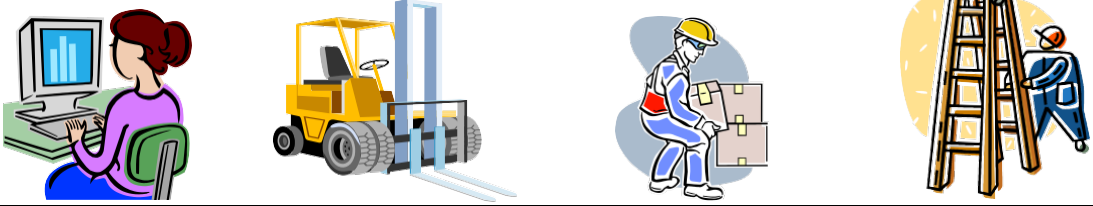
WORKERS' COMPENSATION



"Your safety is everyone's responsibility, especially yours"

PROCEDURE MANUAL

Risk Management Department – 2016

SANTA MONICA COLLEGE EMPLOYEES

IN CASE OF WORK INJURY OR ILLNESS

⬇

⬇

⬇

REPORT TO YOUR SUPERVISOR

⬇

OBTAIN REFERRAL FORM FROM SUPERVISOR FOR BRENTVIEW MEDICAL OR MIDWAY INDUSTRIAL HEALTH CARE SERVICES

OR

⬇

GO TO HEALTH SERVICES

-Business Hours-

Monday-Thursday

8:00 a.m. – 7:30 p.m.

Friday

8:00 a.m. – 2:30 p.m.

If Health Services is closed, Campus Police will provide the authorization/referral form for medical treatment and work injury claim forms.

MEDICAL TREATMENT

Brentview Medical
11611 San Vicente Blvd.
Los Angeles, CA 90049
(310) 820-0013

BUSINESS HOURS:
Monday – Friday
8:00 a.m. – 8:00 p.m.
Saturday & Sunday
9:00 a.m.-4:00 p.m.

After Office Hours:
Please call (310) 820-0013 to have physician paged or go to nearest ER. FOLLOW-UP at Brentview Medical

Parking will be validated for work related injuries only
See additional parking instructions on Treatment Authorization form.

Emergencies-call Campus Police at Ext. 4300

PLEASE DO NOT GO TO YOUR PRIMARY CARE PHYSICIAN FOR WORK INJURIES UNLESS YOU AND YOUR PRIMARY CARE PHYSICIAN HAVE COMPLETED AND RETURNED THE WORKERS' COMPENSATION PRE-DESIGNATION OF PERSONAL PHYSICIAN FORM PRIOR TO AN INJURY
(SEE PAGE 6 - *TREATING PHYSICIAN*).

MEDICAL TREATMENT

Midway Industrial Health Care Services (IHCS)
5901 W. Olympic Blvd., Suite 203
Los Angeles, CA 90036
(323) 930-1331

BUSINESS HOURS:
Monday – Friday
8:30 a.m. – 5:00 p.m.

After Office Hours:
Please call (310) 202-4745 and go to Southern California Hospital at Culver City Emergency Room-3828 Delmas Terrace, Culver City, CA., or (323) 932-5104 and go to Olympia Medical Center-5900 W. Olympic Blvd., Los Angeles, CA.
FOLLOW-UP at Midway IHCS

See parking instructions on Treatment Authorization form.
(Employee will get reimbursed for parking charges)

Emergencies-call Campus Police at Ext. 4300

PLEASE DO NOT GO TO YOUR PRIMARY CARE PHYSICIAN FOR WORK INJURIES UNLESS YOU AND YOUR PRIMARY CARE PHYSICIAN HAVE COMPLETED AND RETURNED THE WORKERS' COMPENSATION PRE-DESIGNATION OF PERSONAL PHYSICIAN FORM PRIOR TO AN INJURY
(SEE PAGE 6 - *TREATING PHYSICIAN*).

Introduction

Santa Monica College Workers' Compensation Insurance provides benefits to those employees who suffer injury/illnesses which are determined to have originated in the workplace. Department Supervisors/Managers are responsible for providing Risk Management with appropriate documentation when such injuries/illnesses are reported. This manual is to provide useful information regarding workers' compensation procedures.

Reporting an Injury/Illness:

Any occurrence, which results in injury, illness, exposure or death arising out of or in the course of employment, should be reported to the supervisor immediately to make sure that he/she receives appropriate care.

Claim Forms:

Several Workers' Compensation Claim forms will need to be completed during the duration of the workers' compensation claim. Timely submission of all forms is required by law and should be submitted to Risk Management immediately.

During normal business hours the supervisor will give the employee the (DWC-1) Workers' Compensation Claim form **(Sample 1**); SMCCD Report of Work Injury/Illness form **(Sample 2)** and PRIME Advantage MPN Employee Notification **(Sample 3)**. The employee must fill out the top portion of both forms (questions 1 through 8 on the claim form (DWC-1), keep the green copy (employee's temporary receipt), and Part I on the SMCCD Report of Injury form). The supervisor must complete the bottom portion of the Claim form (questions 9 through 13) and the bottom portion of the SMCCD Report of Injury form, retain the yellow copy and send the remaining copies to Risk Management. Risk Management will complete the bottom portion of the claim form (questions 14 through 18) and will send a completed copy to the employee. If the injury does not occur during normal business hours, the employee should report to the Campus Police Office to pick up the required forms. It is also important for the employee to receive and review the MPN information/Covered Employee Notification of Rights Material (sign, date and return top page to Risk Management).

