

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
- ❖ **First Fill Form** - 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, 413-572-5274

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

JEFF McCUE
ASSISTANT SECRETARY
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 an my Matrixx an 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.

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.

Updated March 2023

Workers' Compensation Temporary Prescription ID Card

»» To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer). Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at **(800) 945-5951**.

»» To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitation is \$150.00, or a day supply exceeding 14 days. This form is valid for up to 30 days from DOI. Limitations may vary. For assistance, call Express Scripts at **(888) 786-9640**.

Pharmacy Processing Steps

- Step 1: Enter bin number 003858
- Step 2: Enter processor control A4
- Step 3: Enter the group number as it appears above
- Step 4: Enter the injured worker's nine-digit ID number
- Step 5: Enter the injured worker's first and last name
- Step 6: Enter the injured worker's date of injury
(enter in DOI field in the format YYYYMMDD)

Express Scripts

ID #: _____
Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____ / _____ / _____
MM/DD/YYYY

Group #: M5AA

Employee Date of Birth: _____ / _____ / _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare. *Please see other side for a list of participating retail network pharmacies.*

»» **To the Supervisor:** Please fill in the information requested for the injured worker.

Employer Name
Commonwealth of Massachusetts

Employee Information

First M Last

Street Address or PO Box

City State ZIP

Participating Retail Network Pharmacies

A & P	Drug Emporium	Major Value	Schnucks
Acme Pharmacy	Drug Fair	Marsh Drugs	Scolari's
Albertson's	Drug Town	Medic Discount	Sedano
Albertson's/Acme	Drug World	Medicap	Shaw's
Albertson's/Osco	Eckerd	Medistat	Shop 'N Save
Albertson's/Sav-On	Econofoods	Meijer	Shopko
Amerisource	EPIC Pharmacy	Minyard	ShopRite
Bergen	Network	NCS HealthCare	Snyder
Anchor Pharmacies	FamilyMeds	Neighborcare	Stop & Shop
Arrow	Farm Fresh	Network	Sun Mart
Aurora	Farmer Jack	Pharmaceuticals	Super Fresh
Bartell Drugs	Food City	Northeast	Super Rx
Bigg's	Food Lion	Pharmacy Services	Target
Bi-Lo	Fred's	Osco	Texas Oncology
Bi-Mart	Gemmel	P & C Food	Srvs
BJ's Wholesale	Giant	Markets	The Pharm
Club	Giant Eagle	Pamida	Thrifty White
Brooks	Giant Foods	Park Nicollet	Times
Brookshire Brothers	Hannaford	Pathmark	Tom Thumb
Brookshire Grocery	Harris Teeter	Pavilions	Tops
Bruno	H-E-B	Price Chopper	Ukrop's
Carrs	Hi-School	Publix	United Drugs
Cash Wise	Pharmacy	Quality Markets	United
Coborn's	Hy-Vee	Raley's	Supermarkets
Costco	Jewel/Osco	Randalls	Vons
Cub	Kash n Karry	Rite Aid	Waldbaums
CVS	Keltsch	Rosauers	Walgreens
D&W	Kerr	Rx Express	Wal-Mart
Dahl's	Kmart	RXD	Wegmans
Dierbergs	Knight Drugs	Safeway	Weis
Discount Drugmart	Kroger	Sam's Club	Winn Dixie
Doc's Drugs	LeaderNet (PSAO)	Sav-On	
Dominicks	Longs Drug Store	Save Mart	

To search for participating pharmacies in your area, please use the "Find a Pharmacy" tool located at: <http://www.express-scripts.com/services/workerscompensation/>

NOTE: This form is not valid in the state of Ohio. For all other states, liability of a workers' compensation claim is not assumed based on the dispensing of medication(s) to a patient.



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.