Administrative Policies and Procedures

Title: Workers' Compensation	**Effective Date:** 02/03/2020
	Date Last Reviewed/Revised: N/A
Number: HR-44	**Next Review Date:** 02/03/2022

I. Purpose

The purpose of these procedures is to outline the processes related to the County's administration of the Virginia Workers' Compensation Act.

II. Background

The Virginia Workers' Compensation Act (Va. Code §§ 65.2-100 *et seq*.) requires employers to provide compensation, including wage loss benefits and medical treatment, for employees who sustain an injury by accident arising out of and in the course of their employment. The Act also requires employers to provide benefits for employees who suffer from an occupational disease arising out of and in the course of employment.

Loudoun County Government provides Workers' Compensation coverage to all employees (full-time, part-time, and temporary) and volunteers in the Combined Fire and Rescue System through a self-insured program administered by a third-party administrator. The third-party administrator is responsible for investigating claims, determining compensability of claims, authorizing medical treatment, processing payment of claim-related expenses, and responding to the Virginia Workers' Compensation Commission as necessary. The decisions made by the third-party administrator are governed by the Virginia Workers' Compensation Act and case law interpreting the Act.

All inquiries pertaining to workers' compensation benefits should be directed to Risk Management in the Department of Human Resources.

III. Related Policies and Laws

HR Policy 6.04.07 Injury Leave as Supplement to Workers' Compensation (HR Policy Handbook); *HR Policy 6.04.02 Family and Medical Leave* (HR Policy Handbook); *HR-18 Family and Medical Leave Act Procedures* (Administrative Policies and Procedures); and *HR-02 Americans with Disabilities Act (ADA) Employment Procedures* (Administrative Policies and Procedures); Va. Code §§ 65.2-100 *et. seq.*

IV. Notice of Injury

A. All employees shall give written notice of all work-related illnesses or injuries to their immediate supervisor or alternate designated person on the date of the

occurrence of an accident, or as soon thereafter as practical, but not to exceed twenty-four (24) hours after the incident or notification from a physician regarding a work-related occupational illness.

B. Upon giving notice of an illness or injury, all employees shall complete the Employee's Work-Related Injury Report (Form #500) found on the Loudoun County Employee Intranet and the public Loudoun County website within forty-eight (48) hours after the incident. If the employee is incapacitated during the forty-eight (48) hours after the incident, the Employee's Work-Related Injury Report shall be completed as soon as practical.

C. The Employee's Supervisor or HR Liaison must complete the state mandated Employer's Accident Report (Form #600) and submit both that form and the completed Form #500 to County Risk Management at risk@loudoun.gov, and to the third-party administrator within forty-eight (48) hours after the incident. Form #600 must be submitted after notice of an accident, even if the employee refuses to complete Form #500.

D. The Employee's Supervisor or HR Liaison shall provide the Workers' Compensation Accident Reporting Packet ("Packet") to the employee. The Packet can be found on the Loudoun County Employee Intranet and on the public Loudoun County website at https://www.loudoun.gov/1138/Human-Resources-Forms?NID=1138.

V. Medical Attention

A. In a medical emergency situation, employees may seek medical treatment from a hospital emergency room or walk-in clinic. If follow-up treatment is required, the employee must select one (1) authorized physician from the "Panel of Physicians: Primary Care."

B. If medical treatment is required beyond basic first-aid or upon discharge from an emergency room, the employee shall select one (1) authorized physician from the "Panel of Physicians: Primary Care" provided by the County government, which can be found on the Loudoun County Employee Intranet and on the public Loudoun County website. In the event the employee's medical treatment plan requires a referral to a specialist, the employee must select a new authorized physician from the "Panel of Physicians: Specialty Care" document located on the Loudoun County Employee Intranet in the Safety and Emergency portal. If the specialty requested is not listed on the panel, the employee shall request a panel of physicians from the third-party administrator.

C. Failure to choose an authorized physician from the panel of physicians will result in non-payment of medical bills for treatment sought.

D. After an employee chooses a physician, the employee may not change physicians without prior approval by the third-party administrator, with the exception of the initial selection of a specialty physician, as indicated in V(B).

E. At each medical appointment, the employee shall have the authorized physician complete the "Medical Treatment and Physical Demands Analysis" form (Form #700), which can be found on the Loudoun County Employee Intranet in the Safety and Emergency portal. This form must be returned, by facsimile or electronic mail, to the department HR Liaison, third-party administrator, and County Risk Management within twenty-four (24) hours of the appointment.

