Workers Comp 101

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AGENDA

- Workers' compensation overview
- Classification of claims
- Roles and responsibilities
- WC benefits
- Return to work issues
- Settlement
- Fraud issues

What is Workers' Compensation?

- Insurance plan provided by the employer which pays all medical costs if an employee is injured on the job
- It also provides for the payment of monetary (indemnity) benefits as a result of the injury

  -Temporary Disability

  -Permanent Disability

Advantages of Workers' Compensation Insurance:

- Provides immediate medical treatment for work-related injuries
- Provides income to the injured worker while he/she is recovering
- Reduces costly litigation and provides a speedy, simple and inexpensive procedure for an injured worker to obtain benefits, regardless of who is at fault
- Encourages employer workplace safety
- Insurance carrier is responsible for medical treatment and indemnity benefits

BIG PICTURE

Injury → File notice of injury forms → Medical

treatment → Temporary disability paid if off work →

P&S or MMI status reached → Settlement

Workers' Compensation

- Provides WC coverage
- Reports injuries
- Attempts to accommodate work restrictions provided by the physician

- Receives medical treatment
- Receives indemnity benefits
- Returns to work when able to do so

- Medical providers
- Pharmacy

- Administers the claim
- Issues indemnity benefits
- Provides authorization for medical treatment

What is work related injury?

- An injury that arises out of and in the course of employment

Examples:

- A broken arm from falling off a ladder
- A lower back strain from lifting a box
- Hearing loss due to ongoing exposure to excessive noise levels
- Carpal tunnel injury caused by repetitive keyboarding

Not related work injury

- Injuries caused by intoxication or drugs (medical evidence by physician)
- Ordinary commute to or from work
- Injuries arising from the willful intent of the employee to injure or kill himself

Types of Injuries

SPECIFIC injuries

- Occurs at a specific moment

CUMULATIVE TRAUMA injuries

- No clear or defined accidental occurrence
- Gradual onset of symptoms
- Injury sustained over time due to repetitive activity

Reporting An Injury

1. Employer completes the medical authorization form
2. Employer completes the report of injury form
3. Injured worker completes the notice of injury form

Note:

When an injury occurs, notify your workers' compensation insurance carrier immediately.

Provide a copy of these documents to your workers' compensation insurance carrier and the Workers' Compensation Commission (WCC).

Reporting An Injury

1. Employer must prepare a medical authorization form which authorizes a physician to examine and/or treat the injured worker. (GWC-101 a/b)

    a. Complete the form in its entirety to ensure that the billing invoices are correctly routed to the insurance company.

    b. Advise the injured worker that he/she should NOT use his/her own personal health insurance to obtain treatment.

    c. Employer issues the initial (first) authorization.

    d. Insurance carrier is responsible for all other subsequent authorizations for medical treatment.

WORKER'S COMPENSATION COMMISSION

Department of Labor * Government of Guam * P.O. Box 9970 Tamuning, Guam 96931
Tel: (671) 300-4571/77 * Fax: (671) 475-6811

WCC File#

INSTRUCTIONS: This side of the form should be completed in full. It authorizes a physician (duly qualified physicians include surgeons, osteopathic acupuncturists within the scope of their practice as defined by law) to examine and/or treat the employee for the injuries arising out of such accidental occupational injury, illness, or disease covered by the Guam Worker's Compensation Law. PLEASE TYPE OR PRINT LEGIBLY.

1. Name of Authorized Physician:	2. Name of Medical Facility:	
3. Physician's Address:	4. Medical Facility's Address:	
5. Name of Injured Employee , DoB, & SSN:	6. Occupation:	7. Date of Injury:

8. Description of Injury:

9. YOU ARE AUTHORIZED TO PROVIDE MEDICAL SERVICES TO THE EMPLOYEE AS FOLLOWS: (Please check one)

	A) If you believe the condition is related to the injury, furnish office and/or hospital treatment as necessary for the effects of the injury.
	B) If there is doubt as to whether the condition is related to the injury, you are authorized to examine the employee, using indicated non-surgical diagnostic studies, and should promptly advise those listed in Item 14 whether you believe the disability is due to the alleged injury. Pending further advice, you may provide such necessary conservative treatment.
	C) Other

YOU ARE REQUESTED TO SUBMIT A WRITTEN REPORT OF FIRST TREATMENT WITHIN 20 DAYS TO THE COMMISSIONER AT THE ADDRESS INDICATED ITEM 13 BELOW. (See back of this form for instructions as to the medical report and the submission of your charges). Reports <u>are requisite</u> if services are to be paid.

