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## **JOB DESCRIPTION – ORM-C200**

### **Responsibility**

The Workers' Compensation State Risk (SRA) Adjusters 1– 4 update the SRA Adjuster job description when requested by Workers' Compensation supervisor or ORM Administration.

### **Forms or Reference Material Required**

Current job description

### **Procedure**

Depending on the line of coverage an Adjuster is assigned to, some of the following duties may not be fully applicable.

### **Claims Adjuster 1-4**

Adjusters 1-4 are in a training series and have the same job description.

The Workers' Compensation State Risk (SRA) Adjuster position is a highly responsible advanced journeyman position dealing with the investigation and management of claims relative to workers' compensation line of coverage handled by the Louisiana Self-Insurance Program. This position requires advanced knowledge of claims investigation, claims law, insurance coverage, civil and criminal law and procedures, court rulings and procedures, and medical terminology. Advanced training and experience in claims investigation and adjusting are required.

The position utilizes computerized claims processing system, extensive reference materials, forms and documents, comprehends and applies benefits provided in insurance contracts. Document information and maintains necessary reports and files.

The Workers' Compensation SR Adjuster position performs the following:

- Receives and reviews notice of loss along with supporting documentation, verifies coverage and processes claim data in a computerized claims processing system.
- Performs investigations and acquires pertinent information necessary to validate insurance coverage and accurately apply benefits of insurance contracts.
- Contacts state agencies, claimants, medical facilities, etc., during claims investigation and evaluation process.
- Obtains recorded statements from injured party and witnesses, takes photographs and requests police reports.
- Requests and reviews medical reports, claimant reports, damage estimates, and medical bills and invoices to determine if items billed are related to the loss.
- Reviews claim forms and supporting documents to support establishment of claim.

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- Assigns complex cases for referral to medical specialists, vocational rehabilitation specialist and/or consultants for expert opinions and evaluations.
- Reviews and pays invoices on computerized claims processing system.
- For some claims, may evaluate incoming requests for claim histories for staff physicians, resident interns and other healthcare providers who may be under contract with the State.
- Completely compares and verifies newly received information with existing records for possible matches and/or to establish a pattern of losses.
- Utilizes computer queries for claims.
- Is responsible for requesting issuance of contracts to defense attorneys, contract adjusters, experts and other contract vendors, and monitoring them to ascertain that they are approved timely.
- Maintains current valid contracts, reissuing and amending as necessary.
- Reviews contract vendor's bills for appropriateness and accuracy, adjusting any inappropriate charges, then approves and requests payment for services rendered.
- Prepares a claims history sheet for new claims utilizing detailed information gathered from existing computer records.
- Requires extensive knowledge of the claims process for the line of insurance in which working, whether medical malpractice, workers' compensation, road hazards, general liability, property, auto liability or auto physical damage and familiarity with computer codes which designate particular phases in the process.
- Coordinates a process to transfer information gathered on certain claims to appropriate parties that have an interest in the claim outcome. This may include copies of pertinent legal documents.
- Reviews diary on claim suspense to ensure timely processing of claims and payment of invoices.
- Reviews work of independent adjusters, rehabilitation firms and other professionals assigned to cases that may be under contract with the State.
- Processes requests for payments of related charges after determining if fees are reasonable and customary or unnecessary or unrelated.
- Sends notice to appropriate party if charges are unrelated to injury or damaged loss or if the charges exceed the fee schedule.
- When handling workers' compensation claims, payment of invoices for medical services must be fee scheduled and processed for payment within sixty (60) days of receipt by this office. Otherwise, we can be faced with penalties and attorney fees.
- Obtains estimates for work to be done to modify homes, and to purchase and modify vehicles for handicapped claimants.
- Establishes and monitors reserves on all types of claims and requests increases as appropriate as proper reserving of claims aid in premium development and have a direct impact on the state's fiscal liability.

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- Meets with agency personnel, public and private officials as well as other professionals to establish and maintain daily relationships of a complex nature at the highest level requiring a high degree of tact and diplomacy.
- Provides information and advisory services to claimants with future medical care claims, workers' compensation claimants, caregivers, attorneys, vendors, nurse case managers, health care providers/networks and credentialing agencies. Goes on field travel required to accomplish some of these tasks.
- Refers cases involving the potential for salvage and subrogation recovery to the subrogation unit.
- Attends meetings and conferences as may be required for information regarding coverage and/or to obtain or assist in the current handling/closing process for a specific claim.
- Attends training/educational opportunities in order to gain additional knowledge and improve job performance.
- Engages in joint projects with the loss prevention unit and the underwriting unit, coordinating the activities in addressing and resolving problems in specific agencies and departments which have produced or could result in personal injury and/or property damage.
- Is ready and able to travel to any part of the State of Louisiana or elsewhere.
- Performs any and all other duties as assigned, which includes but is not limited to transfer/reassignment to other claims units.
- Investigate, evaluate, and negotiate workers' compensation claims.
- Perform field investigation, as needed, that may include inspecting an accident site, developing facts of an accident from physical evidence available, taking photographs, taking measurements, inspecting vehicles for damages/defects, making field notes, making sketch drawings of accident scenes, performing background checks on claimants, researching agency documents, and obtaining recorded statements from claimants, witnesses, and law enforcement officers.
- Evaluate litigated and non-litigated cases involving but not limited to all levels of temporary, permanent, and /or multiple disabilities, future medical care payments.
- Evaluate findings, prepares written report, and makes recommendations toward further handling of the claim which would include settlement/defense if the case is in litigation.
- Handle litigated and non-litigated files with reserves in excess of \$1,000,000 which include but are not limited to the following types of cases: catastrophic losses, quadriplegia, paraplegia, double amputation, brain damage, and/or total blindness. Note: These coverages are mandated to be reported to the Excess Carrier
- Resolve unique coverage issues including cumulative trauma cases where coverage may involve multiple carriers or claims.
- Provide notice and updates to excess carrier regarding any claim that may exceed ORM primary policy limits.

