness statements should be attached.

Was the injury a result of horseplay, under the influence of drugs, or purposely self-inflicted? ☐ **Yes** ☐ **No**

If yes, please specify details on the back of this form or on another page.

Has there been any recent disciplinary action taken against this employee? ☐ **Yes** ☐ **No**

If so, please describe:

____

____

Has the employee submitted medical documentation for the injury? If so, please attach. ☐ **Yes** ☐ **No**

Was the employee treated in an emergency room or similar? ☐ **Yes** ☐ **No**

Was the employee hospitalized overnight as an in-patient? ☐ **Yes** ☐ **No**

If known, please provide us with the name, address and telephone number of attending physician and/or hospital:

Physician:____________________________________ Facility:____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

Has the employee returned to work? ☐ **Yes** ☐ **No**

Last Day worked ________________________ Returned to work _________________

Does the employee have restrictions to duty? ☐ **Yes** ☐ **No** Applicable dates:________________________

Is the employee performing their full duties? ☐ **Yes** ☐ **No**

Was the employee given a prescription by the physician? ☐ **Yes** ☐ **No**

Employee Date of hire: __________________________

Have the conditions that caused the accident been controlled? ☐ **Yes** ☐ **No**

Describe action taken to prevent the accident in the future:____

____

With the information you have, would you recommend the claim be accepted? ☐ **Yes** ☐ **No**

If no, why? ____

Completed by:

____ ________________________________
Supervisor Signature/Title/Phone Date

____ ________________________________
Workers' Compensation Coordinator Signature Date

**Please attach completed incident reports, witness statements and any accumulated medical bills and information. Additional comments may be noted on the reverse side.

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STATEMENT OF WITNESS TO ACCIDENT

I. INCIDENT INDENTIFICATION INFORMATION

Name of employee alleging incident: ______________________ Shift: ______________________

Title/Position: ______________________ Department: ______________________

II. WITNESS STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your Name: ______________________ Your Title/Position: ______________________

Your Address: ______________________ Your Phone Number: ( ) ______________________

____

Did you see an accident involving the above employee: ☐ Yes ☐ No

If not, how did you learn about the accident? ______________________

____

If you did see an accident occur?: Date of accident: ______________________

Time of accident: ______________________ ☐ am ☐ pm

Describe what you saw: ______________________

____

____

____

____

____

____

____

____

____

____

____

____

____

______________________	______________________	______________________
Your Signature	**Please Print Your Name**	**Date**

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SICK LEAVE OPTION FORM

Employee Name: ____

Date of Injury: ______________________

The purpose of this document is to notify any eligible employee who sustains a compensable workers' compensation injury of their right to elect to use accrued Sick Leave in lieu option of applying for Bureau of Workers' Compensation disability (Temporary Total compensation) benefits.

Sick Leave can be used when there is an industrial injury.

The injured worker can, however, notify the employer of an election to stop using Sick Leave at a future date. The worker then files a request to the BWC for Temporary Total compensation accompanied by a statement from the employer as to the last day Sick Leave is paid.

To qualify for the Temporary Total compensation from the Bureau of Workers' Compensation **YOUR INJURY MUST CAUSE MORE THAN SEVEN CALENDAR DAYS OF DISABILITY.**

____
Employer

___________________________ ______________________
Signature **Title**

OPTION 1	OPTION 2
I acknowledge the above and elect to RECEIVE ***SICK LEAVE*** IN LIEU OF COMPENSATION FROM BWC. I also understand compensation can be elected for a period subsequent to Sick Leave benefits but may not overlap.	I acknowledge the above and ELECT TO RECEIVE ***TEMPORARY TOTAL COMPENSATION*** FROM THE BUREAU OF WORKERS' COMPENSATION for which I may be eligible.
______________________________ **Employee's Signature**	______________________________ **Employee's Signature**
______________________________ **Date**	______________________________ **Date**

MUSKINGUM VALLEY
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WAGE CONTINUATION OPTION FORM

Employee Name: ____

Date of Injury: ________________________

The purpose of this document is to notify any eligible employee who sustains a compensable workers' compensation injury of their right to elect to use Wage Continuation in lieu of applying for Bureau of Workers' Compensation disability (Temporary Total compensation) benefits.

Wage Continuation can be used when there is an industrial injury.

The injured worker can, however, notify the employer of an election to stop using Wage Continuation at a future date. The worker then files a request to the BWC for Temporary Total compensation accompanied by a statement from the employer as to the last day wage continuation is paid.

To qualify for the Temporary Total compensation from the Bureau of Workers' Compensation **YOUR INJURY MUST CAUSE MORE THAN SEVEN CALENDAR DAYS OF DISABILITY.**

____
Employer

______________________ ______________________
Signature **Title**

OPTION 1	OPTION 2
I acknowledge the above and elect to RECEIVE ***WAGE CONTINUATION*** IN LIEU OF COMPENSATION FROM BWC. I also understand compensation can be elected for a period subsequent to Wage Continuation benefits but may not overlap.	I acknowledge the above and ELECT TO RECEIVE ***TEMPORARY TOTAL COMPENSATION*** FROM THE BUREAU OF WORKERS' COMPENSATION for which I may be eligible.
______________________ **Employee's Signature**	______________________ **Employee's Signature**
______________________ **Date**	______________________ **Date**

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

Date:

[Click **here** and type PHYSICIAN name]
[Click **here** and type PHYSICIAN ADDRESS]
[Click **here** and type PHYSICIAN city state zip]

Re: [Click **here** and type INJURED WORKER name] Claim #: [Click **here** and type CLAIM NUMBER]

SUBJECT: Physician Release to Modified Duty

Dear Doctor:

The Muskingum Valley Educational Service Center is prepared to support the return to work of the above-referenced injured worker under our BWC certified transitional work program beginning immediately upon your release. The injured worker will return to us in a very controlled process under the direction of our Return to Work team. They will return to accommodated duties under the following job title: [Click **here** and type job title]. He/she will perform the following accommodated tasks:

1.
2.
3.
4.
5.

They will be assigned work within their present restrictions and will only progress as coordinated through the Return to Work Team and your office.

The supervisor has been contacted and understands the limitations of the return. Additionally, they will be given additional instructions and support as the worker returns. When necessary, we have a relationship with an independent BWC approved vocational rehabilitation group to provide advice and support as needed.

Please sign and acknowledge your support of this return to work plan and fax the signed form back to me at the number listed below.

If you have any questions please do not hesitate to contact me at 740-452-4518 .

Sincerely,

Christine Wagner, Treasurer
Muskingum Valley Educational Service Center

Physician's Release to Return to Work:

I hereby acknowledge the return to work plan noted above and release the injured worker to perform these duties as assigned.

______________________	______________________	______________
Physician Name (Print)	Signature	Date

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

VIA CERTIFIED MAIL

Date: 11/22/2011

[Click **here** and type employee name]
[Click **here** and type employee address]
[Click **here** and type employee city state zip]

Reference: Workers' Compensation Claim #: [Click **here** and type claim #]
Date of Injury: [Click **here** and type injury date]

Dear [Click **here** and type name]:

We have reviewed your current restrictions as indicated by your physician and we have developed an appropriate temporary modification of your present job duties. This return has been coordinated with your attending physician and is available beginning [Click **here** and type DATA] at [Click here and type time]and you should contact me to coordinate your return. You will be scheduled for [Click here and type DATA] hours per week at your current hourly rate of [Click here and type DATA]. You will perform the following duties:

1.
2.
3.
4.
5.

You may refuse Transitional Work and take available paid leave or leave without pay. If you refuse transitional work however, you may not be eligible for continued temporary total compensation from the Ohio Bureau of Workers' Compensation. If your condition changes and you are no longer eligible for transitional work, you may be eligible for temporary total compensation from the Ohio Bureau of Workers' Compensation.

We are looking forward to your return. If you have any questions or experience any difficulty performing transitional work, please advice your supervisor immediately. You have three calendar days from receipt of this letter to contact me to discuss your transitional work duties or you will have been determined to refuse this offer.

Very Truly Yours,

Christine Wagner, Treasurer
Muskingum Valley Educational Service Center

ق I accept this temporarily modified work within my current job duties/position as part of a transitional work plan and I will report to work as advised.
ق I choose not to accept a temporary modified work position as part of a transitional work plan. I acknowledge that my refusal may result in discontinuation of my compensation benefits through workers' compensation.

Employee's signature:_______________________________ Date:_______________________

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

Date of Request: 11/22/2011

To: GatesMcDonald HealthPlus, Inc.
Vicki Bechtel, R.N.

From: Christine Wagner, Treasurer
Muskingum Valley Educational Service Center

SUBJECT: Vocational Rehabilitation Referral Request

Regarding: Injured Worker: [Click **here** and type name] Claim #: [Click **here** and type claim number]

We are requesting that you immediately request authorization to begin vocational rehabilitation services. Please note the following statements concerning this request:

1. We certify the claim.
2. We believe that there is a high likelihood that, with this support, the injured worker will return to their pre-injury position.
3. The injured worker is using Temporary Total wages from the BWC, or we certify that we have continued their wages, or we certify that they are using sick leave.

Please assign our case, and all subsequent cases, to Integrated Support Services. You may contact them at 740-965-9407. The assigned case manager is to be John P. Goodman, RN, BSN, COHN-S/CM, provider number 274606030-00, unless otherwise directed. We request that you send our preferred provider an authorizing email as soon as assigned from the BWC (info@issids.com) so that these services are not delayed.

Thank you for your kind attention in this matter and for your continued support of our injured workers. **If there is any expected delay longer than three days to process this request please inform me personally as to the barrier.**

______________________________ ______________________________
Signature Title

____
Date

**MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER**

Date:

GatesMcDonald HealthPlus, Inc.
P.O. Box 182720
Columbus, Ohio 43218

Subject: Vocational Rehabilitation Referral Request

RE: [Click **here** and type worker's name]
Claim # [Click **here** and type claim number]

Dear GatesMcDonald HealthPlus, Inc. :

I am requesting vocational rehabilitation services to assist my recovery to my pre-injury position. Therefore, pursuant to BWC rules, I am requesting that you immediately request authorization to begin vocational rehabilitation services from the BWC.

Please assign my case to Integrated Support Services You may contact them at 740-965-9407. The assigned case manager is to be John P. Goodman, RN, BSN, COHN-S/CM, provider number 274606030-00, unless otherwise directed.

Thank you for your kind attention in this matter and for your continued support during my recovery.

Respectfully,

[Click **here** and type name]
Muskingum Valley Educational Service Center

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

SUPERVISOR'S

GUIDELINES &

FORMS

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

Supervisor's Guide to Managing On-the-Job Injuries

Employee Responsibilities:

- Employee reports injury to supervisor/principal and seeks treatment from a BWC-certified medical provider (All providers in **GatesMcDonald HealthPlus, Inc.** network are BWC-certified).
- Employee identifies **GatesMcDonald HealthPlus, Inc.** as his/her MCO and shows identification card, if available.

Supervisor Action:
Step 1: Verify employee has received medical treatment.

Step 2: Verify that the location of the accident is safe and secure. Protect the site as necessary.

Step 3: The employee and/or supervisor/principal fill out the "Initial Injury Report Form".

Step 4: Supervisor/principal will perform an accident investigation as required and complete the "Supervisor Investigation Report". All witnesses to the accident will need to complete the "Witness Statement Form". Submit both forms to **Christine Wagner, Treasurer** .

Step 5: The employee will return to work in one of these scenarios. Take appropriate action as noted:

1. The employee returns immediately from the hospital or clinic.
    a. Have the employee report directly to supervisor/principal.
    b. Employee will provide the physician paperwork received.
    c. Employee and Supervisor will fill out "Injured Worker Report of Return to Work".
2. The employee reports off for a period more than one day.
    a. Request physician paperwork from the employee.
    b. Notify **Christine Wagner, Treasurer** immediately. Send paperwork immediately when received. Note restrictions.
    c. Coordinate with **Christine Wagner, Treasurer** for the future return to work.
    d. Begin planning for the return to work with the "Return to Work Plan" Form with coordination with **Christine Wagner, Treasurer** .

Step 6: Upon the return to work, or at your next conversation with the injured worker while off work, request that the employee contact **Christine Wagner, Treasurer** regarding the Sick Leave Option or Wage Continuation forms.

General Action: Notify Christine Wagner, Treasurer of any changes in the duties of the injured worker and send any paperwork received immediately.

Christine Wagner, Treasurer
Phone: 740-452-4518 * Fax: 740-455-6702

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

EMPLOYEE INCIDENT/ACCIDENT REPORT

To Be Completed by Injured Employee * OSHA 301 Info in BOLD

Name: ________________________________ Social Sec. No. XXX-XX-_______ (Last 4-digits only)

Home Address: ________________________________ **Date of Birth:** _______ **Sex:** ☐ Male ☐ Female

City/State/Zip: ________________________________ Telephone: ( ) ____________________

Title/Position: ________________________________ Department: ____________________

Accident Location: ____

Date of Injury or onset of symptoms: ______________________ Time: ________ ☐ am ☐ pm

Described what caused the injury/symptoms, what you were doing just before the incident, and what you did after the incident (if you need more space, write on the back of this form). Be specific-name any objects or substances involved:

Were you performing regular duties at the time of accident? ☐ Yes ☐ No

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who? ____________________

Did you report this incident to anyone? ☐ Yes ☐ No If no, why not? ____________________

If yes, to whom did you report it?:______________ Title/Position:______________ When: __________

What time did you start work today? ________ am/pm. **What time was the injury?**________am/pm ☐ Unknown

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger**):**

____

____

What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull): __________

____

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe: ____________________

____

Provided by: ____

Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?: ____________________

Where?: ______________________ If treatment was not sought immediately, explain why?: ____________

____

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury?: ______________________ By whom or where?:______________________

Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury: ____________________

Medical Release **– Under current Workers' Compensation Law, the employer is entitled to a signed medical release.** I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative. A copy of this form will serve as the original.

Employee Name (print): ______________________ **Employee Signature:** ______________________

Date (required): __________________

MUSKINGUM VALLEY EDUCATIONAL SERVICE CENTER

SUPERVISOR'S INVESTIGATION REPORT

Employee Name: ______________________ **Date of Injury:** ______________ **OSHA Log #**___________

OSHA 301 Info in Bold

Was the employee killed as a result of the accident? If yes, indicate date of death:______________________

Were there any witnesses to this injury? ☐ **Yes** ☐ **No**
If yes, witness statements should be attached.

Was the injury a result of horseplay, under the influence of drugs, or purposely self-inflicted? ☐ **Yes** ☐ **No**
If yes, please specify details on the back of this form or on another page.

Has there been any recent disciplinary action taken against this employee? ☐ **Yes** ☐ **No**
If so, please describe:

____

____

Has the employee submitted medical documentation for the injury? If so, please attach. ☐ **Yes** ☐ **No**

Was the employee treated in an emergency room or similar? ☐ **Yes** ☐ **No**

Was the employee hospitalized overnight as an in-patient? ☐ **Yes** ☐ **No**

If known, please provide us with the name, address and telephone number of attending physician and/or hospital:

Physician:_________________________________ Facility:____

_________________________________ ____

_________________________________ ____

Has the employee returned to work? ☐ **Yes** ☐ **No**
Last Day worked ____________________ Returned to work ______________

Does the employee have restrictions to duty? ☐ **Yes** ☐ **No** Applicable dates:____________________

Is the employee performing their full duties? ☐ **Yes** ☐ **No**

Was the employee given a prescription by the physician? ☐ **Yes** ☐ **No**

Employee Date of hire: _____________________

Have the conditions that caused the accident been controlled? ☐ **Yes** ☐ **No**
Describe action taken to prevent the accident in the future:____

____

With the information you have, would you recommend the claim be accepted? ☐ **Yes** ☐ **No**
If no, why? ____

Completed by:

____ _______________________________
Supervisor Signature/Title/Phone Date

____ _______________________________
Workers' Compensation Coordinator Signature Date

**Please attach completed incident reports, witness statements and any accumulated medical bills and information. Additional comments may be noted on the reverse side.

**MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER**

STATEMENT OF WITNESS TO ACCIDENT

I. INCIDENT INDENTIFICATION INFORMATION

Name of employee alleging incident: ______________________ Shift: ______________

Title/Position: ______________________ Department: ______________________

II. WITNESS STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your Name: ______________________ Your Title/Position: ______________

Your Address: ______________________ Your Phone Number: (   ) __________

____

Did you see an accident involving the above employee: ☐ Yes ☐ No

If not, how did you learn about the accident? ______________________

____

If you did see an accident occur?: Date of accident: ______________

Time of accident: ______________ ☐ am ☐ pm

Describe what you saw: ______________________

____

____

____

____

____

____

____

____

____

____

____

____

____

____

______________	______________	______________
Your Signature	**Please Print Your Name**	**Date**

**MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER**

INJURED WORKER
REPORT OF RETURN TO WORK

To: Christine Wagner, Treasurer

From: ___________________________________
(Supervisor/Principal Name)

____
(Department or Building)

The following employee has returned to work: ____.
(Employee's Name)

This employee returned to work on ___________________________________.
(Date)

This person is/has (check all that apply):

☐ Provided copies of all BWC paperwork including physician release.

☐ It has been two days since the event and the employee has not returned to work. Needs monitoring.

☐ Performing their full duties with no restrictions.

☐ Is working with restrictions.

☐ Is working their full schedule.

☐ Working a partial day for _________ hours per day during the time period from _________am/pm to ___________am/pm.