Medical Treatment:

If immediate, non-emergency medical treatment is needed, the employee will be referred to either Brentview Medical or Midway Industrial Health Care Services. The employee is entitled choose preferred medical clinic. *Treatment Referral* forms **(Sample 4 & 5)** should be completed and signed by Risk Management, authorized Supervisor, Health Office, Campus Police, or Human Resources (V.P., Dean, or Director). Employee MUST take the completed Referral form to Brentview Medical or Midway IHCS for medical treatment. After normal business hours, contact Campus Police to report the injury and to obtain a *Treatment Referral* and additional work injury forms.
Employee should also be given a copy of the PRIME-Express Scripts **(Sample 6)** prior to going to the medical facility. The Express Scripts is a temporary prescription card that can be used for any medication prescribed by the physician.

Treating Physician:

The employee will be *referred* to Santa Monica College's Frontline Provider treating physicians (Brentview Medical or Midway IHCS), *unless* he/she has pre-designated his/her personal physician by submitting the *Workers' Compensation: Pre-Designation of Personal Physician* form **(Sample 7)**. The pre-designation form must be on file in the District's Risk Management office **prior** to an injury/illness. ("Personal Physician" is defined as the employee's regular physician and/or surgeon, who have previously directed the medical treatment of the employee, who retains the employee's medical records, including his or her medical history, and has agreed to treat the employee in the event of an industrial accident).

Change in Medical Status:

Any change in the injured employee's status should be reported to the supervisor, Risk Management and Human Resources. If the injured employee has not been cleared to return to work, he/she will need to be cleared to return to work with or without restrictions by the treating physician.

IMPORTANT! INJURED EMPLOYEE MUST NOT TAKE TIME OFF FROM WORK UNLESS THE AUTHORIZED TREATING PHYSICIAN CERTIFY ON THE WORK STATUS REPORT THAT THE EMPLOYEE IS UNABLE TO RETURN TO WORK FOR A WORK-RELATED INJURY. OTHERWISE, LOSS TIME WILL BE TAKEN FROM AVAILABLE SICK LEAVE.

Employee will not receive any reimbursement for certified work injury absence until the workers' compensation claim has been accepted by the Insurance Administrator. Copies of all documentation must be sent to Risk Management, including the "Release to Return to Work". The "Release to Return to Work" should state with/without restrictions. Restrictions must get cleared with the immediate supervisor and Human Resources to ensure they are compatible with the employee's assigned duties. *Employees may be asked to perform different duties within their job classification that are more appropriate for the restrictions, on a temporary basis.*

Early Return To Work

Departments are obligated to attempt, in good faith, to provide meaningful temporary work to those employees who are placed on restricted duties by their physician. The objective of the Early Return to Work Program (RTW) is to return Santa Monica College employees to safe and productive work as soon as medically possible following an injury or illness. Please contact Risk Management or Human Resources for additional information on Early RTW.

Declination of Workers' Compensation Benefits

You have the right to decline from filing a workers' compensation claim. This means, no further treatment is needed and you have no desire to proceed with filing a claim. If you wish not to proceed, please complete the Declination of Workers' Compensation Benefits form and return it to Risk Management immediately **(Sample 8)**.

Please contact Risk Management at Ext. 8170, if you have any additional questions regarding workers' compensation procedures or if you need to request workers' compensation claim forms. Forms are also available outside the Risk Management Office.

IN AN EMERGENCY, PLEASE FOLLOW THE EMERGENCY PROCEDURES POSTED IN YOUR DEPARTMENT OR CALL CAMPUS POLICE AT EXTENSION 4300.

FLOWCHART & SAMPLE ATTACHMENTS

FC-Employee Workers' Compensation Claim Process

1. Workers' Compensation Claim Form (DWC 1)
2. Report of Work Injury/Illness
3. PRIME Advantage MPN-Employee Notification
4. Brentview Medical Treatment Authorization Form
5. Midway Industrial Health Care Services
6. PRIME Workers' Compensation Temporary Prescription Services ID
7. Workers' Compensation: Pre-Designation of Personal Physician
8. Declination of Workers' Compensation Benefits

WC-procdr.manual-2016

EMPLOYEE WORKERS' COMPENSATION CLAIM PROCESS

Injury or illness Occurs at work

Immediately report injury to your supervisor/manager

Supervisor/manager authorizes medical treatment/referral to Brentview Medical or Midway IHCS.

Employee returns copy of medical work status note to supervisor.

Supervisor/manager sends copy of work status note to Risk Management.

Supervisor/manager gives employee claim forms to complete. Employee returns forms to supervisor/manager. Employee keeps temporary receipt.

Supervisor completes their section of claim forms and forward to Risk Management for claim processing.

Within 14 days, the insurance administrator should send employee one of three notices letting you know the status of your claim. The notice will infonn you if your claim is accepted, denied or delayed for further review.

First Aid injuries do not qualify for workers' compensation benefits and are not processed through the insurance administrator.

SAMPLE-I

Stat.: or C:ilifomia
Depanmenl or Industrial Relations
DIVISION OF WORKERS' COMPENSATION

E.ttac/c, de Ca{ifnrnia
Dcpan(lmemo de Rclacioncs /11d1mrial,·J
/)/\'JS/ON DE COMPENSACJ6N Al TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (D\\'C J)

PE.TIT/ON DEL E.MI'LF.AOO PAR,\ DE. COMPENSACION DF.L TRARAJADOR (D1\'C I)

Em1J111ycc: Complete the "Employee" section 11nd give the form to your employer. Keep a copy and mark ii "Emplo)'ec's Tcm11orury RL-ccipt" until you receive the signed and dated copy from your employer. You may call the Di,·ision of Workers' Compcn tion and hear recortkd information 01 **(806)** 736,7401. An explanation of workers' compensation benefits is included in lhe Notice of Potenlial Eligibility, which is Ilic cover sheet or lhis form. Deu1ch and save this notice for future reference.

