

PREFACE

Sheakley UniComp, Inc. is an Ohio Workers' Compensation Managed Care Organization dedicated to providing quality, cost effective medical care that will facilitate a safe and early return to work, or a return to functional lifestyle in the event a return to work is not medically feasible. **Sheakley UniComp, Inc.** is owned and operated by **The Sheakley Group of Companies**, in Cincinnati, Ohio. **The Sheakley Group of Companies** has over 37 years experience providing employers with assistance in the field of Ohio Workers' Compensation.

Sheakley UniComp, Inc. utilizes the **Ohio Comp Network, Inc.** preferred provider network, one of the largest and most innovative P.P.O.'s in the State of Ohio. The **Ohio Comp Network** was established in 1993 and is available throughout the entire state.

Sheakley UniComp, Inc. offers Medical Case Management, and Vocational Rehabilitation services are provided through our alliance with **Parman & Associates, Inc.** Established in 1975, **Parman and Associates, Inc.** is a firm which enjoys high credibility in the rehabilitation field and has offices strategically located throughout the State of Ohio.

Sheakley UniComp, Inc. also provides Medical Bill Review, Utilization Management, and Quality Assurance programs complete with informative employer report card capability. **The Sheakley UniComp, Inc.** program promotes continuous communication between the injured worker, the employer, the provider and the **Bureau of Workers' Compensation**. Our goal is to offer exemplary service, assistance and education to all of our program participants.

This manual is designed to anticipate our participant's needs and questions. We encourage a thorough review of this material to ensure familiarization with the policies and procedures of **Sheakley UniComp, Inc.** Proper utilization of the services available ensures success of the program for its most valuable assets.

EMPLOYERS

EMPLOYEES

PROVIDERS

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INJURY REPORTING PROGRAM

- Work related injury occurs.
- Employee **IMMEDIATELY** notifies supervisor of injury.
- If an emergency, supervisor directs employee to nearest facility for treatment or dials 911 for emergency assistance.
- If not an emergency, supervisor refers to provider directory for physician location nearby or calls Sheakley UniComp, Inc. at **1-888-743-2559/(513) 326-8003** for provider assistance.
- Supervisor and employee complete the First Report of Injury Form (FROI) for the initial visit (Sheakley UniComp, Inc. provides this capability on line at www.sheakley.com).
- Supervisor verifies the injured worker has a Sheakley UniComp, Inc. identification card and the employee is sent for treatment.
- Supervisor/Personnel Department notifies Sheakley UniComp, Inc. of injury **IMMEDIATELY** by calling **1-888-743-2559/(513) 326-8003**, faxing accident report form to **1-888-626-2667/(513) 326-8005** or reporting the injury on-line at www.sheakley.com under Managed Care.
- If case management is indicated, a Case Manager will review medical information and/or contact physician regarding treatment plan, continually updating the Bureau of Workers' Compensation of the treatment progress.
- If case management is not warranted, the return to work/medical information is forwarded to the Bureau of Workers' Compensation for claims management purposes.

Sheakley UniComp, Inc. is required to notify the Bureau of Workers' Compensation through electronic data interchange (EDI) of an initial claim within 3-5 days of notification.

Tear off this sheet and return completed form to your employer's managed care organization (MCO) or to your local BWC customer service office.



Better Workers' Compensation

Built with you in mind.



First Report of an Injury, Occupational Disease or Death

WARNING:
Any person who obtains compensation from BWC or self-insuring employers by: knowingly misrepresenting or concealing facts, making false statements, or accepting compensation to which he/she is not entitled, is subject to felony criminal prosecution for fraud.

(R.C. 2913.48)

For faster service

Complete as much of all four sections of this form as possible. Type or print in black or blue ink.

Injured Worker Info.	Last Name, First Name, Middle Initial			Social Security Number	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Date of Birth
	Home Mailing Address			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Number of Dependents	
	City	State	9-digit ZIP Code	Country if different than U.S.A.	Department Name	
	Wage Rate \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Year <input type="checkbox"/> Other _____			What days of the week do you usually work? <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> Sat		Regular Work Hours From _____ To _____
	Have you been offered or do you expect to receive payment for this claim from anyone other than the Ohio Bureau of Workers' Compensation or the employer? <input type="checkbox"/> YES <input type="checkbox"/> NO				Occupation or Job Title	
	Benefit Application/Medical Release <i>I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider who attends to, treats or examines me to release all medical, psychological, and/or psychiatric information that is related to my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Industrial Commission of Ohio, the employer listed in this claim, that employer's managed care organization, and any authorized representatives.</i>					
				Telephone Number	Work Number	
				Injured Worker Signature		Date

Injury/Disease/Death Info.	Date of Injury/Disease	Time of Injury _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	If fatal, give date of death	Date Last Worked	Date Returned to Work	
	Accident Location (street address)		Date Hired	State Where Hired	Date Employer Notified	
	City		State	Was place of accident or exposure on employer's premises? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	Description of Accident (Describe the sequence of events that directly injured the employee, or caused the disease or death)			Type of Injury/Disease and Part(s) of Body Affected (For example: sprain of lower left back, etc.)		

Treatment Info.	Physician/Health-Care Provider Name		Telephone Number () ()	Fax Number () ()	Initial Treatment Date	
	Street Address		City	State	9-digit ZIP Code	
	Diagnosis(es): Include ICD-9 Code(s)			Will this incident cause the injured worker to miss eight or more days of work? <input type="checkbox"/> YES <input type="checkbox"/> NO		
				Is this injury causally related to the industrial incident? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	Provider Signature		BWC Provider Number	Date		

Employment Info.	Employer Name	Policy Number	<input type="checkbox"/> Employer is Self-Insuring <input type="checkbox"/> Injured Worker is Owner/Partner/Member of Firm			
	Mailing Address (Number and Street, City or Town, State, and ZIP Code)				County	
	Location, if different from mailing address				Manual Number	
	Telephone Number () ()	Fax Number () ()	Federal ID number			
	<input type="checkbox"/> CERTIFICATION - The employer certifies that the facts in this application are correct and valid.		<input type="checkbox"/> REJECTION - The employer rejects the validity of this claim for the following reason(s) below:		FOR SELF-INSURING EMPLOYERS ONLY: <input type="checkbox"/> CLARIFICATION - The employer clarifies and allows the claim for the condition(s) below:	
Employer Signature and Title			Date	OSHA Case Number		

PROVIDER NETWORK

Sheakley UniComp, Inc. partners with Ohio Comp Network, Inc.

