HWCF

managed by Inspirien

HEALTHCARE WORKERS' COMPENSATION FUND HANDBOOK

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INTRODUCTION

The purpose of this Healthcare Workers' Compensation Fund Handbook is to provide you, the members, with information, initiate procedures, and clarify existing policies which will enable us to more effectively handle your workers' compensation claims. We hope this will be a useful resource when processing workers' compensation claims for your facility.

Included in this packet are definitions of workers' compensation terms, policies and claim procedures. While many of you have experience in the workers' compensation process, we hope that this information will answer many questions you may have, as well as serve as a reference guide. Also enclosed is a sample First Report of Injury and a set of instructions for correctly completing these forms. A wage statement is also included which will serve as a reference for computing the average weekly wage of an injured employee in accordance with the State of Alabama Workers' Compensation Statute.

One procedure which we strongly believe should be initiated is the use of the Medical Authorization/Return to Work Form. We request that injured employees take these forms with them when referred to a physician. The first sample is for use when utilizing a physician gatekeeper initially following an injury. The second sample is to be used when the injured employee has already been seen in your emergency room or by a company physician and is now being referred outside your system. The physician should complete and return the bottom portion of this form indicating the date when the employee is medically able to return to work. Enclosed are sample forms for your implementation.

We hope that this reference guide will contain the answers to many questions which may arise; but we will, of course, be happy to answer any questions you may have on specific claims. A current contact list is included which should provide direction in reaching the appropriate claims representative to assist you with specific problems.

There are certain questions that are frequently asked and are in a "gray area" concerning coverage. We have attempted to establish policies regarding these questions and have included a list of these policies. Please understand, however, that the judicial system interprets the statute and their decisions become case law. Determinations on future claims will be governed by these continually changing decisions.

Thank you for your cooperation in fully and accurately reporting all on-the-job injuries and in following these procedures. Your compliance will facilitate prompt processing of benefits for your employees. We would welcome any comments or suggestions that might enable us to better serve you.

FUND CLAIMS MANAGEMENT

The Healthcare Workers' Compensation Fund (HWCF) is administered by Inspirien Holding Company (IHC). The claims department seeks to maintain a mutually beneficial relationship with our members by providing a resource for information on workers' compensation coverage and a cost-effective claims management program.

The IHC claims staff assigned to HWCF consists of a team of dedicated and experienced claims professionals. Each Fund member will be assigned a specific claims representative to service workers' compensation claims for their facility and to be available for consultations.

Fund claims management incorporates claims investigation, research of Statute and case law, medical management, monitoring of benefits, assessment of settlement potential, and litigation management to provide a comprehensive cost-efficient program.

Educational programs and materials that are related to workers' compensation issues are made available to Fund members. In addition, the Fund claims department monitors current legal trends and attempts to address potential problems in order to minimize claim costs.

CONTACT LIST

The following list of Inspirien personnel is provided as a reference guide to facilitate communications on workers' compensation claims filed with HWCF.

Doug Hughes: Chief Operating Officer – Administrative functions over claims, risk management, legal, regulatory and compliance. Email-Dhughes@inspirien.org
Direct Line – 334-323-4108. Toll Free – 1-800-821-9605 ext. 4108.

Dawn W. Adams: Senior Vice President, Operations – Administrative functions, overall supervision of workers' compensation claims department including coverage questions, mediation, litigation process and on-site investigations. E-mail address: Dadams@hwcf.net
Direct Line - 334-323-4131. Toll Free - 1-800-821-9605 ext. 4131.

Shannon Cole: Director of Operations - Supervision of workers' compensation claims department, settlement and coverage questions, statistical reporting, specific loss data reporting, and assistance with administrative functions. E-mail address: Scole@hwcf.net
Direct Line - 334-323-4124. Toll Free - 1-800-821-9605 ext. 4124.

Debbie Moser: Workers' Compensation Claims Supervisor – Daily supervision of claims adjusters, lost time claims, litigation claims, settlement and coverage questions. E-mail address: Dmoser@hwcf.net Direct Line - 334-323-4133. Toll Free - 1-800-821-9605 ext. 4133

Tiffany Weaver: Workers' Compensation Claims Adjuster – Medical only claims, lost time claims, litigation claims, settlements and coverage questions. E-mail address: Tabbey@hwcf.net
Direct Line - 334-323-9134. Toll Free - 1-800-821-9605 ext. 8134.

J.C. Minter: Workers' Compensation Claims Adjuster – Medical only claims, lost time claims, litigation claims, settlement and coverage questions. E-mail address: Jminter@hwcf.net
Direct Line - 334-323-4125. Toll Free - 1-800-821-9605 ext. 4125.

Carol Seamon: Workers' Compensation Claims Adjuster – Medical only claims, lost time claims, litigation claims, settlements and coverage questions. E-mail address: Cseamon@hwcf.net Direct Line - 334-323-4109. Toll Free - 1-800-821-9605 ext. 4109.

Stacy McGowin: Workers' Compensation Claims Adjuster – Lost time claims, litigation claims, settlement and coverage questions. E-mail address: Smcgowin@hwcf.net
Direct Line - 334-323-4115. Toll Free - 1-800-821-9605 ext. 4115

Felicia Hardman: Workers' Compensation Claims Coordinator – Administrative and clerical support for workers' compensation claims. E-mail address: Fhardman@hwcf.net
Direct Line – 334-323-9136. Toll Free – 1-800-821-9605 ext. 4137

Teresa Fields: Risk Management/Loss Control Consultant – Classes, surveys and loss control assistance. E-mail address: Tfields@inspirien.net Direct Line-334-323-4118.
Toll Free-1-800-821-9605 ext. 4118.

DEFINITIONS

There are several definitions used in workers' compensation that we would like to call to your attention. These definitions are found in Article I, The General Provisions, Section 25-5-1 of the Alabama Workers' Compensation Statute.

A. **Accident.** The law provides a broad definition of the term accident. The key words are:

1. unexpected or unforeseen event,

2. happening suddenly and violently,

3. with or without human fault,

4. producing at the time injury to the physical structure of the body or damage to an artificial member of the body by accidental means.

B. **Authorized Treating Physician** - The physician and subsequent referral physicians selected by the employer to provide treatment to the injured worker or the physician the employee selects from a panel of four physicians.

C. **Average Weekly Wage** - An employee's average weekly wage is based on a gross average of the employee's wages for the 52 week period prior to the date of injury.

D. **Compensation.** Compensation, also known as indemnity, means the money paid for an on-the-job injury or death. This is payable in various forms:

1. Temporary Total Disability,

2. Temporary Partial Disability,

3. Permanent Partial Disability,

4. Permanent Total Disability, and

5. Death Benefits.

These will be covered in more detail later.

E. **Date Employer Notified -** The first day that the employer (supervisor, manager, etc.) was notified either orally or in writing that an on-the-job injury/illness occurred.

F. **Date of Disability –** The first day that the employee lost time without pay due to an injury/illness.

G. **Date of Injury -** The date that the alleged injury occurred. The date of injury for cumulative trauma injuries and occupational disease shall be the date of last injurious exposure to the activity alleged to have caused the injury/occupational disease.

H. **Defendant** – The party who is named in a lawsuit or required to answer a complaint in litigation.

I. **Dependent** - The employee's surviving spouse or dependent children.

J. **Dependent Children** - An unmarried child under the age of 18 years or one over that age who is physically or mentally incapacitated from earning.

K. **Employee or Worker.** These terms include every person in the service of another under any contract of hire, express or implied, oral or written, including aliens and minors who are legally permitted to work under the laws of the State. In 1977, an Alabama Court of Civil Appeals case set out a test to determine whether the job caused the injury. The test is:

"If in the performance of his job, he has to exert or strain himself or is exposed to conditions of risk or hazard and he would not have strained or exerted himself or been exposed to such conditions had he not been performing his job and the exertion or strain or the exposure to the conditions was, in fact, a contributing cause to his injury or death, the test whether the job caused the injury or death is satisfied."

L. **Employer.** Includes any person, corporation, co-partnership, association, or group who employs five or more people (Section 25-5-50) to perform a service for hire and pays wages directly to these people. If the employer is insured, such insurer shall be entitled to the employer's rights, immunities, and remedies under the workers' compensation law. This term also includes a service company for a self-insurer.

M. **Employer's First Report of Injury Form -** The method used by employers to report worker related injuries/illness.

N. **Fund Member** - Any employer who is a member of a group self-insured fund. Each fund member is assigned a group self-insured number by the Department of Labor.

O. **Injury.** Injury or personal injury shall mean only injury by accident "arising out of and in the course of employment". Injury shall include physical injury caused either by carpal tunnel syndrome disorder or by other cumulative trauma disorder if either disorder 'arises out of and in the course of the employment", and breakage or damage to eyeglasses, hearing aides, dentures, or other prosthetic

devices which function as part of the body, when injury to them is incidental to an on-the-job injury to the body.

Changes in the Alabama Workers' Compensation Statute in 1992 clarify – "**Injury does not include a mental disorder or mental injury that has neither been produced nor been proximately caused by some physical injury to the body**."

The key phrases "arising out of" and "in the course of employment" have led to numerous court decisions. One thing that the courts have agreed upon is that both terms must be satisfied in order for compensation to be paid. The courts have recognized that while an accident can "arise out of employment", it is not necessarily true that it occurs "in the course of employment". The phrase "arising out of" involves the idea of a causal relationship between the employment and the injury, and refers to employment as the source and cause of the accident. The phrase "in the course of employment" generally refers to time, place, and circumstances of accident.

P. **Jurisdiction -** This is the Circuit Court in the county in which the claim occurred, where the injured employee resides, or where the employee regularly conducts business.

Q. **Lawsuit -** A court action by an injured worker or their legal representative against a member.

R. **Mediation** - A voluntary attempt to bring about a peaceful settlement between parties through the non-bidding intervention by a neutral party. Mediations may be conducted by a State of Alabama Ombudsman or a paid mediator.

S. **Occupational Disease -** A disease arising out of and in the course of employment which is due to hazards in excess of those ordinarily incident to employment in general and is peculiar to the occupation in which the employee is engaged.

T. **Ombudsman.** An individual who assists injured or disabled employees, persons claiming death benefits, employers, and other persons in protecting their rights and obtaining information available under the Workers' Compensation Statute.

U. **Plaintiff–** The party who files the lawsuit to obtain a remedy for a dispute or the complaining party in litigation.

V. **Providers** - A medical clinic, pharmacist, dentist, chiropractor, psychologist, podiatrist, physical therapist, pharmaceutical supply company, rehabilitation service, or other person or entity providing treatment, service, or equipment, or person or entity providing facilities at which the employee receives treatment.

W. **Statute of Limitations** - A law which sets out the maximum time that parties have to initiate legal proceedings from the date of an alleged offense. All claims for compensation shall be barred unless within two years from the date of the accident a verified complaint is filed in the courts. Where payments of

compensation have been made, such complaint must be filed within two years from the date of the last compensation payment.

X. **Subrogation -** The right for an insurer to pursue a third party that caused an insurance loss to the insured. This is done as a means of recovering the amount of the claim paid to the insured for the loss. The workers' compensation statute allows for subrogation of compensation and medical payment only.

Y. **Wages or Weekly Wages** - The terms shall in all cases be construed to mean "average weekly earnings", based on those earnings subject to federal income taxation and reportable on the Federal W-2 tax form which shall include voluntary contributions made by the employee to a tax-qualified retirement program, voluntary contributions to a Section 125 cafeteria program, and fringe benefits as defined herein. Average weekly earnings shall not include fringe benefits if and only if the employer continues the benefits during the period of time for which compensation is paid. "Fringe benefits" shall mean only the employer's portion of health, life, and disability insurance premiums.

Z. **Waiting Period** - There is a three (3) day waiting period following all accidents. The injured employee will not be compensated for these days until the worker has been disabled for 21 days.

CLAIM PROCEDURES

A. Prompt reporting will help to insure control over a claim. This will also allow for a timely investigation as to the compensability of the claim and will avoid a time lag in which facts may be changed. Likewise, it will limit the likelihood of attorney involvement.