You should also hove received II pamphlt:t from your employer describing worker:;' compensation benefits and the procedures 10 obtain 111cm. You may receive wriucn notices from yoor employer or its claims lldminislrnlor about your claim. If your claims 11dministralor offers to send you notices electronic.illy, and you 111,lrce lo n:ceh·e these notices nnly tiy email, plCllsc pro,·idc your email address below and check Ille appropriate bo. Jr you later decide you want lo receive the notices by mail, you mus1 infonn your employer in writing.

Any pcr.;on who mllkl'S or causes In be made any knowin ly folse or fraudulent mall•riul statl'mcnl or maleriul rcprcsmtatinn for the purpo c of nhtuinini.: or dL•n 'ing worhcr • compcn alinn hcnclil. or payments Is gllllty or u felony

*Emplrado: Cnmplcte la seccicfa "Emplcado" }' rntrcsur la fimua a .m empleadnr. Qut!dese can la copi,1 dcsig11ada "Rtcibo Tempura/ def Emplcad,," luma que VJ. reciha fa copir: firn1ada y fcc11ada de su emp{c(ldor. VJ p11cdt•Uamar a la Di,isinn dr C,m1(11'nsaci611al Trubajador al **(800)** 736-7401 porn otr informaci,l11 gmw1da. Vnt1 expllcacitln de la1 /,c11f'jicios de compensacion dr rrahajadorcs esrd incluido "" la Notificacion de Posi/,le Elcgibilidad. quc es la hoja de panada df' csta forma. Separc y guarde f's/a 11oti.ficacicfo como referenda para cl futum.*

Vd /ambicn debcr(a l1abcr recihido de su empleador un foUcro dcscrihie11da los btmflcins de compensacio11 al trabajador lnfrmado }' /or procedimicmos para obtenerl<is, F.s posiblc q11e rcciha notijicacioncs escrila.t de su emplcador o Jc su administrador de rcclamos sobrc su reclamo. SI su administrador de reclanros ofrt:ce e111iarle norijicaciones c/rctro11icanremc. y ustcd acep,a recibir rs/as no1jicacio11ts solo por corrt:o dt:clronico. por favor pmfl(1rcionc su direcci6n de correo ,:/cctronico a/,ajo} marq11e la caja apropiada. Si u:ucd decide dcspucs quc quicre rccil,ir las 11n1ijic:ac-io,1cs 1mr correo, ustcd debe de iafnnnnr n su emplt:11dor por escrilo.

Toda 11quell11 persona {Jllr 11 pro(l<i ilo ha u o cnUSl' quc sc pruduzrn cualquicr dcclurud,in o rcprc nt11cl1in mntcritil fulsa o fraudulcntu con cl fin de ohtmcr o nc ur hrnclidos o pagos d romp nsadun II truhajmlon•s h-sionurlns culpuhlc dL' un crimcn muyur "frluniu"

Employt't'-Completc this section and sec note above *Empleado-complctc esta secciotr y note la notacio11 arriba.*

1. Name. *Nombrc.* _____ Today's Date. *Fcc/1a de Hoy.* ----------
2. Home Address. *Direccion Residencial:* ----------
3. City. *Ci11dad.* _____ State. *Estado.* _____ Zip. *Codigo Postal.* _____
4. Date of Injury. *Fecha de Ia lesi6n (accidente).* _____ Time of Injury. *Hora* en *qi,e ocurrio.* ___ a.m. _ p.m.
5. Address nnd description of where injury happened. *Direcci6n/111gar dondc occurio el accide111e.* _____
6. Describe injury nnd part of body affected. *Describa la lesion y pane de/ cuerpo afectada.* ----------
7. Social Security Number. *Numero de Seguro Social de/ Empleado.* ----------
8. Oheck if you agree to receive notices about your claim by email only. 0 *Marque si usted acepta recibir notificaciones sabre s11 redamo solo par corrco electronico.* Employee's e-mail._____ *Correo eleclronico del empleado.* ----------
   You will n:ccive benefit notices by regular mail if you do not choose, or your claims adminislnltor docs not offer, an electronic service: option. *U:rted recibird notijicacioatsde l,encflcios par correo ordinario si usted no escoge, o su adminisrrador de reclamo:r nu le ofuu. una opeion de servicio e/ectronico.*
9. Signature of employee. *Firma de/ empleado.* ----------

Employer-complete this !icdion and sec note below. *Empleadar-complete esta seccion y note la notacion abajo.*

10. NDme of employer. *Nombrc del emp/eador.* _____
11. Address. *Direccion.* ----------
12. Dllte employer first knew of injury. *Fecha en quc cl emplcador supo por primera vc;: de la lesion o accidcnre.* _____
13. Date claim fonn was provided to employee. *Fecl1a en que se le emreg6 al empleado la peticion.* _____
14. Dnte employer received clnim fonn. *Fecha en que el emplcado dcvofrio la pericion al emp/eador.* _____
15. Name and address of insurance earner or adjusting agency. *Nombre y direccion de la compaiifa de seguros o agencia adminstradora de seguros.* _____
16. Insurance Policy Number. *El numero de la poliza de Seguro.* ----------
17. Signature of employer representative. *Fimia de/ represcllla1lle de/ empleador.* ----------
18. Title. *Ti111l0.* _____ 19. Telephone. *Tclcfono.* ----------