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- Determine litigation, prepare claims with attorneys for legal action, attend mediations and trials, and testify in court concerning the results of investigations conducted as needed.
- Direct supervision of cases on appeal, excess carrier cases, and second injury fund cases.
- Identify and refer cases involving potential subrogation recovery to the subrogation unit for handling.
- Maintain daily relationships of a complex nature with public and private officials at the highest level requiring a high degree of tact and diplomacy.
- Oversee the rehabilitation of injured workers, working closely with the rehabilitation counselors in an effort to return the claimant to a gainful occupation.
- Evaluate permanent partial and permanent total disability cases upon completion of the rehabilitation program to determine claimants' occupational ability and/or settlement value of the case.
- Contact treating physician(s) and/or arrange independent examinations of claimant with a medical specialist.
- Assume an active role in litigation management.
- Maintain direct and constant contact with the assigned defense counsel.
- Evaluate cases involving litigation, working closely with the assigned attorney in developing strategy, budget, etc.
- Obtain legal opinions and case evaluations from defense attorney especially on cases requiring legal interpretation and/or posing major financial losses to the State.
- Be responsible for analyzing, planning, and managing activities of counsel in determining responses to pleadings, motions, discovery, etc.
- Authorize the taking of necessary depositions of employees, plaintiffs, or expert witnesses.
- Supervise the preparation of state employees for trial.
- Attend trials and offer defense counsel assistance and evaluate performance of counsel
- Request issuance of contracts to experts and other contract vendors and monitor contact for professional services and request amendments when necessary.
- Analyze results of contracted services upon completion of work product.
- Work closely with defense counsel in determining plan of action and a litigation budget based upon complexity and exposure of case.
- Review bills received on all vendors providing contracted services for accuracy and appropriateness; make adjustments as necessary, then approve for payment.
- Authorize payment of benefits, damages, and/or judgments, including receipt of invoices, verification of services/equipment.

- Consult with claimants and/or their attorneys concerning the possibilities of settlement of claims.
- Receive and review bills associated with the claim, reduce costs as necessary and approve for payment.
- Maintain liaison with other state agencies, i.e., social security, unemployment, retirement system, family security, police departments, group benefits, Office of the Attorney General, others, in exchange of information to coordinate claims.
- Make recommendations and participate in the development of policies and procedures for the claims unit.
- Assume the duties of the State Risk Adjuster 5 in his/her absence.
- Attend meetings and conferences as required for information regarding coverage and/or to obtain or assist in closing a specific file.
- Attend training/educational opportunities in order to gain additional knowledge and improve job performance.
- Be available to travel to any part of the State of Louisiana or elsewhere to perform the duties for this position.
- Perform any or all other duties as assigned.
- Adjusters, Supervisors and Managers are subject to be moved to another unit at the discretion of management.

### **Update job description**

The SR Adjuster uses the following procedure for updating and maintaining the SR Adjuster job description.

1. Revise the SR Adjuster job description as requested.
2. Give the revised job description to the requesting manager and/or administrator for review and approval.
3. Make changes as needed and return it to the approval authority.

## **PROCESS LOST TIME CLAIM – ORM- C201**

### **Responsibility**

The assigned Workers' Compensation State Risk (SRA) Adjuster performs activities to process lost time workers' compensation claims as described in this procedure.

### **Forms or Reference Material Required**

ORM-C800 Claims Adjuster 1-4 General – Set up New Claim File section

LDOL 1002, 1003, 1007

Adjuster Checklist (g:\Claims-General\ORMtemplates)

Calculation of Temporary total Benefits (R. S., 23:1021 (10) (b))

Recorded statement from claimant

Index Report

### **Procedure**

If the injured worker misses 7 days of work within a 14 day period, then the claim is processed as "lost time".

## **Compensable Claim**

### **Receive and Review claim**

All claims must be set up immediately upon receipt or at least within 24 hours regardless of compensability.

1. Supervisor receives the claim from the State agency via hardcopy, e-mail, or via STARS and assigns to appropriate Adjuster.
2. Review the claim form (E-1/LDOL 1007) thoroughly. Contact agency within 24 hours for any information not on the form.
3. Update claim data in STARS and ensure all data is complete. (See ORM-C800 – Set Up New Claim File section.
4. Check for past claims filed by the claimant.
5. Contact employer within 24 hours of claim assignment.
  - Verify that the claimant is not working and information on the claim.
  - Determine status and obtain any new information that may be pertinent to the claim.
6. Contact Injured Worker within 24 hours of claim assignment to obtain appropriate information and recorded statement when needed.
7. Contact treating physicians within 24 hours of claim assignment for medical status and records.

