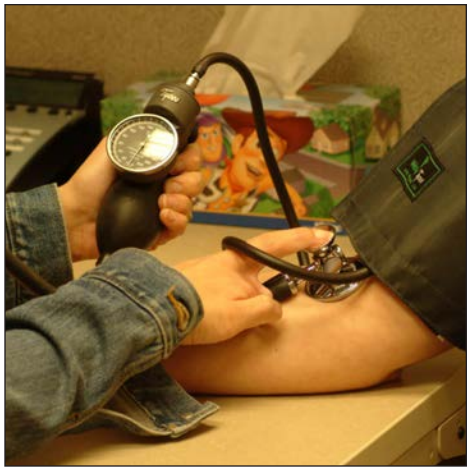

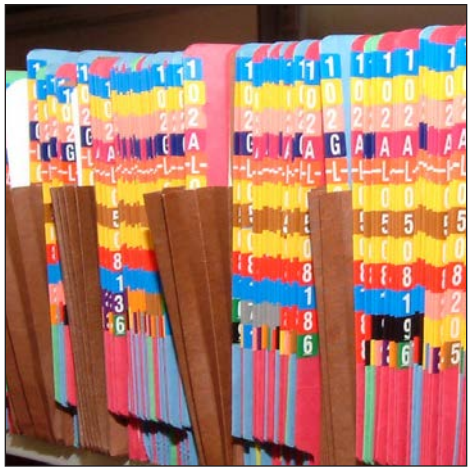

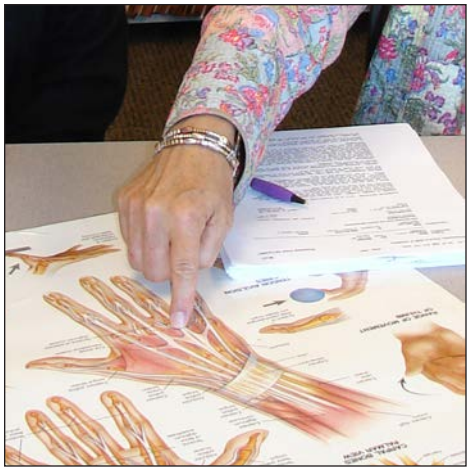

W/C Claims

Minnesota Counties Intergovernmental Trust

Workers' Compensation Claims Reporting Guide

How to Prepare for and Report a Work-related Injury or Illness

Pre-injury

Step 1: Maintain the most current forms (First Report of Injury, Accident Report and Report of Work Ability).

Step 2: Train supervisors and department heads about the injury reporting process and their related responsibilities.

Step 3: Train new and existing employees about the injury reporting process and their related responsibilities.

An Injury/Illness or Incident Occurs

Evaluate the need for emergency or urgent care medical treatment.

Reporting the Incident

Step 1: The injured employee reports the incident or illness to the supervisor. The two complete the Accident Report and review any safety issues that need to be addressed.

Step 2: The supervisor provides a Report of Work Ability (ROWA) to the employee to bring to his or her medical provider.

Step 3: The supervisor sends the Accident Report to the Human Resource Department or designated workers' compensation coordinator at the MCIT member.

Step 4: The workers' compensation coordinator completes a First Report of Injury (FROI) and sends it to MCIT as soon as possible (electronic filing is preferred).

Managing the Claim

Step1: MCIT receives the FROI and triages the claim into three categories:

1. Record Only (RO)—no medical care or lost time
2. Medical Only (MO)—no lost time, but medical care received
3. Indemnity (IND)—lost time and medical care received

Step 2: An initial packet is mailed to all injured employees who have an medical only or indemnity claim. As part of the packet, they receive information that is required by the Department of Labor and Industry (DLI). The member also receives a letter outlining that the claim has been established. On record only claims, the member receives a letter indicating the claim has been set up and if there is any additional activity related to the incident, the member should contact MCIT.

Step 3: The FROI on medical only and indemnity cases are reviewed by the workers' compensation claim staff. If appropriate, contact is made with the member, the employee and the medical provider.

Step 4: On indemnity (lost time) or contested cases, MCIT must make a compensability determination within 14 calendar days from the first day of lost time. Notice of the compensability determination is sent to all parties (member, DLI and employee) via the Notice of Primary Liability Determination.