B. An employee must have authorization before obtaining medical treatment. We encourage you to use the enclosed sample form or to adapt a similar form for this purpose. If the employee is aware that he/she will need authorization before receiving medical treatment, the employee is more likely to report the injury. The use of this form is very important when an employee is claiming a back injury. Too often an employee with a back injury is either referred to or allowed to go to his family physician. In most cases, it is best to refer him/her to a specialist who is trained to deal with back injuries. If an employer does not direct an employee for treatment, then the physician chosen by the employee will become the authorized physician.

C. When selecting or authorizing a physician to provide medical attention, consider the following:

1. Is the doctor cooperative?

2. Will he/she furnish timely medical reports?

3. Will he/she talk to claims adjusters, medical case managers and rehabilitation specialist?

4. Is the physician willing to release the employee to return to work when there are no objective findings to warrant continued disability?

5. Is he/she willing to review surveillance activity?

D. In accordance with State of Alabama Workers' Compensation Statute, Article 3, Section 25-5-77, if the employee is dissatisfied with the initial treating physician, he/she is entitled to select from a panel of four (4) physicians selected by the employer. In the event surgery is required and the employee is dissatisfied with the designated surgeon, he/she may select a second surgeon from a list of four (4) surgeons selected by the employer.

E. An on-the-job injury should only be reported one initial time. This can be accomplished by either completing and submitting the WCC-2, Employers' First Report of Injury or electronically filing a claim through the HWCF Portal at www.HWCF.net. After the injury has been reported, all medical bills should be submitted to our office upon receipt. In accordance with the Alabama Department of Labor Administrative Code, 480-5-5-22, all bills must be

submitted on the appropriate form and include a report of treatment rendered before we can apply benefits. Copies of all medical reports, hospital records, and work excuses should be forwarded to the Fund without delay.

F. There is a three (3) day waiting period for all accidents. On the day of the injury, if the employer pays the employee in full, then we do not consider that day. If, however, the employer does not pay him/her for the day of the accident, then we would count that day as the first day of the waiting period.

G. After the injured employee is disabled for twenty-one (21) days, then the initial three (3) day waiting period will be payable on the next installment after the expiration of the twenty-one (21) days

H. Temporary Total Disability benefits begin after the waiting period and cease when the physician states that the employee is capable of returning to his/her employment or that the employee has reached maximum medical improvement.

I. Opening notification letters are sent to the employee and employer by HWCF on all lost time claims. A sample of these letters is included in the back of the handbook.

J. Compensation benefits are 66 2/3% of the employee's average weekly wage; however, these benefits are subject to a maximum and minimum. If their average weekly wage is less than the minimum weekly benefit, then the weekly compensation rate shall be their average weekly wage. The minimum and maximum rates are changed by the Department of Labor annually on July 1st. A copy of current and past maximum and minimum rates is included the back of the handbook.

K. An employee's average weekly wage is based on a gross average of the employee's wages for the 52 week period prior to the date of injury. The Alabama Workers' Compensation Statute provides that the average weekly wage is to be based on earnings subject to federal income taxation and reportable on the Federal W-2 form, these wages are to include certain fringe benefits. These benefits should include the employer's portion of health, life and disability insurance premiums only if they are **not** continued during the period of disability. A sample of the wage statement is included in the back of the handbook.

L. Effective January 1, 1993, Section 37, 38 and 39 of the Alabama Workers' Compensation Statute provides for an alternative to the courts by providing a mediation program to settle disputes on claims that may arise between the employer and employee in the handling of a workers' compensation claim. Mediators who are called "Ombudsmen" conduct benefit review conferences to mediate disputes. These are Merit System State employees. They are trained in mediation and workers' compensation law. Mediation is not mandatory. Settlements reached under this process are not required to be court approved but may be taken by either party to the court for final approval. The telephone

number for contacting an Ombudsman is 1-800-528-5166. The Fund has found this process to be very beneficial in the resolution of disputes and in the settlement of claims.

M. When the injured employee returns to employment, either light duty or normal duty, please contact our office and advise us. Whenever an employee returns to work, it is very important that we know the exact date the doctor released him/her as medically able to return to work, as well as the exact date they return. We also need to know if the release is with restrictions and whether the employee is returning to work at his/her pre-injury rate of pay.

TIME REQUIREMENTS

INDEMNITY

A. The Alabama Workers' Compensation Statute, Article 3, Section 25-5-78, states that an employee has only five (5) days to submit written notice of such accident. Written notice by the employee is not required if the employer had actual notice of such accident. Written notice within five (5) days is generally not required provided the employee promptly reports the injury. Hence, the employer would have knowledge of the injury and would provide medical treatment. The Courts have made no distinction between verbal notice and actual knowledge, but, if **the employee does not report the injury and does not have authorization for medical treatment, he/she will be responsible for the expense of the treatment. However, no compensation will be payable unless written notice is given within ninety (90) days after the occurrence of an accident or where death results, within ninety (90) days after the death**. Please request that your department heads and supervisors report all accidents without delay.

B. Immediately after notice of an injury, the employer should complete (answering all questions) an Employer's First Report of Injury or electronically submit a claim through the HWCF Portal at www.HWCF.net. By law, Article 1, Section 25-5-4, all injuries must be reported to the Department of Labor, Workers' Compensation Division, within 15 days of injury or notice of injury. In order to comply with this requirement, we ask that all employee injuries be reported to the Healthcare Workers' Compensation Fund as soon as possible after you have knowledge of an injury. **Do not wait on medical records before filing a claim.**

C. In order to comply with this filing requirement, employers should have policies and procedures in place for reporting of accidents. Many of our member facilities require reporting during the shift in which the incident occurs or within 24–48 hours.

D. Prompt reporting by the employer also allows greater control in the areas of physician management, claims investigation, and also reduces the likelihood of attorney involvement or lawsuits.

E. Once we receive the claim it will be reviewed for compensability. Opening letters are sent to the employer and the injured employee within 24 hours of receipt for **all lost time claims**. These letters acknowledge that we have received notice of the injury and instruct the employee to contact us regarding their claim. The employee is also asked to sign a medical records release form and provide a list of all physicians that have rendered treatment to them in the past five (5) years. **Recorded statements are required on all lost time claims.** This enables us to confirm the information we have received regarding the injury along with other pertinent details from the employee that may assist in our investigation. **A**

statement from the employee is needed before we can initiate indemnity benefits. Most statements are taken by phone, but there may be occasions where we will need to take the statements in person. We will make every effort to accommodate an employee in obtaining this information. If the employee does not contact us within two (2) weeks of the opening letter, we will send another letter by certified mail to the employee advising them that if they do not contact us within two (2) weeks their claim will be denied. If within that two (2) week period the employee fails to contact us, we will send a denial letter to you, the employer, and a copy of this letter to the employee denying their claim. The same procedure applies to questionable medical only claims. A sample of these letters is included in the back of the handbook.

F. An employee's indemnity check will not necessarily coincide with your payroll. If an employee has already returned to work when we receive notice of the claim, there should be no additional delay in his/her payment. If, however, an employee is still off work, **his/her benefit check will not be due until the 17th day of authorized disability**.

G. State of Alabama Workers' Compensation Statute, Article 3, Section 25-5-59, provides a penalty for overdue compensation payments. This section states **if any installment of compensation payable is not paid without good cause within thirty (30) days after it becomes due, an additional ten (10) percent should be added and paid at the same time.**

I. Workers' compensation indemnity benefits are also subject to a Statute of Limitations. Article 3, Section 25-5-80, Alabama Workers' Compensation Statute, states that **all claims for compensation will be forever barred unless within two (2) years from injury, parties shall have agreed upon compensation payable or shall have filed a verified complaint**. If indemnity has been paid, **the Statute of Limitations tolls two years from the time of last payment**. The Alabama Workers' Compensation Statute, Section 25-5-52, provides for a two year Statute of Limitations for occupational disease cases to conform with the Statute of Limitations in injury cases.

PAYING COMPENSATION

After an investigation reveals a claim to be compensable, the injured employee will receive compensation which is due in accordance with the Workers' Compensation Statute.

A. **Temporary Total Disability (TTD)**: The most common form of compensation is Temporary Total Disability (TTD), which is paid at the rate of 66 2/3 percent of the employee's average weekly wage which is based on the past 52 weeks of earnings. This is payable when an employee is unable to work due to a compensable injury. There is a three (3) day waiting period. Temporary total disability payments will start on the fourth (4) day of authorized disability. If the disability exists for twenty-one (21) days, then the three (3) day waiting period will be paid. TTD is subject to a maximum and minimum weekly benefit as determined by the state every July 1st. TTD benefits will cease when the employee returns to work or when he/she reaches maximum medical improvement (MMI). There is no limit on the number of weeks TTD benefits may be paid.

B. **Temporary Partial Disability (TPD)**: Temporary Partial Disability is payable when the employee, due to injury, is restricted to light duty or limited work which results in lower wages. When this occurs, the employee will receive 66 2/3 percent of the lost earnings, or the difference between what he can earn in his partially disabled condition and what he was making prior to the injury. TPD benefits are also subject to the same maximum weekly compensation and shall not be paid beyond 300 weeks.

C. **Permanent Partial Disability (PPD)**: Permanent Partial Disability is payable if an injury results in the loss of use of a member of the body or the body itself. An impairment rating will be assigned by the treating physician. PPD benefits are paid for a maximum of 300 weeks in total benefits. PPD for injuries, other than for injuries to the body as a whole, are paid in accordance with a schedule of benefits set out in Section 25-5-57 (3) of the law. Scheduled injuries occurring on or after February 1985 are subject to maximum and minimum weekly benefits for PPD benefits. The minimum amount is determined in accordance with the average weekly wage of the state which is determined every July 1st and the maximum is the lesser of $220.00 and the employee's average weekly wage.

PPD benefits for unscheduled or body as a whole injuries are to be based on actual loss of earnings, vocational ratings, compromise basis or awarded by the Court. Unscheduled injuries are subject to a maximum weekly benefit of the lesser of $220.00 and the average weekly wage of the employee.
The Alabama Workers' Compensation Statute states that for injuries occurring on or after August 1, 1992, if an injured worker returns to work after reaching maximum medical improvement at a wage equal to or greater than his/her pre-

injury wages, he/she is entitled to a Permanent Partial Disability rating equal to his or her physical impairment. It further states that the court shall not consider any evidence of vocational disability. However, if the employee loses his/her job through no fault of his/her own within 300 weeks from date of injury, he/she may petition for vocational disability.

D. **Permanent Total Disability (PTD):** The revised definition of Permanent Total Disability, as defined in the State of Alabama Workers' Compensation Statute, provides that total and permanent loss of sight of both eyes or the loss of both arms at the shoulder or any physical injury or mental impairment resulting from an accident, which injury or impairment permanently and totally incapacitates the employee from working at and being retrained for gainful employment shall constitute prima facie evidence of PTD but shall not constitute the sole basis on which an award of PTD may be based. Various courts have ruled that Permanent Total Disability does not mean absolute helplessness, but means the inability to perform the work of one's trade or the inability to obtain reasonable gainful employment. The courts have also considered the employee's loss of ability to earn or his/her earnings capacity. The revised definition of PTD further states that "Any employee whose disability results from an injury or impairment and who shall have refused to undergo physical or vocational rehabilitation or to accept reasonable accommodation shall not be deemed permanently and totally disabled". Permanent Total Disability benefits will be payable as long as the disability exists as defined by the Workers' Compensation Statute. There is no limit as to time but benefits are subject to a maximum and minimum as determined every July 1st.

E. **Death Following Disability:** If an injury results in death and there are dependants, either a surviving spouse and/or children will receive benefits as follows:

1. One dependant – 50% of deceased employee's average weekly wage for 500 weeks.

2. Two or more dependants – a total of 66 2/3% of deceased employee's average weekly wage for 500 weeks.

As in both examples, the amount payable will be subject to a maximum and minimum compensation rate that would be in effect at the time of the accident. In addition to the benefits paid to the dependants of the deceased employee, the expense of the burial, not exceeding $3,000.00 for all claims with dates of injury prior to July 1, 2014 and $6,500 for all claims with dates of injury after this date, will also be paid.

Effective May 19, 1992 a payment of $7,500.00 is to be made to the estate of a deceased worker who had no dependants.

