**Worker’s Compensation**

An employee who is injured in his or her workplace falls under Worker’s Compensation regulations. The processes for treating this type of patient differ from treating private patients (those patients who either pay for their own care or whose care is covered by private insurance).

There are very specific standards that must be followed in Worker’s Compensation cases. These standards vary from State to State. The policy will include guidelines regarding patient authorization, consent forms, drug testing procedures, claims and billing procedures.

**Workerscompensation.com** is a website that includes worker’s comp forms sorted by each State. <http://www.workerscompensation.com/>

***Workers Compensation Injuries***

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| EmergencyMD | **Policies & Procedures** | | |
| **Subject:** | WORKERS COMP INJURIES | |
| **Section:** POC | | |
| **Effective Date:** | | JANUARY 2015 |
| **Revised Date:** | | September 2015 |

**PROCEDURE:**

The **following are the steps** that need to be taken when an injured employee presents to our facilities stating his/her visit is workers compensation.

* 1. **Front Desk** Locate and Review the employers preferences on file in our Occupational Health Front Desk Binder
  2. **Front Desk** Obtain written/verbal authorization from the employer. Fax authorizations are accepted by every clinic. In the event of verbal auth, ask for first and last name and position of person authorizing treatment and their direct contact number. Confirm necessary drug testing.
  3. **Front Desk** Have the patient sign all consent forms (i.e., 1) medical records release to employer, 2) drug/alcohol consents, etc.) necessary.
  4. **Clinical Staff** - State law is to perform all drug testing required prior to any treatment. The only exception is life or limb threatening conditions which require immediate attention. **In the event of a positive drug test, you MUST notify the employer (authorizing personnel) immediately without rendering additional treatment.**
  5. Positive drug results mean the employer does NOT have to pay for any medical treatment. **Positive drug results disqualify all worker compensation claims,** except for self-funded/smaller companies who may choose to pay for medical services. \*\*\*You will need to confirm whether the employer will still pay the claim, even though positive drug results.\*\*\*\* **If they say no, the patient would then become Private Pay**. Please notify patient and collect their insurance information or self pay deposit.
  6. We cannot file any medical claims to the private insurance carrier as the patient has already notified us it was work related.

Reviewer’s Signature:

Date:

***Workers Compensation Claims Processing***

**SUBJECT: Workers Compensation Claims Processing**

1. **PURPOSE**

It is the purpose of this policy to provide guidelines to ensure the proper processing of all patient claims resulting from a work related incident.

1. POLICY

It is the policy of EmergencyMD to process all work related patient claims in an appropriate and timely manner.

1. PROCEDURE
   1. The administrative support staff will obtain the following information upon check-in:
      1. Have patient fill out registrations and HIPAA forms. Claim Number. (If after hours try to contact employer by phone)
      2. Contact name, telephone number, and claims mailing address for Workers Compensation Carrier.
      3. Date of Injury.
      4. Company name and Address for Employer. Contact name, phone number and title for employer
      5. Medical Insurance Information (in the event that the claim is disputed) and photo ID.
   2. In the event that the patient does not have the information outlined in Section A, the following rules apply:
      1. The administrative support staff must obtain either verbal or written authorization to treat the patient. **Please Note**: **The verbal authorization must be documented on the Employers authorization form (Attachment A) for evaluation and treatment with the name of the person authorizing the service and their telephone number.**
      2. The administrative support staff must obtain either verbal or written verification of the method of payment for visit and any additional services (ex: urine collection). **Please Note: The verbal authorization must be documented on the Employers authorization form (Attachment A) for evaluation and treatment with the name of the person authorizing the service and their telephone number and title.**
      3. In the event that the employer is filing a workers compensation claim, please continue following Section B.
         1. In the event that the employer wishes to pay for the visit without filing a claim, please follow Section c.
         2. If authorization/verification is not obtained from the employer, the patient must pay in full at the time of service for the visit according to the EmergencyMD fee schedule based on CPT codes.
      4. In the event that the employer wishes to file a claim with their workers compensation carrier, the following applies:
         1. The information outlined in Section A must be obtained by the end of the third business day.
         2. If the proper information is not obtained by the end of the third business day, the patient is to be informed that they will be responsible for the full amount of the charges.
         3. If additional testing is required, (i.e., urine collection), we can bill the employer only for that required test.
      5. In the event that the patient obtains the necessary information after they have paid the charges, EmergencyMD will bill the workers compensation carrier and reimburse the patient once the claim has been paid by the carrier.
2. In the event that the employer requests to pay for the visit at the time of service, the following applies:
   1. The employer must send written or verbal authorization to pay for the visit at the time of service.
   2. If the employer requests a bill to be mailed after the services have been rendered, then it must be billed to the work comp carrier. Under no circumstance will we send a bill to the employer.
3. Once the necessary information is received, the administrative support staff may begin registering the patient.
4. After the registration is complete, the administrative support staff must enter the incident information in the ailment screen. (Date of injury and indication that injury was work related).
5. When the patient is being charged out, the employers authorization to treat must be scanned into the chart and then A **COPY MUST BE LEFT IN ASSISTANT MANAGERS MAILBOX. PLACE PATIENT IN REFERRALS AFTER COMPLETE**.
6. Business owners have the option to exclude themselves from their companies work comp policy. In the event a business owner presents for treatment for a work related injury and has excluded themselves, their claims are processed under their medical insurance or the employer may choose the self pay option..
7. The administrative support staff will fax the return to work note to the employer.

APPROVED:

(Medical Director) Date (Practice Manager) Date

***Attachment A: Employer’s Authorization for Examination or Treatment***

**EMPLOYEEMPLOYERS’S AUTHORIZATION FOR EXAMINATION OR TREATMENT**

(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

Date: Patient Name: \_ Company Name:

Date of Birth: Date of Injury:

Address / Location#:

**WORK-RELATED \_ INJURY /**

**\_ILLNESS**

Post Accident Substance Abuse Testing:

Drug Screen: **[ ]** Urine **[ ]** Hair

**[ ]** 5 Panel **[ ]** 10 Panel

Breath Alcohol

Urine Collection Only

**TEST TYPE**

DOT Regulated

Non-Regulated

**BILLING**

Bill company for services (excludes Work Comp)

Employee to pay at time of service

Bill Workers’ Compensation Carrier Carrier: Claim#: Phone #: Address:

**PHYSICAL EXAMINATIONS**

Job Title:

DOT physical

Pre-employment / return to work

Other:

**DRUG TESTING**

Breath Alcohol

Hair Collection

DOT Urine

Non DOT Urine **[ ]** 5 Panel **[ ]** 10 Panel

Urine Collection Only

**OTHER**

TB Test

Hep B Vaccine

**[ ]** Individual **[ ]** Series

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FOR EmergencyMD USE ONLY** | | |  | |
| [ | ] Yes | Obtained consent for treatment | | Signature:  Date / Time: |

**EMPLOYER AUTHORIZATION**

Authorized By: Title: Phone #: Date / Time: