



Workers' Compensation **USERS' KIT**

EVERYTHING YOU NEED TO KNOW ABOUT
WORKERS' COMPENSATION AND WHO TO CONTACT





Workers' Compensation Users' Kit

All materials contained in this kit are available on our website at www.cmregent.com.

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July 2018

Workers' Compensation Division

2018 – 2019 Policy Year

All CM Regent Insurance Company Workers' Compensation Policy Holders:

Thank you for choosing CM Regent Insurance Company (CMRIC), to fulfill your Workers' Compensation needs.

CMRIC has earned an excellent reputation for providing superior claim administration to participants of the Workers' Compensation program. Considered to be best practice in workers' compensation claims handling, CMRIC focuses on care and concern for injured workers in order to provide the best medical care for a full recovery and timely return to work.

The care and concern approach to claims handling allows school administrators and staff to focus on daily priorities while knowing their claims are being handled professionally. CMRIC also assists participants in developing medical provider panels, safety education programs, transitional modified return-to-work plans, and other tools that help reduce claims and associated costs. We have medical personnel on staff who are involved in the management of your claims at every step of the process. Our Litigation Management model allows us to know what the cost of litigation will be for a case before the litigation even begins, putting a stop to runaway legal costs. Our claim representatives have the technical expertise to find the most effective solutions to problematic claims.

Now Available – Pre-Employment Screening for insureds enrolled in our Workers' Compensation program! Let CMRIC assist you with the resources to complete pre-employment screening for your potential "new hires." Contact Christine Curtis, Managed Care Manager, at 866-402-6600, ext. 2339, for more details.

To help explain our services and guide you through the benefits we have to offer, we have developed the Workers' Compensation Users' Kit. It is available on our website for your convenience.

As part of our ongoing efforts to expand the service we provide to our customers, we offer the School District Portal, located on the CM Regent Insurance Company website (www.cmregent.com). The portal is dedicated to the information and claim reporting needs of our school district personnel, and will allow those registered to report new Workers' Compensation claims online 24/7. If you do not have your login information, follow the steps on the following page to register for the portal:

School District Portal Registration

Step 1:

Send an email to

webcomments@cmregent.com requesting to be registered to use the School District Portal.

Provide the following information: first and last name, title, school district, email address and phone number.

Step 2:

The information you provide will be entered into the School District Portal and an automatically generated email will be sent to you with instructions on how to complete the registration process.

Step 3:

Once you complete the registration process you will have immediate access to add and view Workers' Compensation claims via the School District Portal.

Step 4:

Bookmark **www.cmregent.com** as the site to use for entering and viewing Workers' Compensation claims. If you have any problems with the portal registration process, please direct all questions to:
webcomments@cmregent.com.

Thank You! And as always, we value your business and appreciate the opportunity to partner with you to achieve successful outcomes in your Workers' Compensation program.

► Workers' Compensation Team

Christine Curtis

Managed Care Manager
866-402-6600, ext. 2339
CCurtis@cmregent.com

Harriet Gaither

Claim Supervisor
866-402-6600, ext. 2306
HGaither@cmregent.com

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866-402-6600, ext. 2346
CWolf@cmregent.com

Administrative Support

Angel Klasnick

Claim Service Assistant
AKlasnick@cmregent.com
ext. 2312

Erin Varian

Claim Support Assistant II
EVarian@cmregent.com
ext. 2325

Lost Time Claim Representatives

Joellen Kalp

Claim Representative III
JKalp@cmregent.com
ext. 2305

Carole Schmuck

Claim Representative III
CSchmuck@cmregent.com
ext. 2319

Tiffany Holland

Claim Representative II
THolland@cmregent.com
ext. 2373

Medical Only Claim Representatives

Brenda Ressler

Claim Representative I
BRessler@cmregent.com
ext. 2343

► Claims Process Timeline

Get the Facts/Document the Injury:

- Document the injury and its cause on the attached Accident Investigation Form after talking with the injured worker and witnesses.
- Take all necessary safety precautions, photograph the area of the accident and secure any object(s) that may have caused the injury.