F. If an employee is referred to physical therapy by the authorized treating physician, the employee may use the physical therapy facility of his/her choice. The "Medical Treatment and Physical Demands Analysis" form does not need to be completed after physical therapy appointments.

VI. Wage Loss Benefits

A. For compensable workers' compensation claims, wage loss benefits (Temporary Total Disability) are provided at the rate of two-thirds (2/3) of the employee's average weekly wage, subject to weekly minimums and maximums as set forth by the Virginia Workers' Compensation Commission. Pursuant to Virginia law, the average weekly wage is calculated using the employee's gross wages from the fifty-two (52) weeks preceding the work-related illness or injury.

1. Temporary Total Disability benefits for benefit-eligible employees are processed through County Payroll during the applicable period for injury leave.
2. Temporary Total Disability benefits are paid directly by the third-party administrator to:
    a. Employees not eligible for County leave benefits;
    b. Employees after injury leave eligibility exhausts; and
    c. Persons no longer employed with Loudoun County.
3. Temporary Partial Disability and Permanent Partial Disability awarded by the Virginia Workers' Compensation Commission will be paid directly to the employee by the third-party administrator.

B. As a supplement to Workers' Compensation wage loss benefits, employees who are out of work due to a compensable work-related illness or injury are eligible for injury leave as delineated in *HR Policy 6.04.07 Injury Leave as Supplement to Workers' Compensation* in the Human Resources Policy Handbook. Injury Leave is available for up to a maximum of twenty-six (26) calendar weeks within a twelve (12) month period from the later of the initial date of injury or the date of the employee's first absence.

1. If a claim is pending a compensability determination, the employee is eligible for injury leave.
2. If a pending claim results in a determination of non-compensability by the third-party administrator, the employee is required to use accrued leave to repay any advanced injury leave. If no accrued leave is available, the employee will be required to repay the monetary value of the advanced injury leave.

C. If an employee remains out of work beyond twenty-six (26) weeks and exhausts the maximum time period for injury leave, the employee must file a Long-Term Disability (LTD) claim to supplement the workers' compensation benefits.

1. LTD claim determinations are made by the County's limited-term disability vendor.
2. Accepted LTD claims will be paid directly to the employee by the limited-term disability vendor.
3. The employee is responsible for directly paying his/her portion of County healthcare premiums, as applicable, in order to avoid disruption of his/her personal healthcare plan.

D. All absences from work due to a work-related illness or injury must be documented by a "Medical Treatment and Physical Demands Analysis" form (Form #700) signed by the authorized treating physician.

E. Upon receiving a release to return to modified duty or full duty from the employee's authorized treating physician, a completed "Medical Treatment and Physical Demands Analysis" form (Form #700) must be presented to the employee's supervisor and HR Liaison, with a copy sent to Risk Management and the third-party administrator.

VII. Temporary Restricted Duty

A. Temporary Restricted Duty positions may be available for those employees with a compensable work-related illness or injury, provided the employee is able to return to work with restrictions as stated by an evaluating physician on the "Medical Treatment and Physical Demands Analysis" form (Form #700). Requests are evaluated by the department and County Risk Management to determine feasibility and availability of modified duty for the employee.

B. Sheriff's Office, Fire & Rescue, and Juvenile Detention Center employees shall adhere to their internal agency/department policies and procedures regarding temporary restricted duty.

VIII. Family and Medical Leave Act

Lost time due to a work-related illness or injury runs concurrent with leave under the Family and Medical Leave Act ("FMLA"). If an employee is expected to be out of work for more than three (3) days or three (3) shifts, the employee must initiate a request through the County's FMLA claims administration vendor in accordance with Administrative Policies and Procedures *HR-18 Family and Medical Leave Act Procedures*.

IX. Americans with Disabilities Act Amendments Act (ADAAA) Notice

If an employee is unable to return to work because of a medically certified condition, but could perform the essential functions of his/her pre-injury position with an accommodation, the employee may request an accommodation in accordance with Administrative Policies and Procedures *HR-02 Americans with Disabilities Act (ADA) Employment Procedures*.

X. False Claims

Any employee who falsifies an injury claim or collaborates with an individual making a false claim of a job-related injury/illness shall be subject to the full penalties provided by the law, as well as disciplinary action up to and including termination.

