WORKERS' COMPENSATION GUIDE FOR EMPLOYERS

LHA TRUST FUNDS

MALPRACTICE ▪ GENERAL LIABILITY ▪ WORKERS' COMPENSATION

4646 Sherwood Common Blvd. | Baton Rouge, LA 70816 | LHATrustFunds.com

HSLI is the claim administrator for the LHA Workers' Compensation Fund. We administer claims for employers within the Fund and act as a third-party administrator for self-insured employer clients. We are here to adjust claims in accordance with statutory guidelines and support your injured worker throughout their recovery if the injury is work-related.

How to Report a Claim

Emailed: info@hsli.com or info@lhatrustfunds.com

Fax: 225-272-1090

Phone: 800-542-4754

Contact	Direct Phone Number	Email
Alan Daigrepont *Senior Claims Consultant*	225-368-3848	alandaigrepont@hsli.com alandaigrepont@lhatrustfunds.com
JoAnna Hall *Senior Claims Consultant*	225-368-3846	joannahall@hsli.com joannahall@lhatrustfunds.com
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What is Workers' Compensation?

This is a benefit an employer who meets certain criteria must provide by state law for employees that are injured while in the course and scope of their employment.

What Benefits Does Workers' Compensation Pay For?

- Medical Bills
- Lost Wages subject to state maximum weekly wage benefits
- Rehabilitation
- Prescription medications
- Mileage to and from medical appointments
- Permanent disability, scarring, or loss of earning capacity

What To Do When an Employee is Injured?

1. Obtain Medical Care.
2. Document Accident in Writing.
3. Complete the **First Report of Injury Form (FROI).**
4. Report the claim within 24 hours to HSLI/LHAWC Fund by sending the FROI to info@lhatrustfunds.com or info@hsli.com.
5. Investigate the accident, take photos and save any video if applicable.
6. Consider using the **Employee Interview Form** to conduct a post-injury interview with the employee.
7. Stay in touch with the employee.
8. Know your internal policies and procedures for handling workers' compensation eligible employees.
9. Provide us with additional information as needed depending on the injury or disability such as job description, salary information, second injury fund questionnaires, etc.

Investigation by Employer

In workers' compensation, the main purpose of an investigation is to determine when the injury is compensable under the worker's compensation system. This investigation can also be utilized to prevent other accidents. The investigation should begin as soon as possible after the incident occurs.

It is important to ask the injured worker when and where but also what happened and how can we keep this from happening again.

If you need assistance with how to interview an injured worker, you can utilize our **Employee Interview Form**.

Our Role

What Does HSLI and the LHAWC Fund Do?

Our role is to investigate and evaluate the claim to determine if it is compensable under workers' compensation benefits. We will pay all benefits, including wages and medical bills due to the injured employee, subject to the Louisiana Workers' Compensation Statutes. Once a claim is reported to our office, if the injured worker is off work or expected to be off work for at least 7 days, we will file the First Report of Injury Form directly with the Office of Workers' Compensation as required by law.

We will collaborate with you, the employer, throughout the process of the claim. Our commitment to you is that we will treat you and your injured worker with care and concern. We will assist and educate you about the workers' compensation process and are here as a resource to aid you as the employer.

We take our commitment to you as the employer very seriously and will discuss potential disciplinary actions up to the level of prosecution for any employee who we learn has filed a fraudulent claim.

Classification of Claims

Workers' Compensation claims can be filed under three different types of claims depending on the injury and event.

The three types of claim categories are:

Reporting Purposes Only or RPO: These are accidents where, at the time of report, the employee has not sought any medical care or lost any wages. The purpose of reporting purposes only events is to document your knowledge of the injury and report to us. These will not be recorded on your loss history.

Medical Only Claim or MO: This is a claim where the employee requires medical attention but incurs no lost wages beyond the initial 7-day statutory waiting period.

Lost Time Claim or LT: This is a claim where the employee sought medical care and is unable to work for more than 7 days. A claim can be reported as MO and should the employee's ability to work change, it can be converted into a LT claim.

When you complete the **First Report of Injury Form (FROI)** it is important to fully complete the form as this indicates to us how the claim should be set up and handled. This is a state required form for all workers' compensation claims. On the bottom right side of the FROI form, there is a box labeled "initial treatment" which you can designate which type of claim you are reporting. The box labeled Return to Work Date is also used to determine the type

of claim to be set up. The initial treatment choices and the type of claim for each are listed below.

