FOR ALL ON THE

JOB INJURIES

(PROVIDED FOR POSTING IN ER WORK AREA)

Your employer is part of a managed care system for worker's compensation. This means in order to have your medical care paid for in a work-related accident/illness, you MUST use one of the OMCA network physicians unless:

Here are the limited situations in which treatment may be obtained outside of a Gatekeeper:[12]

(a) For emergency care as defined in 803 KAR 25:110[13];
(b) If the employee is referred by a gatekeeper physician outside the managed care plan for medical services;
(c) If authorized treatment is unavailable through the managed care plan; and
(d) To obtain a second opinion if a managed care plan physician recommends surgery.

QUESTIONS

For any questions relative to your occupational medical care call:

Long distance: 1-800-KYCOMP-1

Louisville area: 502-499-6000

(toll free, 24 hours/day, 7 days/week)

Should you be dissatisfied with any aspect of your care, write OMCA for a Grievance Form:

Occupational Managed Care Alliance, Inc.
P.O. Box 20908
Louisville, KY 40250-0908

---

[12] 803 KAR 25:110 Section 4(a)-(d).

[13] 803 KAR 25:110 Section 1(2) defines "emergency care" as: (a) Medical services required for the immediate diagnosis or treatment of a medical condition that if not immediately diagnosed or treated could lead to serious physical or mental disability or death; or (b) Medical services that are immediately necessary to alleviate severe pain. "Emergency care" does not include follow-up care, except when immediate care is required to avoid serious disability or death.

A VERY IMPORTANT ANNOUNCEMENT
REGARDING INJURIES AND ILLNESSES OCCURRING ON THE JOB

Your employer has workers' compensation insurance with Kentucky Employers' Mutual Insurance (KEMI). KEMI is part of a certified managed care plan with Occupational Managed Care Alliance, Inc. (OMCA). OMCA is the certified plan Administrator for this managed care plan. OMCA's purpose is to assist you in receiving medical care when you are injured or ill as a result of a work-related incident.

This system requires that all care be delivered or authorized by an approved gatekeeper physician (Gatekeeper). Therefore, in all cases (with the exceptions listed below), you **must** use one of the Gatekeepers on the approved list for your treatment. A list of Gatekeepers is available at www.omca.biz. If your physician believes you need care from a specialist, he or she will authorize that care within the specialist panel.

Here are the limited situations in which treatment may be obtained outside of a Gatekeeper:[5]

(a) For emergency care as defined in 803 KAR 25:110[6];
(b) If the employee is referred by a gatekeeper physician outside the managed care plan for medical services;
(c) If authorized treatment is unavailable through the managed care plan; and
(d) To obtain a second opinion if a managed care plan physician recommends surgery.

If initial emergency care following a compensable injury is rendered by a medical provider outside the managed health care plan, you may remain under the care of that provider so long as the provider complies with utilization review, reporting standards, and quality assurance mechanisms required by the managed care plan.[7]

Change of Gatekeeper

If you are dissatisfied with your Gatekeeper, you have the right to change to another Gatekeeper within the network one time without prior approval by submitting a new Form 113 (Designated Physician Form) to KEMI. Thereafter, approval must be granted by KEMI prior to any change. If you need information about what to do, where to go, or a Gatekeeper listing, call 1-800-KYCOMP-1, toll free, 24 hours a day, 7 days a week. Louisville area employees can call 502-499-6000.

Grievances

If you are dissatisfied about some aspect of your medical care, you may submit a completed Grievance Form.
According to 803 KAR 25:110, a grievance shall be made when a written complaint or written request is delivered by the employee or provider to OMCA setting forth the nature of the complaint and remedial action requested.[8] An employee or provider must file a grievance within thirty (30) days of the occurrence of the event giving rise to the dispute.[9] OMCA shall render a written decision upon a grievance within thirty (30) days of receipt by OMCA.[10]

An employee or provider that is dissatisfied with the OMCA resolution or a grievance may apply for review by an administrative law judge by filing a request for resolution within thirty (30) days of the date of the OMCA final decision.[11] Upon review by an administrative law judge, the movant shall be required to prove that the OMCA final decision is unreasonable or otherwise fails to conform with KRS Chapter 342. Grievance forms should be submitted to Occupational Managed Care Alliance, Inc. (OMCA), P.O. Box 20908, Louisville, Kentucky 40250-0908. To receive a copy of a Grievance Form, call 1-800-KYCOMP-1 or write a letter to the same address.

I understand that my employer has joined a certified managed care plan for workers' compensation, and my signature below indicates that I have read and understand this explanation of that plan.

EE Signature_____ Date_____

---

[5] 803 KAR 25:110 Section 4(a)-(d).
[6] 803 KAR 25:110 Section 1(2) defines "emergency care" as: (a) Medical services required for the immediate diagnosis or treatment of a medical condition that if not immediately diagnosed or treated could lead to serious physical or mental disability or death; or (b) Medical services that are immediately necessary to alleviate severe pain. "Emergency care" does not include follow-up care, except when immediate care is required to avoid serious disability or death.
[7] 803 KAR 25:110 Section 9(1)(c).
[8] 803 KAR 25:110 Section 10 (3(a).
[9] 803 KAR 25:110 Section 10(3)(b).
[10] 803 KAR 25:110 Section 10(3)(c).
[11] 803 KAR 25:110 Section 10(5)(a).