22 GCA §9132 "Any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment under this Title, or for the purpose of evading liability for any benefit or payment under this Title, shall be guilty of a misdemeanor."

10. Signature and Title of Authorizing Official:	11. Name and Address of Employer:
12. Date:	

13. Send your REPORT to:	14. Name & address of Insurance Carrier to whom COPY of your report and BILL are to be sent:
WORKER'S COMPENSATION COMMISSION P.O. Box 9970 Tamuning, Guam 96931	

FOR STATISTICAL PURPOSES ONLY:

Employee's ethnicity (please choose one):	*Employee's citizenship (please choose one):*
Yapese Pohnpeian American Korean *Chuukese Marshalls Pacific Islander Chinese* *Kosraean Palauan Filipino Japanese* *Other (specify):*	*U.S.* *Permanent Alien Resident* *Other (specify):*

ATTENDING PHYSICIAN'S REPORT OF INJURY AND TREATMENT

INSTRUCTIONS TO PHYSICIAN: This initial report should be completed and mailed within 20 days, the original to the Commissioner (see item 13 for address), with a copy to the Company in item 14. Subsequent reports should be made regularly on Form GWC-204 or in narrative form while employee is in your care. Please read item 9 on the front of this form. PLEASE TYPE OR PRINT LEGIBLY.

15. What history of injury or disease did Employee give to you?

16. Is there any history or evidence of PRE-EXISTING injury, disease, or physical impairment? [ ] NO [ ] YES (Describe):

17. What are your findings?

18. What is your diagnosis?

19. Do you believe the condition found was CAUSED or AGGRAVATED by the employment activity described? [ ] YES [ ] NO
(Please explain if there is doubt):

20. Did injury require hospitalization? [ ]YES [ ]NO
Hospital:
Admission date:
Discharge date:

21. Is additional hospitalization required? [ ] YES [ ] NO

22. Surgery (If any, please describe):

Date performed:

23. Other types of treatments:

24. What PERMANENT DEFECTS do you anticipate?

25. Date of first examination:

26. Dates of treatments:

27. Date of discharge:

28. Period of TEMPORARY DISABILITY
(Indicate if unknown):
Partial Disability: From To
Total Disability: From To

29. Date Employee was able to resume work:

LIGHT WORK [ ]
REGULAR WORK [ ]

30. If Employee is able to resume work, date when advised:

31. If Employee is able to resume only light work, indicate extent of PHYSICAL LIMITATIONS and type of work he could reasonably perform with limitations:

32. General remarks and RECOMMENDATIONS for future care, if indicated:

33. Do you SPECIALIZE? [ ] NO [ ] YES (Please specify):

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34. Name & Signature of Physician:

35. Address:

36. Date of report:

37. MEDICAL BILL (Charges for your services may be presented in the space below or on your billhead).

Date/Period of treatment(s)	Service/Supplies (MUST be itemized)	Quantity	Unit Price	Amount

Reporting An Injury

2. Employer must complete a report of the occupational injury. (GWC 202)
    a. Date of injury
    b. Date of employer's knowledge
    c. Date when injured worker first lost time from work
    d. Date the employer stopped paying salary benefits
    e. Injured worker's wages

File this form with the WCC within 10 days of the date of the accident or when you first become aware of the injury.

The day the employer obtained knowledge of the accident/injury is day 1.

Failure to file this report in a timely manner may subject your company to penalties amounting to $500 for each failure or refusal to do so.

If the injured worker refuses medical treatment, put "employee refuses medical treatment at this time" in item #14.

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WCC File #:

INSTRUCTIONS: This form may be used by the Employer to report an injury or illness. 22 GCA 9131 requires the Employer to report to the Commissioner within ten (10) days from the date of or knowledge of any injury or illness. Failure or refusal to file this report may subject the Employer to a penalty of up to $500.00. **PLEASE PRINT OR TYPE.**

1. Name of injured Employee, DOB & SSN:	2. Name of Employer & EIN:
3. Employee's address & telephone no: ( )	4. Employer's address & Telephone no.: ( )
5. Date & time of alleged injury/illness:	6. Date of Employer's first knowledge of injury:
7. Date & hour Employee first lost time because of injury/illness:	8. Date & hour Employee returned to work:
9. Date & hour pay stopped:	10. Days usually worked per week (x days): S M T W TH F S Average hours per week:
11. Employee's occupation:	12. Employee's wages/earnings (overtime, etc):
13. Is another person not of your employment caused the accident? [ ] YES [ ] NO	a. Hourly: $ b. Weekly: $

14. DESCRIBE IN FULL HOW THE ACCIDENT OCCURRED: Relate the events which resulted in the injury/illness. Tell what the injured was doing at the time of the accident. Tell what happened and how it happened. Name any object or substance involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. Use additional sheets if required and attach to this report.