Employer: You are required to dote this fonn and provide copies to your insurer or clnims administrator and to the employee, dependent or representative who filed the clnim within one working day of receipt of the fonn from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

***Emplcador:** Se requierc que Ud. feche esta Jonna y que proiiea copias a s11 companfa de seguros, administrador de reclamos, odepe11dientelrcprcsenta111c de reclamos }' al empleado q11e lwyan presentado esta petici611 dentro de/ plaw de un dia htibil_ desde el momenta de Imber sido recibida la Jonna de/ empleado.*

El FIRMAR ESTA FORMA NO SIGNIFICA ADM/SION DE RESPONSAB/UDAD

D Employer copy/Coria *d<1 Empltador* 0 Employo:c *copy/Cop/a d,1 Emplrado* 0 Claim, Adminillnalnr/Admi"u,,,.dor *dr Ru/omos* 0 TcmpoDry Roooipi/R,ci/., *de/ Empl,m/o*

Rev. 1/1/2016

EMPLOYER'S COPY

SAMPLE-2

SANTA MONICA COMMUNITY COLLEGE DISTRICT
REPORT OF WORK INJURY/ILLNESS

Part I (Employee to complete)

Employee's Name._____Date of Birth_____
(Last) (':frst)

Home Address._____;Phooe Number_____
(Street} (City} (Zip)

Date of accident"----- Time_____am/pm. Location injury occurred _____

Sex_____ Occupation_____Dept._____

Certificated ___ Classified ___ Full-time ___ Part-time ___ Temp ___ Hourly ___ _

Did employee remain on the job? _____Was employee taken/referred to a doctor? Yes ___ _ No___

Name and address of Doctor/Hospital_____

_____

Describe injury, e.g. strain, cut, etc. _____ Part of body affected, e.g. wrist, back, etc._____

What was employee doing when injured? (Please be specific. Identify tools, equipment or material being used.)

_____

_____

How did the accident happen? (fell where, what and how it happened) _____

_____

Employee signature _____ Date _____

****

Part II (Supervisor to complete)

Comments . _____

_____

What machine, tool, substance or object was most closely connected with accident?

_____

Was injury due to a contributory act of the employee? ____ /an overt act by **another** employee/Student? ___ _

Witnesses_____

Was injury caused by unsafe conditions? _____If yesJ bas unsafe conditions been corrected? _____

How can a recurrence be prevented? _____

Cause can be corrected by: Employee ___ _ Supervision ___ _ Maintenance ___ _

Signed by supervisor _____ Date _____

Forward original to RISK MANAGEMENT WITHIN 24 HOURS OF ACCIDENT
S11pervisor to retai11 yellow copy

6/2016

:JJjPRIME
A Keenan Solution

Important Information about Medical Care if you have a Work-Related Injury or Illness

Complete Written Employee Notification regarding Medical Provider Network
(Tille 8. Cal1for111a Code of Regulations. Section 9767.12)

California law requires yolK employer to provide and pay for medical treatment if you are injured at \YOrlt Your employer has chosen to provide this medical care by using a Workers' Compensation physician network called a Medical Provider Network (MPN). This MPN is administered by Harbor Health Systems.

This notification tells you what you need to know about the MPN program and describes your rights in choosing medical care for work•related injuries and illnesses.

- **What happens If I get Injured at work?**

  In case of an emergency, you should call 911 or go to the closest emergency room.

  If you are injured at work, notify your employer as soon as possible. Your employer will provide you with a daim fomi. \Vhen you notify your employer that you have had a work•related injury, your employer or insurer will make an initial appointment with a doctor in the MPN.

- **What Is an MPN?**

  A Medical Provider Network (MPN) is a group of health care providers (physicians and other medical providers) used by YOUR EMPLOYER to treat workers injured on the job. MPNs must allow employees to have a choice of provider(s). Each MPN must include a mix of doctors specializing in work•related injuries and doctors with expertise in general areas of medicine.

- **What MPN Is used by my employer?**

  Your employer is using the PRIME Advantage MPN Powered by Harbor Health Systems MPN with the identification number 2358. You must refer to the MPN name and the MPN identification number whenever you have questions or requests about the MPN.

- Who can I contact if I have questions about my MPN?

  The MPN Contact listed in this notification will be able to answer your questions about the use of the MPN and will address any complaints regarding the MPN.

  The contact for your MPN is:

  Name: Harbor Health Systems MPN Contact
  Trtle: MPN Contact
  Address: PO Box 54770, Irvine, CA 92619-4770
  Telephone Number: (888) 626-1737
  Email address: MPNcontact@harborsys com

  General infom,ation regarding the MPN can also be found at the following website: www.harborsys.com/Keenan

- **What If I need help finding and making an appointment with a doctor?**

  The MPN's Medical Access Assistant wiD help you find available MPN physicians of your choice and can assist you with scheduling and confirming physician appointments. The Medical Access Assistant is available to assist you Monday through Saturday from 7am•Bpm (Pacific) and schedule medical appointments during doctors· normal business hours. Assistance is available in English and in Spanish.