Step 5: Ongoing communication between the member and MCIT until all issues in the claim have been resolved.

Important Contacts for Reporting Injuries Occuring at Work

When injuries or incidents occur at the workplace, there are three entities outside of the employer that need to be notified: MCIT, Minnesota Occupational Safety and Health Administration (OSHA) and Minnesota Department of Labor and Industry (DLI). Below is the contact and notification information that you need to know for MCIT and OSHA. MCIT notifies the Department of Labor and Industry when it receives the First Report of Injury from members; members do not need to do any direct reporting to DLI.

CALL MCIT IF YOU HAVE ANY QUESTIONS ABOUT WHO NEEDS TO BE NOTIFIED. MCIT SHOULD RECEIVE FIRST REPORT OF INJURY FORMS ON ALL CLAIMS THAT ARE REPORTED TO OSHA OR DLI.

1. MCIT WC Claim Staff Contact Information

What: All First Report of Injury forms or incidents
Reports of death
Reports of serious injury
All reports that go to OSHA and DLI

When: As soon as possible, no later than three days after incident

How:

Phone:	651.209.6400	WC Claim Fax:	651.209.6493
Toll-fee:	866.547.6516	Website:	MCIT.org/reporting-mcit/
After Hours:	651.343.4359		

2. Minnesota OSHA Contact Information

Minnesota employers are required by law to report to OSHA the following incidents within specified timeframes.

What: Occupational accidents in which an employee is killed
When: Within eight hours

What: Occupational accidents in which an employee is hospitalized, or for any amputations or loss of an eye
When: Within 24 hours

How:

St. Paul Phone:	651.284.5050
Toll-free:	1.877.470.6742
Afterhours (federal):	1.800.321.6742
Website:	OSHA.compliance@state.mn.us during business hours

Business hours are 8 a.m. to 4:30 p.m. Monday through Friday

MN Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

First Report of Injury

See Instructions on Reverse Side

PRINT IN INK or TYPE
ENTER DATES IN MM/DD/YYYY FORMAT

FR01

DO NOT USE THIS SPACE

1. **EMPLOYEE SOCIAL SECURITY #**	2. OSHA case #	3. Time employee began work on date of injury ☐ am ☐ pm

4. **DATE OF CLAIMED INJURY**	5. Time of injury ☐ am ☐ pm	6. Date of death	# of dependents (if death is related to injury)

7. **EMPLOYEE** Name (last, suffix, first, middle)	8. Gender ☐ M ☐ F	9. Marital status ☐ Married ☐ Unmarried

10. Home address	11. Home phone #	12. Date of birth	13. Date hired
City State Zip Code	14. Occupation	15. Regular department	16. Apprentice ☐ Yes ☐ No

17. Average weekly wage	18. Rate per hour	19. Hours per day	20. Days per week	Normal work schedule Sun - Sat (S M T W T F S) ☐ ☐ ☐ ☐ ☐ ☐ ☐	21. Employment status (check all that apply) ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*	24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No Name and address of the place of the occurrence	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI
	28. Date employer notified of injury	29. Date employer notified of lost time
	30. Return to work date	31. RTW same employer ☐ Yes ☐ No 32. RTW with restrictions ☐ Yes ☐ No

33. Treating physician (name)	34. Extent of medical treatment (check all that apply) ☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital ☐ Emergency room ☐ Hospitalization more than 24 hours ☐ Future major medical anticipated
35. Certified Managed Care Organization (if any)	

36. **EMPLOYER** Legal name	37. EMPLOYER DBA name (if different)	
38. **Mailing** address	39. Employer FEIN	40. Unemployment ID #
City State Zip Code	41. Employer's contact name and phone #	
42. **Physical** address (if different)	43. Witness (name and phone) - if more than 1 attach a separate sheet	
City State Zip Code	44. NAICS code	45. Date form completed

46. **INSURER** name	51. **CLAIMS ADMIN COMPANY (CA)** name (check one) ☐ Insurer ☐ TPA	
47. Insured legal name and FEIN	52. CA address	
48. Policy # (including effective dates) or self-insured certificate #	City State Zip Code	
49. Insurer FEIN	50. Date insurer received notice	53. CA FEIN	54. CA claim #

55. To be completed by the **CA**:	Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?	Death result of injury?

Employer: Send copies to Insurer (or Workers' Compensation Division if no insurer), employee, and employee's union (if applicable)

GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at www.dli.mn.gov.

