

INJURED EMPLOYEE WORKERS COMPENSATION PACKET

The Commonwealth of Massachusetts is the worker's compensation insurer for all state employees. Workers compensation insurance pays for medical expenses associated with job-related injuries and may also provide a weekly income if you are unable to work due to such an injury for five (5) calendar days or more.

PROCESS FOR REPORTING A WORK-RELATED INJURY OR ILLNESS

- ❖ All work-related injuries, serious or otherwise, must be reported to your immediate supervisor and to Human Resources on the day they occur.
 - The supervisor, first responder, or authorized individual arranges for any immediate medical attention required.
- ❖ Within 48 hours of the injury, the supervisor and employee must complete, sign, and forward to HR Benefits the **Notice of Injury Report** with accompanied Authorization for Release of Medical Records.

EMAIL Notice of Injury Report to: benefits@westfield.ma.edu

- ❖ Upon receipt of the **Notice of Injury Report**, Human Resources will open a claim. The claim number and assigned adjuster will be provided to the injured employee as confirmation that the claim was filed and if ongoing claim administration is required.

MEDICAL TREATMENT

- ❖ If the injury requires medical attention:
 - The employee must inform the treating medical provider that the injury is work related and not to bill the employee's insurance.
 - The employee must provide the items listed below and included in this packet to the treating medical provider.

Important documents included in this packet:

- ❖ **Injured Workers Guide to Medical Treatment** - know your responsibilities and rights as an injured worker and **provide this guide to your treating medical provider for billing information**
- ❖ **Physicians Report** - to be completed by the treating medical provider
- ❖ **MyMatrixx Temp Prescription Card**- for prescriptions filled after medical evaluation
- ❖ **Concurrent Employee Review** - for employees who may work with another employer in addition to their Westfield State University employment.

RESOURCES:

University Coordinator: HR Benefits, 413-572-8476

EMAIL for assistance: benefits@westfield.ma.edu

General Claims Administration: HRD/Workers' Compensation Unit, 100 Cambridge St, Suite 600, Boston, MA 02114, Phone: (617) 727-3437, Fax: (617) 727-7816

Medical Providers Seeking Payment (medical bills and related records): All bills must be received on a HICFA 1500 or UB 90 form with a detailed description of the services rendered attached and mailed to HRD/Workers' Compensation Unit, P.O. Box 211134, Eagan, MN 55121



EXECUTIVE OFFICE FOR ADMINISTRATION & FINANCE
COMMONWEALTH OF MASSACHUSETTS
HUMAN RESOURCES DIVISION
100 CAMBRIDGE STREET, SUITE 600
BOSTON, MA 02114

MAURA T. HEALEY
GOVERNOR

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

MATTHEW J. GORZKOWICZ
SECRETARY

MELISSA J. PULLIN
INTERIM CHIEF HUMAN
RESOURCES OFFICER

Injured Workers' Guide to Medical Treatment

The Human Resources Division/Worker's Compensation Unit (HRD/WC) is the insurer and the Utilization Review provider for your industrial accident. Your agency workers' compensation agent will provide you with an HRD/WC Notice of Injury Packet and my Matrixx and Express Script (hereinafter ESI) First Fill Form. Please make sure that your agency workers' compensation designee has completed the entire packet and advised HRD/WC of your claim. Upon receipt of your claim, the HRD/WC will assign a file number. **If you have questions regarding your claim, you may call HRD/WC 1(617) 727-3437 and ask to speak with the adjuster for your employer agency.**

The Department of Industrial Accidents (DIA) requires all workers' compensation insurers to perform utilization review to determine the medical necessity of health care services. You or your medical provider must contact HRD regarding treatment for your work-related injury. You may contact the Utilization Review department once a claim has been filed at 1(800) 266-7991 or by fax at 1(617) 727-7816.

Please notify your medical provider to forward medical bills and their attachments to HRD/Workers' Compensation Unit, P.O. Box 211134, Eagan, MN 55121. Under no circumstances should you provide your employing agency as the insurer. HRD does not reimburse for co-payments resulting from the use of another insurance policy.

The Executive Office of Health and Human Services (EOHHS) has statutory authority under M.G.L. c. 152, §13 and M.G.L. c. 118G to regulate rates of payment for hospitals, health care providers and prescription drugs covered by insurers under the Workers' Compensation Statute. The rates of payment provided by HRD/WC is consistent with the fee schedule established by EOHHS. Reimbursement for health care services is considered payment in full; your provider may not bill you more than the established rate of reimbursement. **Please inform your medical provider, that to be considered for reimbursement, all bills must be received on a HICFA 1500 or UB 04 form with a detailed description of the services rendered attached.**



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Injured workers are required to use the First Fill Form referenced above to fill prescriptions related to the work injury. A prescription card will be mailed to you directly from ESI after your claim has been filed. ESI is a pharmacy benefit management company that is uniquely set up to provide prescription medications for work-related injuries. Please refer to the First Fill Form in your Notice of Injury Packet for information and participating pharmacy.

