City of Coral Gables

Employee Handbook

For

Workers' Compensation

Department of Human Resources Rev. 06/2012

INTRODUCTION

The intent of the workers' compensation system is to provide disability income and medical benefits to eligible employees, at a reasonable cost to the employer, in order to assist the employee return to gainful employment. A Third Party Administrator (TPA) handles the individual workers' compensation cases for the City of Coral Gables. The TPA currently responsible for handling workers' compensation claims is ***Johns Eastern Company***. They are responsible for adjusting claims according to the state law and providing medical case management.

PROCEDURES

When an injury occurs, whether minor or serious, it must be reported in a prompt manner, but no later than 30 days from the date the injury occurred. Injuries shall be reported to the employee's immediate supervisor and the Human Resources Department as soon as possible. Prompt reporting allows the employee to receive appropriate medical care at the earliest possible opportunity. It also allows the adjuster to begin investigation of the claim to determine if it is payable under the law. Failure to timely report an injury may result in denial of benefits.

- All job related accidents must be reported to the employee's immediate supervisor and the Human Resources Department within 24 hours of the occurrence.

- If the injury requires immediate medical attention, the employee should proceed to the nearest emergency room. If Non-critical medical care is needed, the employee will be transported to an authorized treating facility.

  The supervisor and employee must complete the ***First Report of Injury or Illness*** form. The Department Head shall review the First Report of Injury or Illness form and the original shall be forwarded to the Human Resources Department.

- It is the employee's responsibility to notify their supervisor of any lost time resulting from the injury. It is also the employee's responsibility to keep their supervisor informed of the treatment and recovery process.

- It is the supervisor's responsibility to investigate the accident and complete the ***Employee Job Injury or Illness Supervisor Report***.

- The supervisor is responsible for reporting any lost time to the Human Resources Department. The supervisor must advise the injured employee to maintain close contact with his/her operating department and provide updates regarding his/her work status.

- The employee must provide the Work Status Report form (this form is provided by the treating physician – it is not a City form) to his/her supervisor and the Human Resources Department after each visit to the medical provider.

- Employees should contact the Human Resources Department with any questions pertaining to the work related injuries.

- It is important that employees cooperate with all reasonable requests by the adjuster, medical provider and the City to assist in treatment, recovery and returning to work.

POST INJURY/ACCIDENT DRUG SCREENING

All employees (except sworn employees in the Fire and Police Departments) incurring on the job injuries must be drug tested. If ***Physicians Health Center*** furnishes the initial medical treatment, then it will perform the drug screening. If, however, the employee is referred to a specialist for the initial medical treatment without first receiving treatment at ***Physicians Health Center***, then the employee must immediately (upon leaving the specialist's office) go to ***Physicians Health Center*** for a drug screening.

MEDICAL BENEFITS

Under the workers' compensation law, the City (through its third party administrator, ***Johns Eastern Company***) pays all authorized doctor, hospital, surgical, prescription and related costs for treatment of a work-related injury. If the employee receives a bill from a provider, it should be forwarded to ***Johns Eastern Company***. If the employee pays out of pocket for authorized treatment, the employee should submit the receipt to the adjuster for reimbursement.

Physicians Health Center provides the first treatment for injuries requiring medical services. In the event that ***Physicians Health Center*** refers the employee to a medical provider for follow up treatment, the employee must contact ***Johns Eastern Company*** to verify that the medical provider is in their network. A list of approved medical providers is available from ***Johns Eastern Company***.

All medical care received must be authorized by ***Johns Eastern Company***, with the exception of emergency care.

SCHEDULING APPOINTMENTS FOR FOLLOWUP TREATMENT

If follow-up medical treatment is required after initial treatment by ***Physicians Health Center,*** the employee must contact the ***Johns Eastern Company*** claims adjuster. **Only the medical providers within the approved network shall be used.** Employees shall not make their own appointments for follow-up care. Treating physicians or therapists may schedule future appointments; however, prior approval from ***Johns Eastern Company*** must be obtained. If there is a question about making appointments or about specific medical providers, contact the Human Resources Department. Appointments for follow-up care should be scheduled during off-duty.