The contad infonnation for the Medical Access Assistant Is:

Toll Free Telephone Number: (855) 521-7080
Fax Number: (703) 673-0181
Email Address: MPNMAA@harbofsys com

- How do I find out which doctors are In my **MPN?**

You can get a regional list of all MPN providers rn your area by calling the MPN Contact or by going to our website at: www.harborsys.com/Keenan. At minimum, the regional list must include a list of all MPN providers within 15 miles of your workplace and/or residence or a list of all MPN providers within the county where you live and/or work. You may choose which list you wish to receive. You also have the right to obtain a list of all the MPN providers upon request.

You can access the roster of all treating physicians in the MPN by going to the website at www.harborsys.com/Keenan.

- How do I **choose a provider?**

Your employer or the insurer for your employer will arrange the initial medical evaluation with an MPN physician After the first medical visit, you may continue to be treated by that doctor, or you may choose another doctor from the MPN. You may continue to choose doctors within the MPN for all of your medical care for this injury.

If appropriate, you may choose a speciaUst or ask your treating doctor for a referral to a specialist. Some specialists will only accept appoinbTlents with a referral from the treating doctor. Such specialist might be listed as "by referral only" in your MPN directory.

If you need help in finding a doctor or scheduling a medical appointment, you may can the Medical Access Assistant

- Can I **change providers?**

Yes. You can change providers within the MPN for any reason, but the providers you choose should be appropriate to treat your injury. Contact the MPN Contact or your daims adjuster if you want to change your treating physician.

- **What standards does the MPN have to meet?**

The MPN has providers for the entire State of California.

The MPN must give you access to a regional list of providers that includes at least three physicians in each specialty commonly used to treat work injuries/illnesses in your industry. The MPN must provide access to primary treating physicians within 30 minutes or 15 miles and specialists within 60 minutes or 30 miles of where you work or live.

If you live in a rural area or an area where there is a health care shortage, there may be a different standard.

After you have notified your employer of your injury, the MPN must provide initial treatment within 3 business days. If treatment with a specialist has been authorized, the appointment with the specialist must be provided to you within 20 business days of your request.

If you have trouble getting an appointment with a provider in the MPN, contact the Medical Access Assistant.

If there are no MPN providers in the appropriate specialty available to treat your injury within the distance and timeframe requirements, then you will be allowed to seek the necessary treatment outside of the MPN.

- What If there are no MPN providers where I am located?

If you are a current employee living in a rural area or temporarily working or living outside the MPN service area, or you are a former employee permanently living outside the MPN service area. the MPN or your treating doctor will give you a list of at least three physicians who can treat you. The MPN may also allow you to choose your

own doctor outside of the MPN network. Contact yot.W" MPN Contact for assistance in finding a physician or for additional information.

- **What If I need a speclallst that Is not available In the MPN?**

  If you need to see a type of specialist that is not available in the **MPN,** you have the right to see a specialist outside of the **MPN.**

- **What If I disagree with my doctor about medical treatment?**

  If you disagree with your doctor or wish to change your doctor for any reason, you may choose another doctor within the MPN.

  If you disagree with either the diagnosis or treatment prescribed by your doctor, you may ask for a second opinion from another doctor within the MPN. If you want a second opinion, you must contact the MPN contact or your daims adjuster and teU them you want a second opinion. The MPN should give you at least a regional or full MPN provider list from which you can choose a second opinion doctor. To get a second opinion, you must choose a doctor from the MPN list and make an appointment within 60 days. You must teU the MPN Contact of your appointment date, and the MPN will send the doctor a copy of your medical records. You can request a copy of your medical records that will be sent to the doctor.

  If you do not make an appointment within 60 days of receiving the regional provider list, you will not be allowed to have a second or third opinion with regard to this disputed diagnosis or treatment of this treating physician.

  If the second opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer and you. You will get another list of MPN doctors or specialists so you can make another selection.

  If you disagree with the second opinion, you may ask for a third opinion. If you request a third opinion, you will go through the same process you went through for the second opinion.

  Remember that if you do not make an appointment within 60 days of obtaining another MPN provider list, then you will not be allowed to have a third opinion with regard to this disputed diagnosis or treatment of this treating physician.

  If you disagree with the third-opinion doctor, you may ask for an MPN Independent Medical Review CIMR). Your employer or MPN Contact will give you information on requesting an Independent Medical Review and a form at the time you select a third-opinion physician.

  If either the second or third-opinion doctor or Independent Medical Reviewer agrees with your need for a treatment or test, you may be allowed to receive that medical service from a provider within the **MPN, or** if the MPN does not contain a physician who can provide the recommended treatment, you may choose a physician outside the MPN within a reasonable geographic area.

- What if I am **already being treated** for **a work-related** Injury **before** the **MPN begins?**

  Your employer or insurer has a *"Transfer of* Care• policy which will determine if you can continue being temporarily treated for an existing work-related injury by a physician outside of the MPN before your care is transferred into the MPN.

  If your current doctor is not or does not become a member of the MPN, then you may be required to see a MPN physician. However, if you have properly predesignated a pnmary treating physician, you cannot be transferred into the MPN. (If you have questions about predeslgnation, ask your supervisor.)

  If your employer decides to transfer you into the **MPN,** you and your primary treating physician must receive a letter notifying you of the transfer.

  If you meet certain conditions, you may qualify to continue treating with a non-MPN physician for up to a year before you are transferred into the **MPN.** The qualifying conditions to postpone the transfer of your care into the MPN are set forth in the box below.