XI. Denied Claims Policy

A. Employees shall submit bills for denied Workers' Compensation Injury claims to their personal health insurance carrier and may appeal the denial decision by filing a claim with the Virginia Workers' Compensation Commission.

B. The County will remit payment for the first date of medical services for an injury by accident that results in a claim denial by the third-party administrator, provided the injury was not sustained through a willful violation of known safety rules. Further, the County will not remit payment for the first date of medical services for employees who have pre-existing medical issues and illnesses common to the general public that manifest at some point during the work day requiring medical treatment.

Responsible Department/Division: Human Resources / Risk Management

This policy remains in effect until revised or rescinded.

Applicable forms available on the intranet at https://intranet.loudoun.gov/1046/Workers-Compensation **and internet at:** https://www.loudoun.gov/1138/Human-Resources-Forms?NID=1138**. Contact HR/Risk Management at (703)777-0517 for more information.**

1. Employee's Work-Related Injury Report (Form #500)
2. Employer's Accident Report (Form #600)
3. Medical Treatment and Physical Demands Analysis (Form #700)

Employee's Work-Related Injury Report

(Must be handwritten)

Employee: Complete this report and return to your supervisor or HR Liaison. **Supervisor:** Review incident with employee. Complete the *Employer's Accident Report*. Send both reports to Smart Casualty Claims (formerly Healthsmart Casualty Claims Solutions) at CCS_Virginia_Claims@HeathSmart.com and Risk@Loudoun.gov **within 48 hours** of the incident.

Name (first, middle, last) _____Employee ID # _____

Address_____ City_____ State_____ Zip_____

Phone # _____ Date of Birth _____ Social Security #_____

Job Title _____ Department _____ Site/Location _____

Injury Date _____ Time of Injury _____ Last Day Worked_____

When was your supervisor notified? _____ Supervisor's Name_____

Have you returned to work? _____ Date/Time Returned _____

What was the injury or illness? State the body affected and nature of the injury / illness.

Injury_____

Body Part_____ ☐ Left ☐ Right ☐ N/A

What were you doing just before the incident occurred? Describe the activity, as well as the tools, equipment or material you were using. Be Specific. Example: "Arresting subject."

_____

_____

How did the injury/illness occur? Example: "While arresting subject, fell to the ground and landed on arm."

_____

_____

Where did the incident happen?

_____

What can be done to prevent future occurrence?

_____

Did you receive medical treatment? _____ If so, where? _____

I certify that the information in this Work-Related Injury Report is true and accurate to the best of my knowledge. I understand that Smart Casualty Claims (formerly Healthsmart Casualty Claims Solutions) will rely upon this form in evaluating my claim. I further understand that this document may be presented or used in support of or against a claim for payment under the County's policy of workers' compensation insurance. I understand falsification of any information on this injury report and/or the assertion of a false workers' compensation claim are violations of Virginia's Criminal laws and may result in a fine, imprisonment and/or termination of my employment.

Employee Signature_____ Date _____

Supervisor Signature_____ Date _____

FORM #600

Employer's Accident Report

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond, VA 23220
See instructions on the reverse of this form

The boxes to the right are for the use of the insurer	Reason for filing	VWC file number
	Insurer code or PEO Ref. No. 90267	Insurer location 760
	Insurer claim number	

Employer

1. Name of employer (trading as or doing business as, if applicable)	2. Federal Tax Identification Number	3. Employer's Case No. (if applicable)
County of Loudoun, VA	54-0948306	
4. Mailing address P. O. Box 7000, 1 Harrison Street, SE Leesburg, VA. 20177 (MSC42)	5. Work Site Location (if different from mailing address)	
6. Parent corporation /Policy Named Insured (if applicable) or PEO name	7. Nature of business County Government or Volunteer Fire & Rescue	
8. Name and Address of Insurer or self-insurer for this claim Smart Casualty Claims	9. Policy number	10. Effective date

Time and Place of Accident

11. City or county where accident occurred	12. Date of injury	13. Hour of injury a.m. p.m. 13a. Time began work a.m. p. m.	14. Date of incapacity	15. Hour of incapacity
Loudoun County, VA				
16. Was employee paid in full of day of injury? ☐ Yes ☐ No		17. Was employee paid in full for day incapacity began? ☐ Yes ☐ No		
18. Date injury or illness reported	19. Person to whom reported	20. Name of other witness	21. If fatal, give date of death	