Comments:____
____
____

____
Injured Worker Signature Date

____
Supervisor/Principal Signature Date

<u>FAX TO WORKERS' COMPENSATION COORDINATOR ASAP</u>

Letter 6

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

RETURN TO WORK PLAN

To: ____

From: _____________________________ _________________________________
(Supervisor/Principal name) (Department or Building)

You are working with the following restrictions as per your physician:
____
____
____

You have been scheduled to return to work on (date) ____________________________________ at the following time:____.

The following review and briefing has occurred:
- ☐ The physician's restrictions have been reviewed and are clear to the supervisor/principal and injured worker.
- ☐ The supervisor/principal is able to provide accommodated work.
- ☐ The injured worker has been told how to get help from others or their supervisor/principal if needed.
- ☐ A review of pertinent safety policies/practices applicable to their restrictions has occurred.
- ☐ A review of pertinent Human Resources policies, including reporting off work, clocking in/out, and similar, have been reviewed.
- ☐ The Job Demand Analysis has been reviewed in conjunction with the restrictions indicated by the physician. Duties have been assigned as noted below.
- ☐ Requirements of the injured worker to work within restrictions have been clarified.
- ☐ Requirements of the supervisor/principal to only assign work within restrictions have been clarified.
- ☐ Requirement of the injured worker to immediately go to their physician's office (or emergency room) if they are leaving work because they feel that they cannot perform the work or because they feel that they may have been re-injured. Bring paperwork back to supervisor/principal.

Assigned Tasks (attach separate page if necessary):

Assigned Time Period	Assigned Duties	Evaluation/Review
		• Employee feedback
		• Employee feedback
		• Employee feedback

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

Assigned Time Period	Assigned Duties	Evaluation/Review
		• Employee feedback
		• Employee feedback
		• Employee feedback

Required follow-up date with Workers' Compensation Coordinator :__________________
Clearance: Continued Modified Duty? ☐ Full Return to Work? ☐ Date:__________________

Required follow-up date with Workers' Compensation Coordinator :__________________
Clearance: Continued Modified Duty? ☐ Full Return to Work? ☐ Date:__________________

Agreement:
I, the undersigned injured worker, agree to participate in the Transitional Work plan described herein. I agree to consider work to be performed carefully and to work within my restrictions, ask for help when work exceeds my abilities, to notify my supervisor/principal if there are duties assigned that exceed my abilities, or if I need assistance.

Signed:

_________________________________ _________________________________
Employee Date

_________________________________ _________________________________
Supervisor/Principal Date

cc: Worker's Compensation Coordinator
Supervisor/Principal file
Employee file

Letter 7

TYPES OF WAGE COMPENSATION

An employee who suffers a compensable workers' compensation injury and who is totally off from work on a temporary basis or a short period of time as a result of a work related injury or disease is eligible to receive compensation from the Bureau of Workers' Compensation. BWC offers a variety of compensation types.

A. Sick Leave Option for Compensation:

The purpose of the Sick Leave Option is to notify any eligible employee who sustains a compensable workers' compensation injury of their right to elect to use accrued Sick Leave. The injured worker must decide to use Sick Leave in lieu of compensation from the BWC.

The injured worker can, however, notify the employer of an election to stop using Sick Leave at a future date. The worker then files a request to the BWC for Temporary Total compensation accompanied by a statement from the employer as to the last day sick leave is paid. ****Refer to "Sick Leave Option Form".**

B. Wage Continuation Compensation:

Wage Continuation is recommended to expedite payment of income, eliminate hardship to injured employees, and effectively manage lost time claim costs. The process of making application for compensation from the BWC can be cumbersome with many delays.

The wage continuation in lieu of Temporary Total paid by the employer should begin in "good faith" under the assumption that a work-related injury/occupational disease occurred.

The injured worker is not required to accept Wage Continuation in lieu of Temporary total compensation. ****Refer to "*Wage Continuation Guidelines" & Option Form.***

C. Temporary Total Compensation:

Temporary Total compensation is provided to compensate an injured worker who is totally off from work on a temporary basis or a short period of time due to a work related injury or occupational disease. Temporary Total is generally the initial award of compensation paid to the injured worker to compensate for lost wages.

To qualify for the Temporary Total compensation from the Bureau of Workers' Compensation the injured worker must have MORE THAN SEVEN CALENDAR DAYS OF DISABILITY. ****Refer to the BWC's "*First Report of Injury" (FROI) Form* and choose the appropriate selection for this option.**

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EDUCATIONAL SERVICE CENTER

WAGE CONTINUATION GUIDELINES

An employee who suffers a compensable workers' compensation injury and who is totally off from work on a temporary basis or a short period of time as a result of a work related injury is eligible to receive compensation from the Bureau of Workers' Compensation. The injured worker is not required to accept Wage Continuation in lieu of Temporary Total compensation.

Wage Continuation is recommended to expedite payment of income, eliminate hardship to injured employees, and effectively manage lost time claim costs. The process of making application for compensation from the BWC can be cumbersome with many delays.

The Wage Continuation in lieu of Temporary Total paid by the employer should begin in "good faith" under the assumption that a work-related injury/occupational disease occurred.

Wage Continuation payments usually are based on the employee's base rate of pay and normally scheduled hours, not to exceed forty (40) hours per week. Employees continue to accrue sick and vacation leave while on Wage Continuation. An employee continues to receive holiday pay while on Wage Continuation. Employer contributions for retirement, health and life insurance and etc. will continue while on Wage Continuation.

Wage Continuation cannot exceed twelve (12) weeks for any one claim over the lifetime of that claim. Payments are made only for periods the employee would have been eligible for workers' compensation benefits and will be terminated upon return to work; or when twelve (12) weeks of Wage Continuation have been paid. A return to work does not eliminate eligibility for the balance of Wage Continuation in the future if re-injury or disability resumes for this claim.

An injured employee receiving Wage Continuation cannot concurrently receive, for the same period of time, other compensation (e.g. sick leave, injury leave, comp time, vacation, etc.) or Temporary Total compensation payments from the Bureau of Workers' Compensation. Wage Continuation may be paid for medical appointments documented under an approved Transitional Work Program.

If an injured worker ceases employment with the incident employer, salary continuation is no longer payable by that employer.

If BWC discovers at any time that an employer is not paying the regular (full) salary/wages, BWC will immediately begin the payment of Temporary Total or Living Maintenance compensation and set the appropriate reserves, unless the employer agrees to make the necessary adjustment to comply within 48 hours of notification by BWC.

The payment of Wage Continuation in lieu of Temporary Total is a privilege granted by BWC. Payment must continue uninterrupted following the injury.

The employer must notify BWC when the payment of Wage Continuation is discontinued and/or when the injured worker returns to work. The employer must report the return to work within 72 hours. Failure to do so may impact the employer's eligibility to participate in the Wage Continuation program.

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EDUCATIONAL SERVICE CENTER

WAGE CONTINUATION OPTION FORM

Employee Name: ____

Date of Injury: __________________________

The purpose of this document is to notify any eligible employee who sustains a compensable workers' compensation injury of their right to elect to use Wage Continuation in lieu of applying for Bureau of Workers' Compensation disability (Temporary Total compensation) benefits.

Wage Continuation can be used when there is an industrial injury.

The injured worker can, however, notify the employer of an election to stop using Wage Continuation at a future date. The worker then files a request to the BWC for Temporary Total compensation accompanied by a statement from the employer as to the last day wage continuation is paid.

To qualify for the Temporary Total compensation from the Bureau of Workers' Compensation **YOUR INJURY MUST CAUSE MORE THAN SEVEN CALENDAR DAYS OF DISABILITY.**

____
Employer

______________________ ______________________
Signature **Title**

OPTION 1	OPTION 2
I acknowledge the above and elect to RECEIVE ***WAGE CONTINUATION*** IN LIEU OF COMPENSATION FROM BWC. I also understand compensation can be elected for a period subsequent to Wage Continuation benefits but may not overlap.	I acknowledge the above and ELECT TO RECEIVE ***TEMPORARY TOTAL COMPENSATION*** FROM THE BUREAU OF WORKERS' COMPENSATION for which I may be eligible.
______________________ **Employee's Signature**	______________________ **Employee's Signature**
______________________ **Date**	______________________ **Date**

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

SICK LEAVE OPTION FORM

Employee Name: ____

Date of Injury: ______________________

The purpose of this document is to notify any eligible employee who sustains a compensable workers' compensation injury of their right to elect to use accrued Sick Leave in lieu option of applying for Bureau of Workers' Compensation disability (Temporary Total compensation) benefits.

Sick Leave can be used when there is an industrial injury.

The injured worker can, however, notify the employer of an election to stop using Sick Leave at a future date. The worker then files a request to the BWC for Temporary Total compensation accompanied by a statement from the employer as to the last day Sick Leave is paid.