OBTAINING MEDICATIONS

Most pharmacies will honor Workers' Compensation prescriptions if the employee provides a copy of the Injury Report. Should the pharmacist require additional authorization, have the pharmacist contact ***Johns Eastern Company*** at 1-800-749-3044. The employee will receive a pharmacy card from ***Johns Eastern Company*** for processing prescriptions.

*If you happen to pay for your prescription, submit your receipts to **Johns Eastern Company** for applicable, appropriate reimbursement pursuant to the Florida Workers' compensation fee schedule.*

RETURN TO WORK & LIGHT DUTY

The authorized treating medical provider will provide the City with a Work Status Report that will indicate any physical limitations. The City may make reasonable efforts to assign the employee to available tasks within the physical limitations imposed by the medical provider, if possible.

The City, however, is under no obligation to provide work to employees who fail to perform any modified duty work when there are no modified work duties available. Employees who refuse to cooperate with and/or work as indicated by the medical provider jeopardize their benefits and may be subject discipline, up to and including termination of employment.

All modified duty work is temporary. The modified duty work ends when the employee is released to full duty or reaches maximum medical improvement.

COMPENSATION FOR WORKERS' COMPENSATION LEAVE

The operating department shall notify the Human Resources Department of any employee who incurs Lost Time as the result of an on the job injury or illness. Employees injured on the job or who are unable to return to a modified work duty position may be eligible for *disability leave*.

1. For those employees released to modified work duty (**8** hour days) — Up to four hours of workers' compensation leave may be approved for medical appointments.

2. For those employees released to partial modified work duty (less than **8** hour days) — Doctor's appointments and therapy appointments are covered as long as they are scheduled during the non-working portion of the day. (Example: An employee released on a modified work duty schedule of **4** hours per day — The employee must work the actual 4 hours and schedule any medical appointments during the remaining 4 hours.)

3. For those employees released to partial modified work duty for time periods between four and eight hours per day (example: 6 hours) — Medical appointments and therapy appointments are covered as long as scheduled during the non-working portion of the day. (Example: Employee works an actual 6 hours and must schedule medical appointments during the remaining 2 hours of the workday)

MEDICAL BILLS & WORK STATUS REPORTS

All original medical invoices must be submitted to ***Johns Eastern Company*** by the medical provider. A copy of the Work Status Report will be provided to the employee's supervisor for the purpose of evaluating the availability of modified or light duty assignments. The employee must not pay the invoice for authorized

medical treatment; invoices mailed to the employee's home address must be forwarded to the Human Resources Department.

REIMBURSEMENT FOR TRAVEL EXPENSES

An employee injured on the job may be eligible for reimbursement of travel expenses to and from authorized medical treatment. Reimbursement is paid at the rate of $0.445 per mile for travel necessary to and from medical treatment, but not for such trips as visits to the drugstore. The employee is responsible for recording miles traveled, the location traveled to and from, and the dates and forwarding said information to ***Johns Eastern Company***.

ANTI-FRAUD REWARD PROGRAM

Workers' compensation fraud occurs when an employee, knowingly and with the intent to defraud or deceive an employer or insurance company, files a statement of claim containing false or misleading information and is a third degree felony that can result in fines, civil liability and jail time. The State of Florida may pay rewards up to $25,000 to individuals who provide information that leads to the arrest and conviction of persons committing insurance fraud. Report suspected workers' compensation fraud by calling 1-800-378-0445.

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)

Social Security Number

Date of Accident (Month-Day-Year)

Time of Accident ☐ AM ☐ PM

HOME ADDRESS

Street/Apt #: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

DATE OF BIRTH _____/_____/_____

SEX ☐ M ☐ F

EMPLOYER INFORMATION

COMPANY NAME: _____

D. B. A.: _____

Street: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

DATE EMPLOYED _____/_____/_____

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street: _____

City: _____ State: _____ Zip: _____

LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED _____/_____/_____

RETURNED TO WORK ☐ YES ☐ NO
IF YES, GIVE DATE _____/_____/_____

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP _____/_____/_____

PLACE OF ACCIDENT (Street, City, State, Zip)

Street: _____

City: _____ State: _____ Zip: _____

COUNTY OF ACCIDENT _____

DATE OF DEATH (If applicable) _____/_____/_____

AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO

RATE OF PAY ☐ HR ☐ WK

$ _____ PER ☐ DAY ☐ MO

Number of hours per day _____

Number of hours per week _____

Number of days per week _____

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S.