- No Medical Care is an RPO claim
- Minor Treatment by Employer is an MO claim
- Minor Clinic/Hospital Treatment is a MO claim
- Emergency Care is an MO claim.
- Hospitalized > 24 hours is a LT claim
- Future Major Medical/Lost Time Anticipated is a LT claim

It is important that you complete the FROI form in its entirety to the best of your ability. Do not write on the shaded boxes that are to be completed by the Office of Workers' Compensation.

Wage Loss Calculations

Wage loss is calculated based on statutory formulas. There are four different benefits available to compensate injured workers for lost wages.

- Temporary Total Disability
- Permanent Total Disability
- Supplemental Earnings
- Permanent Partial Disability

The Workers' Compensation Act has divided hourly wage earners into three possible categories:

- The worker who is hired for 40 hours per week or more
- The worker who is hired for 40 hours per week or more but "regularly" at their own discretion works less than 40 hours per week
- Part-time employee

We will gather all the necessary information from both you and your injured worker to identify their class of disability and employment. We then calculate the income loss benefits according to the statutory requirements applicable at the time of the claim and issue payments as required to your injured worker. **It is imperative that you help us to know when your employee returns to work.** Late notice of when your employee returns can result in an inaccurate payment of benefits.

Employee's Monthly Report of Earnings

When your employee has been taken off duty beyond the statutory 7 day waiting period, to collect wage loss benefits, we will request three documents each month from the injured worker to verify their lost income and continued disability. These forms include a work slip from your treating physician after each office visit, a **Mileage Reimbursement Form**, and a completed **Employee's Monthly Report of Earnings (1020) Form**.

Supplemental Earnings Benefits

Louisiana workers' compensation system allows for payment of supplemental income of a worker who has returned to work after a job accident but is earning less than his/her pre-injury wage. There are several factors used with calculating this benefit. We will work with both the care providers, the employee, and you as the employer to determine eligibility for any payments in relation to this benefit.

Medical Appointment Disability Form

We strive to work as a team in attempting to return your injured worker back to work as soon as medically cleared. To assist in this process and aid us in documenting any work or disability restrictions, we recommend that you use the **Work Evaluation Form.** This form can be printed and provided to your injured worker to take and have completed by their treating provider at their medical appointments where restrictions of their duties will be addressed.

Mileage Reimbursement for Medical Appointments

Injured workers may submit a mileage log monthly to seek reimbursement for mileage to and from medical appointments. This form will be sent to the injured worker by our office. They may return the form directly to the claims consultant handling their claim, or they may be returned to the employer's designated staff, and you may forward it to the consultant. Depending on your process and staffing for employee injuries, having the employee bring the form to the employer each month can provide an opportunity for direct in person contact between the employer and the employee.

Prescription Medications

In order to help ensure that only reasonable costs are paid for any prescription medications, we utilize a pharmacy benefit management company. It is imperative that that your injured worker not accept physician dispensed medications and utilize the benefit card and management company information that we provide them upon initial contact. Durable medical equipment can also be directed through our pharmacy benefit management vendor. We can provide you with a **First Fill Card** to give to your injured worker.

What Is the Second Injury Fund?

The Second Injury Fund (SIF) is a state agency that reimburses employers or their insurance provider for part of the costs of a worker's compensation claim in certain situations where the injured worker with a pre-existing permanent partial disability is injured on the job.

One of the largest determining factors for a claim to be eligible for SIF is that the employer must have prior knowledge of the employee's pre-existing medical condition. **Second Injury Fund Questionnaires** can be effectively managed by implementing a process where new employees complete the form, and existing employees update it annually.

We will handle the pursuit and recovery of any claim that has potential for SIF recoveries.

Ready to Help

Our Claim consultants will work with you, the employer, to bring the claim to resolution. We have a wealth of resources to assist in evaluating the claim including but not limited to:

- Medical Bill Adjudication and Negotiations
- Precertification and Utilization Reviews
- Pharmacy Benefit Management
- Nurse Case Managers
- Durable Medical Equipment
- Vocational Rehabilitation Counselors
- Bona fide Job Offer Letters
- Functional Capacity Evaluations
- Medicare Set Asides

We encourage you to contact any member of our claims or leadership team at any time.

First Report of Injury Form

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE SELF INSURANCE ☐	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS ■ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?	☐ YES ☐ YES	☐ NO ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED ☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT ☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC/HOSP ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HOURS ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

LWC-WC IA-1

IAIABC 2002

Employee Interview Form

Employee Interview Form

Location Code:

Section 1

Name (First, MI, Last):	Date of Birth:	SSN:	Job Title:

Home Address:	Email Address:	Phone Number:

Initial Complaint:	Date:

Section 2

Where did the injury occur?