**Human Resources Division
Workers' Compensation Section
100 Cambridge Street, Suite 600
Boston, MA 02114**

PHYSICIAN'S REPORT

Report status: Initial ____ Follow-up ____

TO BE COMPLETED BY EMPLOYER:

1. Name of Facility/Agency _____ phone () _____
Address: _____
Name/Title of Workers' Compensation Contact: _____

TO BE COMPLETED BY EMPLOYEE:

2. Full Name _____ Date of Birth: ____/____/____
First Middle Last
Address: _____
3. Date of Injury: _____ Social Security No.: _____ - _____ - _____
4. Has employee received prior medical treatment for this injury? Yes ____ No ____
If yes, by whom? _____

TO BE COMPLETED BY MEDICAL PROVIDER/OFFICE STAFF:

5. Physician Name (print or type): _____ Date of Exam ____/____/____
License No.: _____ Specialty: _____ Date of Report ____/____/____
6. Mailing Address: _____

TO BE COMPLETED BY PHYSICIAN(MEDICAL EXAMINATION RESULTS):

7. Provide patient's statement as to how the injury occurred: _____
8. Is there a history/evidence of pre-existing injury/disease: Yes ____ No ____
If yes, explain: _____
9. Subjective Complaints: _____
10. Objective Findings: _____
11. Neurological Findings (if any): _____
12. Diagnosis: _____
13. Plan of Treatment: _____
14. In your opinion, was the accident/exposure a producing/contributing cause of the injury? Yes ____ No ____
15. Is the employee able to perform his/her regular work duties? Yes ____ No ____
If no, employee may return to full duty in _____ days/weeks. (Circle one)

16. **FUNCTIONAL LIMITATIONS:**

Temporary modified work may be available at state facilities. The employer may develop a modified job based on any restrictions described below. Patient **CANNOT:**

SIT	more than ____ hours/day
STAND/WALK	more than ____ hours/day
CARRY/LIFT	more than ____ 10 ____ 20 ____ 30 ____ 40 ____ 50 lbs.
PUSH	more than ____ 10 ____ 20 ____ 30 ____ 40 ____ 50 lbs.
PULL	more than ____ 10 ____ 20 ____ 30 ____ 40 ____ 50 lbs.
DRIVE VEHICLE	Yes ____ No ____

OTHER (please describe): _____

17. (Physician Referrals Only) Indicate Physician: _____ Specialty: _____

SIGNATURE OF PHYSICIAN

I certify under the pains and penalty of perjury that I have personally examined the above named employee.

Signature: _____ Date: _____

(I am a duly licensed physician)

MyMatrixx

By ~~EVERNORTH~~



To the Injured Worker:

On your first visit, please give this form to any pharmacy listed on the back side to speed processing of your approved work-related injury prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the MyMatrixx Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

En su primera visita, entregue este formulario a cualquier farmacia que se encuentre en el reverso del boleto para acelerar el procesamiento de sus recetas aprobadas para lesiones relacionadas con el trabajo (según las reglas establecidas por su empleador).

¿Tiene preguntas o necesita ayuda para localizar una farmacia participante? Llame al centro de contacto para pacientes de MyMatrixx al 800.945.5951.

Temporary Prescription Card

ID#: _____

Your SSN is your temporary ID.

RxBIN#: 003858

PCN: WC

RxGroup #: M5AA

Date of Injury: _____

MM/DD/YYYY

For Workers' Compensation Only

Employee Information

Full Name

Street Address or PO Box

City

State

ZIP

Date of Birth

Employer Name



To the Pharmacist:

MyMatrixx administers this Workers' Compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-day supply or a cost of \$150. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary.

For assistance, please call MyMatrixx at 888.786.9640.

Processing Steps:

1. Enter RxBin 003858
2. Enter PCN WC
3. Enter Rx Group Number M5AA
4. Enter 9-digit member ID (Patient SSN)
5. Enter Date of Injury

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

AHF PHARMACY
AHOLD CORPORATION
ALBERTSONS
ALIGNRX LLC
AMERITA INC
AURORA PHARMACY INC
BIG Y FOODS INC
BI-LO HOLDINGS LLC
BROOKS/MAXI DRUG
BROOKSHIRE BROTHERS LTD
BROOKSHIRE GROCERY CO
CARDINAL HEALTH
CHEN NEIGHBORHOOD MEDICAL CENT
COBORN'S INC.
COSTCO WHOLESALE, INC
CVS CORP
DEDICATED US HOLDINGS LLC
DISCOUNT DRUG MART
ECKERD
EPIC PHARMACY NETWORK
ESSENTIA HEALTH
EXPRESS RX
FAIRVIEW PHARMACY SVCS
FAMILY FARE, LLC