Can *I Continue Being Treated By My Doctor?*

You may qualify for continuing treatment with your non-MPN provider (through transfer of care or continuity of care} for up to a year if your injury or mness meets any of the following conditions:

- **(Acute)** The treatment for your injury or illness will be completed in less than 90 days;
- **(Serious or** Chronic) Yoix injury or illness is one that is serious and continues for at least 90 days without full cure or worsens and requires ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made.
- **(TennInal)** You have an incurable mness or irreversible condition that is likely to cause death within one year or less.
- **(Pending Surgery)** You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date, or the termination of contract date between the MPN and your doctor.

You can disagree with your employer's decision to transfer *your* care into the MPN. If *you* don't want to be transferred into the MPN, ask your primary treating physician for a medical report on whether you have one of the four conditions stated above to qualify for a postponement of your transfer into the MPN.

Your primary treating physician has 20 days from the date of your request to give you a copy of his/her report on your condition. If your primary treating physician does not give you the report within 20 days of your request, the employer can transfer your care into the MPN and you will be required to use an MPN physician.

You will need to give a copy of the report to your employer if you wish to postpone the transfer of your care. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete Transfer of Care policy for more details on the dispute resolution process.

For a copy of the Transfer of Care policy, in English or Spanish, ask your MPN Contact.

- **What If I am being treated by a MPN doctor who decides to leave the MPN?**

Your employer or insixer has a written *"Continuity of Care·* policy that will determine whether you can temporarily continue treatment for an existing work injury with your doctor if your doctor is no longer participating in the MPN.

If your employer decides that you do not qualify to continue your care with the non-MPN provider, you and your primary treating physician must receive a letter notifying you of this decision.

If you meet certain conditions, you may qualify to continue treating with this doctor for up to a year before you must choose a MPN physician. These conditions are set forth in the, "Can *I Continue Being Treated By My Doctor?"* box above.

You can disagree with your employer's decision to deny you Continuity of Care with the terminated MPN provider. If you want to continue treating with the terminated doctor, ask your primary treating physician for a medical report on whether you have one of the four conditions stated in the box above to see if you qualify to continue treating with your current doctor temporarily.

Your primary treating physician has 20 days from the date of your request to give you a copy of hisnier medical report on your condition. If your primary treating physician does not give you the report within 20 days of your request, your employer's decision to deny you Continuity of Care with your doctor who is no longer participating in the MPN will apply, and you will be required to choose a MPN physician.

You will need to give a copy of the report to your employer if you wish to postpone the selection of an MPN doctor treatment. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it See the complete Continuity of Care policy for more details on the dispute resolution process.

For a copy of the Continuity of Care policy, in English or Spanish, ask your MPN Contact.

- What If I have questions or need help?

  - MPN Contact: You may always contad the MPN Contad if you have questions about the use of the MPN and to address any complaints regarding the MPN.

  - **Medical Access Assistants:** You can contad the Medical Access Assistant if you need help finding MPN physicians and scheduling and confirming appointments.

  - **Division of Workers' Compensation (DWC):** If you have concerns, complaints or questions regarding the MPN, the notification process, or your medical treatment after a work-related injury or illness, you can call the DWC's Information and Assistance office at 1-800-736-7401. You can also go to the DWC's website at www.dir.ca.gov/dwc and click on "medical provider networks" for more information about MPNs.

  - **Independent Medical Review:** If you have questions about the MPN Independent Medical Review process contad the Division of Workers' Compensation's Medical Unit at

    DWC Medical Unit
    P.O. Box 71010
    Oakland, CA 94612
    (510) 286-3700 or (800) 794-6900

Keep this information in case you have a work-related injury or Illness.

BRENTVIEW MEDICAL

URGENT CARE & OCCUPATIONAL MEDICINE

TREATMENT AUTHORIZATION

(Please select which location by checking the box)

DATE: _____

EMPLOYEE {company name): _____

_____

EMPLOYER (address & phone): _____

_____ _____

AUTHORIZED BY (name & tttle): _____

SIGNATURE: _____

WORKERS COMP. **CARRIER:** _____

_____

_____

POLICY#: _____

AUTHORIZED BODY PART: _____

SERVICE REQUESTED: _____ ___

D Treatment for work related Injury
D Pre-placement Physical
O Spirometry/Pulmonary Function Test
O D.O.T. Physical (Dept. of Transportation)
O Other (specify}: _____

O EKG/Stress Test
D Return to work exam
O Drug Screening

TO HOSPITAL EMERGENCY ROOM: Please refer patient to Brentview Medical for all follow up care.

Questions? Please call 310-820-0013 or email staff@BrentviewMedical.com

0 **BRENTVIEW MEDICAL- BRENTWOOOD**

11611 SAN VICENTE BLVD., GROUND FLOOR
LOS ANGELES, CA 90049
CROSS STREET: Bringham **Ave.** (2 blocks east ot Banfngton)

P: 310-820-0013 I F: 310-207-2630

PARKING: We validate parking for work related Injuries ONLY. Drive 1 block west to Brentwood Gardens (3 story whtte building) 11677 San Vicente Blvd. (Turn right Into the 2nd driveway before Barrington **Ave.)** Leave your car with the valet and make sure we stamp your ticket.
NOTE: There are 2 San Vicente Blvd.'s In L.A.

