SECURING SAFETY & SPENDING WISELY WITH A STRONG WORKERS' COMPENSATION PROGRAM

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Overview

What is Workers' Compensation?

- Compensable Claims

How Can You Help Control Claim Costs?

- Loss Control Measures
- Money-Saving Suggestions

What Is Workers' Compensation?

01. No-Fault System

02. State-Mandated and Regulated

03. Exclusive Remedy

04. Limited Amount Worker Can Recover

Review

When are workers covered?

- "Designed to cover only injuries arising out of and in the course of employment."

"…arising out of…"

- Refers to casual relationship between the event and disability

"..in the course of…"

- Refers to connection of the event with employment

Review

- A custodian falls off a ladder while changing a light bulb in the school hallway…

  …is this covered?

- A teacher walks down the school hallway and trips over his own feet…

  …is this covered?

- A business manager leaves for a conference, stops at a convenience store and falls in the store parking lot…

  …is this covered?

Litigation Process

01. File Petition with the State

02. Mediation

03. Trial Docket

04. Attorney Representation

05. Trial or Redemption

Review

Benefits for Compensable Work-Related Injuries:

- Compensable Claims
- Wage Loss Benefits
- Rehabilitation Benefits
- Death Benefits

How Long Are Wage Benefits Paid?

- No wage loss for first seven days – waiting period
- Wage loss benefits begin on the eighth day
- Waiting period waived if disabled longer than 14 consecutive days
- Wage loss benefits continue as long as employee is disabled

Medical Benefits

Employees are entitled to all reasonable and necessary medical care for work-related injuries.

First 28 days after beginning medical care, employers direct treatment. After 28 days, employees may elect to see a doctor of their own choice.

The responsibility to provide medical care continues indefinitely as long as the need for care is related to the worker's injury.

Calculating Wage Loss Benefits

How is a person's average weekly wage calculated?

- Highest 39 of the 52 individual weeks paid before the injury
- Not taxable income by IRS guidelines

Wage Loss Benefits

Fringe Benefits

- Health Insurance
- Employer Contribution to Pension
- Vacation/Holiday Pay

Are They Included?

- If employer continues paying for fringe benefits, they're not included in wage loss benefits
- If employer discontinues fringe benefits, their cash value is added to the average weekly wage

Calculating Wage Loss Benefits

How is a person's average weekly wage calculated?

- Pre-injury average weekly wage (AWW)
- Dependents
- Marital Status

Benefits payable 80% after-tax value of pre-injury AWW (estimate)

Vocational Rehabilitation Benefits

01. Used on specific cases that would allow a return to work

02. Wages can cease if employee returns to any job earning equal or greater pay

03. A portion of the wages can cease if able to perform lower-paying work

Non-Compensable Claims

Common Reasons For Disputes

- Injury not work related
- Pre-existing conditions
- Ordinary disease of life
- Disability no longer work-related
    - Maximum medical improvement
    - Recovery
- Refused job offer

Non-Compensable Claims

Does the district have coverage if an employee files a WC claim that they contracted COVID-19 on district premises?

The Fund would handle the WC claim. SET SEG would investigate and determine if the loss is compensable under the Michigan Workers' Compensation Statute. However, the Workers Compensation Act is very specific in this situation:
[Per Section 418.401 2(b)]

"An ordinary disease of life to which the public is generally exposed outside of the employment is not compensable."

The SET SEG Workers' Comp Fund pays benefits based on compensability under the Michigan WC Statute.

If a workers' compensation accident occurs, what do you do?

Plan of Action

Tell Someone - Do Not Wait!