I have reviewed, understand and acknowledge the above statement.

_____ EMPLOYEE SIGNATURE (If available to sign)

_____ DATE

_____ EMPLOYER SIGNATURE

_____ DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1(a) Denied Case - DWC-12, Notice of Denial Attached

☐ 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached

☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3)

Employee's 8TH Day of Disability _____/_____/_____

Entity's Knowledge of 8TH Day of Disability _____/_____/_____

☐ 3. Lost Time Case - 1st day of disability _____/_____/_____ Full Salary in lieu of comp? ☐ YES Full Salary End Date _____/_____/_____

Date First Payment Mailed _____/_____/_____ AWW _____ Comp Rate _____

☐ T.T. ☐ T.T. - 80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ DEATH ☐ SETTLEMENT ONLY

Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

REMARKS:

INSURER NAME

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

INSURER CODE #

EMPLOYEE'S CLASS CODE

EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE #

CLAIMS-HANDLING ENTITY FILE #

CITY OF CORAL GABLES

EMPLOYEE JOB INJURY OR ILLNESS
SUPERVISOR REPORT

THE UNSAFE ACTS OF PERSONS AND THE UNSAFE CONDITIONS THAT CAUSES ACCIDENTS CAN BE CORRECTED ONLY WHEN THET ARE KNOWN SPECIFICALLY, IT IS YOUR RESPONSIBILITY TO FIND THEM AND NAME THEM AND TO STATE THE REMEDY FOR THEM IN THIS REPORT.

- NAME OF EMPLOYEE:_____ DEPT.DIVISION: _____
- DATE OF ACCIDENT:_____ DATE & TIME SEEN PHYSICIAN/HOSPITAL:_____
- TO WHOM WAS IT FIRST REPORTED :_____ DATE/TIME:_____
- HAVE YOU CONFIRMED THIS AS AN ON THE JOB INJURY ❑ YES ❑ NO
- NAME OF IMMEDIATE SUPERVISOR:_____ Ph: (W)_____ (Cell)_____
- WAS THIS FIRST REPORTED AS A MINOR INJURY ON THE MINOR INJURY LOG? ❑ Yes ❑ No Date:_____ Time: _____ ❑ am ❑ pm
- DID EMPLOYEE GO TO: ❑ CLINIC ❑ DOCTOR OR ❑ HOSPITAL? NAME OF CLINIC, DOCTOR OR HOSPITAL_____

- DESCRIBE THE INJURY:

- DESCRIBE THE ACCIDENT: (STATE WHAT THE INJURED WAS DOING AND THE CIRCUMSTANCES LEADING TO THE ACCIDENT)

- UNSAFE CONDITION: (DESCRIBE AS OILY FLOOR, POOR LIGHT, LACK OF GUARDS, NO EYE PROTECTION, ETC.)

- UNSAFE ACT / UNSAFE WORK CONDITION: (LACK OF PLANNING, REMOVED EYE PROTECTION, REMOVED GUARDS, ETC.)

- REMEDY: (AS A SUPERVISOR, WHAT ACTION HAVE YOU TAKEN OR DO YOU PROPOSE TO TAKE TO PREVENT A REPEAT ACCIDENT?)

SUPERVISOR'S SIGNATURE / DATE _____

DEPARTMENT HEAD'S SIGNATURE / DATE _____

EMPLOYEE'S SIGNATURE / DATE _____

WITNESS (S) TO ACCIDENT: _____

_____

_____

REMARKS: _____

_____

_____

ubmit to: ORIGINAL • RISK MANAGEMENT (Phone: 305-460-5527/Fax: 305-460-5518); 2801 SALZEDO STREET, CORAL GABLES, FL. 33134
Copy • EMPLOYEE FILE

07/08