Worker's Compensation for Supervisors

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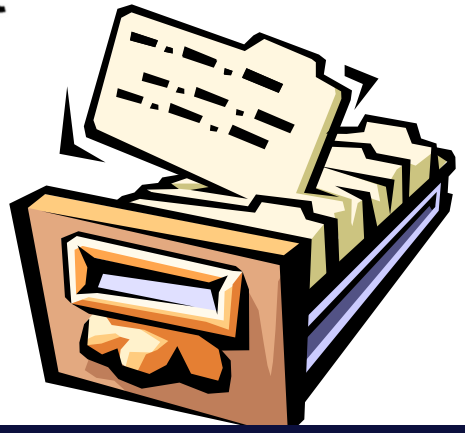
Workers' Compensation Overview

- Benefit delivery system
- Exclusive remedy doctrine
- No Fault system
- AOE/COE
- Serious & Willful Misconduct
- Labor Code 132a
- Liberal construction
- WCAB jurisdiction



Set The Stage

- Implement an Injury & Illness Prevention Program
- Review Training Programs
- Conduct Ergonomic Evaluations
- Ensure Notices are posted
- Be familiar with locations and hours of Clinics
- Be consistent with RTW protocols

Types of Industrial Injuries

- Specific injury or trauma
  - Sprains, strains, falls, lacerations, etc.
- Occupational disease or illness
  - Cancer, heart disease, asbestos, Lyme disease, etc.
- Cumulative trauma (CT) claims
  - Repetitive type injuries that occur over time
- Aggravation of a prior injury
- Exacerbation of a pre-existing condition

Types of Claims

- First Aid claims – no lost time, minor treatment
- Medical Only Claims – 3 or less days of lost time
  - Medical benefits only
- Indemnity Claims – more than 3 days lost time or hospitalization,
  - Medical benefits
  - Temporary disability benefits
  - Labor Code 4850 benefits for sworn officers
  - Permanent disability benefits
  - Supplemental Job Displacement Benefits
  - Death benefits

First Aid Claims

- No lost time or work restrictions
- Minor first aid treatment (no PT, stitches, prescription meds)
- Can be reported to claims administrator for payment
- Can be paid internally
- DWC1 not required