Our extensive network of panel physicians, hospitals, durable medical equipment companies, home health care agencies, urgent care centers, and occupational health centers provide wide accessibility to our client base. The network will continue to expand as the need arises in relation to our clientele.

Accessibility and Expansion:

- Providers will be geographically situated in relation to our client's various work sites.
- Providers will be geographically situated in relation to an employee's residence.
- Any provider specialty that is currently not part of the network may be obtained on a case by case basis until that provider type has completed the full credentialing process with the BWC and Sheakley UniComp, Inc.

Availability and Extent of Services

- Providers will be required to treat an injured worker within 24 hours of his (her) request and additional treatments within a reasonable time frame.
- Providers will recognize the need to treat injured workers so that they may obtain optimal improvement.
- Providers agree to follow Sheakley UniComp, Inc.'s practice standards, which include a prompt response regarding treatment plans and a 72-hour turnaround time on completion of forms.

Credentialing and Education

- Providers must meet Ohio Comp Network's credentialing criteria. All information submitted by an applicant will be verified through four sources: the American Board of Medical Specialties, the Federation of State Medical Boards, the National Practitioner Data Bank and the State Medical Board of Ohio.
- Recredentialing occurs every 2 years upon the anniversary date of the contract.
- Providers will be knowledgeable in the treatment of occupational injuries and illnesses.
- Sheakley UniComp, Inc. will assist network physicians who are not currently BWC certified apply for enrollment or certification with the Bureau.

Contracting

- Providers will agree to observe their contractual obligations and fully cooperate with the case management process.
- Providers will uphold their Bureau of Workers' Compensation agreement and Sheakley UniComp, Inc.'s practice standards.


Coordination and Medical Management

- Providers agree to communicate all necessary medical information and contact Sheakley UniComp, Inc. within one business day of treating an injured worker.
- Provider agrees to fully cooperate with Sheakley UniComp, Inc.'s case management process.

Sheakley UniComp, Inc. utilizes a wide range of facilities and hospitals, many of which contain occupational medicine centers and rehabilitation programs.

All Sheakley UniComp, Inc. network providers are BWC certified.

Employers and employees can reach Sheakley UniComp, Inc. 7 days a week through a toll free number, 1-888-743-2559. Weekend coverage will allow the caller to leave a message for a prompt response on the next business day. This access will allow the opportunity to report an occupational injury/illness, to relay information regarding referral requests and updates on an injured workers' condition.

	<p>Sheakley UniComp, Inc.</p> <p>An Ohio Workers' Compensation Managed Care Organization</p> <p>TREATMENT OF WORK RELATED INJURIES OR ILLNESSES</p> <p>IMMEDIATE NOTIFICATION IS REQUIRED:</p> <p>1-888-743-2559 (513) 326-8003</p>	<p>SHEAKLEY UNICOMP, INC. FOLLOWS BWC STANDARDIZED PRIOR AUTHORIZATION GUIDELINES</p> <p>PHONE: 1-888-743-2559 OR (513) 326-8003 FAX: 1-888-626-2667 OR (513) 326-8005</p> <p>SUBMIT ALL BILLS OR NOTIFICATION OF TREATMENT TO: SHEAKLEY UNICOMP, INC. P.O. BOX 422402 CINCINNATI, OH 45242</p> <p>RX NET PHARMACIES 1-888-796-3864</p>
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SAMPLE

Upon enrollment into Sheakley UniComp, Inc., a Sheakley UniComp, Inc. identification card will be forwarded to each employee by his employer. The employer shall be supplied with extra identification cards to insert into employee orientation packets. Employment at the time of injury is verified through the use of the BWC First Report of Injury (FROI) Form to prevent fraudulent use or misuse of the cards. The identification card clearly states the role of Sheakley UniComp, Inc., as an Ohio Workers' Compensation Managed Care Organization, and as such, alerts providers should the card be used for non-occupational illness or injury.

CUSTOMER SERVICE PROGRAM

The Sheakley UniComp, Inc. customer service program includes an 888-customer service line (1-888-743-2559) available to employers, employees, and providers from 8:00 a.m. to 5:00 p.m., E.S.T. Monday through Friday. After hours and weekend calls will be handled by an answering machine with 24 hour coverage. All incoming calls to Sheakley UniComp, Inc. within normal business hours are to be returned within one business day. After hours or weekend calls are to be returned the next business day.

The date of incoming calls will be logged into the UniComp computer system by the customer service representatives, as well as the nature of the injury and content of response.

INJURED WORKERS' RIGHTS AND RESPONSIBILITIES

As a member of the Sheakley UniComp, Inc. Managed Care Organization,

You have the right:

- to receive upon request, all information pertaining to your injury and any treatment ordered in relation to the injury.
- to be treated in a courteous and considerate manner by all Sheakley UniComp, Inc. personnel and providers related to the Managed Care Organization.
- to be an informed participant in the decision making process in regard to the treatment of your injury.
- to refuse medical treatment, including that which is considered experimental, and to be informed of the consequences of this decision.
- to know the names and professional status of providers caring for you and your injury.
- to receive prompt medical attention in the case of an emergency situation.
- to confidentiality of information regarding your medical conditions.
- to access the grievance processes if there is a dispute over medical or non-medical issues.
- to be reasonably informed of all choices in regard to the treatment of your injury.
- to treat with any BWC certified physician.
- to change physicians as long as it is a BWC certified physician.
- to be informed of Sheakley UniComp, Inc.'s case closure guideline.
- to receive notification and rationale when case management services are changed.
- to decline case management services.

You have the responsibility:

- to make a full and complete disclosure of your medical history and symptoms before and during the course of treatment.
- to cooperate fully with those providers caring for you.
- to notify your physician and/or employer if you do not understand the nature of your physical condition or treatment rendered.
- to cooperate fully with the case managers assigned to you, who will be actively participating in your care to ensure a safe and timely return to work.
- to be actively involved in the treatment of your injury.