**Obtain Recorded Statement**

1. Pull prepared recording information form for using when recording claims information needed for following through on a claim.  
**NOTE:** Using the prepared questions when you contact the claimant and record his/her statements ensures that statements and questions are consistent from one claim to the next.
2. Call claimant and obtain claimant's permission to record the information.
3. Obtain claimant's name, address, phone number, social security number, date of birth, driver's license number, age, weight, height, etc.
4. Ask claimant the series of questions on the recording information form.
5. Record claimant's responses to questions.
6. Obtain information about prior accidents, when treated, physician, and injury.
7. Obtain information if there was any automobile accident including injuries, what injuries, physician who provided treatment, if claimant was paid by insurance company, and if so, how much.
8. Obtain previous employment information.
9. Obtain information concerning other employment such as any part-time job the injured worker may have at the time of the accident.
10. NOTE: Find out if the injured worker has part-time employment as this may affect the calculation of benefits. Consult supervisor for further directions. Obtain details about the accident the claimant is filing workers' compensation for including others present at the time of the incident/accident.
11. Obtain all information regarding treatment including emergency room visit, date, attending physician, prescribed medications, and recommended treatment.
12. Inform the claimant of benefits provided by workers' compensation and options for seeking medical treatment from a physician.
13. Send the claimant a choice of physician form.
14. At the end of recording, remove the tape from the recorder and write claimant name on the tape case.

**Steps in Determining Compensability**

1. To determine compensability, use criteria including but not limited to:
  - Does the description of the accident meet the definition of an accident in R. S. 23:1021(1)?
  - Did the accident occur on or off the premises?
  - Did the accident arise out of the employment?
  - Was the injured worker in the course and scope of the employment?
  - Did the accident occur on break or before or after hours? While traveling?
  - If a State Trooper was the injured worker in the course and scope of his duties?
  - If National Guard, was the National Guard on State Active Duty?

- NOTE: Members of National Guard are only covered for workers' compensation when they have been called to State Active Duty (SAD) by the Governor. Please refer to R. S. 23:1211 for calculation of benefits.
2. If the injured worked misses more than 7 days of work, coordinate transitional/full duty release. The adjuster calculates the compensation rate based on R. S. 23:1021(10) and completes the following forms to set up a lost time claim: PLEASE REMEMBER TO INCLUDE ALL INCOME IN CALCULATIONS i.e., overtime, premium pay, shift differential pay and part-time employment if applicable.
    - Obtain check stubs for the four weeks prior to the date of loss. Do not include the week of injury.
    - Indemnity Benefits tab (STARS)
    - Intro Letter
    - Index Bureau Request (Refer to ORM-C800 – Miscellaneous Activities - ISO ClaimSearch for Bodily Injury Claims section)
    - LDOL 1002
    - Medical Information
      - Contact the physicians office within 24 hours of claim assignment; verify that the claimant was treated, date of treatment, and what treatment was provided.

**If claim has second injury fund potential**

1. Determine if claim has second injury fund potential. Coordinate referral with second injury vendor.
2. If so, ensure claim is processed as second injury fund claim (see Process Second Injury Fund Claim procedure).

**If claim has subrogation potential**

The Worker's Compensation adjuster, supervisor, or manager will determine what type of settlement will be recommended on all indemnity claims. The Subrogation Adjuster and/or Supervisor will not settle any indemnity claims without permission from the Worker's Compensation Unit.

1. Check if claim has subrogation potential by determining the following:
  - Was the accident due to third party involvement?
  - Automobile accident?
  - Product liability?
  - Unsafe act or hazardous working conditions? (Report these to loss prevention.)
2. If the claim has subrogation potential, complete a referral to subrogation unit per procedure in ORM-C800 General – Case Management / Subrogation Process section.
3. As the claim progresses, follow these settlement steps:
  - a. The Subrogation Adjuster and/or Supervisor will contact the adverse party and the injured employee's attorney, if represented, and request their settlement proposals/requests in writing.

- b. The Subrogation Adjuster and/or Supervisor will email the Worker's Compensation Adjuster and his/her Supervisor with the settlement proposals/requests from the adverse party and the injured employee's attorney.
- c. A decision will be made concerning the terms of settlement and the Worker's Compensation Adjuster and/or Supervisor will confirm that decision in an email (so each unit will have the settlement in writing for their records) to the Subrogation Adjuster and Supervisor.
- d. The Subrogation Adjuster and/or Supervisor will contact the injured employee or his/her attorney and the adverse party and discuss the terms of the settlement. If these terms of settlement are not agreeable with these parties, then the Subrogation Adjuster and/or Supervisor will contact the Worker Compensation Unit for another meeting.
- e. The Subrogation Adjuster and/or Supervisor will handle the final settlement paperwork with DRL.
- f. The supervisor will make a STARS note that the approved settlement documents are in Filenet.