IA-1

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

Employer (Name & Address Including Zip)		Carrier/Administration Claim Number	Report Purpose Code
		Jurisdiction	Jurisdiction Claim Number
		Insured Report Number KY	
		Employer's Location Address (if different)	Location #
SIC Code	Employer FEIN		Phone #

Carrier/Claims Administrator

Kentucky Employers' Mutual Ins. Lexington Financial Center 250 W. Main Street, Suite 900 Lexington, KY 40507 Telephone: (859) 425-7800 Fax: (859) 425-7822	Policy Period To Check if Appropriate ☐Self Insurance	Claims Administrator (Name, Address, Phone No) Kentucky Employers' Mutual Ins. PO Box 14808 Lexington, KY 40512 Ph. (859) 425-7800 Fax. (859) 425-7822
Carrier FEIN	Policy/Self-Insured Number	Administrator FEIN
Agent Name & Code Number		

Employee

Name (Last, First, Middle)	Date of Birth	Social Security No.	Date Hired	State of Hire
Address (Include ZIP)	Sex ☐ M – Male ☐ F - Female ☐ U - Unknown	Marital Status ☐ U - Unmarried Single/Divorced ☐ M - Married ☐ S - Separated ☐ K - Unknown	Occupation/Job Title Employment Status	
Phone	# of Dependents		NCCI Class Code	

Wage

Rate	Per ☐ Day ☐ Month ☐ Week ☐ Other	**# Days Worked/Week**	Full Pay for Day of Injury? ☐ Yes ☐ No Did Salary Continue? ☐ Yes ☐ No

Occurrence/Treatment

Time Employee Began Work ☐ AM ☐ PM	Date of Injury/Illness	Time of Occurrence ☐ AM ☐ PM	Last Work Date	Date Employer Notified	Date Disability Began
Contact Name/Phone Number		Type of Injury/Illness		Part of Body Affected	
Did Injury/Illness exposure occur on employer's premises? ☐ Yes ☐ No		Type of Injury/Illness Code		Part of Body Affected Code	
Department or location where accident or illness exposure occurred		All equipment, materials, or chemicals employee was using when accident or illness exposure occurred			
Specify activity the employee was engaged in when the accident or illness exposure occurred		Work process the employee was engaged in when accident or illness exposure occurred			
How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill				Cause of Injury Code	
Date Returned to Work	If Fatal, Give Date of Death	Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No Were they Used? ☐ Yes ☐ No			
Physician/Health Care Provider (Name & Address)		Hospital (Name & Address)		Initial Treatment ☐ 0 No Medical Treatment ☐ 1 Minor by Employer ☐ 2 Minor Clinic/Hosp ☐ 3 Emergency Care ☐ 4 Hospitalized>24 Hrs ☐ 5 Future Major Medical/ Lost Time Anticipated	
Witnesses (Name & Phone #)					
Date Admin/Carrier Notified	Date Prepared	Preparer's Name & Title		Phone Number	

FORM IA-1

SEE BACK FOR IMPORTANT INFORMATION & SIGNATURE

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. Reprinted with permission of the IAIABC (as modified by and for KEMI).

Employee Report of Injury

The purpose of this report is to prevent similar incidents from occurring. It should be completed and signed by the injured worker.

Incident: ☐ Near Miss ☐ Minor Injury ☐ Minor Illness ☐ Major Injury ☐ Major Illness

Incident Date: _____ Time: _____ AM/PM

Injured Employee: _____

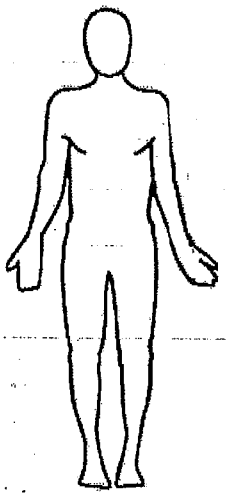
Occupation: _____ Months on this job: _____

Incident Description

When did you report the incident and to who?

_____

_____



Circle Affected Body Part

Did you require medical attention? Yes: _____ No: _____

Location of incident (entrance, loading dock, bathroom, etc.) _____

_____

Witness(es)

_____

_____

Describe in detail how the incident occurred and what you were doing when it occurred?

_____

_____

What body part(s) were affected?

_____

_____

What unsafe act(s) or condition(s) contributed to the incident?

_____

_____

What is at least one thing that can be done to prevent this type of incident from recurring?

_____

_____

Employee Signature: _____ Date: _____

This investigation is being conducted pursuant to the advice of counsel in anticipation of potential litigation. All information and recommendations are confidential.

Witness Incident Report

The purpose of this report is to prevent similar incidents from occurring. Remember, we are fact finding, not fault finding. Please make this report as accurate and thorough as possible.

Witness Name:_____ Time: _____ AM/PM

Job Title/Occupation:_____Work Phone:_____

Incident: ☐ Near Miss ☐ Minor Injury ☐ Minor Illness ☐ Major Injury ☐ Major Illness

Incident Date: _____ Time: _____ AM/PM

Injured Employee: _____

Incident Description

Location of incident (entrance, loading dock, bathroom, etc.)_____

_____

Describe in detail how the incident occurred and what the employee was doing when it occurred.

_____

_____

What unsafe act(s) or condition(s) contributed to the incident?

_____

_____

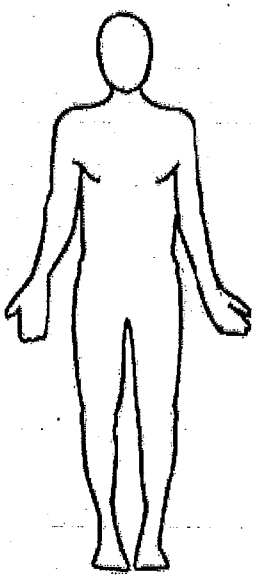
What body part(s) were affected?

_____

What is at least one thing that can be done to prevent this type of incident from happening again?

_____

_____



Circle Affected Body Part

Witness Signature: _____ Date: _____

This investigation is being conducted pursuant to the advice of counsel in anticipation of potential litigation. All information and recommendations are confidential.