0 BRENTVIEW MEDICAL - WEST HOLLYWOOD

8264 SANTA MONICA BLVD.
WEST HOLLYWOOD, CA 90046
CROSS STREET: Harper **Ave.** (2 blocks east of La Cienega)

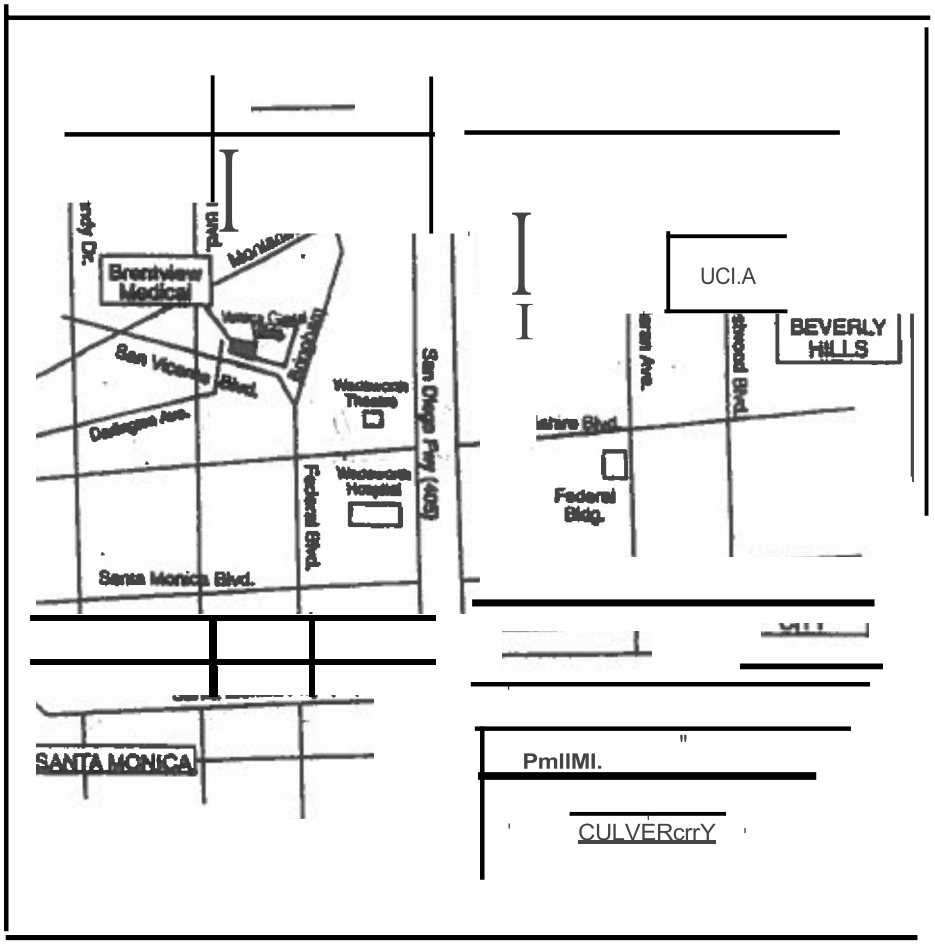
P: 323-522-2222 I F: 323-654-2221

PARKING: There Is free parking located directly behind the building & in the residential area surrounding the clinic.

SAMPLE - 4

Brentview Medical

11611 San Viceme Blvd., Ground floor, Los Angel&:s, CA 90049
Telephone: (310) 8 13 Fu(3;10)207-2630
www.BrenlViewMedical.com



WE VALDM.TE PAJIKING FOR ALL WOU llEL.UED INJURIES.

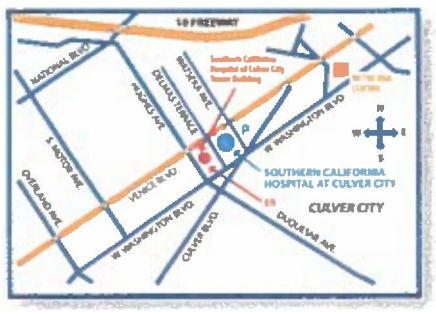
PLEASE PARK: WITH THE VALET AT COllAL TaEE CAFE
AT 'l'BE C orIWILINGToN ANDSAN VICENTE BLVD.
(2 DOOIIS WEST)

Midway Industrial Health Care Services

5901 W. Olympic Blvd., Suite 203
Los Angeles, CA 90036
(323) 930-1331 • After Hours: (310) 20 2-4745

Hours: 8:30 am to 5:00 pm

After Hours Care: Emergency Room at Southern California Hospital at Culver City



MEDICAL TREATMENT AUTHORIZATION

COMPANY

Company _____

Address _____

Phone Number (_____

EMPLOYEE

Name of Employee _____

Address _____

Phone Number (_____ Date of Birth __ _

Social Secunty Number _____

WORKERS COMPENSATION INSURANCE

Name of Carner _____

Address _____

Phone Number (_____

APPROVED BY:

Signature _____

Phone Number (_____ Extension __ _

SOUTHERN CALIFORNIA HOSPITAL

3828 Delmas Terrace
Culver City, CA 90232-6806
(310) 836-7000
www.SCH-culvercity.com

(Formerly Brotman Medical Center)

SAMPLE - 5

MIDWAY INDUSTRIAL HEALTHCARE SERVICES

SAMPLE-6

Workers' Compensation Temporary Prescription ID Card

)) To the Injured Worker:

On your first visit, please give this notice to any phamiacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pham,acy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

Este fomiulario de identificaci6n para servicios temporales de prescripci6n de recetas por compensaci6n del trabajador DEBERA SER PRESENTADO a su farmaceutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una fam,acia participante, por favor contacte al area de Atenci6n a Clientes de Express Scripts. en el telefono 800.945.5951.