PRIOR AUTHORIZATION REQUIREMENTS

Sheakley UniComp, Inc. utilizes BWC standard prior authorization requirements. Below is a sample list.

- All inpatient hospitalizations
 - All outpatient/inpatient surgeries
 - Inpatient and outpatient rehab, or pain management programs
 - All extended care admissions
 - Vocational services
 - All home care (i.e. Nursing support, IV's, etc.)
 - All ancillary services ordered in relation to the primary diagnosis such as, but not limited to massage therapy, weight loss programs
 - Ambulance services
 - All durable medical equipment of a cost of \$250.00 or greater
 - Physical therapy after the 10th visit within 45 days from date of injury
 - Chiropractic and Osteopathic therapy after the 10th visit within 45 days from date of injury
 - Physical medicine after 45 days from date of injury
- v The above criteria must be adhered to by all panel and non-panel providers regardless of in or out of state and/or country.

CASE MANAGEMENT REFERRAL LIST

1. Claim is lost time (injured worker misses eight or more calendar days of work)
2. Claim meets "Remain at Work" criteria for medical only claims (employer approves as a risk charge)
 - ∅ Injured worker has an allowed or certified medical only claim
 - ∅ Injured worker is experiencing difficulty at work due to the allowed condition
 - ∅ Employer, injured worker or physician has identified a difficulty in physical function at work, as to the work ability of the injured worker.
3. Injured worker is diagnosed with Carpal Tunnel, Hernia, Amputation, an Occupational Disease, or one of the following ICD-9 codes, if no return to work:

354	Mononeuritis UE	739	Nonallopathic lesion
715	Osteoarthroses and allied disorders	836	Dislocation-knee
716	Arthropathies	840	Sprains and strains-shoulder
717	Internal derangement of knee	842	Sprains and strains-wrist
720-724	Dorsopathies	844	Sprains and strains-knee
725-729	Rheumatism, Exc back	846-847	Sprains and strains-back

4. A C-9 has been received on the claim, which requires a case manager to review.
5. Claim is catastrophic. Examples include, but are not limited to: (claims should be made “lost time”)
 - Ø Requires a hospital stay or needing immediate surgery
 - Ø Spinal cord injuries
 - Ø Traumatic brain injuries (Neurological deficits)
 - Ø 2nd and 3rd degree burns requiring hospitalization
 - Ø Multiple trauma injuries (multiple fractures), such as serious falls, serious motor vehicle accidents, and cases that involve Aircare.
6. Accidents that occur outside the United States.

CASE MANAGEMENT

Purpose

The purpose of the Sheakley UniComp, Inc. case management program is to provide timely coordination of quality health care services to the injured worker in the state of Ohio, focusing on return to work, and the reduction of complications which lead to delayed recovery and increased chance of re-injury. The case management program includes utilization management, return to work planning, and quality management.

Definition

Case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communications and available resources to promote quality cost effective outcomes.

Overview or Process

- A. ASSESS – The case manager will gather, assess and evaluate relevant data by:
- Reviewing claimant's diagnosis and submitted treatment plan
 - Assessing resource utilization
 - Assessing cost management
 - Evaluation of injured worker current status
- B. PLAN – The case manager will plan short and long term goals in the treatment plan as to minimize re-injury or complications. The case manager will also develop a plan to evaluate ongoing treatment. This will involve demonstration of:
- Knowledge of the injured workers' medical and work status
 - Knowledge of cost containment strategies
- C. MONITOR – The case manager will continuously check the quality of health care services to determine if the goals are being met. This will include:
- Maintaining excellent communication
 - Assessing the effectiveness of the plan
 - Making revisions to the treatment plan

- D. EVALUATE – Case managers will measure the injured worker’s response to health care while monitoring the treatment plan. This will include:
- Assessment of the injured workers’ clinical status
 - Assessment of transitional work
 - Assessment of the injured worker’s effort to return to work
 - Assessment of the employer’s effort in return to work
 - Assessment of employer/employee dynamics
- E. OUTCOMES – The case manager will review the treatment plan with the physician if goals are met or not being met. This review will consist of:
- Evaluating cost and quality outcomes
 - Evaluating quality of life improvements
 - Evaluating employee satisfaction
 - Evaluating employer satisfaction
 - Evaluating return to work options
- F. IDENTIFICATION – The case manager identifies cases reflecting trends or patterns where patient outcomes can be positively influenced. These may include:
- Under utilization of services
 - Over utilization of services
 - Use of inappropriate medical care
 - Lost time claims
 - Complications within the treatment plan
 - Psychosocial problems affecting the plan
 - Lack of specific goals in the treatment plan
 - Non compliance of the injured worker in the plan
 - Non compliance of the employer in the plan
 - Provider non compliance within MCO/BWC rules

SHEAKLEY UNICOMP CASE MANAGEMENT PROCESS

The following is an overview of the steps that take place in the initial processing of a claim and the medical management for an injured worker by a Sheakley UniComp, Inc. case manager.

1. The injured worker notifies his supervisor immediately when a work related injury occurs.
2. The injured worker, employer, and/or provider report to Sheakley UniComp or the BWC the data information for filing a claim via an electronic form (fax, internet), call or mail. The BWC will make all claim and compensation determinations. The injured worker seeks immediate medical attention, if necessary or chooses to do so.
3. The injured worker provides the physician with his Sheakley UniComp, Inc. MCO identification card that the employer is supplied for identification. The provider submits a C-9 or may substitute a similar form used internally at their practice, as long as it supplies the same information requested on the C-9 form supplied by the BWC. UniComp will review claims for case management services based on the transfer to case manager criteria. A case intake, case development or case manager will contact the employer for further injury information.
4. The C-9 form serves as the treatment plan and communication tool for medical information for the BWC and UniComp. The provider is to follow the guidelines within the BWC Billing & Reimbursement Manual, 1-23.
5. The physician treats the injured worker, completes the C-9, and faxes it to Sheakley UniComp, Inc. The provider is to follow the guidelines within the BWC Billing & Reimbursement Manual, 1-2, 1-3, and 1-24. The physician may be required to pre-certify certain procedures as outlined within the presumptive approval guidelines and standardized prior authorization table. The case manager will work with the physician in securing treatment, if a referral for specialized care is needed. UniComp is responsible for the transmission of all medical/claim data to the BWC for claim eligibility determination and continuing management of the claim. The transmission of this data will occur through the use of a Medical Repository System implemented by the BWC and Sheakley.
6. A Case Manager will review the case including treatment guidelines and disability duration for return to work purposes, and will conduct timely evaluations and continuous monitoring.
7. The Sheakley UniComp case manager will work with the physician, employer, BWC and injured worker to help facilitate a timely return to work in either alternate or full duty employment. In catastrophic cases, the Sheakley UniComp case manager will coordinate care with the BWC catastrophic nurse. A Life Care Plan will be implemented as needed with authorization from the catastrophic nurse. Cases will be assessed on a case by case basis using the following criteria: established treatment guidelines, patient indicators (psychosocial, socioeconomic, education level), and practice standards within the industry.