MEDICAL BENEFITS

A. The Workers' Compensation Statute Section 25-5-77 provides that **all undisputed medical bills shall be paid within 25 working days** of receipt of claims on the approved form and, if not paid, a 10% penalty shall be added to the amount. An administrative penalty may be assessed as well, if the employer or insurer responsible for payment fails to add the additional 10%. This penalty is not to exceed $500.00.

B. In accordance with the Alabama Department of Labor, Administrative Code Rule 480-5-5-.33 "all authorized workers' compensation claims shall be filed to allow processing and reimbursement within twelve (12) months from the date of service. All actions against an authorized claim cease when the said twelve (12) month time limitation has expired"

C. This makes it extremely important that bills be forwarded to the Fund immediately upon receipt to allow ample time to review and investigate charges and process for payment. Equian currently provides bill review and repricing for HWCF. We receive the benefit of PPO deductions from their membership with AlaMed. This service is used on all medical bills subject to the State of Alabama Fee Schedule excluding pharmacy charges. All pharmacy services are assigned to our Pharmacy Benefit Manager (PBM), Carlisle Medical. We attempt to enroll all employees in this program once a claim is received. This program has proven to be more cost beneficial than the repricing allowed by the State of Alabama Fee Schedule.

D. Effective August 1, 1992 an employer shall pay an injured worker mileage cost for travel to and from a health care provider at the State of Alabama mileage rate. It will be the employee's responsibility to file for mileage reimbursement. A sample form is included in the back of the handbook.

E. The Fund will be responsible for providing written notification to medical providers of any disputed claims and any delay in processing of payments.

F. There is no statute of limitations on medical expenses under workers' compensation.

PHYSICIANS

The process of selecting authorized treating physicians for injured employees is more important than ever. Escalating medical costs associated with the workers' compensation industry nationwide are forcing us to exercise greater control over medical treatment.

A. **Initial Treating Physician:** As previously stated, you, as the employer, have the initial choice of physician. An employee must have medical authorization for treatment. We, therefore, strongly encourage the use of a medical authorization form; such as, the examples in the back of this handbook.

Once a physician has been authorized, the employer cannot discontinue an employee's treatment with that physician unless the employee elects to do so. For this reason, we must make smarter and more discriminating choices at the onset of the claim. This process usually takes place prior to our receiving notice of the injury. We would, however, like to encourage your cooperation in providing us with a list of physicians you will be recommending for workers' compensation employees. We would like to discuss any concerns regarding potential problems in advance.

Once we have been notified of the initial authorized physician, it is our procedure on all lost time claims to correspond with the physician to explain our requirements concerning medical reports, referrals, and equipment orders. A sample of our standard physician letter is included in the back of this handbook.

B. **Physician Referrals:** As indicated above, we will notify the authorized physician that we must give prior approval to any physician for outside treatment referral before we will be responsible for payment of services. The injured employee will receive a copy of this letter. We would appreciate your assistance in this matter. Please make sure your employees know that they must have prior approval. We would again recommend the use of medical authorization forms. We need to be notified when you are contacted regarding referrals. Ideally, we would like to be included in the approval process, especially if the new physician is not on your list. This allows us to send a similar letter to this physician.

C. **Independent Medical Examinations:** While we cannot discontinue treatment with an approved physician, we may require injured employees to submit for independent medical examinations (IME). We frequently exercise this option when an approved physician does not release a patient who has no objective findings. Article 3, Section 25-5-77, states that if the employee refuses to comply with any reasonable request for examination or refuses to accept the medical service which the employer elects to furnish, employee's right to compensation can be suspended and no compensation will be payable for the period of refusal. There is no stated limit on the number of medical evaluations that the employer

can request. An IME does not usually carry the same weight as the opinion of the authorized treating physician. An IME report may be provided to the authorized physician to consider relative to their opinion or recommendations.

D. **Second Surgical Opinions:** One of the areas where there has been a significant cost increase is in the surgical procedures that are performed following on-the-job injuries. We have witnessed too many surgeries that have resulted in repeat surgical procedures and have had negative results. In the interest of controlling cost and in the well-being of the injured employees, we reserve the right to require second opinions on **all surgeries that are not emergencies**. The physician for the second surgical opinion will be **our choice**. We will have to receive and review reports from the original physician and the second opinion before authorization may be given.

   Even in the case of emergency surgery, we should be notified immediately since pre-certification is required on certain procedures.

E. **Employee's Choice of Physician:** As previously mentioned, in accordance with State of Alabama Workers' Compensation Statute, if an injured employee is dissatisfied with the initial treating physician he/she may choose from a list of four (4) physicians. This panel of physicians must be provided only once. When an employee makes his/her selection, this will be his/her only authorized treating physician for the duration of the claim. HWCF personnel will document this fact by letter to the employee, employer, the new physician, and previous authorized physicians. An example of this letter is located at the back of this handbook. We will work with you in preparing a list of four (4) physicians or surgeons from which the injured employee may select a new treating physician.

GROUNDS FOR DENIAL AND BURDEN OF PROOF

Section 25-5-51, gives the employee the right to compensation without regard to the employee's negligence. It also gives the grounds for denial of compensation. They are as follows:

A. Willful misconduct of the employee;

B. The employee's intention to bring about the injury or death of himself or another;

C. Employee's own intoxication/drugs;

D. Employee's willful failure or willful refusal to use safety appliances provided by the employer; and

E. The willful refusal or willful neglect of the employee to perform a statutory duty.

Section 25-5-36 and Section 25-5-51 provide that **where the employer defends on any of these grounds, he has the burden of proving such a defense**. In the area of willful misconduct and burden of proof, the key to a successful defense is documentation by you, the employer. A suggested means to accomplish proper documentation is to have a training plan to indoctrinate employees to the company's rules and regulations and a company policy to ensure compliance of rules and regulations. When a regulation is violated, a company policy should be in effect for warnings, documentation in the employee's personnel file, and disciplinary action.

POLICIES

The following are policies of the Healthcare Workers' Compensation Fund based on our understanding of the Alabama Worker' Compensation Law at the present time. However, changes occur frequently in case law. We have established these policies for the following recurring situations. It is our practice, however, to investigate each claim on an individual basis and to monitor current legal trends. In circumstances where coverage is questionable, we occasionally file a Motion for Declaratory Judgment to ask the court for guidance. These policies are subject to change.

A. **Injuries Sustained While Playing Sports or Games.** We do not pay for injuries sustained while an employee is playing for a hospital team. However, if the hospital sponsors a team to the degree that they provide equipment, uniforms, etc., we may have to consider payment of claims made for injuries incurred by employees. These claims will have to be investigated on a case-by-case basis.

B. **Outside Hospital Functions.** We will not be responsible for injuries sustained while employees are attending hospital-sponsored functions such as parties, picnics, etc., unless employees are **required** to attend.

C. **Idiopathic Falls.** Injuries resulting from falls caused by purely personal conditions are not compensable. There must be some causal connection between the fall and the employment environment.

D. **Chicken Pox and Communicable Diseases.** For a disease to be compensable, it must be caused solely by a hazard recognized as peculiar to a particular trade, process, occupation or employment, which occurs as a direct result of exposure over a period of time to normal working conditions. We, therefore, do not pay for claims for chicken pox, viruses, etc., which are common to the population in general. An exception for chicken pox might be when an employee works on a pediatric floor and there is a documented exposure. This would only be in the case where the employee has actually contracted chicken pox and not for precautionary leave due to employee's potential to be contagious. Again, claims will have to be investigated on an individual basis.

E. **Injuries Occurring During Lunch/Breaks.** Under normal circumstances, injuries occurring during an employee's lunch break would not be covered under workers' compensation. However, as is the case in most hospitals, if your employees only have a 30-minute break for lunch and are required to remain in the building, we will consider payment of claims for injuries occurring in the hospital cafeteria.

Likewise, injuries occurring during employer sanctioned breaks in authorized area of the workplace will have to be considered for payment of compensation. These claims will be carefully reviewed on an individual basis.

F. **Needlesticks.** The Healthcare Workers' Compensation Fund does not cover the cost of drawing blood from a source patient when an exposure occurs.

G. **Exposures to the unborn.** We are not responsible for any indirect exposure or damage to the unborn since workers' compensation is only for injuries to the employee.

H. **Family Members.** Likewise, we are not responsible for treatment of family members exposed by employees who have contracted an occupational disease.

I. **Cumulative Trauma/Repetitive Motion Disorders.** It is the policy of HWCF to thoroughly investigate each claim for cumulative trauma/repetitive motion disorder. These claims have a higher standard of proof of "clear and convincing evidence" that the injury "arose out of and in the course of employment". According to Alabama Statute, 25-5-81 (c), proof by "clear and convincing evidence" requires a level of proof greater than a "preponderance of evidence" or the substantial weight of the evidence, but less than "beyond a reasonable doubt". We will be sending a letter/questionnaire to you, the employer, to complete when we receive notice of a cumulative trauma claim. A copy of this letter is included in the appendix. The date of injury for repetitive motion injuries is the date of last exposure.

J. **Latex/Occupational Exposure/Allergies.** If you have an employee with an occupational exposure claim which requires referral for treatment, please contact your claims representative for a list of suggested physicians.

EMPLOYER INVOLVEMENT

The Healthcare Workers' Compensation Fund belongs to the members participating in the Fund. Money that is saved by controlling the cost of claims administration benefits you, the member, and not an insurance company. We ask for and encourage your involvement in the administration of claims. There are several items of information that you have available which may be important in claims administration, some of which are not required when the claim is initially reported. Examples of this information are:

A. **Length of Employment.** An employee's past medical/injury history becomes extremely important on recent hires. Likewise, serious injuries to long term employees can have significant impact on the ultimate value of a claim.

B. **Witnesses.** This will be very important in questionable claims since we have the burden of proof in the denial of a claim. Names of witnesses, as well as written statements, will be very helpful.

C. **Video Monitoring.** If your facility monitors areas by video camera where an injury occurred, please obtain and secure a copy for use in our investigation process.

D. **Suspicious Claims.** You, as the employer, may have access to details about a reported accident which may appear suspicious or questionable such as late reporting; no witnesses; or claims occurring early into shift, following a holiday or weekend, etc. which would be beneficial to our claims investigation.

E. **Prior Problems.** Please bring to our attention any knowledge you may have that an individual has had previous injuries or pre-existing medical problems that may be related to the injury now being reported.

F. **Choice of Physician.** You, the employer, have the choice of physician. As discussed earlier, this is most important.

G. **Drug Testing.** Effective August 1, 1992, drug testing may be performed on an employee who has filed a report for an on-the-job injury. This drug test must be performed in accordance with the Department of Transportation regulation 49 C.F.R. Part 40. No compensation shall be allowed if the employee refuses to submit to the drug test, this does not include medical benefits. **Before this action may be taken, all employees must be notified that refusal to submit to a drug test will forfeit the employee's right to recover compensation benefits**. Section 25-5-51, has been clarified to disqualify a claim if an accident was caused by the employee being impaired by illegal drugs, as well as alcohol. The employer still must be able to prove that the accident was due to the impairment.

H. **Misrepresentation on Application.** Effective August 1, 1992, the Alabama Workers' Compensation Statute provides that no compensation shall be allowed if an employee knowingly and falsely misrepresents his or her physical or mental condition and that condition is aggravated or re-injured. This does not include medical benefits. It will be important for each member to bring any misrepresentation to our attention. Caution is advised in this area due to ADA restrictions. Also, the employer has a responsibility to provide the employee with a written warning in bold print at the time the offer of employment is made or when conditions previously placed on a conditional offer of employment are removed. This warning should state "**Misrepresentations as to pre-existing physical or mental conditions may void your workers' compensation benefits**." We request a copy of the employee's health screening and employment application on all lost time claims. This request is made in our opening letters to you, the member. A copy of this letter is enclosed in the back of this handbook.

I. **Set-Off For Other Recoveries.** Effective August 1, 1992, Section 25-5-7 (6) (c), allows for a set-off to compensation benefits paid to an injured worker if they receive other forms of payment such as employer paid disability plan, retirement plan, or sick pay plan**. It will be the responsibility of the employer to monitor this situation and make us aware of any payments the employee is receiving for employer paid plans**. This may be negated due to language in the disability policy.