Assist Your Employee in Obtaining Medical Attention:

- Have your employee sign a copy of your Physician Panel list. Provide one copy to the employee and keep the other in your files.
- Give your employee a copy of the attached Physical Capacities Form and instruct them to immediately provide it to their doctor.
- For emergency care your employee should go to the nearest emergency room. Subsequent treatments should be obtained from a medical provider listed on your Physician Panel list.
- Contact Christine Curtis, Managed Care Manager, at CM Regent Ins. Co. at 866-402-6600 ext. 2339, if your school does not have a Physician Panel or you would like your current panel reviewed.

Contact CM Regent Insurance Company Promptly:

- Report the injury online within 24 hours at www.cmregent.com. The attached Incident Reporting Form will assist you in the reporting process.
- Once the injury is reported, you will receive a confirmation number that is the claim number you will use when referencing the employee's claim.

Process Claim Forms:

- You will receive an email from CM Regent Insurance Company acknowledging the claim and identifying the Claim Representative assigned to work with you and your employee.
- Notify the Claim Representative immediately if a Medical Only claim results in your employee missing more than seven days of work.
- You will receive a Statement of Wage form to be filled out and returned to CM Regent Ins. Co.
- All medical bills should be forwarded to: Coreworks, 333 Technology Drive, Suite 108, Canonsburg, PA 15317 immediately.

Maintain Contact with Your Employee and the Claim Representative:

- Contacting your injured employee on a regular basis after seven days of missed work is an important way to show your concern for their condition.
- You will want to understand the employee's status, what they have planned over the upcoming weeks and whether their situation has changed.
- CM Regent Ins. Co. will rely on you to provide relevant information that will allow us to properly handle your employee's claim.

Identify Return-to-Work and Transitional Work Options:

- The completed Physical Capacities Form will assist you in determining the availability of transitional work for the injured employee.
- You, your Claim Representative and your employee should discuss the availability of transitional work, even before they are released to work.

► What To Do If You Are Injured At Work

As soon as practicable, report the incident to your Supervisor, Human Resources or your employer's Worker's Compensation Coordinator so they can report it to our office, even if you don't think you need medical treatment.

- Make sure your employer has your most up-to-date contact information, including phone numbers, home address and personal email.

Your employer will file your claim electronically with CM Regent Insurance Company, who will assign a Claim Representative to work with you going forward.

- If you require medical treatment, your employer will give you a copy of your Injury Report that will include your confirmation/claim number. To avoid delays, take the Injury Report with you to your initial doctor's appointment.
- When seeking medical attention on for a work-related injury occurring after hours, tell the medical provider that yours is a Workers' Compensation injury. Remember to report the incident to your employer the next business day.

Your employer should give you a copy of your Provider Panel.

- A Provider Panel is a list of medical providers you must with the first 90 days following a work-related injury. You must sign a form acknowledging your receipt of the Provider Panel information.

PLEASE NOTE: If immediate emergency care is needed, go to the nearest emergency room for the initial visit. Follow-up visits should then be scheduled with a medical provider on the Provider Panel.

Write down questions you may have for your medical provider and take them with you on your first visit.

- Communicate any concerns about your treatment to your medical provider and to your CM Regent Insurance Company Claim Representative.

The following services should be scheduled through the providers listed during the first 90 days of a claim.

- MRI, CT, EMG – One Call Medical (800-453-0574)
- Physical Therapy – SPNet Clinical Solutions (888-654-0049)
- Prescriptions – Corvel (800-563-8438)

Continued...

A Model of Care and Concern — How We Can All Work Together

- You can expect contact from your Claim Representative between 8 a.m. and 4:30 p.m. to discuss your injury and if applicable, a treatment strategy.
- Watch your mail for paperwork that will need to be filled out immediately and returned to our office or given to your medical provider. A self-addressed stamped envelope will be included for your use for the materials that are to be sent back to CM Regent Insurance Company.
- A pharmacy card will be issued to you once your claim has been accepted and Workers' Compensation benefits are approved. This card is to be used for all prescription purchases as prescribed by your medical provider.
- Call your Claim Representative after every doctor appointment to relay the most current medical and return-to-work information.

CM Regent Insurance Company wants to help get you back to your pre-accident condition as quickly as possible. If you have any questions or concerns, please do not hesitate to call our office at 1-866-402-6600.