)) To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard claim limitations include quantity exceeding 150 pills or a day supply exceeding 14 days. This fonn is valid for up to 30 days from DOI. Limitations may vary. For

assistance, call Express Scripts at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control A4

Step 3: Enter the group number as it appears above
Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury
(enter in DOI field in the format YYYYMMDD)

Express Scripts

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription 1s filled. You will receive a new ID number shortly.

Date Or Injury: _____ 1___ 1___ _
MM/DDNYYY

Group#: KEENANl

Employee Date of Birth: ___ I___ /_ _

_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

)) To the Supervisor: Please fill in the information reauested for the iniured worker.

Employee Infonnatlon

First -M- llnt

SInlel Address or PO Box

City State ZIP

Employer Name

GPRIMERx
A Keenan Solution

EXPRESS SCRIPTS®

Participating Retail Network Pharmacies

A&P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource
Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale
Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash **Wise**
Cobom's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Oominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy
Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-8
Hi-School
Pharmacy
Hy-Vee
JeweVOsco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network
Pharmaceuticals
Northeast
Pharmacy Services
Osco
P &C Food
Markets
Pamlda
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology
Srvs
ThePharm
Thrifty White
nmes
Tom Thumb
Tops
Ukrop's
United Drugs
United
Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

NOTE: This fonn is not vald in lhe state of Ohio. For all other stales, liability of a workers' compensation claim is not assumed based on lhe dispensing of medication(s) to a patient.

EXPRESS SCRIPTS'

Fonn032014

SANTA MONICA COLLEGE

workers' compensation: Pre-Designation of Personal Physician

If you have heallh insurance and you are injured on the job YOU have theright to be treated immediately by your personal physician (M.D., D.0), or medical group, if you notify your employer. in writing, prior to the injury. Per Labor Code 4600 **to qualify as the** your **predesignated, personal physician, the physician must agree. In writing. to treat you for a work related** Injury, must have previously directed your medical care and must retain your medical history and records. Your predesignated physician must be a famUy practitioner, general practitioner, board certified or board ellgible internist, obstetrician-gynecologist or pediabician. Your "personal physician• may be a medical group if it is a single corporation or partnership composed of licensed doctors or medicine or osteopathy, which operates an integrated multi-specialty medical group providing comprehensive medical services predominanUy for non-occupationalillnesses and injuries.

This is an optional form that can be used to notify your employer of your personal physician. You may choose to use another form, as long as you notify your employer, in **writing, prior** to being injured on the job and provide **written verification** that your personal physician meets the above requirements and agrees to be predesignated. Otherwise, you will be treated by one of your employers' designated workers' compensation medical providers.

EMPLOYEE **NAME** & ADDRESS:

☐I acknowledge receipt of this form and elect not to predesignate my personal physician at thls time. I understand that I will receive medical treatment from my employers' medical provider. I understand that, at any lime in the future, I can change my mind and provide written notification of my personal physician. I understand that the written notification must be on file prior to an industrial injury.

Employee Signature: _____ Date: _____

☐If I am injured **on the job, I wish to be treated by my personal physician*:**

Name of Physician or Medical Group _____ Phone Number _____

Address _____

*This physician is my personal primary care physician who has previously directed my medical care and retains my medical history and records.

Name of Insurance Company, Plan, or Fund providing health coverage for non-occupational injuries or illnesses:

_____

Employee Signature: Date:

A *Personal Physician* must be willing to be predesignated and treat you for a workers' compensation injury. *The remainder of this form is to be completed by your physician and returned to your Employer.*

PERSONAL PHYSICIA_ti_ ACKNOWLEOGEMENT

Per Labor Code 4600 to qualify you must meet the criteria outliled above. You are not required to sign this form, however, if you or your designated employee, does not sign,other documentation of the physicians' agreement to be predesignated will be required pursuant to Tille 8, California Code of Regulations, section 9780.1(a)(3).

PERSONAL PHYSICIAN OR MEDICAL GROUP NAME: _____

☐ *I agree to* treatthe above named employee in the event of an Industrial accident or Injury. I meet the criteria outlined above. I agree to adhere to the AdministrativeDirector's Rules and Regulations, Section 9785,regarding the duties of the employee-designated physician.

_____ _____

(Physicianor Designated Employee of the Physicianor Medical Group) Date

Please return comoleted form to:

Risk Management* 1900 Pico Blvd., Santa Monica, CA 90405 * F x: (310) 434-3602

SANTA MONICA COLLEGE
RISK MANAGEMENT DEPARTMENT

DECLINATION OF WORKERS' COMPENSATION BENEFITS

RE: EMPLOYER: Santa Monica College
EMPLOYEE:
DATE OF INJURY:
CLAIM NO: N/A
OUR FILE NO: N/A

I HAVE BEEN ADVISED OF, AND UNDERSTAND, MY RIGHT TO WORKERS' COMPENSATION BENEFITS, WHICH INCLUDE TEMPORARY DISABILITY, PERMANENT DISABILITY AND MEDICAL TREATMENT.

I AM NOT PURSUING WORKERS' COMPENSATION BENEFITS FOR THE INCIDENT WHICH OCCURRED ON ____ .
(D,\TE OF INCIDEN1)

I HAVE BEEN OFFERED AN EMPLOYEE'S CLAIM FORM AND I HAVE DECLINED A MEDICAL EVALUATION AND AM HEREBY WAMNG ANY RIGHTS I MAY HAVE TO WORKERS' COMPENSATION BENEFITS FOR THE ABOVE-STATED DATE OF INCIDENT.

Print Name

Signature

Date