FOOD LION PHARMACY
FRUTH PHARMACY
GENOA HEALTHCARE LLC
GIANT EAGLE PHARMACY
GUARDIAN PHARMACY LLC
HAC INC
HANNAFORD BROS. CO.
HARPS FOOD STORES INC
HARTIG DRUG
HEALTH MART ATLAS LLC
H-E-B LP
HENRY FORD HEALTH SYSTEM
HOMETOWN PHARMCY INC
HY-VEE FOOD STORES INC
INGLES MARKETS
INSTYMEDS CORP
KPH HEALTHCARE SERVICES
KS PHARM LLC
K-VA-T FOOD STORES INC
LEWIS DRUGS INC
LONGS DRUG STORE
MARC GLASSMAN INC
MEDICAP PHARMACY, INC.
MEDICINE SHOPPE
MEIJER PHARMACY
MERCY PHARMACY SERVICES

NCS HEALTHCARE
NEIGHBORCARE PHARMACY
OSBORN DRUGS INC
PATIENT FIRST
PHARMEDQUEST PHARMACY
PHARMERICA, INC
PMR US HOLDINGS
PRESBYTERIAN MEDICAL
PRESCRIBEIT RX
PRICE CHOPPER PHARMACY
PUBLIX SUPER MARKETS, INC
RALEY'S
RECEPT PHARMACY LP
RITE AID CORPORATION
SAFEWAY, INC.
SAM'S CLUB
SUPERVALU PHARMACIES, INC.
TARGET
THRIFTY WHITE STORES
TOPS MARKETS LLC
UNITED SUPERMARKETS INC
WALGREENS
WAL-MART
WEGMANS FOOD MARKETS,
WEIS MARKETS INC

Visit www.MyMatrixx.com to locate a participating pharmacy near you!



Workers' Compensation Section
100 Cambridge Street, Suite 600
Boston, MA 02114

CONCURRENT EMPLOYMENT REVIEW FORM

All injured workers should complete the Concurrent Employment Review Form. The employee must report all earnings and indicate if he/she will continue to work for another employer(s) (public or private) while the workers' compensation claim is being processed and throughout the course of his/her workers' compensation claim.

If the employee is working at the time of the state industrial accident, the salary from that job must be considered by the HRD adjuster when calculating the AWW and the Compensation rate. If the employee continues to work at his/her other employment, he/she would be paid section 35 benefits and not section 34 benefits.

Your review of concurrent employment is separate from the Earnings Report authorized under M.G.L. Chapter 152, s. 11D requiring the reporting of all earnings including wages or salaries earned from self-employment. The purpose of this review is to insure that the employee receives the appropriate compensation, which is based on the loss of **all earnings**. If the employee returns to any of his/her former employer(s), adjustments must be made to the compensation rate and the payment section.

In the event the injured worker states that he/she has no concurrent employment, that should be noted on the form and filed with the HRD Adjuster.

It is essential that the workers' compensation agent incorporate this review into the initial agency level claims investigation process. Please use the attached HRD "CONCURRENT EMPLOYMENT REVIEW FORM", when meeting with the injured worker when a claim is being filed.



Workers' Compensation Section
100 Cambridge Street, Suite 600
Boston, MA 02114

CONCURRENT EMPLOYMENT REVIEW FORM

CLAIMANT'S NAME: _____ SS# _____

STATE AGENCY: _____

DATE OF INJURY: _____

OTHER EMPLOYER NAME: (public or private) _____

EMPLOYER ADDRESS: _____

CONTACT PERSON: _____ Telephone # _____

DATES OF OTHER EMPLOYMENT: _____ From _____ To _____

DO YOU EXPECT THIS EMPLOYMENT TO CONTINUE? Yes _____ No _____

JOB DESCRIPTION OF OTHER EMPLOYMENT: _____

Please list all positions both private and public other than the position for which you are claiming workers' compensation. Attach a separate sheet for each position.

Week No.	Year: Week Ending Month Day	Gross Amount Paid including overtime
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		

Week No.	Year: Week Ending Month Day	Gross Amount Paid including overtime
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		
32		
33		
34		

Week No.	Year: Week Ending Month Day	Gross Amount Paid including overtime
35		
36		
37		
38		
39		
40		
41		
42		
43		
44		
45		
46		
47		
48		
49		
50		
51		
52		

I hereby certify that the above information is a complete and accurate statement of income from any other employment. Signed under the pains and penalties of perjury.

Claimant's Signature

Date

This statement of income is to be utilized to determine the amount of workers' compensation you may receive for the injury for which you have a claim.