► Provider Panel Information

- The significance of a physician panel list is multifaceted. From an expense standpoint, the listing will assist in direction of care to the most appropriate provider for the injury (i.e. Injured Worker can be evaluated and treated at the designated occupational health clinic versus the local emergency room, for non-emergent injuries, thus resulting in an estimated minimum savings of \$2,000).
- Posted physician panels account for an average of 48.2 lost days versus 63.3 lost days with no posted panel (Medical Access Study Executive Overview).
- Physician panels are required to have a minimum of six providers (including at least three physicians and no more than four coordinated care organizations).
- The school district cannot direct treatment with any one specific provider on the list nor can they restrict the Injured Worker from switching from one designated provider to another. You must advise your Claim Representative if you switch from one provider to another.
- Annual review of your physician panel is strongly encouraged (are the providers on your panel still in practice, have they relocated, are they aware of your district's Return-to-Work and/or transitional duty program, if applicable, etc.)
- Does your current panel include specialties that are needed for your Injured Workers? (i.e. Has your district experienced eye injuries, thus needing an ophthalmologist; dental injuries, thus needing a dentist, etc.)
- Have your employees signed the Notice of Employee Rights and Duties? (See pages 8 and 9.)

You have a direct line to valuable resources through the Workers' Compensation Claims Division at CM Regent Insurance Company.

Your panels can be assessed free of charge and options can be discussed on improving the make-up of your current panel.

Your panel is a primary tool against excessive claim dollars, which can relate directly to your Experience Modification factor development, which can in turn directly affect your Workers' Compensation premium calculation.

The time that it will take to review and update your panel is well worth the improved relationships with your Injured Worker(s), as well as the money that the district could save in expense dollars.

We look forward to assisting you in controlling your Workers' Compensation Claims Costs.

Christine M. Curtis, RN, BSW, CCM

CM Regent Insurance Company

Managed Care Manager

866-402-6600 ext. 2339; Fax: 866-402-6601; Email: ccurtis@cmregent.com

RIGHTS AND DUTIES FORM - SIDE 1

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION 306 (f.1)(1)(i) OF THE PA. WORKERS' COMPENSATION ACT

The Pennsylvania Workers' Compensation Act requires that employees be given written notification of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. Below are your rights and duties under Sec. 306 (f.1)(1)(i) and an acknowledgment signature line. This acknowledgment, signed by you, is to be returned to your employer.

A brief summary: You have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that your employer is not liable for the medical bills incurred.

As an employee of the Commonwealth working at a location where a list of designated health care providers has been established and posted, you have:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be at your expense for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties under Sec. 306 (f.1)(1)(i) and that I understand them to the extent that they are explained above.

Print Name

Employee Signature

Date

See reverse for a complete text of Section 306 (f.1)(1)(i)

If you have any questions, ask your human resources office representative or call
The Bureau of Workers' Compensation at 1-800-482-2383

RIGHTS AND DUTIES FORM - SIDE 2

PENNSYLVANIA WORKERS' COMPENSATION ACT SECTION 306 (f.1)(1)(i)

The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

► Sample Letter to Providers

(Date)

(Provider)

(Address)

(City, State, Zip Code)

Dear (Medical Provider):

Your facility is listed on the Workers' Compensation Provider Panel for (Insured Name). Please be advised that effective July 1, 2017, CM Regent Insurance Company will be the Workers' Compensation claims administrator.

Please forward medical bills and reports for injuries occurring on/after July 1, 2018, to the following address:

Coreworks

333 Technology Drive Suite 108

Canonsburg, PA 15317

Thank you for your continuing cooperation in providing quality care to our employees.

Sincerely,

cc:

► Medical Authorization Form

What Is It: Form signed by injured worker (IW) at time of injury in order to secure medical records and be able to speak to the treating medical providers

Importance: Allows for more timely request for medical records (pre and post injury) thus allowing a more thorough investigation of the claim.

How Form is to Be Used: Upon notification of an injury, provide form to injured worker for review and signature. Fax form to CM Regent at 866-402-6601 upon receipt of on-line claim referral (which will provide claim number).