*THE ONLY EXCEPTION TO THE ABOVE IS IF THE WORKER'S COMPENSATION ADJUSTER AND/OR SUPERVISOR IS STILL HANDLING THE INJURED EMPLOYEE'S CLAIM. IF THIS IS THE CASE, THEN THE WORKER'S COMPENSATION ADJUSTER AND/OR SUPERVISOR WILL CONTACT THE INJURED EMPLOYEE IF HE/SHE IS NOT REPRESENTED AND DISCUSS THE FINAL SETTLEMENT WITH HIM/HER.*

### **Death Claim**

1. Obtain the following:
  - Marriage license  
Note: Common law spouse is not covered.
  - Birth Certificate
  - Divorce decree
  - Proof of dependency
  - Proof of enrollment if dependent is enrolled in an institution of higher learning.  
NOTE: The statute does not cover dependent children between ages 18 – 23 unless they are enrolled in an accredited school. Proof of enrollment must be verified each semester.
  - If no surviving spouse or children, parental information
2. Pay dependent(s) in accordance with statute.
3. During the course of the claim check to see if widow(er) is unmarried. NOTE: Widows/widowers who remarry are only entitled to a two year lump sum of benefits. (Two years from date of remarriage.)
4. Obtain updated Widow/Widower's Affidavit form once a year.

### **Non-Compensable Claim**

**If an alleged incident of heart attack, stroke, cardiovascular disease, mental stress, horseplay, or acts of aggression:**

1. Handle the claim as if it is not compensable. Emergency stabilization / care will be paid until compensability is determined.
2. Complete a written investigative summary within 14 days of claim assignment.
3. Perform a complete review of the applicable statute(s).
4. Obtain a recorded statement from the injured worker, his/her supervisor, and witnesses, if applicable.
5. Review the E-1 thoroughly to ensure all information is properly documented.
6. Set up the claim within 24 hours of receipt.
7. Ensure claim is entered into STARS, reserves are set, and the diary is completed.
8. Present to supervisor within fourteen (14) days from receipt for a decision on compensability.
9. Write denial letter to injured worker, attorney and employer.

**If circumstances of accident are questionable or if agency raises some concerns**

1. Thoroughly investigate the claim.
2. Prepare an investigation summary.
3. Present to supervisor within fourteen (14) days from receipt for a decision on compensability.

**NOTE:** As there is no way to know when a claim/file may end up in litigation, a thorough and proper investigation on the front end of the denial helps to justify decisions made once the case is heard in court.

## **PROCESS MEDICAL-ONLY CLAIMS – ORM-C202**

### **Responsibility**

### **Forms or Reference Material Required**

### **Procedure**

If an injured worker misses less than 7 days within a 14 day period, the claim is handled as medical-only.

If an injured worker has lost time from work, however he has returned to work by the time the claim is reported to ORM, the claim is handled as medical only.

Follow the same steps as in previous section “Process Lost Time Claim”

### **Questionable claims**

**NOTE:** As there is no way of knowing when a medical only claim may become a lost time claim, the medical only claim must be handled with precision, precaution, and accuracy. Questionable claims are defined as a death claim, amputation, heart attack, stroke, stress claims, horseplay, acts of aggression, or Good Samaritan claims (helping someone else).

1. If the circumstances surrounding a claim appear to be questionable (whether the claim meets requirements of statute), obtain a recorded statement from the claimant.
2. Present the claim to the supervisor for a decision of compensability within 14 days of claim assignment.
3. Thoroughly investigate the claim including recorded statements.
4. Review investigation summary.

## **CLAIMS MEDIATION AND LAW SUITS– ORM-C203**

### **Responsibility**

The assigned Workers' Compensation State Risk (SRA) Adjuster performs activities associated with claims mediation as described in this procedure.

### **Forms or Reference Material Required**

ORM-C800 Adjuster 1-4 General – Set Up New Claim File section

LDOL 1008

Notice of Mediation

Appointment and Contract Approval Form

### **Procedure**

#### **Assist in Claims Mediation**

1. Receive a Claim 1008 and note date of mediation on calendar.
2. Complete the OWC tab in STARS
3. If a disputed claim form is not received with the Notice of Mediation, request a copy of 1008 from the mediator. Attempt by phone to resolve the case prior to the mediation date.

**NOTE:** If differences between Workers' Compensation and claimant cannot be mediated, the claimant may request that a claim be filed in court, thus, initiating a court case.

4. If the dispute is unresolved and notification of citation is received, complete an Appointment and Contract Approval Form and send to the Department of Risk Litigation/Attorney General's Office. **NOTE: THIS SHOULD BE DONE WITHIN 24 HOURS OF RETURNING FROM THE MEDIATION.**

**NOTE:** The Attorney General's office must file an answer within 15 days.

5. As information becomes available, update STARS Litigation screen.
6. Ensure the above steps are strictly adhered to on all newly received suits and citations.
7. Ensure all existing suits and citations are tracked as they come up on diary.
8. Refer to ORM-C800, Adjuster 1-4 General Procedures.

#### **Trial Information**

1. If required, appear in court and testify as to how you handled the claim.
2. Should claim proceed to trial, update the STARS Litigation screen.

#### **Request Legal Representation**

Legal representation may be needed to handle lawsuits, OWCA citations, interventions, and settlements involving workers' compensation. The Appointment and Contract Approval Form is used to request legal representation from the Attorney General's Office through the Division of Risk Litigation (DRL) or to request a contract attorney

9. Complete (or receive completed form from the adjuster) the Appointment and Contract Approval Form; state the reason for the request.
10. If a settlement is the reason, enter the settlement amount.
11. Complete transmittal form, cover letter / memo outlining claim dispute, copy of 1007, citation, claim abstract (remember to block out the reserves).
12. E-mail to Attorney General at NSF-ORM@ag.state.la.us.
13. Make a copy of the completed form for the claim file.