J. **Subrogation.** Effective August 1, 1992, Section 25-5-11 (2), extends an employer's subrogation rights to include medical and vocational benefits, as well as compensation benefits. It will be important to report any third party involvement so we may investigate and pursue our rights under this section. This includes any companies contracted in your facility to perform work.

K. **Surveillance.** We often obtain surveillance on employees who are out of work because of alleged on-the-job injuries. We believe surveillance may be very beneficial in reducing claim costs either by allowing the treating physician to observe the employee's actual functioning ability or for use in impeaching the plaintiff's testimony in litigation cases. The employer can be extremely helpful in this process by providing tips when there are concerns about a claimant, providing information about known activities/employment, providing descriptions/photographs, and verifying identification of employee. Once HWCF is contacted, we will be responsible for making the assignment to the surveillance company.

We ask that any information you have regarding these issues be submitted to us in writing when you report a claim. This will make us aware of any concerns or suspicions you may have on a claim so that an appropriate investigation may be conducted.

NOTIFICATION OF RETURN TO WORK

An employee is occasionally released to return to work on light duty. This release does not mean that you have to return them to their previous job, making allowances for their restrictions. You may return them to other areas or departments where you may have openings within their limitations. If this results in a reduction in the pre-injury earnings, we will supplement this income with Temporary Partial Disability benefits. This will reduce the cost of the claim and many times will actually result in the employee returning to his/her regular employment ahead of schedule.

COMPENSATION CHECKS

It is our policy to mail employee's benefit checks to the employer. We request that you have the employee personally pick up their check unless they are medically prevented from doing so, or other arrangements have been agreed upon by HWCF and the employer. The reason we encourage this policy is that it will enable you to maintain personal contact with these individuals.

If health problems necessitate benefit check being released to family members, we recommend that you have a signed request from the employee. We also recommend that you require identification from the person obtaining the check.

When an employee is represented by an attorney, the attorney frequently instructs us to mail the checks to their law office or directly to the employee. We will notify you if this occurs.

COMMUNICATIONS

A. **Electronic Submission.** Claims must be electronically filed with the State of Alabama Department of Labor. HWCF offers electronic submission of claims through our member's portal. The portal may be accessed through the HWCF website, www.hwcf.net. This service is offered at no additional cost to our members. If you are unable to utilize this process, please contact your claims representative for other filing options.

B. **E-Mail.** All claims staff e-mail addresses have been provided in the contact section of this manual. Please feel free to contact us in this manner. We will make every effort to respond to you in a timely manner.

C. **Written Correspondence.** When we receive inquiries by mail, we will make every effort to respond promptly. However, please allow the previously addressed turnaround time before follow up. To help keep you informed on claim files, all correspondence initiated by HWCF will be copied to member facilities. We will also advise you of any settlement negotiations or court findings.

D. **Telephone Calls.** We receive many calls and make every effort to return your important telephone messages in a timely manner. We are here to serve you, but we represent many facilities and process a high volume of claims and payments each day. In order to allow us to more efficiently handle your claims, we would request that you leave a detailed message outlining the nature of your call. Your understanding will be appreciated.

E. **Facsimile Telephone Communication.** Please do not FAX First Reports of Injury unless we have specifically requested that you do so. We request that you do not FAX important legal documents unless they are followed up by the original document through the mail.

F. **Member's Portal**. HWCF members have the capability to submit claims and view claims data which includes financial transactions, adjuster notes and loss run reports. Members may access the portal at www.hwcf.net and clicking on the Members Resource tab.

LAWSUIT PROCEDURES

CAUTION!!! "SUMMONS AND COMPLAINT' are words that you should pay close attention to. Anytime you see a document with either or both of these words captioned on it, please bring that document to the attention of your administration immediately. You may be served several ways including certified mail or by a representative from the Sheriff's Department.

When your facility is served with a Summons and Complaint, you only have a certain number of days in which to respond (30 days for workers' compensation cases filed in Circuit Court). If a complaint is not answered in the time allowed by Statute, then the plaintiff can ask for a default judgment, regardless of the facts surrounding the file.

If your facility is served with suit papers and HWCF is not notified within an appropriate time so that legal representation may be obtained and an answer timely filed, your rights may be waived and your coverage with HWCF may be voided.

This is a serious matter and could have far-reaching implications if not properly handled. Please talk with the appropriate personnel at your facility and take all steps necessary to notify HWCF immediately upon service of a Summons and Complaint. We recommend that your facility have a policy which addresses who may accept service of a lawsuit. Your cooperation will be appreciated.

FRAUD

On April 28, 1994, Governor Folsom signed into law Statute 13A-11-124. This Act provides that any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining compensation as defined in Section 25-5-1 (1), Code of Alabama 1975, as amended, for himself or herself or any other person is guilty of a Class C felony. Conviction of a Class C felony carries a sentence of one (1) to ten (10) years in prison.

As providers of your workers' compensation coverage, it is the policy of the Healthcare Workers' Compensation Fund to review any possible violation whenever there is suspicion of fraud in obtaining workers' compensation benefits.

SAMPLE FORMS AND INSTRUCTIONS

APPENDIX TABLE OF CONTENTS

INSTRUCTIONS FOR COMPLETION
OF THE
STATE OF ALABAMA EMPLOYER'S FIRST REPORT OF INJURY

HWCF offers electronic reporting of claims through our member's portal. You may access the portal at the HWCF website, www.hwcf.net . If you are unable to utilize this process, please contact your claims representative for alternative filing options. If you need to complete a First Report of Injury, the following is instructions for completing the State of Alabama Employer's First Report of Injury. The State of Alabama Department of Labor requires that this form be completed in full prior to submission. Therefore, all incomplete forms will be returned for completion.

Line 1-2.	Leave blank.
Line 3.	Case number from log maintained for OSHA.
Line 4.	Employer's name.
Line 5-9.	Employer's physical address.
Line 10-14.	Employer's mailing address and telephone number.
Line 15.	Employer's Federal ID number.
Line 16.	Employer's U.C. account number. This is the employer's unemployment compensation account number. This number can be obtained from your payroll department since it is used in various reports to the State as it applies to unemployment compensation.
Line 17.	May leave blank.
Line 18.	Healthcare Workers' Compensation Fund.
Line 19.	HWCF Federal I.D. number is 87-0693453.
Line 20.	Group Fund should be indicated. Members of HWCF have individually assigned numbers from the State of Alabama. This number is located on your current Fund Coverage Agreement. It should appear as G-08_____. If you are unable to locate this number, please contact your claims representative.
Line 21-27.	HWCF mailing address-P.O. Box 211359 Montgomery, Alabama 36121. Telephone number is 334-271-5515.
Line 28-43.	Employee information.
Line 44.	Employee's date of hire.
Line 45.	Occupation description. Please write out job title. No abbreviations.
Line 46.	Number of days the employee works per week.
Line 47.	Wages of the employee. HWCF prefers you to provide wages on a weekly basis if possible.
Line 48.	This indicates how wages are represented.
Line 49.	Advise if employee received full pay for the date of injury.

Line 50.	Indicate if employee's wages continued.
Line 51.	Date the employee's injury occurred.
Line 52.	Time injury occurred.
Line 53.	Time employee began work on the date of injury
Line 54.	The first day that the employee lost time due to this injury.
Line 55.	Date of death
Line 56-60.	Please include exact description of location within facility or off-site location, as well as complete address.
Line 61.	Indicate if the injury occurred on your premises.
Line 62.	The first day that the employer (supervisor, manager, etc.) was notified either orally or in writing that an on-the-job injury occurred.
Line 63.	This should include details of how the injury occurred, what the employee was doing at the time of the injury, and specific body part injured (i.e., right arm, left leg).
Line 64.	Nature of injury code. A list of codes and descriptions are provided.
Line 65.	Part of body code. A list of codes and descriptions are provided.
Line 66.	Cause of injury code. A list of codes and descriptions are provided.
Line 67.	Indicate type of treatment employee received at the time of injury.
Line 68-72.	Name and address of facility that provided treatment for injured employee.
Line 73.	Name of physician that rendered treatment to employee.
Line 74-76.	Advise if employee has returned to work along with date/time.
Line 77.	Date First Report of Injury was completed.
Line 78-81.	Name, title and telephone number of person completing form (not the injured employee).

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE ALABAMA WORKMEN'S COMPENSATION LAW

WCC Form 2
Rev. 10/2012

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

CLAIM REFERENCE

1. Insured Report Number	2. Filing Office Claim Number	3. OSHA Log Case Number

EMPLOYER

4. Employer Business Name 5. Physical Address 1 6. Physical Address 2 7. City 8. State 9. Zip	ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS 10. Mailing Address 1 11. Mailing Address 2 12. City 13. State 14. Zip

15. Federal ID Number	16. U.C. Account Number	17. NAICS

INSURER / FILING OFFICE

18. Insurer Name 19. Insurer Federal ID Number 20. Type Insurer Ins Co ☐ Self-Insurer ☐ Group Fund ☐	21. Filing Office Name 22. Mailing Address 1 23. Mailing Address 2 or Telephone Number 24. City 25. State 26. Zip 27. Filing Office Federal ID Number

EMPLOYEE / WAGES

28. First Name 29. Middle Name 30. Last Name 31 Last Name Suffix (ie. Jr., Sr., III)	32. Employee ID Number 33. Type Employee ID Number SSN ☐ Passport Number ☐ Green Card ☐ Employment Visa ☐ Assigned by Jurisdiction ☐
34. Mailing Address 1 35. Mailing Address 2 36. City 37. State 38. Zip 39. Phone	40. Gender Male ☐ Female ☐ 41. Date of Birth 42.Nbr of Dependents
43. Marital Status Unmarried (Single or Divorced or Widowed) ☐ Married ☐ Separated ☐ Unknown ☐	44. Date Hired
45. Occupation Description	46. Number of Days Worked Per Week
47. Wages $ 48. Hourly ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐	49. Received Full Pay For Day of Injury? Yes ☐ No ☐ 50. Did Salary Continue? Yes ☐ No ☐

INJURY / TREATMENT

51. Date of Injury	52. Time of Injury a.m. ☐ p.m. ☐ unk ☐	53. Time Employee Began Work a.m. ☐ p.m. ☐	54. Date Disability Began	55. Date of Death

PLACE OF ACCIDENT, INJURY, OR EXPOSURE 56. Site Address 57. City 58. State 59. Zip 60. County	61. Injury Occurred on Employer's Premises? Yes ☐ No ☐ 62. Date Employer Notified

63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)

PROVIDE DESCRIPTION CODES to identify **Nature of Injury**, **Part of Body** that was affected, and **Cause of Injury**.
(FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC

64. Nature of Injury Code 65. Part of Body Code 66. Cause of Injury Code

67. Initial Treatment		68. Name of Treatment Facility	
First Aid By Employer ☐	Minor Clinic / Hospital ☐	69. Address	
Emergency Room ☐	Hospitalized Overnight ☐	70. City 71. State 72. Zip	
Hospitalized > 24 Hours ☐	Outpatient Treatment ☐		

73. Name of Physician or Other Health Care Professional	74. Has Injured Returned to Work Yes ☐ No ☐	If so, 75. Date 76. Time a.m. ☐ p.m. ☐