Medical Authorization Form	
Injured Worker:	_____
Claim Number:	_____
Date of Injury:	_____
School District:	_____
Your Workers' Compensation claim is in the process of being submitted to CM Regent Ins. Co. A Claim Representative will be assigned to your claim, but if you have any questions in the interim, please contact CM Regent Ins. Co. at (866) 402-6600.	
If you require the following services, please contact the designated providers:	
<ul style="list-style-type: none">- MRI, CT, EMG – contact One Call Medical @ 800-453-0574- Physical Therapy – contact SPNET @ 888-654-0049- Prescriptions – contact Corvel @ 800-563-8438	
Please sign the medical authorization below. Prompt receipt of the signed authorization form will aid in timely investigation of your claim.	
Thank you for your cooperation.	
.....	
MEDICAL INFORMATION AUTHORIZATION	
I hereby authorize CM Regent Ins. Co. and/or any of its representatives to be permitted to review and obtain copies and/or originals of all information regarding my physical condition or regarding any injuries or disease for which I have been treated medically, including the nature of the physical impairment, history, contributing factors, complications, prescriptions, X-rays, copies of the hospital or other records, estimates of the period or amount of disability, subjective symptoms, objective symptoms diagnosis, prognosis and any further medical information which may be available.	
This shall be a continuing authorization for the release of information unless revoked in writing by the undersigned.	
A photostatic copy of this authorization shall be considered as effective and valid as the original.	
Sign: _____	Date: _____
Date of Birth: _____	
Claim Number: _____	
<small>Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.</small>	

Full-sized form on page 12

Medical Authorization Form

Injured Worker: _____

Claim Number: _____

Date of Injury: _____

School District: _____

Your Workers' Compensation claim is in the process of being submitted to CM Regent Ins. Co. A Claim Representative will be assigned to your claim, but if you have any questions in the interim, please contact CM Regent Ins. Co. at (866) 402-6600.

If you require the following services, please contact the designated providers:

- MRI, CT, EMG – contact One Call Medical @ 800-453-0574
- Physical Therapy – contact SPNET @ 888-654-0049
- Prescriptions – contact Corvel @ 800-563-8438

Please sign the medical authorization below. Prompt receipt of the signed authorization form will aid in timely investigation of your claim.

Thank you for your cooperation.

MEDICAL INFORMATION AUTHORIZATION

I hereby authorize CM Regent Ins. Co. and/or any of its representatives to be permitted to review and obtain copies and/or originals of all information regarding my physical condition or regarding any injuries or disease for which I have been treated medically, including the nature of the physical impairment, history, contributing factors, complications, prescriptions, X-rays, copies of the hospital or other records, estimates of the period or amount of disability, subjective symptoms, objective symptoms diagnosis, prognosis and any further medical information which may be available.

This shall be a continuing authorization for the release of information unless revoked in writing by the undersigned.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Sign: _____

Date: _____

Date of Birth: _____

Claim Number: _____ -


Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

► Physical Capacities Form

What Is It: Form completed by treating/panel physician (at time of injury and ongoing throughout course of treatment of work injury) with a detailed breakout of what the current physical abilities are of the injured worker (IW) in order to attempt to allow IW to remain in the workforce.

Importance: Provides immediate update to employer and Claim Representative as to what the IW is able to do with respect to his/her work duties and/or provides assistance to employer in developing transitional duty (if applicable).

How Form Is to Be Used: Upon notification of an injury that requires treatment, provide form to injured worker and to the panel doctor for completion by treating/panel physician.