15. NATURE OF INJURY/ILLNESS (Name part of body affected - fractured leg, bruised arm, lacerated finger, etc) Note any amputations.

16. Has medical attention been authorized? [ ] YES [ ] NO	17. Date authorized:	18. Has insurance carrier been notified? [ ] YES [ ] NO	19. Date notified:
20. Name of treating physician:		21. Name of worker's compensation insurance carrier:	
22. Name of treating facility:		23. Name & signature of person completing report:	

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24. Title of person completing report:	25. Date of this report:

FOR STATISTICAL PURPOSES ONLY

Please choose ONE ETHNICITY:			Please choose ONE CITIZENSHIP:
Yapese	Marshallese	African American	United States
Chuukese	Palauan	Japanese	Permanent Resident Alien
Kosraean	Chamorro	Chinese	Other (specify):
Pohnepian	Filipino	American	
Korean	Other (specify):		

PLEASE CIRCLE THE APPROPRIATE ITEMS (for statistical purposes)

A. EVENT CODE

01 Fatality	02 No Time Loss	03 Time Loss

B. NATURE OF INJURY CODE

01 Amputation	08 Disease/Illness	15 Hearing Loss
02 Asphyxia	09 Dislocation	16 Hernia
03 Bruise/Contusion/Abrasion	10 Electric Shock	17 Poisoning (Systemic)
04 Burn (Chemical)	11 Exertion	18 Puncture
05 Burn (Heat)	12 Foreign Body in Eye/Conjunctivitis	19 Radiation Effects
06 Concussion	13 Fracture	20 Strain/Sprain
07 Cut/Laceration/Puncture	14 Freezing/Frostbite	21 Other (Specify)

C. BODY PART CODE

	LEFT	RIGHT		LEFT	RIGHT		LEFT	RIGHT
Abdomen	01		Thumb	14	15	Great Toe	34	35
Ankle(s):	02	03	Fingers Index-Small			Toes		
Back	04		(First-Fourth)	16 17 18	20 21 22	(First-Fourth)	36 37 38 39	40 41 42 43
Body	05			19	23			
System	06		Wrist			Ankle	44	45
Chest	07		Hand	24	25	Foot	46	47
Head	08		Elbow	26	27	Knee	48	49
Ear(s)	09	10	Arm	28	29	Leg	50	51
Eye(s)	11	12	Shoulder	30	31	Hip(s)	52	53
Face	13			32	33			

D. TYPE OF EVENT CODE

01 Absorption	05 Fall (Same level)	10 Rubbed/Abraded
02 Bite/Sting/Scratch	06 Fall (From elevation)	11 Shock
03 Cardio-Vascular/Respiratory System Failure	07 Ingestion	12 Struck Against
	08 Inhalation	13 Struck By
04 Caught In or Between	09 Repeated Motion/Pressure	14 Other (Specify)

E. SOURCE INJURY CODE

01 Aircraft	15 Electrical Apparatus/Wiring	29 Metal Products
02 Air Pressure	16 Explosives	30 Motor Vehicle (Highway)
03 Animal/Insect/Bird/Reptile/Fish	17 Fire/Smoke	31 Motor Vehicle (Industrial)
04 Boat	18 Food	32 Motorcycle
05 Bodily Motion	19 Furniture/Furnishings	33 Person
06 Boiler/Pressure Vessel	20 Gases	34 Petroleum Products
07 Boxes/Barrels, Etc.	21 Glass	35 Pump/Prime Motor
08 Buildings/Structures	22 Hand Tool (Manual)	36 Radiation
09 Chemical Liquid/Vapor	23 Hand Tool (Powered)	37 Vegetation
10 Cleaning Compound	24 Heat (Environmental/Mechanical)	38 Waste Products
11 Cold (Environment/Mechanical)	25 Hoisting Apparatus	29 Water
12 Dirt/Sand/Stone	26 Ladder	40 Weapons
13 Drugs/Alcohol	27 Machine	41 Working Surface
14 Dust/Particles/Chips	28 Materials Handling Equipment	42 Other (Specify)