To qualify for the Temporary Total compensation from the Bureau of Workers' Compensation **YOUR INJURY MUST CAUSE MORE THAN SEVEN CALENDAR DAYS OF DISABILITY.**

____
Employer

_________________________ _____________________
Signature **Title**

OPTION 1	**OPTION 2**
I acknowledge the above and elect to RECEIVE ***SICK LEAVE*** IN LIEU OF COMPENSATION FROM BWC. I also understand compensation can be elected for a period subsequent to Sick Leave benefits but may not overlap.	I acknowledge the above and ELECT TO RECEIVE ***TEMPORARY TOTAL COMPENSATION*** FROM THE BUREAU OF WORKERS' COMPENSATION for which I may be eligible.
____________________________ **Employee's Signature**	____________________________ **Employee's Signature**
____________________________ **Date**	____________________________ **Date**

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EDUCATIONAL SERVICE CENTER

JOB DEMAND EVALUATIONS

Included are the Job Demands Analyses for specific occupations within your organization. Send the appropriate form, by occupation of your injured employee, at the time of the injury, to the physician so that they may gain an appreciation of the physical demands of the position. You may also include a job description as needed.

Job Title:

1. Assistant Treasurer
2. Behavior Intervention Technician Leader
3. Computer Technician
4. Itinerant Teacher of Preschool Children with Disabilities
5. L.D. Tutor
6. Paraprofessional for Children with Multiple Disabilities
7. Paraprofessional for Preschool Children with Disabilities
8. Preschool Itinerant Teacher
9. Preschool Speech / Language Therapist
10. School Psychologist
11. Secretary
12. Teacher of Children with Disabilities
13. Teacher of Children with Multiple Disabilities
14. Teacher of Preschool Children with Disabilities
15. Technology Director

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

OUR QUALITY ASSURANCE PROCESS

Our quality assurance process has four major components as follows:

1. **Employee feedback via our satisfaction survey:**
   Frequency of evaluation: following the closure of every Vocational Rehabilitation process.
   Responsibility for tracking: Workers' Compensation Coordinator
   Outcome results: Identify deficiencies. Make corrections via Disability Management Council.

2. **Program Review:**
   Frequency of evaluation: Annual.
   Responsibility for tracking: Workers' Compensation Coordinator
   Outcome results: Identify deficiencies. Make corrections via Disability Management Council.

3. **Data Tracking:**
   Data Required: Lost time, Experience modifier
   Frequency of evaluation: Annual.
   Responsibility for tracking: Workers' Compensation Coordinator
   Outcome results: Identify deficiencies. Make corrections via Disability Management Council.

4. **Consultant Review:**
   Frequency of evaluation: Annually and as needed.
   Responsibility for tracking: Workers' Compensation Coordinator
   Outcome results: Identify deficiencies. Make corrections via Disability Management Council.

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Quality Assurance Tracking YEAR: _____

Employee Name	Return to Work Method	Outcome	Action Items From Survey
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE

User Directions (**circle or otherwise positively identify response**):

1. IW: Injured worker's name.
Job Title: Record job title at time of injury.

2. Enter the return to work method used (select only one):
   a. **M** = Modified (your internal process)
   b. **V** = Voc Rehab (the external process done with BWC providers)
   c. **B** = Both (if both methods were used)

3. Enter the outcome as follows (select only one):
   a. **SJSE** (SAME JOB-SAME EMPLOYER) Full return to work in same pre-injury position.
   b. **DJSE** (DIFFERENT JOB-SAME EMPLOYER) Full return to work in a different position with same pre-injury employer.
   c. **DJDE** (DIFFERENT JOB-DIFFERENT EMPLOYER) New position obtained outside of your organization.
   d. **None** (unable to return to work or full duty)

4. Enter negative issues/comments from satisfaction surveys. If none, state "**none**".

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

EMPLOYEE RETURN TO WORK PROGRAM SATISFACTION SURVEY

Your opinion of your care in our Return To Work process is very important to us. We want to appreciate your perspective of this process so that we may improve it if necessary. We would like you to fill out this confidential survey and return it to us. We appreciate your support in this matter.

Directions:
Please fill in the blank of the response that best fits your impressions of the service that you have received. There is space at the end, and on the back of the page, to provide us with other comments about your support.

Statement	Very Good	Good	Neutral	Poor	Very Poor
Please rate your overall ranking for our Return to Work effort.	○	○	○	○	○
Please rate your help from the employer	○	○	○	○	○
Please rate your help from the MCO	○	○	○	○	○
Please rate your help from the Nurse Case Manager	○	○	○	○	○
Please rate your help from the Voc Case Manager	○	○	○	○	○
Please rate your help from the Transitional Work Specialist	○	○	○	○	○
Please rate your help from the Supervisor	○	○	○	○	○
Please rate how you felt about your ability to come back to work <u>before</u> you started the process	○	○	○	○	○
Please rate how you felt about your ability to come back to work <u>after</u> you completed the process	○	○	○	○	○

Comments:____

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

SUPERVISOR RETURN TO WORK PROGRAM SATISFACTION SURVEY

Your opinion of our Return To Work process is very important to us. We want to appreciate your perspective of this process so that we may improve it if necessary. We would like you to fill out this confidential survey and return it to us. We appreciate your support in this matter.

Directions:
Please fill in the blank of the response that best fits your impressions of the process. There is space at the end, and on the back of the page, to provide us with other comments about your support.

Statement	N/A	Very Good	Good	Neutral	Poor	Very Poor
Please rate your overall ranking for our Return to Work effort.	○	○	○	○	○	○
Please rate your help from the workers' comp coordinator	○	○	○	○	○	○
Please rate your help from the MCO	○	○	○	○	○	○
Please rate your help from the provided forms and information	○	○	○	○	○	○
Please rate your help from the on site Case Manager	○	○	○	○	○	○
Please rate your help from the Transitional Work Specialist (P.T.)	○	○	○	○	○	○
Please rate your ability to evaluate the job for suitable modified work	○	○	○	○	○	○
Please rate how you felt about your ability to increase worker duties as they progressed in ability	○	○	○	○	○	○
Please rate how you felt about your ability to return the worker to full duty	○	○	○	○	○	○

Comments:____

____

____

____

WHAT IS TRANSITIONAL WORK?

Transitional work is a coordinated process designed to allow an employee to return to work with temporary limitations and restrictions that may prevent the employee from performing the full range of the essential functions of his or her assigned duties.

The primary goal of Transitional Work is to return the employee to his or her regular job and department. Other work within the department may be used to support the injured worker if the employee is unable to do any part of their regular job. Work outside of their immediate department can be considered if work is not available within their department.

The injured worker, their supervisor/principal, and other critical persons from the organization will jointly identify work to be performed based upon the restrictions provided by the doctor. A written plan will be created in order to insure that all parties are aware of expectations.

At the conclusion of the transitional work process the employee would likely return to full and complete duty. The physician would provide a written release to full duty as required.

This process is coordinated through our MCO, **GatesMcDonald HealthPlus, Inc.** , and is designed to support the injured worker during their return to work.

TRANSITIONAL WORK CONSIDERATION GUIDELINES

The Workers' Compensation Coordinator should consider transitional work for any injury with the following characteristics or concerns:

- The employee is unable to complete the essential functions of their position or may be unable to perform specific tasks assigned to them.
- There is a high potential for re-injury.
- The employee's job skills are, or may be, rusty due to a lengthy stay away from work due to the injury.
- Their job is expected to change while they are away during recovery.
- The employee has restrictions to duty from their doctor lasting more than one day.
- The job is, or may, challenge them ergonomically (they have a hard time doing things like lifting, bending, carrying, etc.) if they return with an injury.
- The employee has not, or may not, return to work within 7 days following their injury.
- Multiple Hospitalizations
- The employee has one of the following injuries or conditions:
    - Back or Spine
    - Head Injury (other than bumps, bruises)
    - Severe Cuts
    - Major Burns
    - Amputations
    - Major Multiple Trauma
    - Stress Claims
    - Vision Loss
    - Severe Strains

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

TRANSITIONAL WORK POLICY

Our transitional work program is designed to allow an employee to return to work with temporary limitations and restrictions that may prevent the employee from performing the full range of the essential functions of his or her assigned duties. Transitional Work is applicable to any work related injury or illness. This program applies to all employee positions and job classifications in all departments.

Transitional work is provided here under two models depending upon circumstances. The first model is the ***Modified Work Model***.

The goal of the Modified Work model is to provide simple work modifications to the employee's duties such that tasks or work is reduced, simplified, or modified in such a way so as to allow the worker to continue to be productive. These modifications shall be coordinated with the supervisor/principal, the injured worker, the Workers' Compensation Coordinator and the physician.