### Mediation Conference

A Mediation Conference is the initial step following filing a disputed claim (LDOL 1008) with the Office of Workers' Compensation Administration (OWCA). Though the OWCA Mediation Conference is informal, it is still a legal proceeding and treated as such.

#### Receive notification and contact mediator

1. Receive the Notice of Mediation.
2. Call the mediator and request a faxed copy of the LDOL 1008.

**NOTE:** This reveals the reason for filing such as denial, late payments of benefits, medicals, etc.

#### If issue is resolved before mediation conference

1. Make an effort to resolve the issue before the mediation conference.
2. If the issue is resolved, **document** in the file the outcome of resolution.
3. **Write a letter of confirmation of the resolution to all involved parties.**
4. **If you agree to something to resolve the 1008, follow through within 30 days.**
5. Obtain a copy of the dismissal.

#### If issue cannot be resolved

1. Attend, in person, the mediation conference.

**NOTE:** Telephone mediation conferences are allowed by law, however, personal appearance is preferable. There are no acceptable excuses or reasons for missing a mediation conference. Failure to appear at a conference results in OWCA assessing a fine.

2. Make every effort to resolve an issue at mediation.
3. If it cannot be resolved, accept service of the Citation.

**NOTE:** A Citation is a law suit and must be handled as such.

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4. Upon return to the ORM with a Citation (WITHIN 24 HOURS OF RETURNING TO THE OFFICE), complete an Appointment and Contract Approval Form (transmittal form) to request representation from the Attorney General's office.
5. Pretrial mediations are mandatory either in person or by phone at the discretion of the defense attorney.

## **APPROVE WORKERS' COMPENSATION PAYMENT – ORM-C204**

### **Responsibility**

The assigned Workers' Compensation State Risk (SRA) Adjuster performs activities to approve payment for workers' compensation as described in this procedure.

### **Forms or Reference Material Required**

Average weekly wage for claimant. NOTE: Please remember to include any overtime, premium pay, shift differential, and income from part-time employment if applicable.

### **Procedure**

#### **Approve Workers' Compensation Payment**

1. Log on to STARS.
2. Select Claims icon.
3. Enter claim number.
4. Go to the Indemnity Benefits tab
  - Select benefit type in drop down menu
  - Enter benefit start date
  - Enter estimated time off
  - Hit tab key to update other fields
  - Go to Payees tab and make sure Payee is there. If not, complete Rolodex information and link to claim.
5. Update Indemnity record according to disability status.
6. If TTD is owed on a prior pay period, generate the initial check through the indemnity benefit module.
7. Complete the Expected Weekly Comp field on the Claimant Information Tab.

## CLAIMS PAYMENTS – ORM-C205

### Responsibility

The assigned Workers' Compensation State Risk (SRA) Adjuster performs activities to process workers' compensation payment for medical and pharmacy bills as described in this procedure

### Forms or Reference Material Required

Medical bill

### Procedure

**NOTE:** Statute R. S. 23:1201.E states the following:

Medical benefits payable under this Chapter shall be paid within sixty days after the employer or insurer receives written notice thereof.

## Indemnity Payments

### Creating an Indemnity Record

- Before creating an indemnity record the following information is required. In the "Claimant Information" tab, the box labeled "Average Weekly Wage" **must** be completed and the box labeled "# Work Days/Week" **must** contain the number "7". Also in the claimant's "Rolodex" under the "Additional Information" tab in the box labeled "Handling Type" select the option "WC Agency Check." "Save and Close"

If TTD is owed on a prior pay period, generate the initial check through the indemnity benefit module.

Complete the Expected Weekly Comp field on the Claimant Information Tab.

### How to create an indemnity record:

- In the "Indemnity Benefit" tab select the button labeled "New".
- Select the "Benefit Type"
- Enter the "Benefit Start Date". \*The benefit start date is the day the claimant began losing time.
- In the "Detail" tab, calculate the estimated time off. Include the seven day waiting period.
- Click on the tab labeled "Payee" and select the button labeled "New".
- Click on the button labeled "Rolodex" and enter the claimant's social security number in the "Tax Id" box.
- Click on the button labeled "Search".

- Double-click on the rolodex flagged “WC Agency”.
- Click on “Save and Close” and “Save and Close” again.

## **Manual Indemnity Payment**

- If the pay period has past, checks must be generated manually in order for the check to print.

### **How to generate an indemnity payment:**

- Once an Indemnity benefit has been created, click on the icon “More” located on the left side of your STARS screen. Then select the icon labeled “Indemnity Benefit”.
- In the box labeled “Claim Number “enter the claimant’s claim number.
- Click on the button labeled “Search”.
- Click on the box located on the left side of the benefit under the heading “Select”. An “X” will appear in the box.
- Click on the icon located at the top labeled “Create Checks”.
- In the drop down box select “Generate Select”.
- The system will run a check for errors. Once the system has completed its check, select “OK”.
- Click on the “X” in order to remove the “X” from the benefit.