F. CONTRIBUTING ENVIRONMENTAL FACTOR CODE

01 Catch Point/Pointer Action	10 Pinch Point Action
02 Chemical Action/Reaction Exposure	11 Radiation Condition
03 Flammable Liquid/Solid Exposure	12 Shear Point Action
04 Flying Object Motion	13 Sound Level
05 Gas/Vapor/Mist/Fume/Smoke/Dust Condition	14 Squeeze Point Action
06 Illumination	15 Temperature Above or Below Tolerance Level
07 Materials Handling Equipment/Method	16 Weather/Earthquake, Etc. Condition
08 Overhead Moving and/or Falling Object Action	17 Working Surface/Facility Layout Condition
09 Overpressure/Under pressure Condition	18 Other (Specify)

G. TASK ASSIGNMENT CODE

01 Employee Working at Regularly Assigned Task(s)	02 Employee Working at OTHER than Regularly Assigned Task(s)

Reporting An Injury

3. Injured worker must complete the Notice of Injury form. (GWC-201)

    a. Injured worker describes how he/she sustained the injury.

    c. Injured worker lists the body parts affected.

    d. Notice must be provided within 30 days of the injury to the employer and the Workers' Compensation Commissioner (WCC)

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Tel: (671) 300-4571/77 Fax: 671-475-6811

WCC File #:

INSTRUCTIONS: This form may be used by the Employee to file a NOTICE of an injury, illness or in the case of death, by Employee's representative. No benefits need be paid without this notice. Notice shall be given to the Commissioner and to the Employer by delivery or to the last known place of business 22 GCA 9113. **PLEASE PRINT OR TYPE.**

**** THIS IS NOT A CLAIM ****

1. Name of injured Employee, DOB, & SSN: - -	2. Name of Employer & EIN:
3. Employee's address & telephone no: ( )	4. Employer's address:
5. Date & time of alleged injury/illness:	6. Did employee stop work? If so, date stopped:
7. Employee's occupation:	8. Name of supervisor at time of injury:
9. Place where injury occurred:	
10. Is another person not of your employment the cause of the accident? [ ] YES [ ] NO	11. Will you file suit against the other person? [ ] YES [ ] NO
12. DESCRIBE IN FULL HOW THE ACCIDENT OCCURRED: Relate the events which resulted in the injury/illness. Tell what the Employee was doing at the time of the accident. Tell what happened and how it happened. Name any object or substance involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. Use additional sheets if required and attach to this report.	
13. Effects of the injury (Indicate parts of body affected and how affected).	

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14. Name & signature of person completing this notice:	15. Date of this notice:

FOR STATISTICAL PURPOSES ONLY

Please choose ONE ETHNICITY:			Please choose ONE CITIZENSHIP:
Yapese	Marshallese	American	United States
Chuukese	Palauan	African American	Permanent Resident Alien
Kosraean	Guamanian	Japanese	Other (specify):
Pohnpeian	Filipino	Korean	
Chinese	Other (specify):		

Workers' Compensation Benefits:

- Medical treatment
- Temporary Disability
- Permanent Disability
- Death Benefits

Benefits: Medical Treatment

- Injured worker receives treatment that is reasonable and necessary to cure or relieve from the effects of the industrial injury
- Medical treatment is provided until the injured worker is medically discharged from care or possibly for life if medically indicated
- Injured worker is covered for 100% of the costs
- Employer provides authorization for the initial treatment
- WC claims adjuster provides authorization for any subsequent requests for medical treatment

Benefits: Temporary Disability

- Paid to compensate the injured worker for his lost wages while he/she is receiving medical treatment
- Physician indicates that injured worker is unable to return to work
- Physician indicates that injured worker can return to work with restrictions but the employer is unable to accommodate those restrictions
- Temporary disability can be paid for up to 5 years
- Minimum weekly rate is $150
- Maximum weekly rate is $250

Benefits: Temporary Disability

- First 3 days are not compensable BUT if the physician certifies the injured worker to be off from work for 2 weeks or more because of the work injury, then temporary disability will be paid from day 1.

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WCC File #:

INSTRUCTIONS: This report must be filed promptly with the Commissioner in every case in which (1) Form GWC-202 does not show the date employee returned to work, and (2) each time an injured employee has returned to work but later becomes disabled for work. If the employee is medically certified disabled for work, compensation payments should be reported on Forms GWC-206 and/or GWC-208. Medical reports must be sent to the Commissioner promptly following first treatment and thereafter while treatment continues.