Employer Mission Statement: Modified Work

- Provide modified work for simple injuries when the facts suggest that the process is within our control where:
  1. The restrictions to duties are clear and understandable;
  2. The supervisor/principal can easily understand the restrictions and apply them within the duties of the employee;
  3. The injured worker understands what is expected and agrees to participate;
  4. Recovery is expected to be simple and straight-forward;
  5. There is no reasonable expectation of a case becoming a lost time case as per BWC rules.
- We will support our worker during this period.
- We will work within restrictions identified by the physician of record.

Eligibility: Modified Work

Eligibility for Modified Work occurs when:

- The employee has a BWC approved claim for an occupational injury or illness.
- The injured worker must perform less than their full and complete duties (essential functions) of their pre-injury position due to their injury.
- The employee has lost seven days or less of work over the life of the claim.
- Workers' Compensation Coordinator, the supervisor/principal, and the employee shall meet to discuss possible modifications to duty.
- All parties shall agree on the duties to be assigned.
- The employee shall be briefed on preventative safety measures, Human Resources policy, or other responsibilities.
- The employee shall be notified in writing of the duties to be performed and shall sign the document indicating agreement to the restrictions or work as noted.

Entry into Modified Work shall be accomplished as follows:

- The MCO, **GatesMcDonald HealthPlus, Inc.** shall be notified via the assigned case manager

that the employee is being considered for transitional work.
- The injured worker shall provide documentation of restrictions, along with a suitable release to duty, in writing to **Christine Wagner, Treasurer** , the Workers' Compensation Coordinator.
- The Workers' Compensation Coordinator, the supervisor/principal, and the employee shall meet to discuss possible modifications to duty.
- All parties shall agree on the duties to be assigned after reviewing the Job Demand Analysis and identifying any unique barriers.
- The written Transitional Work plan shall be developed using the *Return to Work Plan*, Letter 10.
- Prior to beginning work, the employee shall be briefed on preventative safety measures, Human Resources policy, or other responsibilities.
- The employee shall be notified in writing of the duties to be performed and shall sign the document indicating agreement to the restrictions or work as noted.

Timing and Extensions: Modified Work

Employees may be on Modified Work for up to 8 weeks with extensions granted for up to 4 weeks. Extensions shall be granted at the discretion of the employer.

Employees must provide monthly medical documentation from their treating physician regarding the status of their injury. This shall include:
- Specific diagnosis.
- Specific prognosis.
- Applicable restrictions.
- Expected date of full return to work.

Exit Guidelines: Modified Work

Employees on modified work shall continue under this plan until one or more of the following occurs:
- The employee is released to full duty by their physician.
- The employee loses eight or more days of work under this claim and the need for Vocational Case Management is indicated.
- The employee removes himself/herself from duty.

The second model is the ***Vocational Rehabilitation/Transitional Work* Model**.

The goal of the Vocational Rehabilitation model is to provide a coordinated return to work using services provided through the BWC for complex cases involving serious injury, complicated ergonomics, or complex work modifications to the employee's duties. These modifications shall be coordinated with the MCO, **GatesMcDonald HealthPlus, Inc.** , the BWC, supervisor/principal, the injured worker, the Workers' Compensation Coordinator, and the physician. Support shall also be provided through on-site vocational rehabilitation professionals.

Employer Mission Statement: Vocational Rehabilitation/Transitional Work
- Provide a coordinated return to work for complex injuries when the facts suggest that the process is not within our control where:

1. The restrictions to duties are complex or unclear;
2. The supervisor/principal cannot easily understand the restrictions and apply them within the

duties of the employee;
3. The injured worker is uncertain or fearful about what is expected;
4. Recovery is expected to be complex or may require significant support for the injured worker; or;
5. Multiple injuries or claims are present.

- We will support our injured worker during this period.
- We will assign work within restrictions assigned by the physician.
- We will provide support within the guidelines and framework provided by the Ohio BWC.

Eligibility: Vocational Rehabilitation/Transitional Work

General eligibility for Vocational Rehabilitation occurs when:

- The employee has a BWC approved claim for an occupational injury or illness.
- The employee has lost eight or more days of work over the life of the claim.
- The employee's medical condition is stable.
- The MCO and BWC approve vocational rehabilitation.

Entry: Vocational Rehabilitation/Transitional Work

Entry into Vocational Rehabilitation/Transitional Work shall be accomplished as follows:

- The injured worker, employer, MCO **(GatesMcDonald HealthPlus, Inc.**), or physician requests Vocational Rehabilitation.
- The MCO responds by requesting Vocational Rehabilitation from the BWC. If approved the MCO makes contact with the Vocational Nurse Case Manager.
- The Vocational Case Manager will contact the injured worker, the physician, and the employer to develop a coordinated and supportive return to work plan.
- The Workers' Compensation Coordinator shall notify the injured worker's supervisor/principal before starting that the employee is being considered for Transitional Work. Potential duties shall be determined by the supervisor/principal and reported to the Workers' Compensation Coordinator.
- The Vocational Case Manager will determine the best course of action to be followed for the individual injured worker. A written plan will be developed, signed by the employee and the injured worker, and finally approved by the MCO.

Special Entry Criteria: Vocational Rehabilitation/Transitional Work

In some circumstances there are additional requirements that must be completed to gain authorization for Vocational Rehabilitation / Transitional Work. These circumstances vary with the situation and should be considered as required for each case. The situations that apply to our organization are:

1. The employee is off work, has lost 8 days of work, and has received Temporary Total payments from the BWC: The Workers' Compensation Coordinator will verbally request Vocational Rehabilitation from the BWC if desired. No additional requirements apply.
2. The employee is off work, has lost 8 days of work, and has used Sick Leave in lieu of Temporary Total payments from the BWC: Using Letter 1 from Section 12 entitled "Request for Vocational Rehabilitation", send to the MCO.
3. The employee is off work, has lost 8 days of work, and has used wage continuation in lieu of temporary total payments from the BWC: Using Letter 1 from the 'Forms' folder entitled "Request Vocational Rehabilitation", send a copy to the MCO.

4. The employee is back at work, has lost 8 days of work against this claim, and is having difficulty doing the full range of their duties and is in danger of losing their job: Using Letter 2 from Section 12 entitled "Employer Request for Job Retention Vocational Rehabilitation", send to the MCO. Note that the injured worker's physician must also send Letter 3, "Physician Request for Job Retention Vocational Rehabilitation" to the MCO.

Timing and Extensions: Vocational Rehabilitation/Transitional Work

Employees may be on Vocational Rehabilitation/Transitional Work for up to 8 weeks with extensions granted for up to four weeks. Extensions shall be granted at the discretion of the MCO and the BWC. Transitional work will generally consist of a work week or other normally worked time period.

Exit Guidelines: Vocational Rehabilitation/Transitional Work

Employees on Vocational Rehabilitation/Transitional Work shall continue under this plan until one or more of the following occurs:

- The employee is released to full duty by their physician.
- The employee refuses to participate.
- The employee removes himself/herself from duty.
- The employee is not making adequate progress in their recovery and the plan is shifted to look for a new position within the employee's restrictions.
- The supervisor/principal should complete a Return to Work Report by using Letter 9 from the Section 12 entitled "Supervisor Report of Return to Work."

Outcome Measurements: All Models

No matter which model is used, the outcome will be measured by the following criteria:

1. Did the employee return to their full duties?
2. Was the injured worker satisfied with the process? This information will be determined by using Letter 13 from Section 12 entitled "Employee Return to Work Program Satisfaction Survey."
3. Was the supervisor/principal satisfied with the process? This information will be determined by using Letter 14 from the Section 12 entitled "Supervisor Satisfaction Survey."
4. Determination as to whether there was lost time saved as a result of this effort? Information obtained shall be shared with the Disability Management Council for review and follow-up action, where needed.

Pay

Employees participating in Transitional Work shall receive full pay for the period based upon average wages paid at the time of the injury.

Refusal To Participate

Participation in Transitional Work is optional. If, however, a valid offer to return to work is made, and it is supported with objective medical information to suggest that the return is possible, then the employee is expected to return to work.

End of Transitional Work Options: Unable to Return to Full Duties

In the event that an employee completes their Transitional Work period under either model and they are not able to return to their full duties then the following applies:

1. New positions will not be created.
2. If possible, accommodations within restrictions will be offered as per present ADA guidelines.
3. If accommodations are not possible, other open positions may be considered if the criteria for qualification are met for the position. No special privilege will be offered over other employees seeking the same position.
4. If the employee is unable to move to a position then the employee may, at the discretion of the employer, be medically separated.
5. If the employee has been participating in a BWC approved Vocational Rehabilitation Plan then the employee may be eligible for job search, retraining, or other vocational support. However, this support is provided at the discretion of the BWC and cannot be guaranteed.

Dispute Resolution

In the event of a dispute about the Transitional Work effort the employee may request assistance of the Disability Management Council. If the dispute cannot be resolved then the employee may, at any time, file for appeal or engage in other existing dispute resolution processes of the MCO, BWC, Industrial Commission, or present union agreements. Union agreements, when in place, shall not be waived or replaced by this policy.