OTHER

77. Date Prepared	78. Preparer's First Name	79. Last Name	80. Title	81. Preparer's Telephone Number

NATURE OF INJURY	PART OF BODY	CAUSE OF INJURY
01. No Physical Injury	10. Multiple Head Injury	01. Chemicals
02. Amputation	11. Skull	02. Hot Objects or Substances
03. Angina Pectoris	12. Brain	03. Temperature Extremes
04. Burn	13. Ear(s)	04. Fire or Flame
07. Concussion	14. Eye(s)	05. Steam or Hot Fluids
10. Contusion	15. Nose	06. Dust, Gases, Fumes or Vapors
13. Crushing	16. Teeth	07. Welding Operation
16. Dislocation	17. Mouth	08. Radiation
19. Electric Shock	18. Soft Tissue	09. Contact With, NOC.
22. Enucleation	19. Facial Bones	10. Machine or Machinery
25. Foreign Body	20. Multiple Neck Injury	11. Cold Objects or Substances
28. Fracture	21. Vertebrae	12. Object Handled
30. Freezing	22. Disc	13. Caught In, Under or Between, NOC.
31. Hearing Loss or Impairment	23. Spinal Cord	14. Abnormal Air Pressure
32. Heat Prostration	24. Larynx	15. Broken Glass
34. Hernia	25. Soft Tissue	16. Hand Tool, Utensil; Not Powered
36. Infection	26. Trachea	17. Object Being Lifted or Handled
37. Inflammation	30. Multiple Upper Extremities	18. Powered Hand Tool, Appliance
40. Laceration	31. Upper Arm	19. Caught, Puncture, Scrape, NOC.
41. Myocardial Infarction	32. Elbow	20. Collapsing Materials (Slides of Earth) Either Man Made or Natural
42. Poisoning - General	33. Lower Arm	25. From Different Level (Elevation) Off Wall, Catwalk, Bridge, Etc.
43. Puncture	34. Wrist	26. From Ladder or Scaffolding
46. Rupture	35. Hand	27. From Liquid or Grease Spills
47. Severance	36. Finger(s)	28. Into Openings Shafts, Excavations, Floor Openings, Etc.
49. Sprain or Tear	38. Shoulder(s)	29. On Same Level
52. Strain or Tear	39. Wrist (s) & Hand(s)	30. Slipped, Do Not Fall
53. Syncope	40. Multiple Trunk	31. Fall, Slip or Trip, NOC.
54. Asphyxiation	41. Upper Back Area	32. On Ice or Snow
55. Vascular	42. Lower Back Area	33. On Stairs
58. Vision Loss	43. Disc	40. Crash of Water Vehicle
59. All Other Specific Injuries, NOC	44. Chest	41. Crash of Rail Vehicle
60. Dust Disease, NOC	45. Sacrum and Coccyx	45. Collision or Sideswipe With Another Vehicle
61. Asbestosis	46. Pelvis	46. Collision with a Fixed Object Standing Vehicle or Stationary Object
62. Black Lung	47. Spinal Cord	47. Crash of Airplane
63. Byssinosis	48. Internal Organs	48. Vehicle Upset Overturned or Jackknifed
64. Silicosis	49. Heart	50. Motor Vehicle, NOC.
65. Respiratory Disorders	50. Multiple Lower Extremities	52. Continual Noise
66. Poisoning - Chemical, (Other Than Metals)	51. Hip	53. Twisting
67. Poisoning - Metal	52. Upper Leg	54. Jumping
68. Dermatitis	53. Knee	55. Holding or Carrying
69. Mental Disorder	54. Lower Leg	56. Lifting
70. Radiation	55. Ankle	57. Pushing or Pulling
71. All Other Occupational Disease Injury, NOC	56. Foot	58. Reaching
72. Loss of Hearing	57. Toes	59. Using Tool or Machinery
73. Contagious Disease	58. Big Toes	60. Strain or Injury By, NOC.
74. Cancer	60. Lungs	61. Wielding or Throwing
75. AIDS	61. Abdomen Including Groin	65. Moving Part of Machine
76. VDT - Related Diseases	62. Buttocks	66. Object Being Lifted or Handled
77. Mental Stress	63. Lumbar & or Sacral Vertebrae	67. Sanding, Scraping, Cleaning Operation
78. Carpal Tunnel Syndrome	64. Artificial Appliance	68. Stationary Object
79. Hepatitis C	65. Insufficient Info to Properly Identify	69. Stepping on Sharp Object
80. All Other Cumulative Injury, NOC	66. No Physical Injury	70. Striking Against or Stepping On, NOC.
90. Multiple Physical Injuries Only	90. Multiple Body Parts	74. Fellow Worker; Patient
91. Multiple Injuries Including Both Physical & Psychological	91. Body Systems and Multiple Body	75. Falling or Flying Object
	99. Whole Body	76. Hand Tool or Machine in Use
		77. Motor Vehicle
		78. Moving Parts of Machine
		79. Object Being Lifted or Handled
		80. Object Handled By Others
		81. Struck or Injured, NOC.
		82. Absorption, Ingestion or Inhalation, NOC
		84. Electrical Current
		85. Animal or Insect
		86. Explosion or Flare Back
		87. Foreign Matter (Body) in Eye(s)
		88. Natural Disasters
		89. Person in Act of a Crime
		90. Other Than Physical Cause of Injury
		91. Mold
		94. Repetitive Motion Callous, Blister, Etc.
		95. Rubbed or Abraded, NOC.
		96. Terrorism
		97. Repetitive Motion Carpel Tunnel Syndrome
		98. Cumulative, NOC
		99. Other - Miscellaneous, NOC

INSTRUCTIONS FOR FILING WC FIRST REPORT OF INJURY

Employers should send a completed legible form to the insurance carrier or, if self-insured, to the designated office handling their workers' compensation claims. The insurance carrier or designated office should forward this First Report on to the Workers' Compensation Division, Department of Labor, Montgomery, Alabama 36131 within fifteen (15) days from the date of injury or date of notification to the employer for all injuries for which compensation is claimed or paid. This includes deaths, permanent disabilities or temporary disabilities exceeding three (3) days).

Block 1. A number assigned by the insured to identify a specific claim
Block 2. An identifier for a specific claim within a claim administrator's claims processing system.
Block 3. Case number from log maintained for OSHA
Block 4 - Block 14. Self Explanatory
Block 15. Employer Federal ID number
Block 16. Employer Unemployment Compensation Account Number
Block 17. NAICS Industry Codes http://dir.alabama.gov/docs/forms/wc_naics.pdf
Block 18. Carrier's name
Block 19. Carrier's FEIN
Block 20. A code representing the kind of entity providing financial responsibility for the claim, exp: (I) Insurance Carrier (S) Self Insurer (G) Guarantee Fund/Group
Block 21 through Block 63. Self Explanatory
Block 64. Nature of Injury Codes http://dir.alabama.gov/docs/forms/wcio_nature_table.pdf
Block 65. Part of Body Codes http://dir.alabama.gov/docs/forms/wcio_part_table.pdf
Block 66. Cause of Injury Codes http://dir.alabama.gov/docs/forms/wcio_cause_table.pdf
Block 67 through Block 81. Self Explanatory

Workers Compensation Insurance Organizations

Injury Description Codes
Cause Of Injury

Code	Narrative Description
I. Burn or Scald – Heat or Cold Exposures– Contact With	*
01. Chemicals	Includes hydrochloric acid, sulfuric acid, battery acid, methanol, antifreeze.
02. Hot Objects or Substances	*
03. Temperature Extremes	Non-impact injuries resulting in a burn due to hot or cold temperature extremes. Includes freezing or frostbite.
04. Fire or Flame	*
05. Steam or Hot Fluids	*
06. Dust, Gases, Fumes or Vapors	Includes inhalation of carbon dioxide, carbon monoxide, propane, methane, silica (quartz), asbestos dust and smoke.
07. Welding Operation	Includes welder's flash (burns to skin or eyes as a result of exposure to intense light from welding.)
08. Radiation	Includes effects of ionizing radiation found in X-rays, microwaves, nuclear reactor waste, and radiating substances and equipment. Includes non-ionizing radiation such as sunburn.
09. Contact With, NOC	Not otherwise classified in any other code. Includes cleaning agents and fertilizers.
11. Cold Objects or Substances	*
14. Abnormal Air Pressure	*
84. Electrical Current	Includes electric shock, electrocution and lightning.
II. Caught In, Under or Between	*
10. Machine or Machinery	Running or meshing objects, a moving and a stationary object, two or more moving objects
12. Object Handled	Includes medical hospital bed & parts, wheelchair, clothespin vise.
13. Caught In, Under or Between, NOC	Not otherwise classified in any other code.
20. Collapsing Materials (Slides of Earth)	Either man made or natural.
III. Cut, Puncture, Scrape Injured By	*
15. Broken Glass	*

*Description intentionally left blank.

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16. Hand Tool, Utensil; Not Powered	Includes needle, pencil, knife, hammer, saw, axe, screwdriver.
17. Object Being Lifted or Handled	Includes being cut, punctured or scraped by a person or object being lifted or handled.
18. Powered Hand Tool, Appliance	Includes drill, grinder, sander, iron, blender, welding tools, nail gun.
19. Cut, Puncture, Scrape, NOC	Not otherwise classified in any other code. Includes power actuated tools.
IV. Fall, Slip or Trip Injury	*
25. From Different Level (Elevation)	Includes collapsing chairs, falling from piled materials, off wall, catwalk, bridge.
26. From Ladder or Scaffolding	*
27. From Liquid or Grease Spills	*
28. Into Openings	Includes mining shafts, excavations, floor openings, elevator shafts.
29. On Same Level	*
30. Slip, or Trip, Did Not Fall	Slip or trip and did not come in contact with the floor or ground.
31. Fall, Slip or Trip, NOC	Not otherwise classified in any other code. Includes tripping over object, slipping on organic material, slip but fall not specified.
32. On Ice or Snow	*
33. On Stairs	*
V. Motor Vehicle	*
40. Crash of Water Vehicle	*
41. Crash of Rail Vehicle	*
45. Collision or Sideswipe With Another Vehicle	Vehicle collision, both vehicles in motion.
46. Collision with a Fixed Object	Collision occurring with standing vehicle or stationary object.
47. Crash of Airplane	*
48. Vehicle Upset	Includes overturned or jackknifed.
50. Motor Vehicle, NOC	Not otherwise classified in any other code. Includes injuries due to sudden stop or start, being thrown against interior parts of the vehicle and vehicle contents being thrown against occupants.

*Description intentionally left blank.

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VI. Strain or Injury By	*
52. Continual Noise	Injury to ears or hearing due to the cumulative effects of constant or repetitive noise.
53. Twisting	Free bodily motion that imposes stress or strain on some part of body. Includes assumption of unnatural position, involuntary motions induced by sudden noise, fright or loss of balance.
54. Jumping or Leaping	*
55. Holding or Carrying	Applies to objects or people. Includes restraining a person.
56. Lifting	Includes objects or people.
57. Pushing or Pulling	Includes objects or people.
58. Reaching	*
59. Using Tool or Machinery	*
60. Strain or Injury By, NOC	Not otherwise classified in any other code.
61. Wielding or Throwing	Physical effort or overexertion from attempts to resist a force applied by an object being handled.
97. Repetitive Motion	Cumulative injury or condition caused by continual, repeated motions; strain by excessive use. Includes Carpal Tunnel Syndrome.
VII. Striking Against or Stepping On	NOTE: Applies to cases in which the injury was produced by the impact created by the person, rather than by the source.
65. Moving Part of Machine	*
66. Object Being Lifted or Handled	*
67. Sanding, Scraping, Cleaning Operation	Include scratches or abrasions caused by sanding, scraping, cleaning operations.
68. Stationary Object	*
69. Stepping on Sharp Object	*
70. Striking Against or Stepping On, NOC	Not otherwise classified in any other code.
VIII. Struck or Injured By	NOTE: Applies to cases in which the injury was produced by the impact created by the source of injury, rather than by the injured person.
74. Fellow Worker, Patient or Other Person	Struck by co-worker, either on purpose or accidentally. Includes being struck by a patient while lifting or moving them not in act of a crime.

*Description intentionally left blank.