☐ On site ☐ Off site (provide address):

_____

_____

Shift:

☐ 1
☐ 2
☐ 3

Date & Time:

Do you have a job at another company?

☐ Yes ☐ No

Are you:

☐ Right-handed ☐ Left-handed

☐ Ambidextrous (use of both hands)

Side of body with most pain:

☐ Left
☐ Right
☐ Both

Specific body part in pain:

☐ Head ☐ Eye ☐ Back ☐ Arm ☐ Shoulder ☐ Hand
☐ Fingers ☐ Wrist ☐ Leg ☐ Knee ☐ Foot ☐ Elbow
☐ Other: _____

What happened?

What were you doing when the injury occurred?

Please describe how you were performing your job when the injury happened.

How long has this task been assigned to your job?

Were you using the required safety equipment? ☐ Yes ☐ No

Who was there when this injury occurred?

Where was your supervisor when this injury occurred?

Describe the events that contributed to the incident. What would you do differently to avoid this from happening again?

Did anyone else cause this incident?

Witness name(s) and phone numbers:

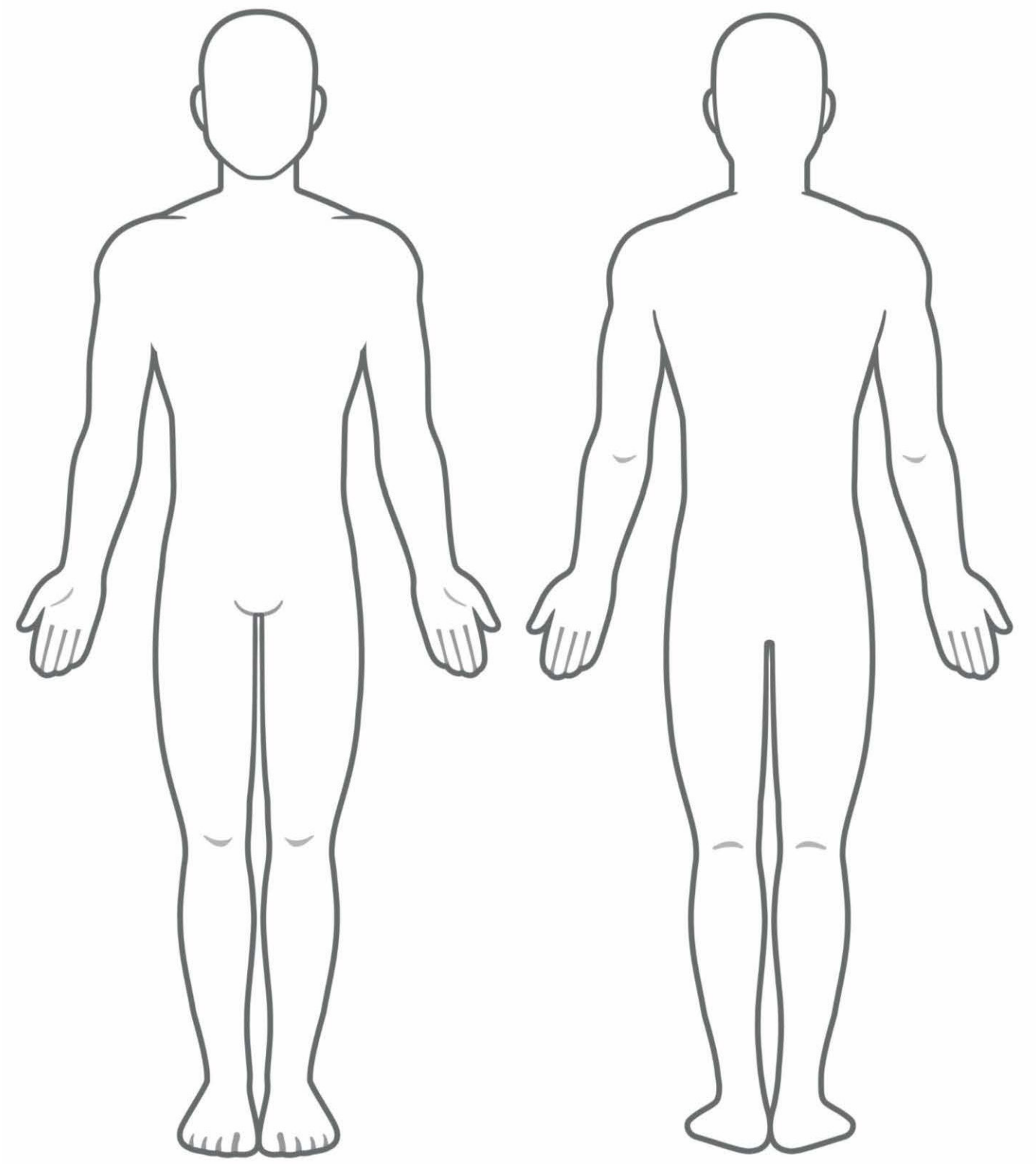
Name	Phone Number

List names and dates of medical care, if already sought.

Physician Name	Date of Treatment	Phone Number

Section 3

Please mark the location(s) where you are injured with an X.



Employee Signature: _____ **Date:** _____

Workers' Compensation Mileage Reimbursement Form

HSLI

LHA TRUST FUNDS
WORKERS' COMPENSATION

Workers' Compensation Mileage Reimbursement Form

Claim #: Date of Injury:	Adjuster:
Employee's Name:	Employer's Name:
Physical Address:	Employee's Telephone #:

Date	Travel From (Provide street address)	Travel To (Provide street address)	Distance (Total Miles) Round Trip	Name of Medical Provider
		TOTAL MILES:		**Amount:**

Warning: Per L.R.S. 23:1208 of the Louisiana Workers' Compensation Statute, it shall be unlawful for a person, for the purpose of obtaining or defeating any benefit or payment under the provisions of this Chapter, either for himself or for any other person, to willfully make a false statement or representation. Penalties for violations include imprisonment, fines, and/or the forfeiture of benefits.

I HAVE READ & FULLY UNDERSTAND THE ABOVE. I certify that the above information furnished by me is true and correct and represents travel related to the treatment of my on-the-job injury.

Signature_____ **Date**_____

Employee's Monthly Report of Earnings Form

EMPLOYEE'S MONTHLY REPORT OF EARNINGS