Education

Education for our employees shall occur as follows:

1. Key Leaders. Key leaders shall be identified as members of the Disability Management Council. They shall be instructed on:
   - The overall plan
   - How it is applied
   - What their role is and how they shall participate.
2. Supervisors/Principals. They shall be instructed on:
   - The overall plan
   - How it is applied
   - What their role is and how they shall participate.
3. Employees. They shall be instructed on:
   - The overall plan
   - How it is applied
   - What their role is and how they shall participate.

Employees and supervisors/principals shall be informed of the plan benefits before beginning Transitional Work via verbal instruction from the Vocational Case Manager, the Workers' Compensation Coordinator, and through educational brochures created during the development of this plan.

The Workers' Compensation Coordinator and the plan developer (Integrated Support Services) shall annually review the training plan. They shall determine if it is working as designed. The Workers' Compensation Coordinator shall be responsible for implementing the training plan.

Program Follow-up

The Disability Management Council shall follow-up annually to determine if the program is progressing as designed. The Council shall use the services of the developer as needed to support this effort. If the developer participates in on-going Vocational Rehabilitation plans then the annual review shall be waived as the developer will be involved more intimately with the program. Improvements, when identified, shall be implemented via the Disability Management Council and will be implemented with 60 days of notice, when possible.

Other Issues

1. Coordination with our Risk Management Plan. This program is part of our overall Risk Management Plan that includes formal accident investigation procedures, safety procedures, injury reporting requirements, MCO notification requirements, and claims management procedures.

2. Coordination with our Third Party Administrator (TPA). This program is coordinated with our TPA in order to reduce claims costs.

3. Coordination with our Managed Care Organization (MCO), **GatesMcDonald HealthPlus, Inc.** . This program is coordinated with our MCO in order to provide outstanding care for our employees.

4. Community Providers. This program is centered on the providers within our community. As such, it is designed to allow flexibility in choice of physician and therapy providers on the part of the employee and/or their physician. When possible we will use Occupational Health Clinic or Occupational Medical services where possible. However, we have selected a Vocational Rehabilitation provider, Integrated Support Services, to support our on-site efforts.

5. Our efforts will meet current ADA guidelines where applicable. No employee will be assigned to a permanent “light duty” position.

6. The employee shall use Sick Leave or other available leave when they must leave the facility to attend doctor’s appointments.

7. No overtime is permitted while on Transitional Work.

8. There is no limit to the number of employees on Transitional Work.

9. Role of the Workers’ Compensation Coordinator:
   - Provides necessary oversight of the Transitional Work Program.
   - Provides necessary coordination with the MCO, BWC, or providers.
   - Provides necessary coordination with the supervisor/principal.
   - Provides necessary support and communication with the injured worker.
   - Provides education, as needed, to support the program.

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

ADDITIONAL FORMS

The following forms are included on your computer directory and are used for the noted purposes. Your folder also includes a file called "Employer data" that is used to capture important contact information about your organization and key disability management leaders. This data is automatically appended to every letter of form found herein in order to reduce the administrative burden on you. In general, all you have to enter is the specific claimant or their claim number. You can change this data at any time and the information will be changed in your program.

1. **Letter 1: Acceptance of Restrictions from POR (Physician of Record).** This letter is used to inform the doctor that you are willing to accept the employee back to modified duty and requests that they release the employee to this modified duty.

2. **Letter 2: Employer Letter Requesting Return To Work:** used to inform your employee that there is alternative work available under Transitional Work. Send this letter via certified mail to all returning employees in order to document that you have informed them of the work that is available.

3. **Letter 3: Employer Vocational Rehabilitation Request:** used to formally notify the MCO and BWC of claim certification, wage history, request for vocational rehabilitation for an injured employee.

4. **Letter 4: Employee Personal Request Transitional Work:** use this form when some party, like the BWC, requires that the employee formally request Transitional Work support by BWC approved vendors.

5. **Letter 5: Claim Tracking Checklist:** Used to track each injured worker from the time of the injury to the time of return to work and to insure all forms and etc. are completed.

6. **Letter 6: Injured Worker Report of Return to Work:** use this form to request documentation from your supervisor that a specific employee has returned to work after being off for a work-related claim.

7. **Letter 7: Supervisor Return To Work Plan:** Use this form to develop the written plan for returning the employee back to work.

8. **Letter 8: TW Program Quality Assurance Tracking Form:** used to track feedback from the employees and the managers/supervisors concerning the quality of the Return To Work program.

9. **Letter 9: Employee Satisfaction Survey:** used to survey employees on their perceptions of the Transitional Work effort following completion of their particular case/return.

10. **Letter 10: Supervisor Satisfaction Survey:** used to survey managers and supervisors on their perceptions of the Transitional Work effort following completion of a particular case/return

11. **Letter 11: Physician Letter Announcing Program:** Use this letter to let your local physicians know that you have a Transitional Work Program in place.

12. **C-101 BWC Form – Authorization of Release Medical Information**

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

Date:

[Click **here** and type PHYSICIAN name]
[Click **here** and type PHYSICIAN ADDRESS]
[Click **here** and type PHYSICIAN city state zip]

Re: [Click **here** and type INJURED WORKER name] Claim #: [Click **here** and type CLAIM NUMBER]

SUBJECT: Physician Release to Modified Duty

Dear Doctor:

The Muskingum Valley Educational Service Center is prepared to support the return to work of the above-referenced injured worker under our BWC certified transitional work program beginning immediately upon your release. The injured worker will return to us in a very controlled process under the direction of our Return to Work team. They will return to accommodated duties under the following job title: [Click **here** and type job title]. He/she will perform the following accommodated tasks:

1.
2.
3.
4.
5.

They will be assigned work within their present restrictions and will only progress as coordinated through the Return to Work Team and your office.

The supervisor has been contacted and understands the limitations of the return. Additionally, they will be given additional instructions and support as the worker returns. When necessary, we have a relationship with an independent BWC approved vocational rehabilitation group to provide advice and support as needed.

Please sign and acknowledge your support of this return to work plan and fax the signed form back to me at the number listed below.

If you have any questions please do not hesitate to contact me at 740-452-4518 .

Sincerely,

Christine Wagner, Treasurer
Muskingum Valley Educational Service Center

Physician's Release to Return to Work:

I hereby acknowledge the return to work plan noted above and release the injured worker to perform these duties as assigned.

______________________	______________________	______________________
Physician Name (Print)	Signature	Date

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

VIA CERTIFIED MAIL

Date: 11/22/2011

[Click **here** and type employee name]
[Click **here** and type employee address]
[Click **here** and type employee city state zip]

Reference: Workers' Compensation Claim #: [Click **here** and type claim #]
Date of Injury: [Click **here** and type injury date]

Dear [Click **here** and type name]:

We have reviewed your current restrictions as indicated by your physician and we have developed an appropriate temporary modification of your present job duties. This return has been coordinated with your attending physician and is available beginning [Click **here** and type DATA] at [Click here and type time]and you should contact me to coordinate your return. You will be scheduled for [Click here and type DATA] hours per week at your current hourly rate of [Click here and type DATA]. You will perform the following duties:

1.
2.
3.
4.
5.

You may refuse Transitional Work and take available paid leave or leave without pay. If you refuse transitional work however, you may not be eligible for continued temporary total compensation from the Ohio Bureau of Workers' Compensation. If your condition changes and you are no longer eligible for transitional work, you may be eligible for temporary total compensation from the Ohio Bureau of Workers' Compensation.

We are looking forward to your return. If you have any questions or experience any difficulty performing transitional work, please advice your supervisor immediately. You have three calendar days from receipt of this letter to contact me to discuss your transitional work duties or you will have been determined to refuse this offer.

Very Truly Yours,

Christine Wagner, Treasurer
Muskingum Valley Educational Service Center

ق I accept this temporarily modified work within my current job duties/position as part of a transitional work plan and I will report to work as advised.
ق I choose not to accept a temporary modified work position as part of a transitional work plan. I acknowledge that my refusal may result in discontinuation of my compensation benefits through workers' compensation.

Employee Signature: ____________________________ Date: ______________________

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

Date of Request: 11/22/2011

To: GatesMcDonald HealthPlus, Inc.
Vicki Bechtel, R.N.

From: Christine Wagner, Treasurer
Muskingum Valley Educational Service Center

SUBJECT: Vocational Rehabilitation Referral Request

Regarding: Injured Worker: [Click **here** and type name] Claim #: [Click **here** and type claim number]

We are requesting that you immediately request authorization to begin vocational rehabilitation services. Please note the following statements concerning this request:

4. We certify the claim.
5. We believe that there is a high likelihood that, with this support, the injured worker will return to their pre-injury position.
6. The injured worker is using Temporary Total wages from the BWC, or we certify that we have continued their wages, or we certify that they are using sick leave.