8. The case development or case manager will supply the physician with a detailed job description including physical requirements when appropriate. The physician will provide written release of return to work for the injured worker to his position or targeted job. If the injured work is of limited functional capacity, the physician will provide the functions that can or can not be done and to what degree. All medical data relevant for return to work issues will be communicated to the BWC per Medical Repository Process.
9. Utilization review will be maintained through the processing of received C-9, telephonic/ written communication with providers and bill review. All cases are reviewed for appropriate medical management, return to work and remain at work by concurrent and retrospective review of documentation. Quality assurance will be conducted on cases randomly selected.



Completing form C-9 Physician's Report/Treatment Plan for Industrial Injury or Occupational Disease

Please complete the items that are applicable based on your evaluation of the injured worker.

The completion of this report does not replace the necessity to provide MCOs or self-insuring employers with other medical documents, e.g., X-ray reports, etc.

If additional documentation is necessary to complete this form, please attach.

Part I

- 1 Enter injured worker's name, Social Security number and BWC claim number, if known.
- 2 Enter the name of the injured worker's employer at the time of injury, occupational disease or death.
- 3 a Enter the date the injured worker was injured or contracted an occupational disease.
- 3 b Enter the date you first treated the injured worker.
- 4 Give a brief description of the industrial injury or occupational disease.
- 5 Indicate the diagnosis and ICD-9-codes for conditions being treated as a result of this injury.
- 6 Complete if you are recommending additional condition(s) after the initial allowance of the claim. Supporting medical documentation is required for all conditions listed.
- 7 Refers to the establishment of a relationship between the injury or occupational disease identified in item 5 and/or item 6 and the industrial accident.
- 8 List any pre-existing conditions or diseases that may affect the direction of this claim.

Part II

- 9 a Indicate date of last exam.
- 9 b Next appointment date if applicable.
- 9 c Return to work. Actual: the date the injured worker returned to work, if known, after his/her injury/occupational disease. Estimated: the anticipated date the injured worker may be able to return to work. Released: the date the injured worker is medically released by the physician of record to return to employment (restricted or unrestricted), but has not actually returned to work.
- 9 d List the dates the injured worker will be unable to work because of the work-related injury/disease (complete this section each time you are extending the period of disability).
- 1 0 Complete if applicable.
- 1 1 This section is an assessment of the injured worker's ability to return to work and is based on the injured worker's physical capacities at the time of this evaluation including modified duty and restrictions i.e., sedentary, lifting 0-10 pounds, occasional walking/standing; light, maximum lifting 20 pounds, frequent carrying 10 pounds; medium, frequent carrying up to 25 pounds, maximum lifting 50 pounds at one time; or heavy, frequent lifting 50 pounds, maximum lifting 100 pounds at one time. Include objective findings to substantiate injured worker's inability to perform any work.
- 1 2 If vocational rehabilitation is identified, explain in treatment plan.
- 1 3 Provide a detailed treatment plan including treating diagnosis ICD-9-code(s), specific type of treatment, frequency and duration, location and site. Include any referrals, therapy, medications and expected outcomes of medical interventions, results of treatments, treatment procedures and authorization requests. This section is to be completed for the initial treatment plan, subsequent treatment plans or if the diagnosis has changed.
- 1 4 Indicate injured worker's subjective complaints regarding the injury in question. Indicate essential elements of medical history, physical examination and test results that support the diagnosis and the treatment plan.

C-9-A Treatment may be denied if information requested on the C-9-A is not received by the appropriate MCO within five business days.



**PHYSICIAN'S REPORT/TREATMENT PLAN
for Industrial Injury or Occupational Disease**

INSTRUCTIONS:

- Please print or type this report.
- **Be sure to enter four digits for the year in all date fields.**
- Complete **Part I and Part II** of this form if this is the initial report/treatment plan, request for additional conditions or diagnosis has changed.
- If this is a subsequent treatment plan, or if extending dates of disability, complete **Part II** only.
- Attach additional file notes if needed.
- Mail or fax to employer's MCO or self-insuring employer.

Part I

1 Injured worker name	Social Security number	Claim number	
2 Employer name			
3 Date of injury or diagnosis of disease	3 Date of first exam		
4 Describe the industrial injury or occupational disease			
5 Provide current diagnosis and ICD-9-code(s), location and site.			
<i>Diagnosis</i>	<i>Code</i>	<i>Location</i>	<i>Site</i>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
6 Complete if you are recommending additional condition(s) after the initial allowance of the claim. Supporting medical documentation is required for all conditions listed.			
<i>Diagnosis</i>	<i>Code</i>	<i>Location</i>	<i>Site</i>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
7 In your opinion is there a direct or proximate causal relationship between the diagnosis in 5 and/or 6 and the description of the industrial accident/exposure? <input type="checkbox"/> Yes, please explain <input type="checkbox"/> No, please explain (attach additional sheet if necessary)			
8 Are there any pre-existing conditions, impairments, complicating factors or disease processes that have been aggravated as a result of the injury or that could impact recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No . . . <u>If yes</u> , please describe (Attach additional sheet if necessary)			