Preferably tell a manager or supervisor

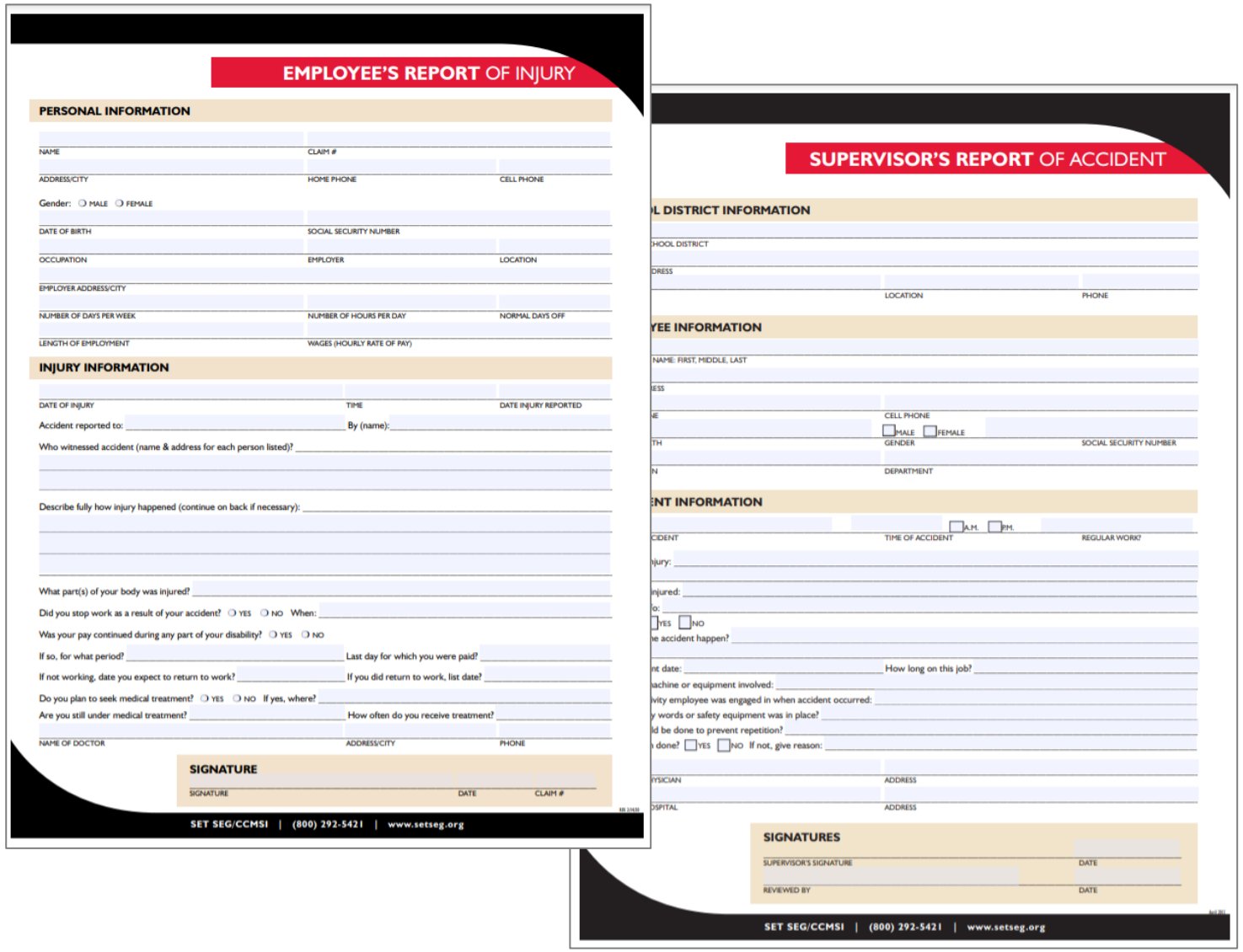
Get Medical Assistance If Needed

Go to the district medical clinic and bring an Authorization to Treat form – utilize the ER for serious incidents

Complete Employee and Supervisor Report of Injury ASAP

This fosters a quicker claim process

Accident Investigation



EMPLOYEE'S REPORT OF INJURY

PERSONAL INFORMATION

NAME | CLAIM #

ADDRESS/CITY | HOME PHONE | CELL PHONE

Gender: ❍ MALE ❍ FEMALE

DATE OF BIRTH | SOCIAL SECURITY NUMBER

OCCUPATION | EMPLOYER | LOCATION

EMPLOYER ADDRESS/CITY

NUMBER OF DAYS PER WEEK | NUMBER OF HOURS PER DAY | NORMAL DAYS OFF

LENGTH OF EMPLOYMENT | WAGES (HOURLY RATE OF PAY)

INJURY INFORMATION

DATE OF INJURY | TIME | DATE INJURY REPORTED

Accident reported to: | By (name):

Who witnessed accident (name & address for each person listed)?