		Patient Name: _____ Date of Birth: _____ Claim#: _____																								
PHYSICAL CAPACITIES FORM																										
Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient.																										
1. In an 8-hour workday, patient can stand/walk: (Hours at one time) (Total hours during day) <input type="checkbox"/> 0-2 <input type="checkbox"/> 2-4 <input type="checkbox"/> 4-5 <input type="checkbox"/> 6-8 <input type="checkbox"/> 0-2 <input type="checkbox"/> 2-4 <input type="checkbox"/> 4-6 <input type="checkbox"/> 6-8		<input type="checkbox"/> No restrictions																								
2. In an 8-hour workday, patient can sit: (Hours at one time) (Total hours during day) <input type="checkbox"/> 0-2 <input type="checkbox"/> 2-4 <input type="checkbox"/> 4-5 <input type="checkbox"/> 6-8 <input type="checkbox"/> 0-2 <input type="checkbox"/> 2-4 <input type="checkbox"/> 4-6 <input type="checkbox"/> 6-8		<input type="checkbox"/> No restrictions																								
3. In an 8-hour workday, patient can drive car/truck: (Minutes at one time) (Hours at one time) <input type="checkbox"/> 10-30 <input type="checkbox"/> 30-60 <input type="checkbox"/> 1-3		<input type="checkbox"/> No restrictions																								
4. Patient can lift/carry: Maximum lbs.: 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 Frequently: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Occasionally: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> No restrictions or above																								
5. Patient can use hands for repetitive: A. Simple Grasping B. Pushing & Pulling C. Fine manipulation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No restrictions																								
6. Patient can use feet for repetitive movement as in operating foot controls: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No restrictions																								
7. Patient is able to: <table border="0" style="width: 100%;"> <tr> <td></td> <td style="text-align: center;">Frequently</td> <td style="text-align: center;">Occasionally</td> <td style="text-align: center;">Not at all</td> </tr> <tr> <td>A. Bend</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>B. Squat</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>C. Kneel</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>D. Climb</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>E. Reach</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>				Frequently	Occasionally	Not at all	A. Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	B. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	C. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	D. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	E. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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C. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																							
D. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																							
E. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																							
8. Is patient restricted by environmental factors, such as heat/cold, dust, dampness, height, etc.? <input type="checkbox"/> No restriction <input type="checkbox"/> Yes – Please explain _____																										
9. Is patient involved with treatment and/or medication that might affect his/her ability to work? <input type="checkbox"/> No restriction <input type="checkbox"/> Yes – Please explain _____																										
10. When will patient be released to return to work: Light duty _____ Full duty _____																										
11. Will patient be required to use any assistive devices or braces? <input type="checkbox"/> No restrictions <input type="checkbox"/> Yes – Please explain _____																										
12. Additional comments: _____ _____ _____																										
Physician's Signature _____		Date _____																								

Thank you for your assistance,
 PLEASE FAX TO: CM Regent Insurance Company Workers' Compensation Division at 866-402-6601 and provide a copy to the patient.

Full-sized form on page 14

Patient Name: _____
Date of Birth: _____
Claim#: _____

PHYSICAL CAPACITIES FORM

Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient.

1. In an 8-hour workday, patient can stand/walk: ☐ No restrictions
 (Hours at one time) (Total hours during day)
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
 0-2 2-4 4-5 6-8 0-2 2-4 4-6 6-8
2. In an 8-hour workday, patient can sit: ☐ No restrictions
 (Hours at one time) (Total hours during day)
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
 0-2 2-4 4-5 6-8 0-2 2-4 4-6 6-8
3. In an 8-hour workday, patient can drive car/truck: ☐ No restrictions
 (Minutes at one time) (Hours at one time)
☐ ☐ ☐
 10-30 30-60 1-3
4. Patient can lift/carry: ☐ No restrictions or above
 Maximum lbs.: 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80
 Frequently: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
 Occasionally: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
5. Patient can use hands for repetitive: ☐ No restrictions
 A. Simple Grasping B. Pushing & Pulling C. Fine manipulation
☐ ☐ ☐ ☐ ☐ ☐
 Yes No Yes No Yes No
6. Patient can use feet for repetitive movement as in operating foot controls: ☐ No restrictions
☐ Yes ☐ No
7. Patient is able to:

	Frequently	Occasionally	Not at all
A. Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is patient restricted by environmental factors, such as heat/cold, dust, dampness, height, etc.?
☐ No restriction
☐ Yes – Please explain _____
9. Is patient involved with treatment and/or medication that might affect his/her ability to work?
☐ No restriction
☐ Yes – Please explain _____
10. When will patient be released to return to work:
 Light duty _____ Full duty _____
11. Will patient be required to use any assistive devices or braces?
☐ No restrictions
☐ Yes – Please explain _____

12. Additional comments: _____

Physician's Signature

Date

Thank you for your assistance,


**PLEASE FAX TO: CM Regent Insurance Company Workers' Compensation Division at
866-402-6601 and provide a copy to the patient.**

► Transitional RTW Duty Form

What Is It: The document used to alert everyone involved in the injured worker's care that the school has transitional/modified duty work.

Importance: Faxed to the medical provider along with the Physical Capacities Form. Can be used anytime during the life of the claim.

How Form is Used: The completed form is used to assist the school and CM Regent Insurance Company WC Department to work together for a timely return to work for the employee


Workers' Compensation Division
TRANSITIONAL DUTY RTW FORM

School District Name: _____
School District Address: _____
School District Contact: _____
School District Phone Number: _____ Fax Number: _____

Employer: Provide this form to the attending Physician
*****REMINDER TO MEDICAL PROVIDER*****
EMPLOYEES ARE OUR MOST VALUABLE ASSET!