Part II on reverse side

Part II

C-9 Part II Complete on initial or subsequent visits

Injured worker name		Social Security number	Claim number																								
9 Date of last exam or treatment	9 Date of next appointment	9 Date of return to work	<input type="checkbox"/> Actual <input type="checkbox"/> Released <input type="checkbox"/> Estimated																								
9 Current period of disability due to the work-related injury/disease																											
From		To																									
1 Has the work-related injury(s) or occupational disease reached a treatment plateau at which no fundamental functional or physiological change can be expected despite continuing medical or rehabilitative intervention (maximum medical improvement): <input type="checkbox"/> Yes <input type="checkbox"/> No																											
If yes, give date _____ If no, please explain (Attach additional sheet if necessary)																											
1 What was the injured worker's position of employment at the time of the injury/disease?																											
1 Is injured worker medically able to return to this position of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain																											
1 Is injured worker able to return to other employment <input type="checkbox"/> light duty <input type="checkbox"/> alternative work <input type="checkbox"/> modified work <input type="checkbox"/> transitional work? Please list any restrictions that may apply. (Attach additional sheet if necessary)																											
1 Is vocational rehabilitation needed to assist with return to original job or different job? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain in the treatment plan below.																											
1 Treatment Plan: <input type="checkbox"/> Treating diagnosis ICD Code(s) _____ <input type="checkbox"/> Initial date _____ <input type="checkbox"/> Subsequent date _____ Provide copies of current medical reports, and include any referrals, therapy, medications, diagnostic testing, expected outcomes of medical interventions, results of treatment, etc.																											
<table border="1"> <thead> <tr> <th>Specific Type of Treatment</th> <th>Meds</th> <th>Frequency</th> <th>Duration</th> <th>Location</th> <th>Site</th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2. _____</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3. _____</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>				Specific Type of Treatment	Meds	Frequency	Duration	Location	Site	1. _____						2. _____						3. _____					
Specific Type of Treatment	Meds	Frequency	Duration	Location	Site																						
1. _____																											
2. _____																											
3. _____																											
1 The following clinical findings are the basis for my recommendations: (Attach additional sheet if necessary)																											
Objective:		Subjective:																									

Physician signature & provider number mandatory

CHECK if Physician of Record

I certify that the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment, or both.

Physician name (please print or type)		Telephone number ()	Fax number ()
Physician address	City	State	ZIP Code
Physician/authorization signature-mandatory		BWC Provider number-mandatory	Date

MCO use only

If this page is not faxed or mailed back to the submitting physician within three business days of receipt or within five business days of receipt of information requested on the C-9-A, the authorization for treatment shall be deemed granted subject to BWC policy. Disputes to the decision may be filed in writing to the MCO.

BWC claim status: <input type="checkbox"/> Pending <input type="checkbox"/> Allowed <input type="checkbox"/> Denied	
List allowed ICD-9-code(s) _____	
Treatment Plan: <input type="checkbox"/> Pending The documentation requested must be submitted to the MCO case manager or self-insuring employer within five business days to allow for a treatment decision. Failure to respond may result in denial.	
MCO signature	Date
<input type="checkbox"/> Approved Date treatment plan begins _____ Date treatment plan ends _____	
<input type="checkbox"/> Amended approval _____	
<input type="checkbox"/> Denied If treatment plan denied, please explain: _____	
MCO signature	Date
MCO company name	MCO number
	Telephone number ()

Self-insuring employer use only

Fax this page to the submitting physician within 10 days of receipt or the authorization for treatment shall be deemed granted per OAC 4123-19-03 (L)(5).

Self-insuring employer signature	Date
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UTILIZATION MANAGEMENT

Purpose

The purpose of the Sheakley UniComp, Inc. Utilization Management Program is to promote quality of care by reviewing and evaluating the appropriateness and efficiency of medical services, facilities, procedures, costs and with the ultimate goal of returning the injured worker back to health and work. This is achieved by focusing on planning, organizing, and directing health care to ensure that the highest quality, most cost effective care is provided.

Hierarchy

The following is the hierarchy established within Sheakley UniComp, Inc. utilization program.

1. Medical Director
2. Peer Review Physicians
3. Director of Case Management
4. Clinical Supervisors
5. RN/Case Managers

References

The Utilization Management program for Sheakley UniComp, Inc. follows the National Worker's Compensation Utilization Management Standards set forth by URAC (Utilization Review Accreditation Commission).

Milliman & Robertson's Healthcare Management Guidelines Vol. VII for Workers' Compensation is referred to by the RN/Case Manager to assist in the delivery of quality care and treatment. In addition, The Medical Disability Advisor assists as a reference in this process for disability duration guidelines for associated ICD-9 codes. The Mercy Guidelines For Chiropractic Quality Assurance and Practice is utilized for reference as to Chiropractic Care.

JOB DESCRIPTION ANALYSIS FOR FUNCTIONAL CAPACITY

EMPLOYER NAME _____

EMPLOYEE _____ SS# _____

JOB TITLE _____

WORK HOURS from _____ to _____ # of days per week _____

DESCRIPTION AND TASKS OF JOB TITLE _____

LEVEL OF ACTIVITY

- _____ Sedentary work - lifting 10 lbs. Max and occasionally lifting/carrying
- _____ Light work - lifting 20 lbs. Max with frequent lifting/carrying objects to 10 lbs.
- _____ Medium work - lifting 50 lbs. Max with frequent lifting/carrying of objects to 25 lbs.
- _____ Heavy work - lifting 100 lbs. Max with frequent/carrying of objects to 50 lbs.
- _____ Very heavy work - lifting in excess of 100 lbs. with frequent lifting/carrying of objects weighing 50 lbs. or more.

Please check the specific weight amount employee is required to lift/carry.