You must submit this report to your employer's workers' compensation insurer within 30 days of your job-related injury, and every 30 days as long as you receive workers' compensation indemnity benefits. You do not have to submit this report if you have only received medical benefits. Your workers' compensation benefits may be suspended if you do not timely submit this report.

Warning: Per L.R.S. 23:1208 of the Louisiana Workers' Compensation Statute, it shall be unlawful for a person, for the purpose of obtaining or defeating any benefit payment under the provisions of this Chapter, either for himself or for any other person, to willfully make a false statement or representation. Penalties for violations include imprisonment, fines, and/or the forfeiture of benefits.

DO NOT leave any blanks on this report. Print or type all responses, and use Not Applicable (N/A) or Zero (-0-) where appropriate.

1. The information in this report is true for the period beginning _____, 20___ and ending _____, 20 ____.

2. For the period covered in this report, did you receive a salary, wage, sales commission, or payment, including cash, of any kind? ☐ Yes ☐ No

   If yes, give name and address of employer _____
   If yes, give your gross earnings_____

3. For the period covered in this report, were you self-employed or involved in any business enterprise? **These include but are not limited to** farming, sales work, operating a business (even if the business lost money), child care, yard work, mechanical work, or any type of family business. ☐ Yes ☐ No

   If yes, describe the type of business you are involved in, your job duties, and the amount of income received from the business. _____
   _____

4. Did you perform any volunteer work during the period covered in this report? ☐ Yes ☐ No

   If yes, describe the type of volunteer work you performed. _____

5. Did you receive any unemployment insurance benefits for the period covered in this report? ☐ Yes ☐ No

   If yes, how much? _____ For how many weeks? _____

6. Did you receive any old age insurance benefits under Title II of the Social Security Act? ☐ Yes ☐ No

   If yes, how much? _____

7. Did you receive any Social Security Disability Benefits, retirement benefits, or any other type of disability or government benefits? ☐ Yes ☐ No

   If yes, how much? _____ What type of benefits did you receive? _____

Employee Certification

I certify that I understand the contents of this entire document and understand I am held responsible for this information. I certify my answers are complete and true, and certify my compliance with the Louisiana Workers' Compensation Act.