WE OFFER MODIFIED DUTY!

It is the policy of _____ to aid an employee's rehabilitation by providing opportunities for return to work at the earliest time possible. We will work to accommodate an employee's restrictions and provide them with work within those restrictions while they are in effect.

We will not ask an employee to do any work outside of their medically prescribed restrictions and expect them not to attempt any work that exceeds those restrictions.

If you have any questions regarding our modified duty program, please contact us.

Thank you!

(To be completed by the Physician)

_____ Yes, employee may return to work on regular duty (no restrictions).
_____ Yes, employee may return to work on modified duty (see restrictions).
_____ No, employee may NOT return to work (see restrictions).

Physician's Signature: _____
Date: _____

Please fax signed form to fax number above, as well as to the Workers' Compensation carrier below:

300 Sterling Parkway, Suite 100, Mechanicsburg, PA 17050
866-402-6600 Fax: 866-402-6601 www.cmregent.com

Full-sized form on page 16



Workers' Compensation Division

TRANSITIONAL DUTY RTW FORM

School District Name: _____

School District Address: _____

School District Contact: _____

School District Phone Number: _____ Fax Number: _____

Employer: Provide this form to the attending Physician

*****REMINDER TO MEDICAL PROVIDER*****

EMPLOYEES ARE OUR MOST VALUABLE ASSET!

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It is the policy of _____ to aid an employee's rehabilitation by providing opportunities for return to work at the earliest time possible. We will work to accommodate an employee's restrictions and provide them with work within those restrictions while they are in effect.

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If you have any questions regarding our modified duty program, please contact us.

Thank you!

(To be completed by the Physician)

_____ Yes, employee may return to work on regular duty (no restrictions).

_____ Yes, employee may return to work on modified duty (see restrictions).

_____ No, employee may NOT return to work (see restrictions).

Physician's Signature: _____

Date: _____

Please fax signed form to fax number above, as well as to the Workers' Compensation carrier below:


300 Sterling Parkway, Suite 100, Mechanicsburg, PA 17050
866-402-6600 Fax: 866-402-6601 www.cmregent.com

► Internal Work-Related Incident Form

What Is It: Internal form for school districts to use to gather information at the time an injury takes place. This form will be used to complete the CM Regent Insurance Company online injury report.

Importance: Provides an immediate resource to memorialize facts and document information.

How Form is Used: This document can be used by any school for internal tracking of information and is especially useful for those districts with more than one location. The completed form can be shared with the person responsible for online reporting of injury claims.

 Workers' Compensation Division Internal School District Work-Related Incident Report								
Section One: Employee and Incident Information								
Employer Name:			Employer Address:			County:		
Employee Name (last, first, initial):			Home Phone #:		Gender: M <input type="checkbox"/> F <input type="checkbox"/>		Marital Status: M <input type="checkbox"/> F <input type="checkbox"/> Dep.: <input type="checkbox"/>	
Home Address (street, city, state, zip code):						County:		
Social Security #:		DOB:	Date of Incident:	Time of Incident:	Date Reported:	To Whom Reported:	Start Time:	
Location of Incident (building, room, etc.):					Type of Injury (cut, sprain, etc.):			
Injured Body Part:				Cause of Injury (machine, tool, equipment, liquid, etc.):				
Employee's Job Title:		Hours Worked Per Week:		Name of Witness(es):				
Description of Incident (please describe in detail what happened):								
Employee Name:			Employee Signature:			Date:		
Employee's Supervisor Name:			Employee's Supervisor's Signature:			Date:		
Section Two: No Medical Treatment								
<input type="checkbox"/> Returned to Work <input type="checkbox"/> Returned to Work with Modified Duties <input type="checkbox"/> Sent Home Supervisor's Signature: _____ Date: _____								
Section Three: Medical Treatment or First Aid								
Type of Injury: _____ <input type="checkbox"/> New <input type="checkbox"/> Other (describe): _____								
Treatment/First Aid: _____								
Diagnosis: _____								
Disposition: _____								
<input type="checkbox"/> Return to work without limitations <input type="checkbox"/> Return to work with limitations (describe): _____ <input type="checkbox"/> May return to work on: _____ <input type="checkbox"/> Follow-up appointment with: _____ on _____								
Signature of medical/first aid provider _____						Date: _____		
Medical Facility Address: _____								
300 Sterling Parkway, Suite 100, Mechanicsburg, PA 17050 (866) 402-6600 Fax: (866) 402-6601 www.CMRegent.com								