LIFTING CAPACITY _____ No limitations _____

Frequent 10 ___ 20 ___ 30 ___ 40 ___ 50 ___ 60 ___ 70 ___ more than 80 ___

Occasional 10 ___ 20 ___ 30 ___ 40 ___ 50 ___ 60 ___ 70 ___ more than 80 ___

CARRYING CAPACITY _____ No limitations

Frequent 10 ___ 20 ___ 30 ___ 40 ___ 50 ___ 60 ___ 70 ___ more than 80 ___

Occasional 10 ___ 20 ___ 30 ___ 40 ___ 50 ___ 60 ___ 70 ___ more than 80 ___

	Hours at one time					Total hours during day				
Standing	_____					_____				
Sitting	_____					_____				
Walking	_____					_____				
	bend	squat	kneel	climb	reach	twist	rotate	crawl	push/pull	
Frequently	_____	_____	_____	_____	_____	_____	_____	_____	_____	
Occasionally	_____	_____	_____	_____	_____	_____	_____	_____	_____	
Not at all	_____	_____	_____	_____	_____	_____	_____	_____	_____	

REPETITIVE MOVEMENT AND USE OF HANDS

- _____ no limitations _____ right hand _____ left hand
- _____ simple grasping _____ right hand _____ left hand
- _____ fine manipulation _____ right hand _____ left hand

EMPLOYER SIGNATURE: _____ DATE: _____

FOR PHYSICIAN USE ONLY: Circle choice: APPROVE DISAPPROVE

Effective Date: _____ PHYSICIAN NAME (print): _____

PHYSICIAN SIGNATURE: _____ DATE: _____

YOUR GUIDE TO TRANSITIONAL WORK

In the new era of workers' compensation managed care, employers will be asked to develop a transitional work program. The following information can be used by employers and employees involved in the development of transitional work.

Q. What is transitional work?

A. Transitional work replaces the terminology of light duty. Transitional work helps the injured worker return to a job that adheres to the medical restrictions placed on the worker by the doctor. Both the job description and restrictions are re-evaluated frequently based on medical necessity. Transitional work allows the injured worker to be productive while recovering from an injury.

Q. Is transitional work always sedentary work?

Sedentary is defined as exerting up to 10 lbs. and/or a negligible amount of force to lift, carry, push, or pull. It involves sitting most of the time but may involve walking or standing for brief period of time.

A. No, depending upon the restrictions set by the doctor, it may mean modifying a part of the original job.

Q. I am a small employer. How do I come up with transitional jobs?

A. First, break down each job into units to identify the tasks at hand. Second, depending on the restrictions, you can revise, delete or add different units.

Q. Should I pay my employee less money if the job is different or less demanding?

A. You can, but remember, the injured worker is entitled to wage loss, which helps make up the difference in his total pay. The wage loss and its associated reserves will be assessed against the employer. So in the long run, it may be better to pay the same salary while in transitional work to avoid additional losses.

Q. What is my role as an employer in transitional work?

A. Your role involves several aspects. Be sure to have a written transitional work policy in the employee handbook that summarizes the philosophy of transitional work, and the roles of the employees in transitional work. If an employee handbook is not utilized, be sure that all employees know (including new hires) that you will accommodate them in transitional work, if they are injured. This lets employees know from the beginning what is expected of them. You must be committed to implementing a transitional work program. All supervisors as well as employees must be committed. You and your supervisors must identify transitional jobs within your employment. You and your injured worker must evaluate his progress while in transitional work. You must have continuous communication with the case manager assigned to the case.

Q. Does an employee have the right to refuse a transitional job offer?

A. If an employee refuses a transitional position that has been approved by the treating physician, the employee could very well lose their disability benefits.

Q. Why should an employee accept a transitional work offer?

A. An employer places value in an employee's ability to be productive. Being productive keeps an employee active, which in the long run shortens the recovery time, and allows the team work process to be maintained.

Q. What is an employee's role in transitional work?

A. To work with the employer by discussing options within the transitional work program. To take an active role in the recovery process so that there can be a safe and timely return to regular duties.

Q. How does Sheakley UniComp intervene in transitional work?

A. The case managers secure restrictions from the physician. They will then discuss appropriate job duties with the employer. The case manager will present the physician with a job description for approval.

In summary, by instituting transitional work, you as the employer may experience lower premium rates while allowing your company productivity to continue. As an employee, transitional work allows the team concept to continue while recovering from an injury. The key to making it work is shared understanding and unity of purpose by all parties.

Supervisor's role:

- Identify jobs compatible with the work restrictions.
- Monitor the employees to ensure they are working within the restrictions.
- Assess the employee's progress weekly to report to the case manager and/or Doctor.

Employee's role

- Understand the reasons for transitional work
- Help to create the transitional work program specific to their needs along with the Doctor, case manager and supervisor.

Whenever possible, returning workers should be included in day to day work site activities and perform their duties in proximity to co-workers.

The goal is to help the injured workers regain the confidence to return to work.

HELPFUL HINTS ON STRUCTURING A RETURN TO WORK PLAN

1. **Be open to accommodating** injured workers with a temporary (transitional) position until returning to full duty is feasible.
2. If a work-related injury occurs and the physician has disabled the worker for a period of more than 7 days, Sheakley UniComp, Inc. may request information regarding the **employee's current job duties and physical requirements of the job**. It is imperative that Sheakley UniComp, Inc. receives this information from the employer in a timely manner so that the coordination of return-to-work planning begins immediately with all parties.
3. Be available to **modify current work duties** of an injured worker to meet the restrictions of the treating physician.
4. Develop a **Return to Work Policy** or Program and incorporate procedures in your personnel manual or post in a high employee traffic area. Letting your employees know that you will work with them and accommodate for the transition will promote the need for that employee and keep the lines of communication open.
5. Sheakley UniComp, Inc. will **identify areas of the injured worker's limitations** and work with you, the employer, to rearrange the process and technique of performing his/her job. The job modification may be temporary or long term.
6. Job Modification may include restructuring the assignments, duties, tasks, and hours of the workday, use of tools or equipment.
7. Good documentation should be kept at all times. Making a transitional job offer to an employee should be done in writing and sent certified mail.
8. In 2001, the BWC began offering a Remain at Work Program and Transitional Work Grants. Please contact our office for additional information.

*******Early Intervention and open communication with your employee is the key to maintaining your current work force and productivity.***

WORKERS' COMPENSATION DEFINITIONS

MAXIMUM MEDICAL IMPROVEMENT

Maximum medical improvement is defined as “A treatment plateau (static or well stabilized) at which no fundamental, functional or physiological change can be expected within reasonable medical probability in spite of continuing medical rehabilitation procedures. An injured worker may need supportive treatment to maintain this level of function.”

