# YOUTH SERVICES
# POLICY

| | |
|---|---|
| **Title:** Worker's Compensation | **Type:** A. Administrative<br>**Sub Type:** 2. Personnel<br>**Number:** A.2.49 |
| | **Page** 1 **of** 5 |
| **References:**<br>ACA Standard 2-CO-1C-05 (Administration of Correctional Agencies); Louisiana Worker's Compensation Act, La. R.S. 23:1081; R.S. 23:1208.1; Civil Service Rule 11.21; YS Policy Nos. A.2.1 "Employee Manual", A.2.7 “Drug-Free Workplace”, and A.2.5 “Family and Medical Leave of Absence” | |
| **STATUS: Approved** | |
| **Approved By:** *James Bueche, Ph.D., Deputy Secretary* | **Date of Approval:** 04/26/2019 |

## I. AUTHORITY:

Deputy Secretary of Youth Services (YS) as contained in La. R.S. 36:405. Deviation from this policy must be approved by the Deputy Secretary.

## II. PURPOSE:

To establish the procedures for income compensation when employees are unable to work due to a job-related injury or illness.

## III. APPLICABILITY:

All employees of YS.

It is the Unit Head's responsibility to ensure that appropriate procedures are in place to comply with the provisions of this policy.

## IV. DEFINITIONS:

***Hazardous Materials --*** Any gaseous, liquid, or solid material which because of its quantity, concentration, or physical, chemical, or biological composition poses a substantial present or potential hazard to human health, the environment, or property when transported in commerce, or which material is identified or designated as being hazardous by rules and regulations adopted and promulgated by the secretary of the Department of Public Safety and Corrections pursuant to the Louisiana Administrative Procedure Act.

***Occupational Health Clinic (OHC) -*** Any general hospital, or any other medical facility which operates a corporate medicine program or an employee wellness program which includes any of the following: (1) routine commercial activities, such as pre-employment examinations, (2) mandated examinations, such as Federal Occupational Safety and Health Administration examinations, (3) routine workers' compensation cases, (4) routine medical evaluations involving establishment of product liability, (5) evaluations consigned to independent medical examiners, (6) employee physical programs, (7) employee wellness programs, or (8) employee drug testing programs.

***Unit Head –*** For purposes of this policy, the Deputy Secretary, Facility Directors and Regional Managers.

***Unusual Occurrence Report (UOR)*** – A form/document that must be completed by staff to report incidents or observations of events that may have an impact on any aspect of the agency. UOR forms shall be made available to all employees, working all areas at all times. Employees must complete and submit a UOR prior to the end of their tour of duty on the day an incident is observed or comes to the employee's attention in any way. If a UOR form is not available, the employee must use any paper available to report the pertinent information. UORs may also be submitted by email in any format. (Refer to YS Policy No. A.1.14)

## V. POLICY:

It is the Deputy Secretary's policy to protect employees from the loss of income due to injuries that occur on the job. Eligible employees will be compensated under the "Louisiana Worker's Compensation Benefits" program.

## VI. PROCEDURES:

A. Should employees sustain an injury while on duty, the following steps shall be taken:

1. Employees shall notify their supervisor immediately;

2. Supervisors shall report the incident to the Unit Head and the unit's Safety Officer as soon as practicable;

3. If it appears from the nature of the accident that the injury occurred during the course and scope of the employment, the Unit Head and/or the unit's HR Liaison shall instruct the employee to report to the Occupational Health Clinic (OHC) or physician designated by the Unit Head to evaluate workplace injuries;

4. YS shall pay for the initial evaluation. Injured employees may, at their own cost, seek an evaluation and receive treatment from a physician of their own choosing after the initial evaluation directed by the designated OHC or physician; and

5**.** Only if one or more of the six factors listed below apply, then any employee directly involved in an on-duty accident or incident, and whose action or inaction may have been a causative factor of same, shall be required to immediately submit to drug and alcohol testing.

   a. Reasonable Suspicion: Circumstances give rise to a reasonable suspicion of the employee's drug or alcohol use or impairment; or

   b. Fatality: The accident or incident resulted in a fatality; or

   c. Hazardous Materials Release: The accident or incident resulted in or caused the release of hazardous was as defined in La. R.S. 30:2173(2) or hazardous materials as defined in La. R.S. 32:1502(5); or

   d. Involves an accidental and/or purposeful discharge of a firearm (refer to YS Policy nos. A.2.19 and C.1.8);

   e. Following an accident/incident that results in property damage; or

   f. While driving a state vehicle or personal vehicle [as authorized by the Undersecretary per YS Policy A.2.48] on state business and being involved in an accident/incident that results in bodily injury or property damage.

   **NOTE:** Employees should be aware of the legal presumption of impairment under La. R.S. 23:1081 if an employee refuses, after being so directed, to submit to drug or alcohol testing as a result of an on-duty accident or incident. As a consequence of such refusal, benefits under the workers' compensation laws of State of Louisiana may be denied.