## **Link a Manual Payment**

### **How to link a manual payment:**

1. Click on Checks, Check Register screen appears, Click on New to get Invoice # to show on the Blue Payment sheet.
2. Click on Rolodex and type in Social Security #, click “Search” to verify address, then double click.
3. Payment screen appears, on Invoice I. D. line type “IB-TTD-(Adj. initials & claimant’s last name)”
4. Invoice date line: type in current date.
5. Memo line type in “TTD-(Adj. Int., Date, Clmt’s Last name & Initial of first name & any other brief description necessary).
6. Click on Save, Click on Transaction, Click on New (takes a few seconds) type in Claim # & click on Search, Verify if correct claim # then click OK on bottom of Screen.

7. Payment screen appears-click from Financial Bucket column on ind/pd/coll, type in transaction code which will be 3P01, Type in service dates from and to, enter payment amount. Click "Save and Close", when screen changes click on "Save and Close" again.

### **Linking Benefit to Check**

1. On the Check Register screen, enter invoice number from the Claims Payment Form and click Search. When the transaction appears double click on the blue line.
2. Invoice/Transaction screen appears, at the top of the screen click Link Benefit.
3. Select Benefit screen appears. Type in claim # & click Search. Verify correct claim # and click OK at the bottom of the screen.
4. When the block screen appears showing link invoice of benefit, verify your service dates and click ok.
5. You will then receive a message that your invoice has been linked to the selected benefit.
6. Transaction is complete and the invoice has been linked.

### **Medical Payments**

Most medical bills for services to an injured worker and provided by a medical provider must be fee scheduled. A medical provider may be a physician, chiropractor, physical therapist, hospital, pharmacy, dentist, home health carrier, or other health care provider.

1. Ensure payments are made within thirty days of receipt of the bill.

**NOTE:** R. S. 1201(E) allows up to sixty (60) days to make medical payments (this includes the time it takes to have the invoice processed according to the Workers' Compensation Fee Schedule). However, all files must be worked on a 30-45 day diary system to ensure payments are made within thirty days of receipt of the bill. Failure to pay medical bills in a timely manner subjects the bill office to being held arbitrary and capricious by the courts and may be assessed penalties, interest, and attorney's fees and internally carries the penalty of an automatic write-up.

2. Ensure all applicable medical bills are fee scheduled.
3. Review the bill for payment for the following:
  - Determine if the treatment is related to the accident.
  - Determine if diagnosis corresponds to the injury.
  - Determine if workers' compensation owes the bill
  - Check for corresponding medical reports in the claim file
  - Receive medical bill from provider and access claim in STARS.

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- Open Transaction screen and verify that medical bill is not a duplication.
  - Review and update E-Roster in CareMC daily.
  - Enter each invoice processed in STARS Attachments.
4. If bills are clearly not related to injury or claim file reports, return the bill to the injured worker or provider with a letter explaining why denied.
  5. Check that doctor bills are on a HCFA 1500 form.
  6. Check that hospital bills are on a UB 92 form.
  7. Ensure bills that must be paid in-house have information marked with double asterisks (\*\*); bills should clearly identify:
    - Name of injured worker (\*\*)
    - Name, address, and telephone number of the provider (\*\*)
    - Date(s) of service (\*\*)
    - Type of service
    - Diagnosis
    - Amount of charge
    - Tax ID or NPI number (\*\*)
    - Calculator tape for mileage benefits
  8. ~~Pay-I~~ In-house payments can either be paid on a Claims Payment Form or directly on the original invoice – **do not** send for fee scheduling. These include but are not limited to:
    - Mileage reimbursement
    - Court Costs
    - Prescriptions that have paid for by the injured worker and third party billers.
    - One-Call Medical
    - Medical Records
    - Court Reporters or depositions unless associated with contract attorney bills

### Contract Payments

1. The following invoices are paid on a Contract Payment Form:
  - TrialNet
  - Surveillance bills
  - Independent adjuster bills
  - SIF Vendor
  - Contract vocational rehabilitation/medical case management/transitional duty employment bills
  - All payments associated with a contract through the Contracts Unit.
2. Tally the invoice.
3. Approve invoice and forward to Administrative Coordinator.

Note: See ORM-C800 Contract Payment section for additional details.

### **Settlement Requests**

1. Complete the Claims Payment Form completely.
2. If the injured worker is represented by an attorney, write both the injured worker's name and the attorney's name on the settlement request; ensure a W-9 is obtained for the attorney and attach the W-9 to the Claims Payment Form. If payment is within authority, the W-9 and Claims Payment Form are all that is required.
3. If payment is greater than authority, ensure documentation is prepared including but not limited to:
  - W-9
  - Signed copy of Attorney General concurrence / RSA / CRD
  - Claims Council Request
4. Make sure all supporting documentation is attached to the Claims Payment Form prior to obtaining signatures.
5. Make sure all appropriate signatures are obtained prior to submitting the Claims Payment Form to clerical for processing.
6. Make sure reserves are adequate to cover the settlement check.
7. Be sure to include reserves for court costs and attorney fees. Allow enough legal reserves to cover the attorney general's bill and not just the OWCA court cost.

Note: Refer to ORM-C800 – Case Management and Claims Payment sections

### **Stop Payment**

Refer to ORM-C800 – Claims Payment section

### **Voiding Checks**

Refer to ORM-C800 – Claims Payment section

## **MANAGEMENT – ORM-C206**

### **Responsibility**

The assigned Workers' Compensation State Risk (SRA) Adjuster performs activities as described in this procedure

### **Forms or Reference Material Required**

### **Procedure**

#### **Perform Duties**

1. Sort, and drop file mail daily.
2. Review all claims every 30-45 days.
3. Refer to ORM-C800 General procedure - Case Management section.