Describe fully how injury happened (continue on back if necessary):

What part(s) of your body was injured?

Did you stop work as a result of your accident? ❍ YES ❍ NO When:

Was your pay continued during any part of your disability? ❍ YES ❍ NO

If so, for what period? | Last day for which you were paid?

If not working, date you expect to return to work? | If you did return to work, list date?

Do you plan to seek medical treatment? ❍ YES ❍ NO If yes, where?

Are you still under medical treatment? | How often do you receive treatment?

NAME OF DOCTOR | ADDRESS/CITY | PHONE

SIGNATURE

SIGNATURE | DATE | CLAIM #

SET SEG/CCMSI | (800) 292-5421 | www.setseg.org

SUPERVISOR'S REPORT OF ACCIDENT

L DISTRICT INFORMATION

HOOL DISTRICT

DRESS

LOCATION | PHONE

YEE INFORMATION

NAME: FIRST, MIDDLE, LAST

ESS

E | CELL PHONE

☐ MALE ☐ FEMALE

TH | GENDER | SOCIAL SECURITY NUMBER

N | DEPARTMENT

NT INFORMATION

CIDENT | TIME OF ACCIDENT ☐ A.M. ☐ P.M. | REGULAR WORK?

jury:

njured:

o:

☐ YES ☐ NO

e accident happen?

nt date: | How long on this job?

achine or equipment involved:

ivity employee was engaged in when accident occurred:

y words or safety equipment was in place?

ld be done to prevent repetition?

done? ☐ YES ☐ NO If not, give reason:

YSICIAN | ADDRESS

OSPITAL | ADDRESS

SIGNATURES

SUPERVISOR'S SIGNATURE | DATE

REVIEWED BY | DATE

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- Employee's Report of Injury
- Supervisor's Report of Accident
- Authorization to Treat Form

All forms available online at:
http://www.setseg.org/workers-compensation/forms

(PLACE ON SCHOOL LETTERHEAD)

INITIAL AUTHORIZATION TO TREAT FORM

All additional treatments/services beyond first visit need approval from CCMSI.

Employer: please complete this form and send with employee for work-related injury.

Employee Information	
Name:	Date:
Date of birth:	Social Security number:
Location where accident/injury occurred:	
Date of injury:	Injured body part(s):
Brief description of injury/accident:	

Employer Information	
Employer:	
Phone:	Fax:
Address:	
Authorized signature:	Printed name & title:

The employer accepts responsibility and authorizes initial treatment, including diagnostic testing, for the employee listed above under a self-insured workers' compensation program managed by a third-party administrator. The employee is to be treated for injuries under the provisions of the Michigan Worker's Disability Compensation Act.

Billing Information		
Workers' compensation insurance/third-party administrator: Cannon Cochran Management Services Inc. (CCMSI)		
Billing address: 2364 Woodlake Drive, Ste. 100, Okemos, MI 48864		
Phone: 517.347.2331	Fax: 217.477.5970	Claim number:

All additional treatments/services beyond initial visit need approval from CCMSI. *The employer, via CCMSI, will pay related and reasonable charges provided that these charges are accompanied by medical records submitted directly to CCMSI. The patient is financially responsible for all other services unless otherwise authorized.*

Medical Clinic	**After-hours care**
(NAME) *(ADDRESS)* *(PHONE)* *(HOURS OF OPERATION)*	*(NAME)* *(ADDRESS)* *(PHONE)* *(HOURS OF OPERATION)*