_____	_____
Print Name Signature	Social Security Number Date
_____	_____(_____) _____
Physical/Street Address City State/Zip	Telephone Number
_____	_____(_____) _____
Date of Injury Claim Number	Insurer Telephone Number

LWC-WC 1020
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Work Evaluation Form

Work Evaluation Form

Section 1

Employee/Patient Name (First, MI, Last):		Employee Date of Birth:
Employer:	Injury Date:	Date of Exam:

Section 2

Injury Type (check all that apply): ☐ New Injury ☐ No Injury Found ☐ Aggravation/Recurrence of Existing	Body Parts Injured:	Diagnosis:
Treatment:	Medications Prescribed:	Further Treatment Needed? ☐ Yes ☐ No ☐ As Needed

Section 3

Is Patient Permanent & Stationary? ☐ Yes ☐ No	Work Status: ☐ Return to full duty with no restrictions on_____(date) ☐ Return to work with restrictions on _____(date) for _____(days) ☐ Return to full duty with no restrictions on_____(date)
Permanent Disability Expected? ☐ Yes ☐ No	
Physical Restrictions (Please indicate restrictions by entering limitation information):	Next Appointments/Comments:

Section 4

Medical Provider Signature

The contents of this report are true and correct and to the best of my knowledge.

_____ _____

Provider Name **Provider Signature**

_____ _____ ( )_____

Date **Clinic Name** **Clinic/Provider Phone Number**

First Fill Pharmacy Card

HSLI / LHAWC Fund

Find a pharmacy

Injured Worker Pharmacy Benefits

For your benefit, these instructions will allow setup of an injured worker in Carlisle Medical's Pharmacy Program. This Pharmacy program allows prescriptions to be filled by the injured worker that are authorized by the physician for treatment of their specific injury.

For the Injured Worker or HSLI / LHAWC Fund Representative Employer:

Please present this information to any participating pharmacy for prescription processing. Keep and provide the Card below for processing approved medications related to your injury. **Call Carlisle Medical at 1.800.553.1783, Option 2** for assistance with the Prescription Card.

For the Pharmacy:

The below information will be needed at the pharmacy in order to process the injured worker's medications. The information can be obtained on the Prescription Card below or from the Card Holder. **For assistance, call Carlisle Medical at 1.800.553.1783, Option 2.**

1	BIN Number: **019132**
2	Group Number: **G0441**
3	Member ID: **AW5P followed by month injured worker was born, day injured worker was born (i.e 09 24) and last 4 digits of the injured workers SSN. Member ID: AW5P_ _ _ _ _ _ _ _ (Example: AW5P09241234)** MM D D
4	Injured Worker's first and last name: **On Card or obtained from Card Holder**
5	Injured Worker's date of birth: **On Card or obtained from Card Holder**
6	Injured Worker's date of injury: **On Card or obtained from Card Holder**

If experiencing any problems filling the needed medications, please contact Carlisle Medical at 1.800.553.1783, Option 2 to speak directly with a Carlisle Medical Retail Pharmacy Representative.

Fold here

Workers' Compensation Prescription Card	Injured Worker's Information
Group Number: G0441 **PCN:** C A R **BIN:** 019132 *For assistance call (800.553.1783, option 2)*	**Name:** _____ **Date of Injury:** _____ **Date of Birth:** _____ **Member ID: AW5P**_____ *See above instructions for format*

Additional Resources

Additional Resources

CHER® Online Education Portal

CHER® is a digital training hub centered around healthcare risk and quality management topics that directly influence the safety of patients, employees, and the environment of care. Relevant courses include:

- Fundamentals in Louisiana Healthcare Risk
  - Contractual Liability
  - Employee Safety
  - Workers' Compensation
- Defensive Driving training
- Attention & Distraction driving training
- Emergency Vehicle Operations course (EVOC) for ambulances

On-demand Webinars

Topics include:

- How to Create a Safe Work Environment for Remote Workers
- Lessons Learned: How to Stay on Your Feet
- MOAB

Click Below to Sign In to CHER®
lhatrustfunds.com/continuing-education-opportunities/cher

Toolkits

Fall Prevention Toolkit > Employee Fall Prevention
https://lhatrustfunds.com/toolkits/fall-prevention-toolkit

Safe Lifting toolkit
https://lhatrustfunds.com/toolkits/safe-lifting-toolkit

Safe Patient Handling toolkit
https://lhatrustfunds.com/toolkits/safe-patient-handling-toolkit

Sharp Injury & Needlestick Prevention toolkit
https://lhatrustfunds.com/toolkits/sharp-injury-needlestick-prevention-toolkit