**NOTE:** Statute RS023 1201.E states the following:

Medical benefits payable under this Chapter shall be paid within sixty days after the employer or insurer receives written notice thereof.

## PRE-CERTIFICATION AND UTILIZATION REVIEW– ORM-C207

### Responsibility

The assigned Workers' Compensation State Risk (SRA) Adjuster performs activities for utilization review as described in this procedure

### Forms or Reference Material Required

UR carrier form (g:\Claims-General\ORMtemplates)

Utilization Review Rules (LDOL Website or LABI Desk book)

### Procedure

#### Initiate Pre-Certification and/or Utilization Review

In the process of verifying coverage for hospital stays or certain diagnostic procedures, it may be necessary to pre-certify the hospital stay with an ORM approved Utilization Review (UR) carrier. In compliance with OWCA mandate and in an effort to contain medical costs, ORM has assigned a vendor through competitive negotiation to perform various components of utilization review.

#### Pre-Certification

1. When a claim involves surgery or hospital stays of more than 24 hours, receive notice from provider.
2. Initiate a pre-certification of the hospital stay with the approved carrier by completing the UR carrier form and faxing the form to UR carrier. Online referrals are acceptable.
3. Advise the requesting vendor that a temporary hospital stay that becomes an overnight stay must be pre-certified at that time.

**NOTE:** Outpatient procedures or hospital stays under 24 hours should not be referred for pre-certification.

4. Receive pre-cert information and report from UR carrier.
5. When physical therapy or chiropractic treatment exceeds twenty-four (24) visits, pre-certification is required.
6. Update Diary claim information in STARS Attachments/Notes accordingly.
7. The following should always be pre-certed:
  - Trial dorsal column stimulator
  - Discogram
  - ESI injections, all type

If pre-cert is denied, schedule SMO.

**Utilization Review**

1. If in doubt about related procedures or surgeries or if receive a questionable bill from a provider, refer the claim for utilization review.
2. Complete a UR carrier form.
3. Fax or mail the completed form and bill and/or other applicable documentation to UR carrier.
4. Receive information, recommendations, and report from UR carrier.
5. Update Diary claim information in STARS Attachments/Notes accordingly.
6. Follow the guidelines in Utilization Review Rules published by the Office of Workers' Compensation.
7. Ensure the UR carrier is evaluated annually at the anniversary of the contract period in accordance with ORM procedures (see ORM Administration Procedure Evaluation of Vendors on the LAN).

**NOTE:** Hospital bills will be submitted for fee schedule review prior to requesting an audit. The adjuster submits bill and hospital records to contract vendor. Exit interview on all hospital audits are required including an agreement on the audit results with the designated hospital representative. On medical providers, there should be an agreement of the audit results. Hospital Pre-Certification, Admission Certification, Continued Stay Review, Discharge Planning, Second Surgical Opinion, and Ambulatory Surgery are performed according to OWCA guidelines and procedures. The Utilization Review vendor provides quarterly reports to ORM as to the cost effectiveness of audit review including ORM costs vs. Savings and annual reports to OWCA. The UR vendor is evaluated annually.

## REHABILITATION AND MEDICAL MANAGEMENT– ORM-C208

### Responsibility

The assigned Workers' Compensation State Risk (SRA) Adjuster performs associated with rehabilitation and medical management of claims as described in this procedure

### Forms or Reference Material Required

Medical Management/Vocational Rehabilitation form (g:\Claims-General\ORMtemplates)

### Procedure

#### Assign Claim for Rehabilitation and Medical Management

All files eligible for medical case management, vocational rehabilitation, and/or transitional duty employment are assigned to a contractor

Complete a referral form for the contract vendor.

8. Keep a copy of the referral form in the claim file.
9. Monitor and supervise the activities of the contract vendor.
10. Monitor cost of these services versus the outcome.

**NOTE:** If properly monitored, not all files should result in the total allowed amount. The maximum amount for each component of service per claim is as follows:

• Medical case management	\$3000
• Transitional duty employment	1500
• Vocational rehabilitation	7500
<hr/>	
• Total allowed per claim	\$12,000

11. Ensure the services are warranted and the vendor is not trying to bill the maximum allowed per component or services.
12. Authorize payment for services per Claims Payment procedure.

## **DIARY AND ACTIVITY REPORT – ORM-C209**

### **Responsibility**

The assigned Workers' Compensation State Risk (SRA) Adjuster performs activities for diarying a claim.

### **Forms or Reference Material Required**

### **Procedure**

Refer to ORM-C800 Adjuster 1-4 General procedure – Diary and Activity Report section

## SECOND INJURY FUND (SIF) – ORM- C210

### Responsibility

The assigned Workers' Compensation State Risk (SR) Adjuster performs activities as described in this procedure

### Forms or Reference Material Required

E-2 Pre-Existing Conditions form (B.4 – E2 – PEC.doc)

Notice of Claim against SIF (B.5 – SIB Form A.doc)

Medical Reimbursement Request (B.7 – SIF Reimbursement Req.doc)

### Procedure

#### Process a Claim for Second Injury Fund

The Second Injury Fund was established by the Louisiana legislature to encourage employers to hire persons with previous disabilities.