Please go to page 2

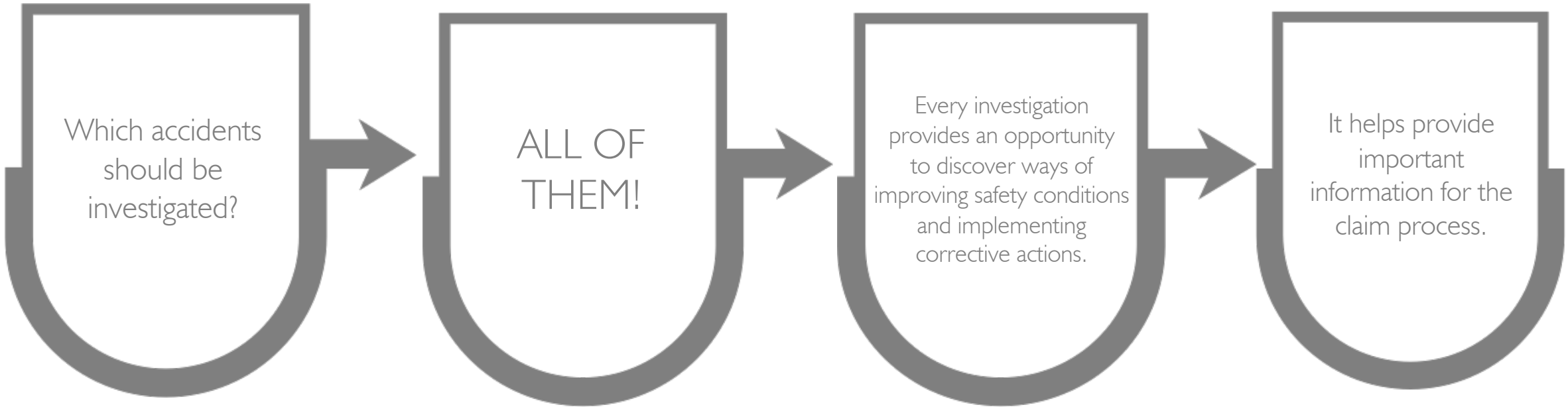
strict name:		
mployee name:		
edical Diagnosis *(to be completed by medical provider)*		
jured body part(s):		
edical diagnosis:		
condition work related?] No ☐ Yes	Is employee able to return to work full duty? ☐ No ☐ Yes	Is employee fully disabled? ☐ No ☐ Yes
unable to perform full duties, please specify restrictions:		
employee is fully disabled, what is the estimated time away from work?		
ysician name (please print):		Phone:
ddress:		
ysician's signature:		Date:
ate & time of next office visit:		

ease note - all additional treatments/services beyond initial visit need approval from CCMSI. The patient is ancially responsible for all other services unless otherwise authorized.

When completed, please fax to:

District Name
Attn: NAME
Address
Phone:
Fax:

Accident Investigation



Who Should Investigate Accidents?

- The employee's supervisor/manager or the school principal should complete a Supervisor Accident Investigation
- They are in the best position to find out what happened and make any immediate changes that are needed
- Investigations should be completed ASAP

Lag Time

Definition: The number of days it takes from the employee date of injury, to the date it gets put into the CCMSI (iCE) system.

- The goal is to have a fiscal year average of TWO days
  - The employee report of injury and the supervisor investigation form should get to HR within 24 hours.
  - These reports and the claim should be processed into the CCMSI (ICE System) within 24 hours.
- It is a State of Michigan law that Workers' Comp claims go through a designated medical clinic set up by the district.