Please assign our case, and all subsequent cases, to Integrated Support Services. You may contact them at 740-965-9407. The assigned case manager is to be John P. Goodman, RN, BSN, COHN-S/CM, provider number 274606030-00, unless otherwise directed. We request that you send our preferred provider an authorizing email as soon as assigned from the BWC (info@issids.com) so that these services are not delayed.

Thank you for your kind attention in this matter and for your continued support of our injured workers.

If there is any expected delay longer than three days to process this request please inform me personally as to the barrier.

______________________________ ______________________
Signature Title

____
Date

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

Date:

GatesMcDonald HealthPlus, Inc.
P.O. Box 182720
Columbus, Ohio 43218

Subject: Vocational Rehabilitation Referral Request

RE: [Click **here** and type worker's name]
Claim # [Click **here** and type claim number]

Dear GatesMcDonald HealthPlus, Inc. :

I am requesting vocational rehabilitation services to assist my recovery to my pre-injury position. Therefore, pursuant to BWC rules, I am requesting that you immediately request authorization to begin vocational rehabilitation services from the BWC.

Please assign my case to Integrated Support Services You may contact them at 740-965-9407. The assigned case manager is to be John P. Goodman, RN, BSN, COHN-S/CM, provider number 274606030-00, unless otherwise directed.

Thank you for your kind attention in this matter and for your continued support during my recovery.

Respectfully,

[Click **here** and type name]
Muskingum Valley Educational Service Center

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

CLAIM TRACKING CHECKLIST

Demographic Information:

Injured Worker: ______________________ Title/Position: ________________________

Department: ________________________ Date of Injury: ________________________

Claim #: ___________________________ Injury:_____________________________

Tracking Items:

►ACCIDENT REPORTING FORMS:

Employee Incident/Accident Report Completed:	☐ Yes	☐ No	Date: _____
Back Injury Incident/Accident Report Completed:	☐ Yes	☐ No	Date: _____
Supervisor's Investigation Report Completed:	☐ Yes	☐ No	Date: _____
Witness Statement Form Completed:	☐ Yes	☐ No	Date: _____
First Report of Injury (FROI) Form Received:	☐ Yes	☐ No	Date: _____
Managed Care Organization (MCO) Notified:	☐ Yes	☐ No	Date: _____
Third Party Administrator (TPA) Notified:	☐ Yes	☐ No	Date: _____
Claim Certified or Denied:	☐ Certified	☐ Denied	
Scheduled Return to Work Date:	Date: _________________		
Actual Return to Work Date:	Date: _________________		
Supervisor Report of Return to Work Received:	☐ Yes	☐ No	Date: _____
Return to Work Plan Developed and Received:	☐ Yes	☐ No	Date: _____

►Preliminary Outcome:

Full Return to Work with No Restrictions:	☐ Yes	☐ No	Date: _____
Return to Work with Restrictions:	☐ Yes	☐ No	Date: _____

►Final Outcome:

Full Return to Work:	☐ Yes	☐ No	Date: _____
Accommodated in Position:	☐ Yes	☐ No	Date: _____
New Position:	☐ Yes	☐ No	Date: _____
New Outside Job:	☐ Yes	☐ No	Date: _____
Medical Discharge:	☐ Yes	☐ No	Date: _____

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

INJURED WORKER
REPORT OF RETURN TO WORK

To: Christine Wagner, Treasurer

From: ________________________________
(Supervisor/Principal Name)

____
(Department or Building)

The following employee has returned to work: ____.
(Employee's Name)

This employee returned to work on ________________________________.
(Date)

This person is/has (check all that apply):

☐ Provided copies of all BWC paperwork including physician release.

☐ It has been two days since the event and the employee has not returned to work. Needs monitoring.

☐ Performing their full duties with no restrictions.

☐ Is working with restrictions.

☐ Is working their full schedule.

☐ Working a partial day for _________ hours per day during the time period from _________am/pm to ___________am/pm.

Comments:____
____
____

____
Injured Worker Signature Date

____
Supervisor/Principal Signature Date

<u>**FAX TO WORKERS' COMPENSATION COORDINATOR ASAP**</u>

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

RETURN TO WORK PLAN

To: ____

From: ____________________________ ______________________________
(Supervisor/Principal name) (Department or Building)

You are working with the following restrictions as per your physician:

____
____
____

You have been scheduled to return to work on (date) __________________________________ at the following time:______________________________________.

The following review and briefing has occurred:

☐ The physician's restrictions have been reviewed and are clear to the supervisor/principal and injured worker.

☐ The supervisor/principal is able to provide accommodated work.

☐ The injured worker has been told how to get help from others or their supervisor/principal if needed.

☐ A review of pertinent safety policies/practices applicable to their restrictions has occurred.

☐ A review of pertinent Human Resources policies, including reporting off work, clocking in/out, and similar, have been reviewed.

☐ The Job Demand Analysis has been reviewed in conjunction with the restrictions indicated by the physician. Duties have been assigned as noted below.

☐ Requirements of the injured worker to work within restrictions have been clarified.

☐ Requirements of the supervisor/principal to only assign work within restrictions have been clarified.

☐ Requirement of the injured worker to immediately go to their physician's office (or emergency room) if they are leaving work because they feel that they cannot perform the work or because they feel that they may have been re-injured. Bring paperwork back to supervisor/principal.

Assigned Tasks (attach separate page if necessary):

Assigned Time Period	Assigned Duties	**Evaluation/Review**
		• Employee feedback
		• Employee feedback
		• Employee feedback

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

Assigned Time Period	Assigned Duties	Evaluation/Review
		• Employee feedback
		• Employee feedback
		• Employee feedback

Required follow-up date with Workers' Compensation Coordinator :__________________
Clearance: Continued Modified Duty? ☐ Full Return to Work? ☐ Date:___________________

Required follow-up date with Workers' Compensation Coordinator :__________________
Clearance: Continued Modified Duty? ☐ Full Return to Work? ☐ Date:___________________

Agreement:
I, the undersigned injured worker, agree to participate in the Transitional Work plan described herein. I agree to consider work to be performed carefully and to work within my restrictions, ask for help when work exceeds my abilities, to notify my supervisor/principal if there are duties assigned that exceed my abilities, or if I need assistance.

Signed:

_________________________________ _____________________________
Employee Date

_________________________________ _____________________________
Supervisor/Principal Date

cc: Worker's Compensation Coordinator
Supervisor/Principal file
Employee file

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

Quality Assurance Tracking YEAR: _____

Employee Name	Return to Work Method	Outcome	Action Items From Survey
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE
IW: Job Title:	M V B	**SJSE** **DJSE** **DJDE** **NONE**	NONE

User Directions (**circle or otherwise positively identify response**):

1. IW: Injured worker's name.
   Job Title: Record job title at time of injury.
2. Enter the return to work method used (select only one):
   a. **M** = Modified (your internal process)
   b. **V** = Voc Rehab (the external process done with BWC providers)
   c. **B** = Both (if both methods were used)
3. Enter the outcome as follows (select only one):
   d. **SJSE** (SAME JOB-SAME EMPLOYER) Full return to work in same pre-injury position.
   e. **DJSE** (DIFFERENT JOB-SAME EMPLOYER) Full return to work in a different position with same pre-injury employer.
   f. **DJDE** (DIFFERENT JOB-DIFFERENT EMPLOYER) New position obtained outside of your organization.
   g. **None** (unable to return to work or full duty)
4. Enter negative issues/comments from satisfaction surveys. If none, state "**none**".

MUSKINGUM VALLEY EDUCATIONAL SERVICE CENTER

EMPLOYEE RETURN TO WORK PROGRAM SATISFACTION SURVEY

Your opinion of your care in our Return To Work process is very important to us. We want to appreciate your perspective of this process so that we may improve it if necessary. We would like you to fill out this confidential survey and return it to us. We appreciate your support in this matter.

Directions:
Please fill in the blank of the response that best fits your impressions of the service that you have received. There is space at the end, and on the back of the page, to provide us with other comments about your support.

Statement	Very Good	Good	Neutral	Poor	Very Poor
Please rate your overall ranking for our Return to Work effort.	○	○	○	○	○
Please rate your help from the employer	○	○	○	○	○
Please rate your help from the MCO	○	○	○	○	○
Please rate your help from the Nurse Case Manager	○	○	○	○	○
Please rate your help from the Voc Case Manager	○	○	○	○	○
Please rate your help from the Transitional Work Specialist	○	○	○	○	○
Please rate your help from the Supervisor	○	○	○	○	○
Please rate how you felt about your ability to come back to work before you started the process	○	○	○	○	○
Please rate how you felt about your ability to come back to work after you completed the process	○	○	○	○	○

Comments:____

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MUSKINGUM VALLEY EDUCATIONAL SERVICE CENTER

SUPERVISOR RETURN TO WORK PROGRAM SATISFACTION SURVEY

Your opinion of our Return To Work process is very important to us. We want to appreciate your perspective of this process so that we may improve it if necessary. We would like you to fill out this confidential survey and return it to us. We appreciate your support in this matter.