1. Employee's name, mailing address, DOB, & SSN: - -	2. Name and address of your insurance carrier:
Home phone: ( ) Work phone: ( )	

3. Date of initial injury/illness:	4. Date of initial disability:	5. Date of initial return to work:

6. Is Employee receiving pre-injury wages?	7. Employee's pre-injury regular wages:
[ ] YES [ ] NO	

8. If this report covers a period of disability after the date shown in Item 5, state each subsequent period of disability. Use inclusive dates for (a) and (b).

(a) From	(b) To	(c) Date of return to work	(d) Wages received

9. Did Employee receive medical attention?

[ ] YES - List dates, names and addresses of physicians and hospitals providing treatments.
[ ] NO - Explain.

10. Name address of Employer:	11. Date insurance carrier provided copy of report:
	12. Name and signature of person making report:
	13. Title of person making report:
	14. Date of this report:

*** * * FOR STATISTICAL PURPOSES ONLY * * ***

Please choose one ETHNICITY:			Please choose one CITIZENSHIP:
Yapese	American	Chamorro	United States
Chuukes	African American	Filipino	Permanent Resident Alien
Kosraean	Korean	Chinese	Other (specify):
Pohnpeian	Other (specify):		

Benefits: Permanent Disability

- Any lasting disability from a work injury that affects the injured worker's ability to earn a living
- Determined at the time the injured worker has reached P&S status or MMI
- Once the physician issues the final report discussing the level of impairment, it is sent to the WCC. The WCC then calculates the amount of permanent disability payments due as a result of the injury.
- Amount of compensation for permanent disability is based on the following:

  (1) the physician's medical report regarding the level of impairment

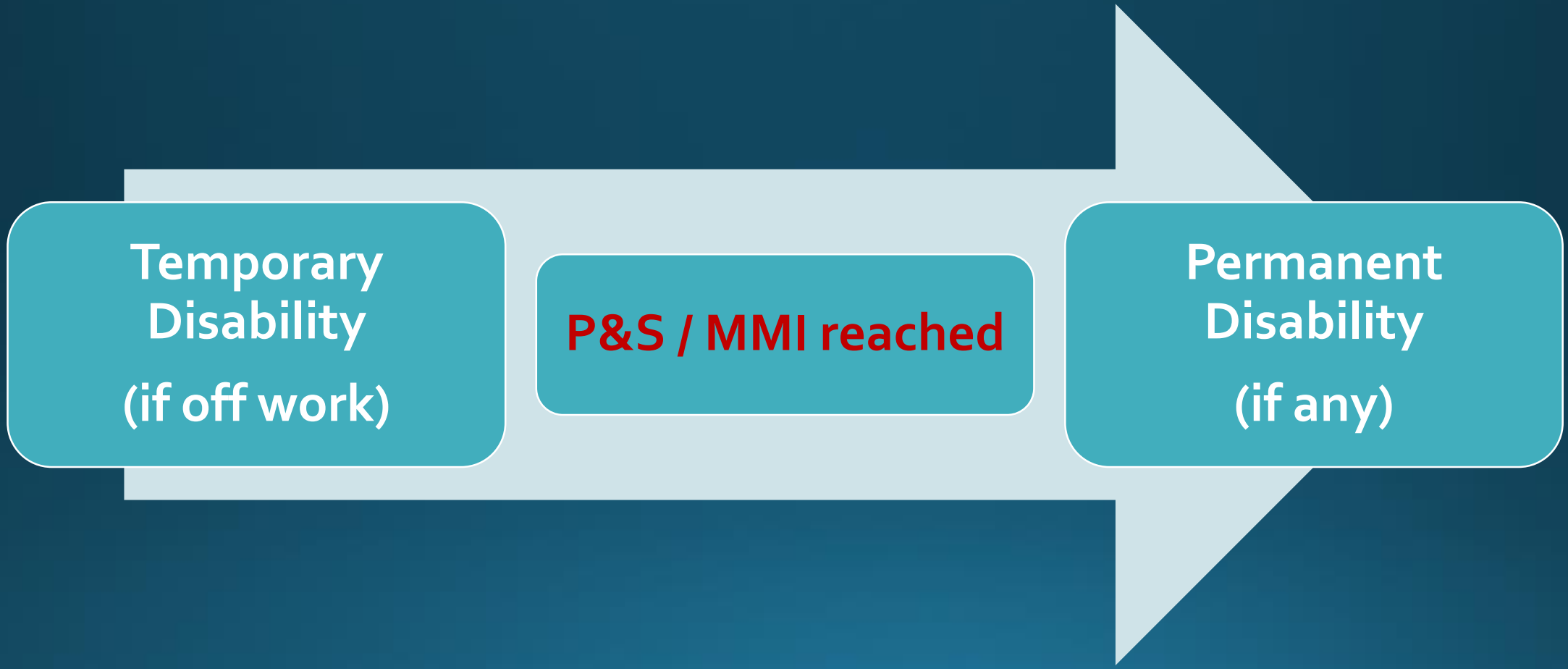
  (2) the whole life factor

  (3) the injured worker's average weekly wage

Maximum Indemnity Benefits

- Total amount of temporary disability and permanent disability benefits shall NOT exceed $100,000
- This amount does not include the cost of medical treatment

When is TD vs PD paid?



Classification of WC injuries

Incident or report only	• No medical care needed
First aid	• Requires one time first aid treatment and one follow up visit for observation • No lost time beyond the date of the injury
Medical only	• Medical treatment needed • No lost time from work
Indemnity	• Lost time from work • Entitled to lost wages and medical treatment • Injury may result in permanent disability

Benefits: Death Benefits

- Payment to injured worker's spouse, children or other dependents if the injured worker dies from a work injury
- Amount of benefits depends on the number of dependents at the time of the work injury
- Burial expenses up to $3,600

Settlement

- Resolution of the claim
- Approved by the WCC

Contact with the injured worker

- Keep up injured worker's morale
- Encourage injured worker to obtain treatment
- Demonstrate that the injured worker is expected back at work
- Alert claims adjuster to any problems if the injured worker has returned to work
- Show concern for the injured worker's well-being

Return to Work

- Full Duty
- Modified work or alternative work
  - -Injured worker is not able to perform his/her regular job duties
  - -Temporary work restrictions are provided by the physician
  - -Employer must verify if they can accommodate those restrictions
- Advantages:
  - -Employee stays in a work routine
  - -Eliminates the “disability syndrome”
  - -Reduces payment of temporary disability benefits

Return to Work

- Developing a return to work plan should be interactive between the employer, the employee and the treating physician
- Important to maintain clear and concise documentation
- If an injured worker is given permanent work restrictions, the employer must verify if they can accommodate those restrictions

Workers' Compensation Fraud

Elements of fraud:

- Knowingly and with the intent to defraud
- Makes a false statement or representation
- For the purpose of obtaining any benefit or payment of benefits

Penalty:

- Forfeit all benefits or payments obtained as a result of the false statement or representation AND
- Forfeit all or any portion of the right to compensation AND
- For fraud involving $10,000 or more:
  - -Fined up to $100,000 or up to 3 years in prison or both
- For fraud involving less than $10,000:
  - -Fined up to $10,000 or up to 2 years in prison or both

Workers' Compensation Fraud

- Symptoms are all subjective
- Misses the first physician's visit or cancels or repeatedly reschedules appointments
- Can't describe the pain or is overly dramatic
- Delays in reporting the injury
  - -Does not report Friday's injury until Monday morning
  - -Reports an injury after missing several days of work
- Changes physicians frequently

Workers' Compensation Fraud

- Has filed several claims in the past
- Exaggerates a work-related injury to obtain more benefits
- Adds symptoms in response to efforts to return him/her to work
- High risk activities as a hobby
- Inconsistent facts between the employee and witnesses to the incident
- Was recently demoted, reprimanded, passed over for a promotion

Workers' Compensation Claim Workflow

- Injured worker completes the Notice of Injury form
- Employer completes the Report of Injury form
- Employer completes the Authorization for Medical Examination and Treatment form

- Physician prepares an initial report regarding medical status and outlines any future medical treatment needed
- Any requests for additional medical treatment will be handled by the claims adjuster
- If the physician indicates that the injured worker is unable to return to work or if the employer is unable to accommodate any work restrictions, the injured worker receives temporary disability benefits

- Once the injured worker reaches P&S/MMI status, the physician will determine if there is any permanent disability
- WCC calculates the amount of permanent disability due, if any
- Claims adjuster contacts the injured worker to settle the claim

WC / ADA / FMLA

- You need to administer Workers' Compensation with your other policies. Be mindful of the interplay between Workers' Compensation, the Americans with Disabilities Act, and the Family Medical Leave Act

Questions?

Thank you!!