May 18, 2010

75. Falling or Flying Object	*
76. Hand Tool or Machine in Use	*
77. Motor Vehicle	Applies when a person is struck by a motor vehicle, including rail vehicles, water vehicles, airplanes.
78. Moving Parts of Machine	*
79. Object Being Lifted or Handled	Includes dropping object on body part.
80. Object Handled By Others	Includes another person dropping object on injured person's body part.
81. Struck or Injured, NOC	Not otherwise classified in any other code. Includes kicked, stabbed, bitten.
85. Animal or Insect	Includes bite, sting or allergic reaction.
86. Explosion or Flare Back	Rapid expansion, outbreak, bursting, or upheaval. Includes explosion of cars, bottles, aerosol cans, or buildings. "Flare back" involves superheated air and combustible gases at temperatures just below the ignition temperature.
IX. Rubbed or Abraded By	
94. Repetitive Motion	Caused by repeated rubbing or abrading; applies to non-impact cases in which the injury was produced by pressure, vibration or friction between the person and the source of injury. Includes callous, blister.
95. Rubbed or Abraded, NOC	Not otherwise classified in any other code. Includes foreign body in ears.
X. Miscellaneous Causes	*
82. Absorption, Ingestion or Inhalation, NOC	Not otherwise classified in any other code. Applies only to non-impact cases in which the injury resulted from inhalation, absorption (skin contact), or ingestion of harmful substances.
87. Foreign Matter (Body) in Eye(s)	Injury to eyes resulting from foreign matter that is not otherwise classified in any other code.
88. Natural Disasters	Injury resulting from natural disaster. Includes hurricane, earthquake, tornado, flood, forest fire.
89. Person in Act of a Crime	Specific injury, other than gunshot, caused as a result of contact between injured person and another person in the act of committing a crime. Includes robbery or criminal assault.
90. Other Than Physical Cause of Injury	Stress, shock, or psychological trauma that

*Description intentionally left blank.

	develops in relation to a specific incident or cumulative exposure to conditions.
91. Mold	Includes mildew.
93. Gunshot	Injury is caused by the discharge of a firearm. Includes instances where injury arises from being struck by the fired projectile, burned by muzzle blast or deafened by report of gunshot.
96. Terrorism	An act that causes injury to human life, committed by one or more individuals as part of an effort to coerce a population group(s) or to influence the policy or affect the conduct of any government(s) by coercion.
98. Cumulative, NOC	Cumulative, not otherwise classified in any other code. Involves cases in which the cause of injury occurred over a period of time, any condition increasing in severity over time.
99. Other - Miscellaneous, NOC	Not otherwise classified in any other code.

*Description intentionally left blank.

Code	Narrative Description
I. Specific Injury	*
01. No Physical Injury	i.e., Glasses, contact lenses, artificial appliance, replacement of artificial appliance
02. Amputation	Cut off extremity, digit, protruding part of body, usually by surgery, i.e. leg, arm
03. Angina Pectoris	Chest pain
04. Burn	(Heat) Burns or scald. The effect of contact with hot substances. (Chemical) burns. tissue damage resulting from the corrosive action chemicals, fume, etc., (acids, alkalies)
07. Concussion	Brain, cerebral
10. Contusion	Bruise - intact skin surface hematoma
13. Crushing	To grind, pound or break into small bits
16. Dislocation	Pinched nerve, slipped/ruptured disc, herniated disc, sciatica, complete tear, HNP subluxtion, MD dislocation
19. Electric Shock	Electrocution
22. Enucleation	Removal of organ or tumor
25. Foreign Body	*
28. Fracture	Breaking of a bone or cartilage
30. Freezing	Frostbite and other effects of exposure to low temperature
31. Hearing Loss or Impairment	Traumatic only. A separate injury, not the sequelae of another injury
32. Heat Prostration	Heat stroke, sun stroke, heat exhaustion, heat cramps and other effects of environmental heat. does not include sunburn
34. Hernia	The abnormal protrusion of an organ or part through the containing wall of its cavity
36. Infection	The invasion of a host by organisms such as bacteria, fungi, viruses, mold, protozoa or insects, with or without manifest disease.
37. Inflammation	The reaction of tissue to injury characterized clinically by heat, swelling, redness and pain

*Description intentionally left blank.

40. Laceration	Cut, scratches, abrasions, superficial wounds, calluses. wound by tearing
41. Myocardial Infarction	Heart attack, heart conditions, hypertension. The inadequate blood flow to the muscular tissue of the heart.
42. Poisoning - General (Not OD or Cumulative Injury)	A systemic morbid condition resulting from the inhalation, ingestion, or skin absorption of a toxic substance affecting the metabolic system, the nervous system, the circulatory system, the digestive system, the respiratory system, the excretory system, the musculoskeletal system, etc. includes chemical or drug poisoning, metal poisoning, organic diseases, and venomous reptile and insect bites. does not include effects of radiation, pneumoconiosis, corrosive effects of chemicals; skin surface irritations, septicemia or infected wounds.
43. Puncture	A hole made by the piercing of a pointed instrument
46. Rupture	*
47. Severance	To separate, divide or take off
49. Sprain or Tear	Internal derangement, a trauma or wrenching of a joint, producing pain and disability depending upon degree of injury to ligaments.
52. Strain or Tear	Internal derangement, the trauma to the muscle or the musculotendinous unit from violent contraction or excessive forcible stretch.
53. Syncope	Swooning, fainting, passing out, no other injury
54. Asphyxiation	Strangulation, drowning
55. Vascular	Cerebrovascular and other conditions of circulatory systems, NOC, excludes heart and hemorrhoids. Includes: strokes, varicose veins - non toxic
58. Vision Loss	*
59. All Other Specific Injuries, NOC	*
II. Occupational Disease or Cumulative Injury	*
60. Dust Disease, NOC	All other pneumoconiosis
61. Asbestosis	Lung disease, a form of pneumoconiosis, resulting from protracted inhalation of asbestos particles.

*Description intentionally left blank.

62. Black Lung	The chronic lung disease or pneumoconiosis found in coal miners
63. Byssinosis	Pneumoconiosis of cotton, flax and hemp workers
64. Silicosis	Pneumoconiosis resulting from inhalation of silica (quartz) dust.
65. Respiratory Disorders	Gases, fumes, chemicals, etc.
66. Poisoning - Chemical, (Other Than Metals)	Man made or organic
67. Poisoning - Metal	Man made
68. Dermatitis	Rash, skin or tissue inflammation including boils, etc., generally resulting from direct contact with irritants or sensitizing chemicals such as drugs, oils, biologic agents, plants, woods or metals which may be in the form of solids, pastes, liquids or vapors and which may be contacted in the pure state or in compounds or in combination with other materials. do not include skin tissue damage resulting from corrosive action of chemicals, burns from contact with hot substances, effects of exposure to radiation, effects of exposure to low temperatures or inflammation or irritation resulting from friction or impact
69. Mental Disorder	A clinically significant behavioral or psychological syndrome or pattern typically associated with either a distressing symptom or impairment of function. i.e., acute anxiety, neurosis, stress, non-toxic depression
70. Radiation	All forms of damage to tissue, bones or body fluids produced by exposure to radiation
71. All Other Occupational Disease Injury, NOC	*
72. Loss of Hearing	*
73. Contagious Disease	*
74. Cancer	*
75. AIDS	*
76. VDT - Related Diseases	Video display terminal diseases other than carpal tunnel syndrome
77. Mental Stress	*

*Description intentionally left blank.

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78. Carpal Tunnel Syndrome	Soreness, tenderness and weakness of the muscles of the thumb caused by pressure on the median nerve at the point at which it goes through the carpal tunnel of the wrist
79. Hepatitis C	*
80. All Other Cumulative Injury, NOC	*
III. Multiple Injuries	*
90. Multiple Physical Injuries Only	*
91. Multiple Injuries Including Both Physical and Psychological	*

*Description intentionally left blank.

Code	Narrative Description
I. Head	*
10. Multiple Head Injury	Any combination of below parts
11. Skull	*
12. Brain	*
13. Ear(s)	Includes: hearing, inside eardrum
IAIABC Subsequent Report of Injury (SROI) Codes:	*
13A.	Total deafness of both ears
13B.	Total deafness of one ear
13C.	Where worker prior to injury has suffered a total loss of hearing in one ear, and as a result of the accident loses total hearing in remaining ear
14. Eye(s)	Includes: optic nerves, vision, eye lids
IAIABC Subsequent Report of Injury (SROI) Codes	*
14A.	The loss of eye by enucleation (including disfigurement resulting there from)
14B.	Total blindness of one eye
14C.	Blindness in both eyes
15. Nose	Includes: nasal passage, sinus, sense of smell
16. Teeth	*
17. Mouth	Includes: lips, tongue, throat, taste
18. Soft Tissue	*
19. Facial Bones	Includes: jaw
II. Neck	*
20. Multiple Neck Injury	Any combination of below parts
21. Vertebrae	Includes: spinal column bone, "cervical segment"
22. Disc	Includes: spinal column cartilage, "cervical segment"
23. Spinal Cord	Includes: nerve tissue, "cervical segment"
24. Larynx	Includes: cartilage and vocal cords
25. Soft Tissue	Other than larynx or trachea
26. Trachea	*
II. Upper Extremities	*

*Description intentionally left blank.

May 18, 2010

30. Multiple Upper Extremities	Any combination of below parts, excluding hands and wrists combined
31. Upper Arm	Humerus and corresponding muscles, excluding clavicle and scapula
32. Elbow	Radial head
33. Lower Arm	Fore Arm – radius, ulna and corresponding muscles
34. Wrist	Carpals and corresponding muscles
35. Hand	Metacarpals and corresponding muscles – excluding wrist or fingers
36. Finger(s)	Other than thumb and corresponding muscles
IAIABC Subsequent Report of Injury (SROI) Codes:	*
36A.	The loss of an index finger and metacarpal bone there of
36B.	The loss of an index finger at the proximal joint
36C.	The loss of an index finger at the second joint
36D.	The loss of an index finger at the distal joint
36E.	The loss of a second finger and the metacarpal bone there of
36F.	The loss of a middle finger at the proximal joint
36G.	The loss of a middle finger at the second joint
36H.	The loss of a middle finger at the distal joint
36I.	The loss of a third or ring finger and the metacarpal thereof
36J.	The loss of a ring finger at the proximal joint
36K.	The loss of a ring finger at the second joint
36L.	The loss of a ring finger at the distal joint
36M.	The loss of a little finger and the metacarpal bone thereof
36N.	The loss of a little finger at the proximal joint
36O.	The loss of a little finger at the second joint
36P.	The loss of a little finger at the distal joint
37. Thumb	*
IAIABC Subsequent Report of Injury (SROI) Codes	*
37A.	The loss of a thumb and metacarpal bone thereof

*Description intentionally left blank.

37B.	The loss of a thumb at the proximal joint
37C.	The loss of a thumb at the second or distal joint
38. Shoulder(s)	Armpit, rotator cuff, trapezius, clavicle, scapula
39. Wrist (s) & Hand(s)	*
IV. Trunk	*
40. Multiple Trunk	Any combination of below parts
41. Upper Back Area	(Thoracic Area) Upper back muscles, excluding, vertebrae, disc, spinal cord
42. Lower Back Area	(Lumbar Area and Lumbo Sacral) Lower back muscles, excluding sacrum, coccyx, pelvis, vertebrae, disc, spinal cord
43. Disc	Spinal column cartilage other than cervical segment
44. Chest	Including ribs, sternum, soft tissue
45. Sacrum and Coccyx	Final nine vertebrae-fused
46. Pelvis	*
47. Spinal Cord	Nerve tissue other than cervical segment
48. Internal Organs	Other than heart and lungs
49. Heart	*
60. Lungs	*
61. Abdomen Including Groin	Excluding injury to internal organs
62. Buttocks	Soft tissue
63. Lumbar & or Sacral Vertebrae (Vertebra NOC Trunk)	Bone portion of the spinal column
V. Lower Extremities	*
50. Multiple Lower Extremities	Any combination of below parts
51. Hip	*
52. Upper Leg	Femur and corresponding muscles
53. Knee	Patella
54. Lower Leg	Tibia, fibula and corresponding muscles
55. Ankle	Tarsals

*Description intentionally left blank.

56. Foot	Metatarsals, heel, Achilles tendon and corresponding muscles – excluding ankle or toes
57. Toes	*
IAIABC Subsequent Report of Injury (SROI) Codes:	*
57A.	Little toe metatarsal bone
57B.	Little toe at distal joint
57C.	The loss of any other toe with the metatarsal bone thereof
57D.	The loss of any other toe at the proximal joint
57E.	Other toe at middle joint
57F.	The loss of any other toe at the second or distal joint
57G.	Other toe at distal joint
58. Great Toe	*
IAIABC Subsequent Report of Injury (SROI) Codes:	*
58A.	The loss of a great toe with the metatarsal bone thereof
58B.	The loss of a great toe at the proximal joint
58C.	The loss of a great toe at the second or distal joint
VI. Multiple Body Parts	*
64. Artificial Appliance	Braces, etc.
65. Insufficient Info to Properly Identify – Unclassified	Insufficient information to identify part affected
66. No Physical Injury	Mental disorder
90. Multiple Body Parts (Including Body Systems & Body Parts)	Applies when more than one major body part has been affected, such as an arm and a leg and multiple internal organs.