Directions:
Please fill in the blank of the response that best fits your impressions of the process. There is space at the end, and on the back of the page, to provide us with other comments about your support.

Statement	N/A	Very Good	Good	Neutral	Poor	Very Poor
Please rate your overall ranking for our Return to Work effort.	○	○	○	○	○	○
Please rate your help from the workers' comp coordinator	○	○	○	○	○	○
Please rate your help from the MCO	○	○	○	○	○	○
Please rate your help from the provided forms and information	○	○	○	○	○	○
Please rate your help from the on site Case Manager	○	○	○	○	○	○
Please rate your help from the Transitional Work Specialist (P.T.)	○	○	○	○	○	○
Please rate your ability to evaluate the job for suitable modified work	○	○	○	○	○	○
Please rate how you felt about your ability to increase worker duties as they progressed in ability	○	○	○	○	○	○
Please rate how you felt about your ability to return the worker to full duty	○	○	○	○	○	○

Comments:____

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MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

To: [Click **here** and type name]

Re: Transitional Work Availability

Dear Sirs:

Muskingum Valley Educational Service Center would like to inform you that we have developed a transitional work program for our injured workers. Our program has been developed with these objectives in mind:

- Facilitate a rapid response to ensure our employee of our concern for their well-being and our desire to provide support during this period;
- Coordinate with providers who support our efforts;
- Provide outstanding vocational services at the worksite;
- Reduce employee frustration following workplace injuries;
- Provide our employee with the best chance to return to full and productive employment; and,
- Provide suitable support in the event that they cannot return to their pre-injury position.

Your support in this effort is critical. Please keep our program in mind as you work with our injured workers. To assist you, we have developed a relationship with an independent third party vocational rehabilitation group to ensure that our employees return within a structured process designed to ensure close cooperation with you, the supervisor, our MCO, **GatesMcDonald HealthPlus, Inc.** , and the BWC. The process is structured to ensure that your needs and concerns are met through careful coordination with you before we start and frequent updates as transitional work proceeds.

If you have any questions we would be happy to discuss our program with you. Please do not hesitate to contact us.

Sincerely,

Christine Wagner, Treasurer
Muskingum Valley Educational Service Center
205 North Seventh Street
Zanesville, Ohio 43701
Phone: 740-452-4518
Fax: 740-455-6702

GRANT

APPLICATION

PAPERWORK

MISCELLANEOUS

EDUCATION

TOOLS

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

TRANSITIONAL WORK PROGRAM ANNOUNCEMENT

We are implementing a Transitional Work Program under a grant from the Ohio Bureau of Workers' Compensation. This program is designed to help ease you back to work following a workplace injury. It is a highly coordinated process that involves working with your chosen physician, your supervisor/principal, our Managed Care Organization and other BWC certified specialists.

Our Transitional Work Program Goals

We are committed to the support of our employees. Implicit in this support is the requirement that we provide a safe workplace for our employees. We recognize workplace accidents may, in spite of our efforts, still occur. Therefore, we have developed our Transitional Work Program to provide the following support:

- Facilitate a rapid response to assure employees of our concern for their well-being and the desire to provide support during this period;
- Coordinate with providers to support rehabilitative efforts;
- Provide support for injured workers and supervisors/principals at the worksite;
- Reduce employee frustration following workplace injuries;
- Provide our employees with the best chance to return to full and productive employment;
- Provide suitable support in the event that the injured employee cannot return to their pre-injury position; and,
- Reduce lost time through efficient management of the injury support process and effectively lowering our Workers' Compensation insurance rates.

The Transitional Work Program is designed to benefit you and the Company. In the event that you do become injured we will provide you with additional information that describes the support available to you and to your family.

For more information please contact the Workers' Compensation Coordinator.

MUSKINGUM VALLEY
EDUCATIONAL SERVICE CENTER

Employee's Guide to Roles and Responsibilities within the BWC Rehabilitation Process

Who Does What?
The Ohio Workers' Compensation process can seem complicated and confusing. We have created this guide to help you understand how the system works and to introduce you to some of the people that you might meet during your recovery process.

The Ohio Bureau of Workers' Compensation
The Ohio Bureau of Workers' Compensation (BWC) is a state agency with responsibility to set guidelines and procedures for workers' compensation claims. As a state agency, they set policy, collect premiums, and monitor the workers' compensation process here in Ohio.

The BWC is the final authority as to whether or not your claim is approved or disapproved. They also make determination as to whether temporary total benefits are paid to you.

There are two people you might meet from the BWC during a typical claim. The first is the Claims Service Specialist, who is over-seeing the claims process. The second person is the Disability Management Coordinator, who is the BWC person assigned responsibility to approve or disapprove vocational rehabilitation requests.

The BWC has assigned the day-to-day responsibility to manage your claim to an MCO.

Managed Care Organization (MCO)
In an effort to improve service to injured workers the BWC has established MCO's to help injured workers. The MCO has three basic functions. They are to medically manage your claim, approve services and pay providers, and manage the paperwork associated with the claim.

We have selected our MCO from a list of approximately 35 certified MCO's authorized by the BWC to work with our injured employees. Our MCO is **GatesMcDonald HealthPlus, Inc.** .

At the time of your injury you will be assigned to a Medical Case Manager. This nurse will work with you to get you appropriate care, make sure that services requested by your doctor are approved, and will be your first line of support following your injury. If you are having difficulty you should contact your Medical Case Manager. Also, our MCO will be providing you with an identification card that may include your claim number. You should carry this card with the claim number to all of your appointments.

Industrial Commission
The Industrial Commission holds hearings when the claim, or any part of your care, is contested. A hearing is where any evidence that you, your representative, your employer, or their representative may be presented to the Industrial Commission. There are multiple steps to this process to contest decisions about the claim.

Third Party Administrator (TPA)
A Third Party Administrator is an organization hired by the employer to manage the claims. They assist the employer in making a determination as to whether to contest a claim or specific care that you have received. They also assist the employer in keeping costs under control by administering group programs where other employers like yours pool their claims together. The TPA represents the employer at hearings.

Bureau of Vocational Rehabilitation (BVR)
In the event that you are seriously injured and you require significant assistance to recover then the BVR will assist you. They may provide tools, equipment, training, or other support as based upon your identified need.

Providers
Certified providers who have been approved by the BWC to accept workers' compensation clients provide all medical, rehabilitative, or therapeutic care. These providers may include your doctor, your chiropractor, your physical therapist, and many other medical and vocational specialists.

All care provided to you for a work-related injury must be provided by BWC certified providers. There is, however, one exception. Your first visit to a doctor, hospital, or clinic for immediate care can be made to any provider, but all follow-up care must be made with BWC certified providers.

How do you know if your doctor or other provider is certified? The MCO maintains a list of all certified providers. Also, you may look up what providers are certified in your area by logging onto the BWC website at **www.ohiobwc.com** and going to "Provider Lookup". If in doubt, ask your provider.

Other Providers
We have a unique relationship with other providers who are available to support you right here in our organization. These providers are vocational rehabilitation specialists who are experts in helping you come back to work. They have helped us create our Transitional Work Program and will also help you return to work safely and effectively if your case is complicated or if your injury is severe.

Once it has been determined by the MCO Medical Case Manager or by our organization that you may require outside assistance in returning to work, then you will be assigned a Vocational Case Manager to coordinate your care. This nurse specialist will work with you, your physician, and our organization to create a plan to return you to work.

The Vocational Case Manager will enlist the support of other specialists to assist you. One such person is the Physical Therapist who will identify your present physical abilities, come to the workplace to review your job requirements, and will then create a customized plan to help you come back to work. The vocational case manager and the physical therapist act as a team to assist you.

The physical therapist may later act as a Transitional Work Specialist. Armed with the special knowledge of you and our workplace, the Transitional Work Specialist will assist you in returning to work. He or she shall be right with you on the day you come back, and will be with you periodically from then until your return is complete.

Our Internal Support Structure
Once we have determined that we will accept the claim for an injury we will move quickly to provide support to you through our selected MCO, vocational rehabilitation providers, and through our own internal systems.

We have created a Disability Management Council to assist us with our Transitional Work Program. The Disability Management Council is lead by the Workers' Compensation Coordinator, from our organization and (also includes union representatives where applicable) and our Department Managers. This council has the following responsibilities:

- Review our program annually;
- Respond to concerns of the injured worker;
- Coordinate care with providers here at the workplace;
- Coordinate return to work with department managers and supervisors; and,
- Provide other support as needed.

The injured worker and their immediate supervisor, along with our vocational rehabilitation providers, will act as a team to facilitate the return to work process. In other words, you are not alone.

Ultimately, we want you to return to work safely, enjoy recovery from your injuries, and be able to take care of your family for years to come.