PERMANENT PARTIAL RATING

An injured worker has the right to file an application for a permanent partial disability award not earlier than forty weeks after termination of the latest period of compensation paid, or forty weeks from the date of injury, or contraction of an occupational disease in the absence of payment of compensation. The evaluation for this award is to be based solely on the allowed conditions of the injured workers' claim and solely on medical or clinical finds reasonably demonstrable. Non-medical factors are not to be included in the permanent partial disability equation. The evaluation of a permanent partial disability award is to be expressed in terms of a percentage of impairment to the body as a whole, the whole body equaling 100%. Evaluations for permanent partial rating are to be conducted in accordance with the 4th addition of “The Guides to the Evaluation of Permanent Impairment,” published by the American Medical Association.

Specific questions involving Permanent Partial Ratings should be addressed to the Consulting Medical Director of Sheakley UniComp, Inc., Dr. David C. Randolph, a Certified Disability Evaluator.

BALANCE BILLING PROHIBITION

Pursuant to Health Partnership Program rule 4123-6-7, no health care provider shall charge, assess, or otherwise attempt to collect from an employer, employee, The Bureau of Workers' Compensation, or Managed Care Organization, any amount for covered services or supplies that is in excess of the allowed amount reimbursed by the Bureau of Workers' Compensation, or Managed Care Organization.

RETURN TO WORK AND DISABILITY MANAGEMENT

Any injured worker who is deemed unable to return to regular duty is subject to case management by Sheakley UniComp, Inc. Every possible effort shall be made to safely return an injured worker to a medically acceptable form of transitional duty as soon as possible. Immediate notification (within 24 hours) of the injury is to be made to Sheakley UniComp, Inc. Further details relative to disability management is to be found in the Case Management section of this manual.

VOCATIONAL REHABILITATION

The vocational needs of the injured worker will be assessed by the Sheakley UniComp, Inc. RN case manager throughout the case management process. The Sheakley UniComp, Inc. case manager will work with the physician, employer, BWC and injured worker to help facilitate a timely return to work either in transitional or full duty employment. If specific vocational intervention is required to fulfill the goal of the return to work, the case will be referred to Parman and Associates, Inc.

Parman and Associates, Inc. will submit written reports and supported documentation every 30 days reflecting goals, case activities and recommendations. In addition, the Sheakley UniComp, Inc. and Parman and Associates, Inc. case managers will continually remain in contact throughout the rehabilitation process.

Potential Referrals:

- Spinal cord injuries resulting in quadriplegia or paraplegia
- Head injuries resulting in complications (coma, confusion, or cognitive deficits)
- Burns on 25% or more of the body
- Chronic illnesses resulting in excessive hospitalizations
- Amputations of a major limb
- Severe crush injuries
- Injuries and illnesses resulting in chronic pain
- Lack of response and progress from treatment plan after 90 days
- Excessive trauma related injuries
- Remain at work services
- Transitional work development/grants
- Job retention referral
- Injured worker receiving compensation

MEDICAL PAYMENT PROCESS

Sheakley UniComp, Inc. has entered into a partnership with Ohio Comp Network, Inc., a privately owned Preferred Provider Organization, which contracts with providers for a reduced fee schedule.

- Provider submits a medical bill to Sheakley UniComp, Inc. through an electronic data interchange (EDI) format approved by the Bureau or hard copy.
- A Sheakley UniComp, Inc. representative will review all submitted billing and consider whether treatment was rendered for the allowed conditions of the claim, the appropriateness of care (cross reference with case management) at the point of payment, and compare the billed amount to the state observed usual and customary tables and any applicable network rate. This comparison is based on CPT-4 procedural codes and ICD-9 coding. The panel provider will be reimbursed the lesser of the three. Duplication of charges is also an issue addressed at this time.
- Non-panel providers are subject to the state observed usual and customary table. No further discounts will be applied without the agreement of the provider.
- A Sheakley UniComp, Inc. representative adjudicates the charges by either approving, pending, or denying the charges. Seven-day turnaround time only applies to claims that have been allowed by BWC.
- Bill approval information for an allowed condition is forwarded to the Bureau of Workers' Compensation through an electronic data interchange (EDI) format approved by the Bureau. This process will take place within 7 days as stated in the HPP rules.
- The Bureau of Workers' Compensation provides the funding to pay the provider for the approved amount. This transfer of funds takes place through an electronic funds transfer (EFT) format approved by the Bureau.
- Sheakley UniComp, Inc. is granted 7 days from receipt of the funding to disburse the payment to the provider, by issuing a system generated check, payable to the provider's federal identification number. Because provider payments will be based on multiple payments to the same provider, a remittance advice sheet will be forwarded to the provider as well. The remittance advice sheet details the breakdown of the aggregate check total.

- Sheakley UniComp, Inc. will not retain any of the funds paid for medical services rendered, nor will Sheakley UniComp, Inc. retain any savings generated by network discounts.
- Retrospective review will be based on a percentage of the total volume of bills per bill processor. Bill payments exceeding \$5,000 must be approved by the supervisor. The system selects bills in numerical sequence to fulfill in house quality assurance duties. Mechanical and payment errors will be shared with the bill processor to improve their accuracy.

All discrepancies regarding the bill payment process filed by an employee, employer or provider will be adjudicated through the grievance procedure for non-medical issues.

MEDICAL DISPUTE RESOLUTION PROCESS

The following procedure is to be implemented if there is a standard appeal regarding a medical dispute between the provider (panel and non-panel), employer, employee, or BWC and Sheakley UniComp, Inc. Dispute issues include quality assurance, utilization review, non-covered services, medical necessary and issues involving health care providers.

To formally appeal a disputable issue, the appealing party must submit dated notification within fourteen (14) days of receipt of written notice to Sheakley UniComp, Inc. utilization review determination or vocational rehabilitation case closure. The notification should be directed to the Medical Dispute Department at Sheakley UniComp, Inc. detailing the nature of the appeal. Notification of the medical dispute received by telephone does not constitute formal notification. The appellant is required to provide all supporting documentation so Sheakley UniComp, Inc. is able to make an appropriate determination.