*Description intentionally left blank.

91. Body Systems and Multiple Body Systems	Applies to the functioning of an entire body system has been affected without specific injury to any other part, as in the case of poisoning, corrosive action, inflammation, affecting internal organs, damage to nerve centers, etc., does not apply when the systemic damage results from an external injury affecting an external part such as a back injury which includes damage to the nerves of the spinal cord.
99. Whole Body	A code referencing the anatomic classification of the injury. **IAIABC Note:** Approved for IAIABC EDI jurisdictional reporting as a Permanent Impairment Body Part Code Only

*Description intentionally left blank.

MEDICAL AUTHORIZATION FORM 1

To: Dr._____
Employee: _____
Date of Occurrence: _____
Nature of Illness/Injury: _____

This employee has reported an on-the-job injury/illness and is being referred for an initial evaluation. Please consider this form, if signed by the employer, authorization to obtain a *urine drug screen*, perform evaluation including necessary diagnostic procedures and provide emergency medical treatment in accordance with the provisions of and under conditions prescribed by the State of Alabama Workers' Compensation Statute.

A report of this injury/illness is being forwarded to our workers' compensation carrier

Healthcare Workers' Compensation Fund
P.O. Box 211359
Montgomery, Alabama 36121-1359
1-800-821-9605

for investigation and handling. Any requests for further treatment should be directed to our carrier. Unless prior approval is given for hospital admission, referral to another physician or outpatient facility, or equipment rental/purchase; the patient will be responsible for payment of charges. Chart notes must be attached to all bills submitted for payment.

_____ _____ _____
Signature Title Date

CERTIFICATE TO RETURN TO WORK

_____ has been under my care from _____ to
(patient's name) (date)
_____ and is able to return to work on _____.
(date) (date)

Diagnosis:_____
Return to Regular Duty _____ Return to Alternate Duty_____
Limitations, if any, _____
_____

Signature:_____ Date:_____
Name: Dr._____
Address: _____
_____

MEDICAL AUTHORIZATION FORM 2

To: Dr._____
Employee: _____
Date of Occurrence: _____
Nature of Illness/Injury: _____

This employee has reported an on-the-job injury/illness and is being referred for evaluation/treatment. The employee has already received an initial evaluation, *drug screen* and emergency treatment. *Employee's medical records are attached*. Please consider this form, if signed by the employer, authorization to perform additional evaluation including necessary diagnostic procedures and provide medical treatment in accordance with the provisions of and under conditions prescribed by the State of Alabama Workers' Compensation Statute.

A report of this injury/illness is being forwarded to our workers' compensation carrier

Healthcare Workers' Compensation Fund
P.O. Box 211359
Montgomery, Alabama 36121-1359
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for investigation and handling. Any requests for further treatment should be directed to our carrier. Unless prior approval is given for hospital admission, referral to another physician or outpatient facility, or equipment rental/purchase; the patient will be responsible for payment of charges. Chart notes must be attached to all bills submitted for payment.

_____ _____ _____
Signature Title Date

CERTIFICATE TO RETURN TO WORK

_____ has been under my care from _____ to
(patient's name) (date)
_____ and is able to return to work on _____.
(date) (date)

Diagnosis:_____
Return to Regular Duty _____ Return to Alternate Duty_____
Limitations, if any, _____
_____

Signature:_____ Date:_____
Name: Dr._____
Address: _____
_____

Kay Ivey
GOVERNOR

Fitzgerald Washington
SECRETARY OF LABOR

STATE OF ALABAMA

DEPARTMENT OF LABOR

May 14, 2018

TO: Insurance Companies, Self-Insurers, Service Companies, Independent Adjusters and Other Interested Parties

FROM: Stephen Garrett, Acting Director
Workers' Compensation Division

SUBJECT: State's Average Weekly Wage

On May 14, 2018, in accordance with the provisions of Section 25-5-68(c), Code of Alabama, 1975, as last amended, the Secretary of Labor determined that the State's average weekly wage for calendar year 2017 was $865.16.

For injuries occurring on and after July 1, 2018, the maximum workers' compensation payable will be $865.00 per week, and the minimum compensation will be $238.00 per week.

Please advise the appropriate personnel in your organization of these changes.

Previous years' maximum and minimum compensation payable as provided under Section 25-5-68 are as follows:

Weekly Compensation

Calendar Year	State's AWW	Effective Date	Maximum	Minimum
2003	607.10	7-1-04	607	167
2004	629.48	7-1-05	629	173
2005	651.32	7-1-06	651	179
2006	682.09	7-1-07	682	188
2007	705.68	7-1-08	706	194
2008	729.04	7-1-09	729	200
2009	740.14	7-1-10	740	204
2010	755.46	7-1-11	755	208
2011	770.80	7-1-12	771	212
2012	787.59	7-1-13	788	217
2013	794.27	7-1-14	794	218
2014	812.96	7-1-15	813	224
2015	831.88	7-1-16	832	229
2016	842.79	7-1-17	843	232
2017	865.16	7-1-18	865	238

649 MONROE STREET MONTGOMERY, ALABAMA 36131

OFFICE OF THE GOVERNOR

ROBERT BENTLEY
GOVERNOR

STATE OF ALABAMA

DEPARTMENT OF LABOR

FITZGERALD WASHINGTON
SECRETARY OF LABOR

December 20, 2016

TO: Insurance Companies, Self-Insurers, Service Companies, Independent Adjusters, and Other Interested Parties

FROM: Charles T. DeLamar, Director
Workers' Compensation Division

SUBJECT: Mileage Reimbursement

Code of Alabama, 1975, Section 25-5-77(f) provides that "The employer shall pay mileage costs to and from medical and rehabilitation providers at the same rate as provided by law for official state travel." This section of the law became effective August 1, 1992 for travel on or after that date. Injured workers are paid at the same rate as persons traveling on official state business. The mileage rates and effective dates are listed below.

EFFECTIVE DATE	REIMBURSEMENT RATE
January 1, 2002	$ 0.365
January 1, 2003	$ 0.36
January 1, 2004	$ 0.375
January 1, 2005	$ 0.405
September 1, 2005	$ 0.485
January 1, 2006	$ 0.445
January 1, 2007	$ 0.485
January 1, 2008	$ 0.505
July 1, 2008	$ 0.585
January 1, 2009	$ 0.55
January 1, 2010	$ 0.50
January 1, 2011	$ 0.51
July 1, 2011	$ 0.555
January 1, 2013	$.565
January 1, 2014	$.57
January 1, 2015	$0.575
January 1, 2016	$0.54
January 1, 2017	$0.535

CD/lk

649 MONROE STREET MONTGOMERY, ALABAMA 36131

Wage Statement

HEALTHCARE WORKERS' COMPENSATION FUND

Employer: _____ Date Employed: _____
Employee: _____ Date Disability Began: _____
Date of Injury: _____
Claim Number: _____

Please complete this Wage Statement form and return to us as soon as possible. This should include the **employee's gross wages for the 52 week period prior to the date of injury.**

SCHEDULE OF WEEKLY EARNINGS

Week No.	Week From Date	Week To Date	Amount Paid	Number of Days Worked	*				Week No.	Week From Date	Week To Date	Amount Paid	Number of Days Worked	*
1					*				27					*
2									28					
3									29					
4									30					
5									31					
6									32					
7									33					
8									34					
9									35					
10									36					
11									37					
12									38					
13									39					
14									40					
15									41					
16									42					
17									43					
18									44					
19									45					
20									46					
21									47					
22									48					
23									49					
24									50					
25									51					
26									52					
TOTAL CARRIED FORWARD									GRAND TOTAL					

*Please indicate by placing an "X" in this column if the employee lost more than seven consecutive days during this pay period. If employee was paid on other than weekly basis explain fully.

Benefits	Monthly Amount Paid by Employer	Are Payments to be continued During Disability?	
Health Insurance		Yes No	Date Discontinued
Life Insurance		Yes No	
Disability Insurance		Yes No	
Other:		Yes No	

I certify that the above is a true copy of payroll record of the Employee's earnings as shown on Employer's records.

Signed

_____

Opening Letter to Employer

RE: Claim Number:
Employee:
Date of Alleged
Injury/Illness:
Report Date:
Date Received by HWCF:
Adjuster Assigned to File:

Dear

The above workers' compensation claim file has been opened with the Healthcare Workers' Compensation Fund. We will be immediately investigating this alleged injury/illness.

To assist us in this process, please promptly forward the Employee's pre-employment health screening, employment application, photo I.D, all medical records and bills related to treatment of this injury/illness to the above address. We have enclosed a wage statement that will need to be completed and returned to us as soon as possible. This should include the Employee's gross wages for the 52 week period prior to the date of injury.

Any additional facts which may be important to the investigation of this accident, including potential third party involvement, should also be ascertained and forwarded as soon as possible. We welcome your involvement and appreciate your assistance in this process. Thank you.

Sincerely,

<Manual Fill In>
Workers' Compensation
<Manual Fill In>
Encl. - Wage Statement

Opening Letter to Employee

RE: Claim Number:
Employer:
Date of Alleged Injury/Illness:

Dear

The above workers' compensation claim has been submitted by your employer to the Healthcare Workers' Compensation Fund. We will be conducting an investigation into the compensability of your claim. Please contact me at your earliest convenience to schedule a recorded statement.

Enclosed is a medical records release form and a physician listing. Please complete, sign, and return these forms to the below address. This information is necessary to complete our investigation into your claim for workers' compensation benefits.

If your claim is determined to be compensable, and benefits are paid by the Healthcare Workers' Compensation Fund, please be advised that we have subrogation rights for the amount paid for medical and/or indemnity. Should you receive payment from a third party for liability associated with this injury, we would be entitled to reimbursement.

Your prompt response will be beneficial in expediting your claim. Should you have any questions or need assistance, please contact us.

Sincerely,

<Manual Fill In>
Workers' Compensation
<Manual Fill In>

cc: <Contact>
«InsuredCompanyName»

Encls

MEDICAL AUTHORIZATION/RELEASE

RE:

Please make available to Healthcare Workers' Compensation Self-Insurance Fund (HWCF), or any of their agents, any and all information they request concerning any hospitalization and treatment including, but not limited to, my entire medical records, hospital records, reports, charts, x-rays, health screenings, etc., concerning any diagnosis and/or treatment of myself at any time whatsoever, for their use in the investigation of my workers' compensation claim. I recognize that the disclosure of such information may include disclosure to Employees of Healthcare Workers' Compensation Self-Insurance Fund (HWCF), their attorneys, agents, experts retained by or on behalf of the firm and other individuals and entities in the ordinary course of this investigation, and I consent to such disclosure. You are further authorized and requested to discuss with them any history or findings you have regarding me or my condition and I do hereby expressly waive any right I may have of privilege as your patient.

This authorization, waiver of privilege and release is made voluntarily and is extended not only to the Healthcare Workers' Compensation Self-Insurance Fund (HWCF), but also to any of their agents.

This authorization, waiver of privilege and release is made with knowledge of my rights pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. § 160 and 164, et seq., and I further waive any and all claims against Healthcare Workers' Compensation Self-Insurance Fund (HWCF), their attorneys, agents, experts retained by or on behalf of Healthcare Workers' Compensation Self-Insurance Fund (HWCF) and other individuals and entities in the ordinary course of this investigation, as well as you, your Employer, Employees and agents, associated with the disclosure of the requested records and information as described herein.

This authorization, waiver of privilege and release expires upon the final disposition of this claim for workers' compensation benefits. I am aware that I may revoke this authorization, waiver of privilege and release at any time, in writing; however, such revocation does not have any effect upon disclosures made pursuant to this authorization, waiver of privilege and release, prior to such revocation.

Date:_____ **Signature**_____ **Date of Birth** _____

Witness: _____

GINA DISCLAIMER

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits Employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, ***we are asking that you not provide any genetic information when responding to this request for medical information.*** "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Physician Listing

Please list all the physicians who have rendered treatment to you within the last five years and any physicians that you have ever seen for similar complaints to your alleged on the job injury.