B. Supervisors shall verbally report all incidents involving an employee, and shall complete a UOR prior to the end of their tour of duty on the day of the accident to the Unit Head/designee. All incidents and near misses must be reported even if the incident does not result in loss of time or incur medical expenses. If an injury requires the employee to miss more than seven (7) consecutive days, the employee is eligible for Worker's Compensation benefits.

It is the responsibility of the employee to contact the Unit's Human Resources (HR) Liaison to complete a UOR.

It is the supervisor's responsibility to notify the Unit's HR Liaison in the event the employee is seriously injured and unable to do so.

The Unit's HR Liaison shall complete a "Worker's Compensation – First Report of Injury or Illness" (see attached LWC-WC 1A-1 Form), with supporting documentation, and forward to the Department of Public Safety Human Resource (DPS/HR) office, to be reported to the Office of Risk Management (ORM) within five (5) days of receipt.

All absences related to the injury shall be recorded as worker's comp leave (LD).

C. The employee can request Family Medical Leave Act (FMLA) time while on worker's compensation leave. The employee must meet the criteria for FMLA as described in YS Policy No. A.2.5 "Family and Medical Leave of Absence." If the employee is eligible for FMLA leave, the unit's HR Liaison should notify the employee in writing that the leave is covered under FMLA and will run concurrent with worker's compensation.

D. DPS/HR shall report the employee's wages to the ORM. This amount must include paid overtime, premium, shift differential, or any other taxable income paid by YS during the four (4) weeks prior to the date of injury. The employee is eligible for weekly compensation at the rate of 66 and 2/3% (percent) of his weekly wage, not to exceed a stated maximum amount. This compensation shall continue until the employee is released by the physician to return to duty. Medical expenses incurred for a work related injury shall be covered by the ORM up to the amount covered by the established fee schedules.

E. If the employee has been granted approved leave (sick, annual or compensatory) for the absence, the worker's compensation check shall be used to buy back a portion of the leave used. The amount of leave to buy back shall be calculated by DPS/HR, based on the employee's average weekly wage, and restored to the employee. If the employee has exhausted all leave and is on leave without pay, the workers' compensation check shall be forwarded to the employee.

**NOTE: Employees do not earn leave on hours purchased from worker's compensation checks**.

F. If the employee requests that the worker's compensation check be mailed to their designated address and elects not to buy back leave, the Unit's HR Liaison shall change the coding in ISIS to reflect leave without pay for the value that could have been bought back.

G. An employee CANNOT receive both a payroll check and a worker's compensation check for lost time from work.

H. All medical expenses shall continue to be paid until the employee is released from the physician's care. If an employee is on FMLA and leave without pay, the agency shall be responsible for paying the employee and employer shares of group health and life premiums, subject to reimbursement by the employee. Miscellaneous insurance premiums shall remain the responsibility of the employee.

I. Copies of all checks shall be maintained by DPS/HR, and deposited by DPS/HR. Worker's compensation checks expire in 60 days and shall be deposited within that timeframe by DPS/HR.

J. DPS/HR shall communicate to timekeepers the appropriate timekeeping codes to be utilized when an employee is on worker's compensation leave.

K. DPS/HR shall notify the applicable retirement system when an employee is out due to a worker's compensation injury and is placed in leave without pay.

L. The Unit's HR Liaison shall be responsible for notifying DPS/HR and ORM when the employee returns to work, retires or terminates employment.

**Previous Regulation/Policy Number:** A.2.49
**Previous Effective Date:** 10/30/2017
**Attachments/References:** LWC-WC 1A-1 – WC – First Report of Injury or Illness 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<br>TO<br>CHECK IF APPROPRIATE<br>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<br>☐ MALE<br>☐ FEMALE<br>☐ UNKNOWN | MARITAL STATUS<br>☐ UNMARRIED SINGLE/DIVORCED<br>☐ MARRIED<br>☐ SEPARATED<br>☐ UNKNOWN | OCCUPATION/JOB TITLE<br>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<br>( ) 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?<br>WERE THEY USED? | ☐ YES ☐ NO<br>☐ YES ☐ NO |
|---|---|---|---|

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

## OTHER

WITNESSES (NAME & PHONE #)

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

## EMPLOYER'S INSTRUCTIONS

**DO NOT ENTER DATA IN SHADED FIELDS**

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

| | | | |
|---|---|---|---|
| Full-Time | On Strike | Unknown | Volunteer |
| Part-Time | Disabled | Apprenticeship Full-Time | Seasonal |
| Not Employed | Retired | Apprenticeship Part-Time | Piece Worker |

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

**EMPLOYER'S INSTRUCTIONS – cont'd**

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

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:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.