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence.

SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

- Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see www.usa.gov/Business/Business-Gateway.shtml and click on "Get an Employer ID Number".
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR
(For first reports of injury filed on or after Jan. 1, 2014)

Pursuant to Minnesota Statutes, section 176.231, and Minnesota Rules, part 5220.2530, insurers and self-insured employers must file with the Department's Workers' Compensation Division an electronic first report of injury, according to the requirements set out in sections 2 to 4 of the Minnesota implementation guide, in all cases where a first report of injury is required to be filed under Minnesota Statutes, chapter 176. The Minnesota implementation guide can be found on the Department's website at www.dli.mn.gov/WC/Edi.asp.

A first report of injury submitted by the insurer or self-insured employer in any other manner or format is not considered filed with the division, except for a written first report of injury on a paper form filed by a self-insured employer within seven days of death or serious injury.

If the claim does not involve lost time beyond the waiting period or potential permanent partial disability (PPD), or has not been requested to be filed by the Department, a first report of injury does **not** need to be filed.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198.

Accident Report

Please Print Clearly. Complete Within 24 Hours.

1. General Information

Employee Name | Employee Address

( )

Employee Telephone Number | Job Title

Employer | Exact Location of Accident

Date/Time of Accident | Date/Time of Injury Report and To Whom

2. Description of Injury/Illness (Be as specific as possible)

- Type of Accident (fall, etc.):_____
- Type of Injury (sprain, etc.):_____
- Body Part(s) Affected:_____

Was first aid administered on job site? ___Yes ___No If yes, by whom?_____

Were employee's injuries treated by a medical provider? (If yes, fill in provider information below.):

- Hospital:_____ Telephone Number:_____
- Clinic:_____ Telephone Number:_____
- Doctor:_____ Telephone Number:_____

Loss of time? ____Yes ____No First day of lost time:_____

Has employee returned to work? ____Yes ____No Date:_____

3. Description Of Incident (To be completed by supervisor and employee)

What happened? How did it happen? Was the injury caused by equipment malfunction? Specify what job was being performed:_____

Name(s) of Witnesses (Use reverse side for statements.):_____

4. Analysis

What was the cause of the incident?_____

Contributing factors (physical surroundings, etc.):_____

Did employee violate safety regulations or instructions?_____

What actions will be taken to prevent a recurrence?_____

What other concerns do you have about this injury, if any?_____

Does the employee have other employment? ___Yes ___No If yes, where?_____

Contact Person at Other Employer:_____ Telephone Number:_____

Hours/Week:_____ Hourly Wage:_____

Supervisor's Signature:_____ Date:_____

Employee's Signature:_____ Date:_____

Minnesota Counties Intergovernmental Trust
Resources
100 Empire Drive, Suite 100, St. Paul, MN 55103-1885 • Ph: 651.209.6400 • 866.547.6516 • Fax: 651.209.6495 • www.mcit.org

First Report of Injury—Avoid the Penalty Box!

Date/Source: *September 2006 Bulletin (Reviewed September 2008; Updated October 2013; Updated April 2015)*

MCIT regularly receives First Reports of Injury that are incomplete (missing critical information), inaccurate, illegible or too late to investigate effectively. This can result in warnings and/or penalties from the Department of Labor and Industry for late reporting.

The first step in effective claims management is proper notice. MCIT depends on members' *thorough and timely submission* of the First Report of Injury. It is important to understand that in the world of workers' compensation, everything is measured in calendar days and *penalties are assessed for untimely action.*

Employers have a legal obligation to report claimed work-related injuries. State law requires that an employer report a serious injury or death within 48 hours of the occurrence. Members must notify MCIT immediately in such a case. Any other claimed work injury that keeps the employee out of work for three calendar days must be reported to MCIT, by law, within 10 days of the occurrence. *MCIT requests receipt of the report within five days of the reported injury or illness to conduct a diligent investigation*.