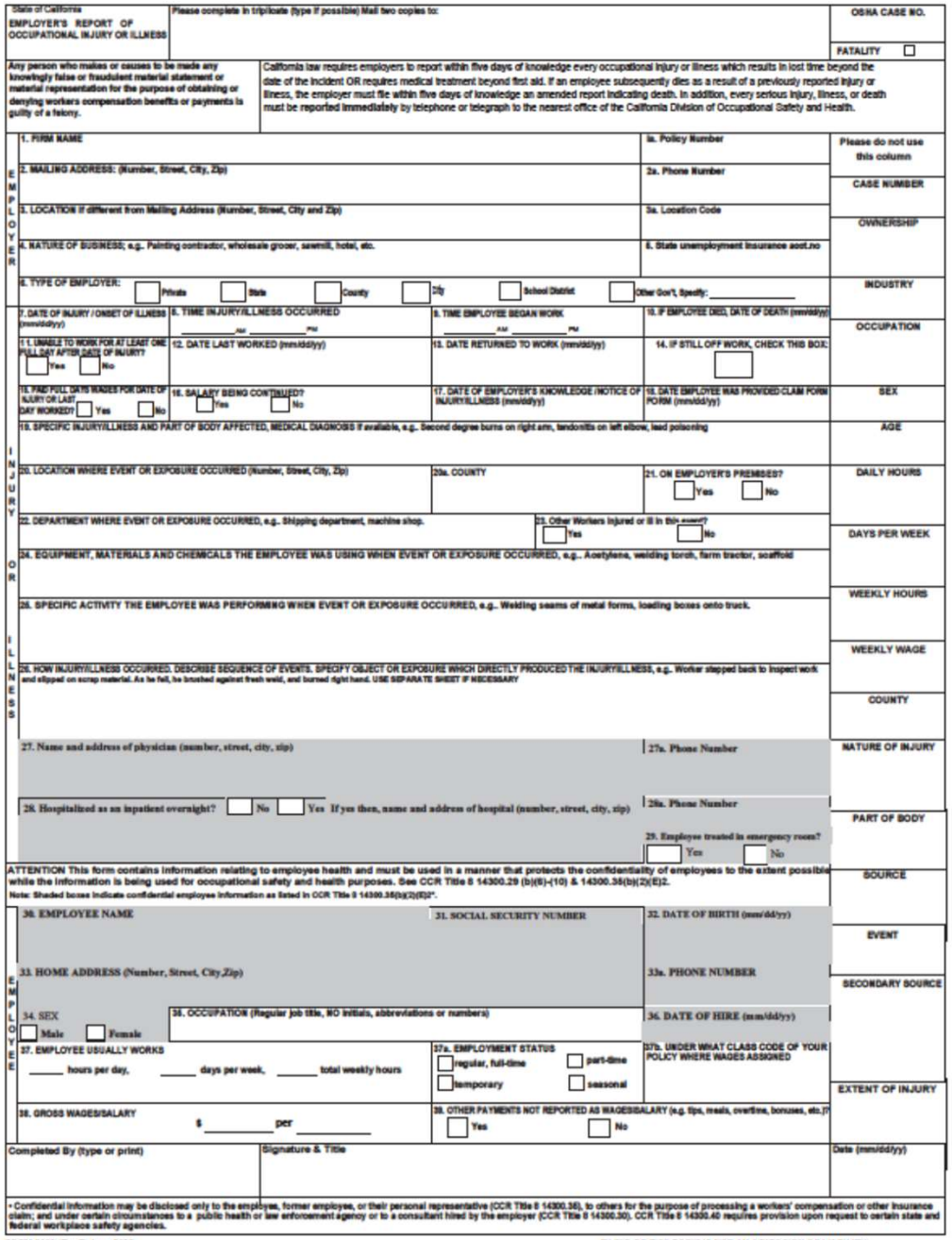
Timely Reporting

- Employer has one working day to provide DWC-1to employee upon notification of injury.
- Labor Code requires employer to report claim within 5 days
- 14 Days for First Indemnity Payment
- Fines and Penalties
- 90 Days to Delay and Investigate

When an Injury Occurs

- Administer initial first aid treatment or make emergency referrals
- Take a thorough claim report
- Refer to designated medical clinic
- Determine if claim is reportable
- Give DWC1 to employee if more than first aid
- Complete DWC 5020
- Report to insurer/administrator

Form 5020



State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____AM _____PM
9. TIME EMPLOYEE BEGAN WORK _____AM _____PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE / NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS If available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34. SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)
Signature & Title
Date (mm/dd/yy)

* Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FORM 5020 (Rev7) June 2002

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

Please do not use this column
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

***Empleado:** Complete la sección **"Empleado"** y entregue la forma a su empleador. Quédese con la copia designada **"Recibo Temporal del Empleado"** hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al **(800) 736-7401** para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrómicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.
   You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. *Empleador—complete esta sección y note la notación abajo.*

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
16. Insurance Policy Number. *El número de la póliza de Seguro.* _____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

***Empleador:** Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de **un día hábil** desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/*Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

Rev. 1/1/2016

Reporting Injury to Claims Administrator

- Three point contact
  - May seem redundant but claims adjuster needs to confirm information
  - Provide as much information as possible
    - Knowledge of outside activities that could have impact on claim
    - Any personnel issues?
    - Witnesses

Interaction with Injured Employee

- Show compassion

- Offer medical treatment.
  - If injury is serious, supervisor should take to ER or call 911 (even if you are unsure that employee has had an industrial injury)
  - Otherwise, provide employee with employer selected medical facility information

Interaction with Injured Employee (Continued)

- Check in with employee during recovery process
  - Call employee at home regularly if they are off work to show concern
  - Address any issues they bring up regarding their claim or the Workers' Comp process
  - If employee is in hospital, have someone from the organization visit the employee

IT'S IMPORTANT TO SHOW
YOU CARE!

Injury Investigation

- Take detailed account of injury
  - Was injury caused by a negligent third party?
  - Was injury caused by an unsafe condition?
  - Was injury caused by improper use of equipment or poor body mechanics?
  - Were there any witnesses?

Injury Investigation (Continued)

- If appropriate, take pictures of the accident scene
  - Account of injury does not coincide with accident scene
    - Alleged slip on spill but nothing visible on floor
  - Negligent 3rd party
    - Uneven pavement on city sidewalk
- Talk to witnesses to confirm account of injury

Common Worker's Compensation Fraud and Abuse

If the injured employee:

- Claims injuries that are inconsistent with facts about the accident
- Provides multiple versions of how the accident occurred
- Protests excessively about a modified position or returning to work
- Has a prior history of suspicious claims involving subjective injuries

Common Worker's Compensation Fraud and Abuse (Continued)

- Works a second job or owns a business
- Files a workers' compensation claim with a different employer
- Is in a motor vehicle or other accident just prior to the alleged work-related injury
- Can't be reached at home while on disability
- Is unusually familiar with the workers' compensation system

Claim Compensability

The claims adjuster must decide within 14 days whether to accept, delay or deny the claim. After gathering the facts surrounding the injury, the claims adjuster will

- Accept if the evidence supports that the injury is work related and covered under the workers' compensation laws and statutes.

Claim Compensability (Continued)

- Delay if the evidence is not conclusive and more information is needed to make a determination as to whether the injury is work related and covered under the workers' compensation laws and statutes.

- Deny if the evidence does not support that the injury is work related and covered under the workers' compensation laws and statutes.