Employee

22. Name of employee (Last, First, Middle)	23. Phone Number	24. Sex ☐ Male ☐ Female
25. Address	26. Date of Birth 28. Social Security Number	27. Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed
29. Occupation at time of injury or illness	30. Is worker covered by PEO policy? ☐ Yes ☐ No	31. Number of dependent children

32. How long in current job?	33. How long with current employer?	34. Was employee paid on a piece work or hourly basis? ☐ Piece work ☐ Hourly
35. Hours worked per day	36. Days worked per week	37. Value of perquisites per week Food/Meals $ Lodging $ Tips $ Other $
38. Wages per hour $	39. Earnings per week (inc. overtime) $	

Nature and Cause of Accident

40. Machine, tool, or object causing injury or illness	41. Specify part of machine, etc.
42. Describe fully how injury or illness occurred	
43. Describe nature of injury or illness, including parts of body affected	43a. Overnight inpatient hospitalization? ☐ Yes ☐ No 43b. Treated in Emergency Room? ☐ Yes ☐ No

44. Physician (name and address)	45. Hospital (name and address)	
46. Probable length of disability	47. Has employee returned to work? ☐ Yes ☐ No	If Yes 48. At what wage? 49. On what date?
50. EMPLOYER: prepared by (name, signature, title)	51. Date	52. Phone Number
53. INSURER: (name of processor)	54. Date	55. Phone number
56. THIRD PARTY ADMINISTRATOR (if applicable)	57. Address	58. Phone number

This report is required by the Virginia Workers' Compensation Act **Employer's Accident Report**

Medical Treatment & Physical Demands Analysis

A new copy of this form must be taken to all doctor appointments and returned to risk@loudoun.gov or Fax 571-258-3212

I. To Be Completed by Employee

Name: Date of Injury: Phone:

Job Title & Brief Description of Job Duties *(or attach copy of job description / performance plan):*

I give permission to my physicians or other healthcare providers, hospitals, or clinics to release the information on this form and to release my medical records relating to this injury/illness to my employer, Smart Casualty Claims (formerly Healthsmart Casualty Claims Solutions), and any entity responsible for providing services in connection with my workers' compensation claim. I understand this information will be used to assist my employer in evaluating my injury/illness, my work status, and proposed courses of treatment.

Employee's Signature: Date:

II. To Be Completed by Healthcare Provider:

☐ New Injury ☐ Follow-up Treatment ☐ Aggravation of Pre-existing Injury Date of Exam_____

Diagnosis:

Treatment: *(including surgery, physical therapy, medications, and diagnostic procedures.)*

☐ Return to regular duty on _____ Patient discharged from care? ☐ Yes ☐ No

☐ Return to work with restrictions on _____, until _____

☐ Follow-up appointment date_____ ☐ No follow-up necessary ☐ Referred to Specialist

☐ Unable to return to work until _____ Copy of job description reviewed? ☐ Yes ☐ No

Physical Demands Analysis: ***Modified duty may be available for employee.***

✓	Lifting Amounts *(check or circle)*	Occasional (1-33%)	Frequent (34-66%)	Constant (67-100%)
	Heavy Work	100 lbs	50 lbs	20 lbs
	Medium Heavy Work	75 lbs	35 lbs	15 lbs
	Medium Work	50 lbs	25 lbs	10 lbs
	Light Work	20 lbs	10 lbs	4 lbs
	Sedentary-Light Work	15 lbs	8 lbs	3 lbs
	Sedentary Work	10 lbs	5 lbs	2 lbs

✓ Check as appropriate.	Never (0 Hrs)	Occasional (1-4 Hrs)	Frequent (4-8 Hrs)	Always (9-12 Hrs)
Sit				
Stand/Walk				
Bend				
Twist				
Squat/Crouch				
Reach				
Climb				
Drive				
Use of hands for repetitive grasping, fine manipulation, pushing & pulling.				
Use of foot/feet for repetitive movement as in operating foot controls.				

Please return form to Loudoun County,
Department of Human Resources
Attn: Risk Management/Workers' Comp,
risk@loudoun.gov
Phone 703.771.5676
Fax 571.258.3212
And/or
Smart Casualty Claims
CCS_Virginia_Claims@healthsmart.com

Signature of Healthcare Provider: _____ Phone: _____ Date: _____