Upon receiving notice of an injury, often MCIT staff needs to gather medical information. This takes time and MCIT staff has 14 calendar days from the date the member is notified of the injury to make a determination of liability, issue payment or deny the claim. These timelines are even more critical if the claim is questionable, as the Minnesota Department of Labor and Industry requires an attachment of supporting documentation to any denial, otherwise it assesses penalties for "frivolous denials."

Minnesota law imposes a penalty of up to $500 for each delayed report. In addition, if MCIT does not commence payments within the 14-day period, an additional penalty of up to 125 percent of the late payment can be assessed. This can result in payment of more than twice the benefits that were initially due!

If a member is unsure whether to file a First Report of Injury on a questionable claim, call MCIT for advice. *Do not delay in reporting a claim because it seems questionable*. Filing the First Report of Injury does not admit liability; it only means a claim has been made by the employee. Again, the sooner MCIT receives the First Report of Injury, the sooner MCIT staff can begin the investigation and make a decision regarding compensability.

Penalty payments affect the member's loss experience, as well as the member's contributions for the next three years.

As a rule, the employee should never complete the First Report of Injury form. The First Report of Injury should be filled in as completely as possible by the employer. Key information includes:

- Social Security number—Required for identification purposes
- Date of injury—If unknown, the best guess, first date of treatment, etc.

- Employee address—Required for MCIT to send Employee Information Sheet mandated by the state
- How injury occurred and which body part injured—be specific
- Date member received notice—This is critical as it this includes the direct supervisor
- Lost time information—This is critical; if none, may note "N/A" in the blanks
- Medical treatment information—If name of facility is unknown, indicate "pending"
- Date form completed
- First day of any lost time
- Return to work date if any
- Address where incident occurred if not on employer's premises

If members are unsure about anything on the First Report of Injury form, they should immediately contact MCIT. They should not delay reporting. When key information is missing, MCIT staff will contact members.

MN Department of Labor and Industry
Workers' Compensation Division
(651) 284-5032 or 1-800-342-5354

First Report of Injury

See Instructions on Reverse Side

Reset

Print in ink or type
Enter dates in MM/DD/YYYY format

FRO 1

DO NOT USE THIS SPACE

REQUIRED FIELD

IMPORTANT FIELD

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA case #	3. Time employee began work on date of injury ☐ am ☐ pm	
4. DATE OF CLAIMED INJURY	5. Time of injury ☐ am ☐ pm	6. Date of death	# of dependents (if death is related to injury)
7. EMPLOYEE Name (last, suffix, first, middle)		8. Gender ☐ M ☐ F	9. Marital status ☐ Married ☐ Unmarried
10. Home address		11. Home phone #	12. Date of birth / 13. Date hired
City / State / Zip Code		14. Occupation	15. Regular department / 16. Apprentice ☐ Yes ☐ No

17. Average weekly wage	18. Rate per hour	19. Hours per day	20. Days per week	Normal work schedule Sun - Sat (S M T W T F S)	21. Employment status (check all that apply)
				☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*	24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No Name and address of the place of the occurrence	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI
	28. Date employer notified of injury	29. Date employer notified of lost time
	30. Return to work date	31. RTW same employer ☐ Yes ☐ No / 32. RTW with restrictions ☐ Yes ☐ No
33. Treating physician (name) 35. Certified Managed Care Organization (if any)	34. Extent of medical treatment (check all that apply) ☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital ☐ Emergency room ☐ Hospitalization more than 24 hours ☐ Future major medical anticipated	

36. EMPLOYER Legal name	37. EMPLOYER DBA name (if different)	
38. Mailing address	39. Employer FEIN	40. Unemployment ID #
City / State / Zip Code	41. Employer's contact name and phone #	
42. Physical address (if different)	43. Witness (name and phone) - if more than 1 attach a separate sheet	
City / State / Zip Code	44. NAICS code	45. Date form completed

46. INSURER name	51. CLAIMS ADMIN COMPANY (CA) name (check one) ☐ Insurer ☐ TPA	
47. Insured legal name and FEIN	52. CA address	
48. Policy # (including effective dates) or self-insured certificate #	City / State / Zip Code	
49. Insurer FEIN / 50. Date insurer received notice	53. CA FEIN	54. CA claim #

55. To be completed by the CA:	Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?	Death result of injury?

Employer: Send copies to Insurer (or Workers' Compensation Division if no insurer), employee, and employee's union (if applicable)