90 Day Delay and Investigation

- 90 days from date of knowledge and/or return of DWC1
- Investigation may consist of
  - Medical evaluation
  - Subpoenaed medical/employment records
  - Statements from injured employee, witnesses, supervisor, co-workers
- Presumptively compensable after 90 days

Stress Claims

- Unique compensability threshold. Work-related stress must be the predominant cause (51%) unless stress is caused by a violent act. Threshold is then 35-40%.
- Employee must be employed for a period of six months or greater unless the incident is "sudden and extraordinary"

Stress Claims (Continued)

- Keys to defending stress claims
  - Employer's cooperation with claims adjuster is vital as we need information to rebut employee's allegations.
  - Compensation is barred when the stress is substantially caused by a good faith, non-discriminatory personnel action

Subrogation

- Employer has a right to seek recovery for money paid for a work related injury caused by a negligent third party

Examples of subrogation claims

- Car Accidents
- Machine Defect or Malfunction
- Dangerous Property Conditions (Public and Private)
- Dog Bites
- Failure to Properly Warn of Danger

Subrogation (Continued)

What to do if injury was caused by negligent third party

- Obtain police report
- Preserve the evidence
- Take photos
- Gather product information, warranties, repair records, maintenance logs
- Insurance Policies and Indemnification Agreements

YOUR ADJUSTER WILL GUIDE YOU AS TO WHAT DOCUMENTS THEY NEED.

Utilization Review (UR)

- 24 visit cap on chiropractic treatment, physical therapy, and occupational therapy (except post-surgery)
- Every employer must have a Utilization Review program in place and on file with the state
- Treatment plans may be reviewed for appropriate treatment
- Utilization review is performed by nurses and is based on evidenced based outcomes
- Current standard is the ACOEM Guidelines
- Strict time requirements to perform Utilization Reviews with penalties for failure to properly administer

Independent Medical Review (IMR)

- Effective July 1, 2013, medical treatment disputes for all dates of injury will be resolved by physicians through an efficient process known as IMR, rather than through the often cumbersome and costly court system.
- A request for medical treatment in the workers' compensations system must go through a "utilization review" process to confirm that it is medically necessary before it is approved.
- If utilization review denies, delays or modifies a treating physician's request because the treatment is not medically necessary, the injured employee can ask for a review of that decision through IMR.
- The costs of IMR are paid by employers who are required by law to provide injured employees with all medical treatment that is reasonable and necessary to cure or relieve the effects of a work-related injury.

Managing the Employee During Treatment

- Employees are not compensated for wages lost while attending to medical treatment
  - Employee should schedule appointments before or after work if possible
- Employees are entitled to one day of temporary disability indemnity for each day of lost wages in submitting to a medical examination

Managing Employee's Disability Status

- Full Duty – Employee is able to return to usual and customary job
- Temporary Disability – Employee is not able to perform any kind of work and is entitled to temporary disability benefits
- Wage Loss – Employee is able to work a reduced schedule and receives wages for hours worked and temporary partial disability to replace lost wages
- Restricted Duty – Employee is provided work restrictions which employer must review to determine whether accommodation can be made

Return to Work Programs

- Requires communication with doctors and clinics
- Claims adjuster will assist and promote return to work
- Should be monitored in conjunction with ADA, FEHA requirements, including interactive process
- May require ergonomic evaluations
- Benefits include:
  - Claims stay in Medical Only status – reduced costs
  - Gradual return to full physical function
  - Improved morale
  - Discourages frivolous claims

Types of Doctors and Their Roles

- Primary Treating Physician (PTP)
  - Directs treatment of injured worker
  - Provides disability statuses
- Qualified Medical Evaluator (QME)
  - Can be used on litigated and non-litigated files
  - Used to settle disputes
  - Carries same weight as PTP
- Agreed Medical Evaluator (AME)
  - Can only be used on litigated files
  - Used to settle disputes
  - Carries more weight than PTP

Litigated Claims

- OK to speak to injured worker on employment/return to work issues
- Refrain from speaking about the details of the claim
  - If injured worker tries to discuss the claim, refer to attorney
- Entitled to lost wages incurred during employer or insurance carrier requested deposition

Permanent Work Restrictions

- Employee is deemed at Maximum Medical Improvement (MMI)
- Doctor imposes permanent work restrictions
- Employer must have an interactive meeting with the injured employee to determine whether employee can return to work with the permanent work restrictions

Permanent Work Restrictions (Continued)

- Employee can work usual and customary job as work restrictions are not a factor
  - Restriction is no lifting over 10 pounds but employee is not required to lift over 10 pounds in their job
- Employer can modify the job to accommodate restrictions
- Employer can provide alternate job within the work restrictions
- Employer cannot reasonably accommodate work restrictions


Q&A
You have
Questions
We have
Answers