Success Factors

Timely Claim Reporting

- Delays in reporting can cause a chain reaction
- Injuries become worse and details become less clear
- Claims unreported for 4+ weeks cost 45% more

Money-Saving Suggestions

- Work with the right clinic
- Utilize an Rx program
- Communicate with injured employees
- Develop a return-to-work program

Money-Saving Suggestions

Benefits of a Return-to-Work Program

- Eliminates disruption to the learning environment
- Increases employee morale
- Keeps additional costs down

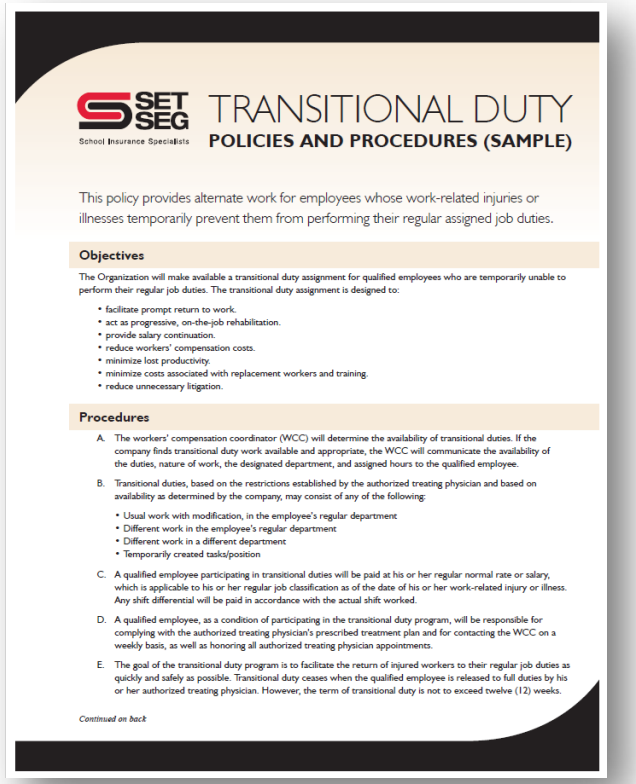
Other Considerations

Alternative job assignments do not have to be the most interesting or desirable.

- Job assignments must be "reasonable employment"
- Job offers must be in writing

The school district does not have to pay an employee the same rates of pay if they are returning to work with restrictions

Return-to-Work Resources



SET SEG School Insurance Specialists

TRANSITIONAL DUTY
POLICIES AND PROCEDURES (SAMPLE)

This policy provides alternate work for employees whose work-related injuries or illnesses temporarily prevent them from performing their regular assigned job duties.

Objectives

The Organization will make available a transitional duty assignment for qualified employees who are temporarily unable to perform their regular job duties. The transitional duty assignment is designed to:

- facilitate prompt return to work.
- act as progressive, on-the-job rehabilitation.
- provide salary continuation.
- reduce workers' compensation costs.
- minimize lost productivity.
- minimize costs associated with replacement workers and training.
- reduce unnecessary litigation.

Procedures

A. The workers' compensation coordinator (WCC) will determine the availability of transitional duties. If the company finds transitional duty work available and appropriate, the WCC will communicate the availability of the duties, nature of work, the designated department, and assigned hours to the qualified employee.

B. Transitional duties, based on the restrictions established by the authorized treating physician and based on availability as determined by the company, may consist of any of the following:

- Usual work with modification, in the employee's regular department
- Different work in the employee's regular department
- Different work in a different department
- Temporarily created tasks/position

C. A qualified employee participating in transitional duties will be paid at his or her regular normal rate or salary, which is applicable to his or her regular job classification as of the date of his or her work-related injury or illness. Any shift differential will be paid in accordance with the actual shift worked.

D. A qualified employee, as a condition of participating in the transitional duty program, will be responsible for complying with the authorized treating physician's prescribed treatment plan and for contacting the WCC on a weekly basis, as well as honoring all authorized treating physician appointments.

E. The goal of the transitional duty program is to facilitate the return of injured workers to their regular job duties as quickly and safely as possible. Transitional duty ceases when the qualified employee is released to full duties by his or her authorized treating physician. However, the term of transitional duty is not to exceed twelve (12) weeks.