1. **Name**_____**Phone**_____
   Speciality _____
   Address_____
2. **Name**_____**Phone**_____
   Speciality _____
   Address_____
3. **Name**_____**Phone**_____
   Speciality _____
   Address_____
4. **Name**_____**Phone**_____
   Speciality _____
   Address_____
5. **Name**_____**Phone**_____
   Speciality _____
   Address_____
6. **Name**_____**Phone**_____
   Speciality _____
   Address_____
7. **Name**_____**Phone**_____
   Speciality _____
   Address_____
8. **Name**_____**Phone**_____
   Speciality _____
   Address_____

Please attach a separate sheet of paper if more space is needed.

Claimant's Name: **Claim Number:**

Claimant Two Week Warning Letter

RE: Employer:
Date of Injury:
Claim Number:

Dear:

We are the workers' compensation carrier for your employer. We have been unsuccessful in our attempts to contact you regarding your workers' compensation claim. Please contact me at 1-800-821-9605 so that I may obtain a recorded statement from you regarding this matter. Please be advised that without this information we cannot complete our investigation into your claim and no benefits will be paid.

If we do not hear from you within two weeks from the date of this letter, we will assume that you do not wish to pursue this claim. In which case, the State of Alabama Department of Labor Workers' Compensation Division will be notified that your claim is being denied based on our inability to adequately investigate this claim. Your claim file will be closed at that time.

I look forward to hearing from you in the near future. Should you have a problem complying with our request, please contact us or your employer as soon as possible.

Sincerely,

<Manual Fill In>
Workers' Compensation
<Manual Fill In>

cc: <Manual Fill In>
«InsuredCompanyName»

Denial Letter to Employer

RE: Employee:
Date of Alleged Injury:
Claim Number:

Dear <Contact-Manual Fill In>:

We have received an Employer's First Report of Injury Form on the above Employee and have been unable to contact them at the address provided. We must deny payment of this claim until the Employee can be contacted and a statement taken regarding the alleged injury. If the Employee should contact you regarding this claim, please have them contact us so that we may complete our investigation. Should you have any questions, please feel free to contact me.

Sincerely,

<Manual Fill In>
Workers' Compensation
<Manual Fill In>

cc: Claimant

Opening Letter to Physician

RE: Employer:
Employee:
Claim Number:
Date of Injury:
Adjuster:

Dear Manual Fill In:

We are the workers' compensation carrier for the above patient's employer. In order to evaluate this claim, it is essential that we receive a narrative medical report on your treatment of this patient.

Since this is a workers' compensation claim, we will need to be updated periodically if treatment is to continue. These reports will need to include a statement, as to your opinion, of the employee's ability to work. We would also appreciate prompt written notification if this patient has reached maximum medical improvement, has been released to return to work, or has sustained any permanent partial impairment as a result of this on-the-job injury.

If this patient requires testing, hospital admission, treatment by any outside facility, physician referral, equipment rental or purchase, we will need to be contacted for authorization in advance. **Healthcare Workers' Compensation Fund will not be responsible for payment of unauthorized services. If prior approval is not given, the patient will be responsible for payment of these charges.** We also reserve the right to obtain a second opinion if surgery is recommended.

If you will forward your bill for services to date, it will receive prompt attention. Your cooperation is greatly appreciated.

Sincerely,

<Manual Fill In>
Workers' Compensation
<Manual Fill In>

cc:<Manual Fill In>
«InsuredMailName»

Claimant

Change of Physician Letter

RE: Claim Number :
Claimant :
Insured :
Date of Injury :

Dear

You have expressed dissatisfaction with your current authorized treating physician, Dr. and have requested to see another physician. We are providing you with the below panel of four physicians from which you may choose another physician.

1. Dr.
2. Dr.
3. Dr.
4. Dr.

Please be advised that the physician you choose from this panel will be your authorized treating physician for the remainder of this claim. If testing, hospital admission, treatment by an outside facility or physician referral is required, please contact Healthcare Workers' Compensation Fund for prior approval.

Please confirm your choice by completing the attached form and returning it to my attention as promptly as possible. Should you have any questions, please do not hesitate to contact me at 334-323- .

Sincerely,

Claims Adjuster
HWCF

Claim Number :
Claimant :
Insured :
Date of injury :

I, , choose Dr. _____, to be my authorized treating physician from the panel of four physicians provided to me by Healthcare Workers Compensation Fund.

I understand that this physician will be my authorized treating physician for the remainder of this claim. Unless prior approval is given, the chosen physician is the only doctor authorized to treat me for this on-the-job injury. If testing, hospital admission, treatment by an outside facility or physician referral is required; I understand Healthcare Workers' Compensation Fund will need to be contacted for prior approval.

You may send this form to me by the following options:

Mailing Address
P.O. Box 211359
Montgomery, AL 36121

Fax - 334-386-4529
Email –

Sign: _____ _____
Print Signature

Date: _____

Healthcare Workers' Compensation Self-Insurance Fund HWCF

MILEAGE REIMBURSEMENT FORM

Employee:

Employer:

Date of Injury:

Date of Service	Destination	From	Purpose of Trip	Round Trip Mileage

I certify that the above form reflects an accurate account of authorized medical visits and the correct mileage traveled.

Signature

Repetitive Motion Disorder Questionnaire

RE: Employee:
Date of Alleged Injury:
Claim Number:

Dear <Contact-Manual Fill In>:

We have received a workers' compensation claim on the above employee for a repetitive motion disorder. The following questions must be answered to help us determine the compensability of the submitted claim. Please feel free to return the requested information on this form in the space provided.

1. How long has the above employee been performing this job?

2. What functions, if any, of the employee's job might possibly contribute to this repetitive motion disorder?

3. How many hours per day does the employee perform these tasks?

4. Have any other employees, performing the same duties, been affected by a similar repetitive motion disorder?

5. If yes, please list these employees and provide lengths of employment and number of hours duties are performed daily.

6. Please investigate as to the employee's hobbies/extracurricular activities and provide us with a list.

7. Please attach a copy of the employee's employment application and job description.

8. Has the employee ever had a similar condition or complaint? If so, please describe in detail.

Please be advised that no benefits will be paid until this investigation has been completed. Once we have received and reviewed the above information, we will make a determination as to whether the repetitive motion disorder meets the standard of proof to be a compensable injury.

Thank you for your assistance in this matter. If you have any questions, please contact me.

Sincerely,

<Manual Fill In>
Workers' Compensation
<Manual Fill In>

POST-OFFER, PRE-PLACEMENT HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

SSN: _____ ADDRESS: _____

PHONE: _____ DOB: _____ SEX: _____

DEPARTMENT: _____ SUPERVISOR: _____

POSITION: _____ PERSONAL PHYSICIAN: _____

PHYSICIAN'S PHONE: _____ DATE OF LAST EXAM: _____

Have you ever had or do you have any of the following? If Yes, please explain under remarks and indicate when each occurred?

1.	Skin problems or chronic rash	Yes No	34.	Tendonitis	Yes No
2.	Shoulder/elbow/hand pain	Yes No	35.	Broken bones	Yes No
3.	Carpal tunnel syndrome	Yes No	36.	Bone or joint problems	Yes No
4.	Numbness or tingling in arms/ hands	Yes No	37.	Neck pain/injury	Yes No
			38.	Back pain/injury	Yes No
5.	Numbness, tingling or cramps in legs/feet	Yes No	39.	Knee injury	Yes No
			40.	Foot problems	Yes No
6.	Hearing loss/ear trouble	Yes No	41.	Paralysis	Yes No
7.	Asthma, hay fever, sinus trouble	Yes No	42.	Dislocation of joints	Yes No
8.	Severe tooth or gum trouble	Yes No	43.	Sciatica or disc problem	Yes No
9.	Kidney trouble/bladder infection	Yes No	44.	Arthritis/gout	Yes No
10.	Gall stones, gall bladder trouble	Yes No	45.	Rheumatism	Yes No
11.	Ear, nose or throat trouble	Yes No	46.	Anemia	Yes No
12.	Eye problems	Yes No	47.	Blood disease	Yes No
13.	Wear glasses/contacts	Yes No	48.	Epilepsy/seizures	Yes No
14.	Color blindness	Yes No	49.	Immune suppression	Yes No
15.	Heart trouble/attack	Yes No	50.	Diphtheria	Yes No
16.	Palpitations	Yes No	51.	Chicken pox	Yes No
17.	Chest pain	Yes No	52.	Measles/Rubella	Yes No
18.	High blood pressure	Yes No	53.	Mumps	Yes No
19.	Low blood pressure	Yes No	54.	Rheumatic fever	Yes No
20.	Yellow jaundice	Yes No	55.	Prostate problems	Yes No
21.	Liver trouble/hepatitis	Yes No	56.	Tuberculosis	Yes No
22.	Bruising of unknown cause	Yes No	57.	Chronic cough	Yes No
23.	Latex sensitivity	Yes No	58.	Allergies	Yes No
24.	Sensitivity to powder in gloves	Yes No	59.	Chronic/frequent colds	Yes No
25.	Severe weakness or tiredness	Yes No	60.	Shortness of breath	Yes No
26.	Frequent trouble sleeping	Yes No	61.	Stroke	Yes No
27.	Hernia or rupture	Yes No	62.	Diabetes	Yes No
28.	Frequent/severe/unusual headaches	Yes No	63.	Low blood sugar	Yes No
			64.	Alcohol/drug problem	Yes No
29.	Dizziness or fainting spells	Yes No	65.	Depression or anxiety	Yes No
30.	Thyroid trouble or goiter	Yes No	66.	Emotional or nervous problems	Yes No
31.	Recent weight gain or loss	Yes No			
32.	Duodenal ulcer/stomach trouble	Yes No	67.	Frequent indigestion	Yes No
33.	Pneumonia/lung problems	Yes No			

Remarks:_____
_____

Do you have any symptoms, conditions, and/or diseases not listed above? Yes No

If yes, please explain: _____
_____

Please answer the following questions. If you answer yes, please explain (beside the question).

1. Have you ever had an accident resulting in injury? Yes No _____
2. Are you presently drawing disability benefits from the government or an insurance company? Yes No _____
3. Have you ever had:
   a. Needlesticks/blood or body fluid exposures? Yes No _____
   b. Rash or symptoms related to glove use? Yes No _____
   c. Pain, numbness or tingling related to hand/wrist/back motions? Yes No _____
4. Are you presently under a health provider's care for any condition? Yes No _____
   (Please list date and reason for your last visit with provider)
5. Have you ever had a reaction, allergy and/or sensitivity to drugs, food, plants, animals, latex gloves, or other substance? Yes No _____
6. Do you presently have any condition requiring medication or treatment? Yes No _____
7. Have you ever been addicted to any substances or admitted for rehabilitation? Yes No _____
8. Do you have any allergies? Yes No _____

Please answer the following questions:

1. List all medications that you regularly or frequently take and explain reason prescribed?
   _____
2. Do you exercise regularly? Yes No
   If yes, what type of exercise and how often?
   _____
3. Do you smoke or use tobacco? Yes No
   If yes, for how long? _____ How many packs per day? _____
4. Do you drink alcohol? Yes No
   If yes, please indicate how many glasses each per week of wine _____, beer _____, and/or liquor _____.
5. Do you have a drug dependency? If yes, please explain: _____
   _____
6. Are you able to perform your job duties with or without reasonable accommodations? Yes No

If you need reasonable accommodations, please include additional information regarding your request. If it is determined at any time that reasonable accommodations are needed in order to allow you to fulfill your job duties, please contact the appropriate supervisor as soon as possible.

This employer does not discriminate against any person for any reason prohibited by applicable law, including because of genetic information; and bases all employment decisions solely on the employee's *current* ability to work.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I hereby certify that the information contained in this health questionnaire for employment is true and correct and any omission or misrepresentation of facts will be a basis for immediate dismissal. Misrepresentations as to preexisting physical or mental conditions may void your workers' compensation benefits.

Signature: _____ Date: _____

Height: _____ B/P:_____
Weight: _____ Pulse:_____
Temperature:_____ Respirations:_____

Notes/remarks_____
_____
_____
_____

Clinician/employer signature: _____ Date: _____