Full-sized form on page 18



Workers' Compensation Division

Internal School District Work-Related Incident Report

Section One: Employee and Incident Information									
Employer Name:				Employer Address:				County:	
Employee Name (last, first, initial):				Home Phone #:		Gender: M <input type="checkbox"/> F <input type="checkbox"/>		Marital Status: M <input type="checkbox"/> F <input type="checkbox"/> Dep.: <input type="checkbox"/>	
Home Address (street, city, state, zip code):								County:	
Social Security #:		DOB:		Date of Incident:		Time of Incident:		Date Reported:	
								To Whom Reported:	
								Start Time:	
Location of Incident (building, room, etc.):						Type of Injury (cut, sprain, etc.):			
Injured Body Part:						Cause of Injury (machine, tool, equipment, liquid, etc.):			
Employee's Job Title:			Hours Worked Per Week:			Name of Witness(es):			
Description of Incident (please describe in detail what happened):									
Employee Name:				Employee Signature:				Date:	
Employee's Supervisor Name:				Employee's Supervisor's Signature:				Date:	
Section Two: No Medical Treatment									
<input type="checkbox"/> Returned to Work <input type="checkbox"/> Returned to Work with Modified Duties <input type="checkbox"/> Sent Home									
Supervisor's Signature:						Date:			
Section Three: Medical Treatment or First Aid									
Type of Injury: _____ <input type="checkbox"/> New <input type="checkbox"/> Other (describe): _____									
Treatment/First Aid: _____									
Diagnosis: _____									
Disposition: _____									
<input type="checkbox"/> Return to work without limitations <input type="checkbox"/> Return to work with limitations (describe): _____ <input type="checkbox"/> May return to work on: _____ <input type="checkbox"/> Follow-up appointment with: _____ on _____									
Signature of medical/first aid provider _____								Date: _____	
Medical Facility Address: _____									

300 Sterling Parkway, Suite 100, Mechanicsburg, PA 17050
 (866) 402-6600 Fax: (866) 402-6601 www.CMRegent.com

► Online Reporting of New Injuries

- For new insureds, obtain your login information (user ID and password) by going to our website, www.cmregent.com.
- Scroll down to the bottom of the page to: SUBMIT.
- Select: *Login to Submit Workers Comp First Report of Injury*.
- Sign in or register for assistance with obtaining your login information.
- Once you have your username/password, enter it, then click *login*.
- Provide the most current personal information on the injured worker.
- Select the "BEST" fitting description of injury, body part and cause of injury.
- If there are multiple body parts, always select the predominant one.
- Never use a "MISC" code.
- In the area for "Description of Incident," you may provide detailed information.
- Upon completion and submission of the information, you will receive a confirmation number. That is the claim number you will use when referencing the employee's claim.

Online Login Information

Username

Password

► Workers' Compensation Glossary

A

Advocate – A person who represents the interests of a party to an injury claim, typically an attorney for an insurance company or an employee.

Apportionment – The splitting of responsibility between insurers for a claim.

C

Claim Representative (aka claims adjuster, claims specialist, claims examiner) – A person who oversees an injury claim. Responsible for investigation and determination of compensability of a claim in accordance with state regulations.

Compensability – The decision made to accept or deny a claim.

Compromise and Release (C & R) – Full settlement of a portion or total claim.

D

Defense Attorney – A lawyer assigned by the carrier to represent the policy holder's interest during a claim process.

Disability Management – To coordinate medical appointments and follow an Injured Worker's progress and coordinate an early and safe return to work. A nurse case manager typically oversees this process.

F

Fraud – Any attempt or action by a person to willingly take or receive benefits of any kind that would not otherwise be rewarded to them.

G

Gross Wages – Total wages earned before taxes are deducted.

I

Incurred Reserve – Total of the outstanding balance and paid-to-date amounts reserved on a file.

Indemnity – Wage benefits.

Independent Medical Examination (IME) – An appointment made with an independent medical provider—one not treating the patient for any reason and usually set up by the insurance carrier.