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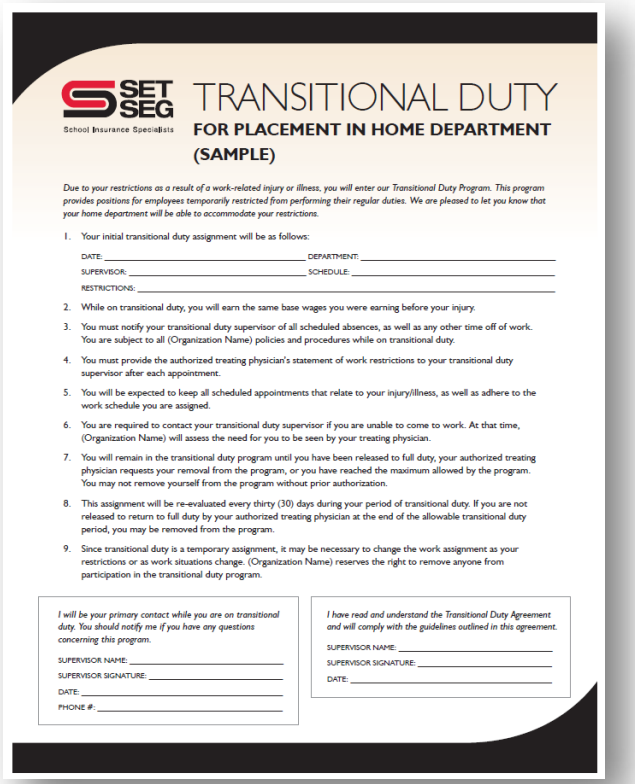
Sample Policies and Procedures Document



SET SEG School Insurance Specialists

TRANSITIONAL DUTY
FOR PLACEMENT IN HOME DEPARTMENT (SAMPLE)

Due to your restrictions as a result of a work-related injury or illness, you will enter our Transitional Duty Program. This program provides positions for employees temporarily restricted from performing their regular duties. We are pleased to let you know that your home department will be able to accommodate your restrictions.

1. Your initial transitional duty assignment will be as follows:

   DATE: _____ DEPARTMENT: _____

   SUPERVISOR: _____ SCHEDULE: _____

   RESTRICTIONS: _____

2. While on transitional duty, you will earn the same base wages you were earning before your injury.
3. You must notify your transitional duty supervisor of all scheduled absences, as well as any other time off of work. You are subject to all (Organization Name) policies and procedures while on transitional duty.
4. You must provide the authorized treating physician's statement of work restrictions to your transitional duty supervisor after each appointment.
5. You will be expected to keep all scheduled appointments that relate to your injury/illness, as well as adhere to the work schedule you are assigned.
6. You are required to contact your transitional duty supervisor if you are unable to come to work. At that time, (Organization Name) will assess the need for you to be seen by your treating physician.
7. You will remain in the transitional duty program until you have been released to full duty, your authorized treating physician requests your removal from the program, or you have reached the maximum allowed by the program. You may not remove yourself from the program without prior authorization.
8. This assignment will be re-evaluated every thirty (30) days during your period of transitional duty. If you are not released to return to full duty by your authorized treating physician at the end of the allowable transitional duty period, you may be removed from the program.
9. Since transitional duty is a temporary assignment, it may be necessary to change the work assignment as your restrictions or as work situations change. (Organization Name) reserves the right to remove anyone from participation in the transitional duty program.

I will be your primary contact while you are on transitional duty. You should notify me if you have any questions concerning this program.