- Level one
Sheakley UniComp, Inc. will do a pre-audit once all the appeal information is received to determine if the supporting documentation meets criteria for resolution. If the submitted documentation does not meet criteria for resolution, an independent level of review will be conducted by an individual or individuals licensed pursuant to the same section of the Revised Code as the health care provider requesting the disputing issue. Sheakley UniComp, Inc. will identify the providers performing the peer review. The peer reviewer will complete a documented review and make a determination within five business days. Sheakley UniComp, Inc. will notify all parties and their representatives within twenty-one days by letter of the peer review decision. Within seven days of receipt of written notice by Sheakley UniComp, Inc. of the decision, the employer, injured worker or provider may request that the dispute be referred to the bureau for an independent review. Sheakley UniComp, Inc. will refer the requested dispute to the BWC within seven days of written notice of the request. The twenty-one days shall be measured from the time the written notice of the medical dispute is received by Sheakley UniComp, Inc. Sheakley UniComp, Inc. will refer the requested dispute to the BWC within seven days of written notice of the appeal to level two. This is in accordance to 4123-6-16 of the HPP rules.
- Level two
Within fourteen days after receipt of an unresolved medical dispute, the BWC will conduct an independent review of the unresolved medical dispute received from the MCO and enter a final bureau order pursuant to section 4123.511 of the Revised Code. The order shall be mailed to all parties and may be appealed to the industrial commission pursuant to section 4123.511 of the Revised Code. Neither the provider nor the MCO is a party entitled to file an appeal under section 4123.511.

GRIEVANCE PROCEDURE FOR NON MEDICAL ISSUES

The following procedure is to be implemented if there is a grievance for non-medical issues (e.g., 1-800 number issues, C-9 or bill processing timeframes, etc.) regarding a dispute between the provider, employer, employee, or BWC and Sheakley UniComp, Inc.

Any named party above must submit dated notification in writing to Sheakley UniComp, Inc. detailing the grievance providing all documentation to enable Sheakley UniComp, Inc. to accurately assess the grievance. The letter and supporting documentation regarding the non-medical issue will be reviewed by the administrative board of the Managed Care Organization made up of the Vice President, Director of Case Management and Operations Managers of Sheakley UniComp, Inc. The decision will be provided in a letter, which will be sent within 30 days from receipt of notification. The decision from the administrative board will be the final decision rendered by Sheakley UniComp, Inc. Sheakley UniComp, Inc. will provide the BWC with grievance documentation.

EMPLOYER SATISFACTION SURVEY

Sheakley UniComp Customer Service Evaluation Survey for Policy # Company Name _____

- 1) Are your phone calls responded to within one business day?
1 2 3 4 5 n/a
- 2) Does your assigned team provide resolution to your issues?
1 2 3 4 5 n/a
- 3) Does your assigned team provide updates on your injured workers' return to work statuses?
1 2 3 4 5 n/a
- 4) If you received a visit from your Sheakley UniComp Client Relations Manager during the last month, did you gain a better understanding of the process and receive clarification if necessary?
1 2 3 4 5 n/a
- 5) If additional research was indicated, how timely was the response from your Client Relations Manager?
1 2 3 4 5 n/a
- 6) Did your Client Relations Manager offer ideas and suggestions on ways to improve your reporting or return to work process?
1 2 3 4 5 n/a
- 7) How informational was the educational material supplied by Sheakley UniComp and/or your Client Relations Manager?
1 2 3 4 5 n/a
- 8) ***Please indicate below how we can improve our services to meet your needs:***

- 9) ***Please indicate what you like most about our services:***

- 10) ***Overall, how would you rate our services:***
1 2 3 4 5

Signature: _____ Date: _____

Sheakley UniComp, Inc.
Sample Employer Outcome Report Card
Date Range

Employer Name
 Address
 City, ST Zip

Policy Number _____

	TOTAL	% OF TOTAL	YTD TOTAL
Total claims			
Total Medical Only Claims			
Total Lost Time Claims			
Date Employer Notified vs Date Reported to MCO (Avg. Day)			
Date of injury vs. date reported to MCO (Avg. Day)			
Claims reported by injured workers			
Claims reported by Provider			
Claims reported by employer			
Claims reported by BWC			
Treatment by non-BWC certified providers			
Treatment by Sheakley UniComp (BWC) providers			
Treatment by BWC certified providers			

* **The above report represents claims reported or paid within the time frame indicated.**
Year to Date Totals represent the current MCO year July 1 – June 30

* Sheakley UniComp, Inc., requires notification of injury within 24 hours. (If possible, reporting should occur 24 hours from date of injury.)

TOTAL QUALITY MANAGEMENT PROGRAM POLICIES AND PROCEDURES

Purpose

The purpose of the Sheakley UniComp, Inc. total quality management program is to establish a process that provides structure and organization to assess problems with care of the injured worker. The total quality management program will strive toward cost effective medical management and high levels of customer satisfaction. The entire management process will allow quality planning, evaluation, measurement, implementation, improvement and redesign.

Objectives

The plan objectives include but are not limited to:

- Ø maintaining a comprehensive quality management program
- Ø effective communication between all core parties, including providers, employers, injured workers, BWC and Sheakley UniComp, Inc. employees
- Ø proper identification and assessment of the overall effectiveness of the case management program
- Ø evaluating provider medical services using accepted methods of data collection
- Ø recommendations, implementation and redesign of existing policies
- Ø continually assess educational needs for staff

Organization for Quality Management Program

The Sheakley UniComp, Inc. total quality management program is enforced by the Quality Committee. The quality committee members may include: Sheakley UniComp, Inc., Medical Director, one to three peer review physicians, the Vice-President, Operations Managers, Clinical Supervisors, Billing Supervisor, Case Development Supervisor, Case Intake Supervisor, Quality Process Coordinator, Director of Case Management, and Administrative Supervisor. The role of this committee is to address delivery and quality of care, such as: over/under utilization issues, review medical dispute outcomes for program improvement, address quality of customer service, review grievance outcomes for program improvement, evaluate quality of case management by audit, evaluate the quality and accuracy of the workflow, and set policies as necessary to assure quality of care within the managed care organization.

The quality committee will meet quarterly to track the quality issues and plan for improvement actions. The medical director and panel physicians will be present, at least annually. A written report, as to the conclusions and recommendations of these committees will be prepared for submission to the Vice President. The committee members will communicate issues, actions and resolution with each other to further the integration of the administrative departments with the case management department. The total quality management program will be evaluated annually for change and improvement.

Thank you...

*...for choosing
Sheakley UniComp, Inc.*

*We look forward to servicing
your managed care needs.*

*Experience
The Sheakley Difference!*