L

Labor Market Survey – Survey of jobs that an injured worker can perform within specific physical capabilities and wages paid for the jobs.

Loss Run – A report of an employer's claims over policy periods. Typically lists all money spent on each claim and if the claim is opened or closed.

Lost Time Claim – Any claim in which the injured worker has been out of work past the PA Workers Compensation specified seven-day waiting period to collect wage reimbursement.

M

Managed Care Arrangement – A carrier who participates in a network of medical providers for treatment of their injured workers for a reduced fee.

Mediation – A meeting between parties with the purpose of issue resolution.

Medical Authorization – Signed release for medical information.

Medical Benefits – Payment for medical treatment by a licensed practitioner for treatment of work-related injuries.

Medical Fee Schedule – State specific rules governing the payment of medical bills in a workers' compensation case. Providers are not legally allowed to collect payment from an Injured Worker for any balances not covered by payments made by Workers' Compensation benefits.

Medical Only Claim – A work-related injury claim paying medical benefits only.

N

Nurse Case Manager – A nurse assigned to help oversee the medical aspect of a claim and assist with timely return to work of an injured worker.

P

Petition – Legal document filed by the injured worker or the carrier when a dispute arises and cannot be resolved. A petition is assigned to a WC judge for a hearing.

Physician Capacity Form – Document a medical provider completes that outlines the physical abilities of a person to perform a job.

Physician Panel – A list of six or more licensed medical providers selected by the employer with whom an Injured Worker is required to treat for a period of 90 days following the first visit.

R

Return-to-Work Program – A program put in place by an employer to provide temporary or permanent light duty positions to accommodate a worker’s physical limitation as a result of their work injury.

Risk Management – To assist in work safety compliance and training, risk avoidance and injury tracking on behalf of a policy holder.

S

Subrogation – The recovery of funds paid on behalf of a policy holder due to the negligence of a third party.

Statement of Wage – A document that is completed by the employer and used to calculate the average weekly wage for an Injured Worker.

Statute of Limitations – A law that limits the time in which a party can file a claim or appeal an unfavorable decision or pursue additional benefits.

T

Temporary Partial Disability (TPD) – Payments made to an Injured Worker to partially replace lost wages when returned to work at less than pre-injury weekly wage.

Temporary Total Disability (TTD) – Payments made to an Injured Worker as replacement of wages loss while out of work.

Transitional Work (aka Alternate Work/Light Duty/Limited Duty/Modified Duty) – Temporary work that is within an Injured Worker’s physical restrictions. It is a bridge back to full regular job duties and medically authorized.

W

Waiting Period – The number of days determined by a state that an Injured Worker must be out of work before qualifying for indemnity (or wage replacement) benefits. Pennsylvania waiting period is seven days.

If you have any questions or concerns, please do not hesitate to call our office at (866) 402-6600.

NOTICE TO EMPLOYEES

of Workers' Compensation Insurance for Industrial Injuries and Diseases

The undersigned, an employer subject to the provisions of the Workers' Compensation Act of Pennsylvania hereby gives notice to its employees and to all other persons interested, that it has secured the payment of the compensation payable to its employees and their dependents, by insuring with the **CM Group**.

**Claims and requests for information
are to be addressed to:**

**CM Regent Insurance Company
Workers' Compensation Division**

300 Sterling Parkway, Suite 100

Mechanicsburg, PA 17050

www.cmregent.com

Toll-free: 866-402-6600

Fax: 866-402-6601

BUREAU CODE # 2389

Expiration Date of Policy – July 1, 2019

**REMEMBER: IT IS IMPORTANT TO TELL
YOUR EMPLOYER ABOUT YOUR INJURY.**

ATTENTION SCHOOL DISTRICTS

Do not jeopardize your financial or legal rights.
Report all workers' compensation claims immediately.

The law requires wage loss claims be paid or denied within 21 days of the date of disability. Failure to comply with the 21-day period could result in legal penalties.

As a **CM Group** Workers' Compensation participant,
your claims are to be reported on-line at:

www.cmregent.com

CM Regent Insurance Company
Workers' Compensation Division
300 Sterling Parkway, Suite 100
Mechanicsburg, PA 17050
Toll-free: 866-402-6600
Fax: 866-402-6601



*Thank you.
We value
our ongoing
partnership.*



300 Sterling Parkway, Suite 100
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Fax 866-402-6601
CMRegent.com