SUPERVISOR NAME: _____

SUPERVISOR SIGNATURE: _____

DATE: _____

PHONE #: _____

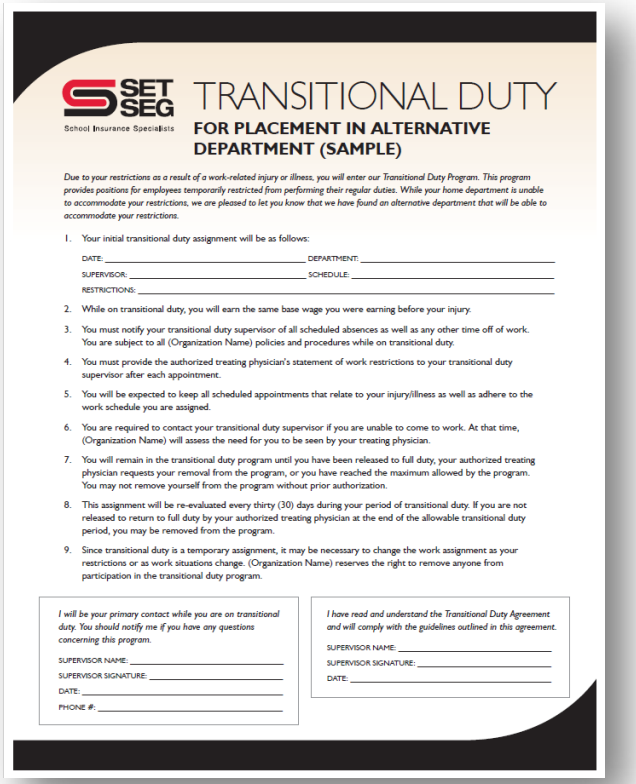
I have read and understand the Transitional Duty Agreement and will comply with the guidelines outlined in this agreement.

SUPERVISOR NAME: _____

SUPERVISOR SIGNATURE: _____

DATE: _____

Sample Placement in Home Department Document



SET SEG School Insurance Specialists

TRANSITIONAL DUTY
FOR PLACEMENT IN ALTERNATIVE DEPARTMENT (SAMPLE)

Due to your restrictions as a result of a work-related injury or illness, you will enter our Transitional Duty Program. This program provides positions for employees temporarily restricted from performing their regular duties. While your home department is unable to accommodate your restrictions, we are pleased to let you know that we have found an alternative department that will be able to accommodate your restrictions.

1. Your initial transitional duty assignment will be as follows:

   DATE: _____ DEPARTMENT: _____

   SUPERVISOR: _____ SCHEDULE: _____

   RESTRICTIONS: _____

2. While on transitional duty, you will earn the same base wage you were earning before your injury.
3. You must notify your transitional duty supervisor of all scheduled absences as well as any other time off of work. You are subject to all (Organization Name) policies and procedures while on transitional duty.
4. You must provide the authorized treating physician's statement of work restrictions to your transitional duty supervisor after each appointment.
5. You will be expected to keep all scheduled appointments that relate to your injury/illness as well as adhere to the work schedule you are assigned.
6. You are required to contact your transitional duty supervisor if you are unable to come to work. At that time, (Organization Name) will assess the need for you to be seen by your treating physician.
7. You will remain in the transitional duty program until you have been released to full duty, your authorized treating physician requests your removal from the program, or you have reached the maximum allowed by the program. You may not remove yourself from the program without prior authorization.
8. This assignment will be re-evaluated every thirty (30) days during your period of transitional duty. If you are not released to return to full duty by your authorized treating physician at the end of the allowable transitional duty period, you may be removed from the program.
9. Since transitional duty is a temporary assignment, it may be necessary to change the work assignment as your restrictions or as work situations change. (Organization Name) reserves the right to remove anyone from participation in the transitional duty program.

I will be your primary contact while you are on transitional duty. You should notify me if you have any questions concerning this program.

SUPERVISOR NAME: _____

SUPERVISOR SIGNATURE: _____

DATE: _____

PHONE #: _____

I have read and understand the Transitional Duty Agreement and will comply with the guidelines outlined in this agreement.

SUPERVISOR NAME: _____

SUPERVISOR SIGNATURE: _____

DATE: _____

Sample Placement in Alternative Department Document

Coordinate Workers' Comp

Some regulations for federal and state leave statutes include:

- Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Family and Medical Leave Act (FMLA)
- Americans with Disabilities Act (ADA)

Tip - Half of all ADA claims involve injured employees, so refer to ADA Guidelines or work closely with legal counsel to coordinate your transitional duty policy with ADA requirements.

MIOSHA Reporting Requirements

- Fatality due to a work-related incident within 8 hours
- Hospitalization of 1 or more employees within 24 hours
- Amputations or loss of an eye within 24 hours

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