1. Upon receipt of a claim, determine if the injured worker has a previous disability and if there is a potential for Second Injury Fund. Forward to contract vendor.
2. Search ORM's computer base to determine if injured worker has prior claims which may qualify for SIF (see list under R. S. 23:1378.F).

**NOTE:** The previous condition must merge with the new injury to render the injured worker more disabled than the new injury alone (see R. S. 23.1371.C). The employer must have knowledge of the previous condition in order for the claim to be accepted by the SIF.

3. If potential SIF is determined, refer to contract worker.
4. Once the adjuster receives information from the SIB that a claim has been approved for SIF reimbursement, the adjuster must:
  - Change the STARS SIF field to **Y** on the General Information screen.
  - Effective with dates of loss on or after 07/01/2004 and before 07/01/2007:  
Medical reserves should be set at \$25,000.00.  
Indemnity reserves are to be set at 130 weeks.  
Indemnity reserves for death benefits are to be set at 130 weeks.
  - Certify to SIF that reserves have been set at the above limits.

**NOTE:** Once medical and indemnity reserves have been set on an approved SIF claim, they **cannot** be increased.

Lump sum settlements on approved claims with a date of loss of October 1, 1995, or beyond must have the approval of the SIF or the Fund will not reimburse the settlement.

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Once the non-recoverable portion has been met for medicals or comp, the adjuster must request reimbursement once every three (3) to six (6) months until the claim is closed. Adjusters have the responsibility of ensuring the contract vendor is actively pursuing recovery.

If the SIF rejects charges for lack of documentation, then the adjuster must gather the appropriate documentation and resubmit it to the SIF.

If the SIF requests information to help them make a determination, this information must be supplied to them no more than thirty (30) days from receipt of the request. Failure to do so may result in the denial of the claim.

If the reserved amount for 104 weeks changes because of an SEB reduction, the file must reflect the change and why. The number of weeks at the reduced rate and the number of weeks at the full comp rate cannot exceed 104, however, the file must reflect what the total sum is for those two. **For example**, If there are 49 weeks of TTB at the full comp rate and 55 weeks at a reduced SEB rate, the reserves should be set at the sum of the 49 weeks and the 55 weeks and the file must clearly reflect why. The adjuster must put a statement in the file to explain why the reserves are where they are.

If there is a file where medicals are owed, however, no indemnity benefits are due because of prescription, then indemnity reserves should be set at zero.

If indemnity benefits DO NOT reach 104 weeks, then reserves must be set to reflect the actual amount paid, not to exceed 104 weeks. For example, if the IW returns to work after 56 weeks, then reserves should be set at 56 weeks and not 104.

Please utilize the table below for critical SIF dates and to set reserves on second injury fund claims based on applicable second injury fund deductibles according to the date of loss:

<b>Date of Loss</b>	<b>Medical Reserves</b>	<b>Indemnity Reserves</b>	<b>Death</b>	<b>Settlements and/or Subrogation</b>
07/01/80-06/30/83	Actual reserves based on medical occurrence rate. No SIF reimbursements.	104 weeks	175 weeks of indemnity	
07/01/83-09/30/85	\$5000.00	104 weeks	175 weeks	
10/01/85-06/30/2004	\$7500.00	104 weeks	175 weeks	
09/09/88-present				Notify SIF of subrogation potential on approved claims.
09/09/88-present				Reimburse/credit SIF for funds

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Date of Loss	Medical Reserves	Indemnity Reserves	Death	Settlements and/or Subrogation
				recovered through third party actions on approved claims.
10/01/95-06/30/2004				Obtain SIF approval on lump sum settlements.
07/01/2004 – 06/30/2009	\$25,000.00	130 Weeks	130	Obtain SIF approval on lump sum settlements
07/01/2009	\$7500	104	175	Obtain SIF approval on lump sum settlements

**NOTE: SIF DEDUCTABLES ARE NOT RECOVERABLE.**

## MISCELLANEOUS ACTIVITIES– ORM- C211

### Responsibility

The assigned Workers' Compensation State Risk (SRA) Adjuster performs the following activities as described in this procedure

### Forms or Reference Material Required

Request for Subrogation Recovery Claim Form

Appointment and Contract Approval Form (H-GL Attorney App. Rev. 1-2001.doc)

Thirty Day Captioned Report

### Procedure

### File Management

1. ALL files (all volumes) must be separated by categories: GENERAL-MEDICALS-PAYMENTS-REHAB-LEGAL-SURVEILLANCE, etc.
2. The STARS Notes should document work done on the claim.
3. Be careful as you punch holes in material to be prong filed – determines how neat your file looks at a glance.
4. Bills that are less than a full sheet of paper should be placed on a full sheet of paper.
5. Remove all envelopes from bills and correspondence except if they contain critical dates or addresses. Remember, only one copy of a document is needed. Extra copies should be discarded.
6. **ALL** conversations where verification is **DENIED** must be documented stating the reason for the denial.
7. If you verify coverage for something that is questionable or not covered, you must document and say why you agreed to pay for it.
8. Bills applicable for fee schedule review are sent directly to fee schedule reviewer.
9. When you pull your file, make sure you have all mail filed for that claimant.
  - Make sure you check between and behind sections to ensure you are not missing something. If a document has a stamped in date before you work your diary and it has not been processed, it will be assumed you failed to thoroughly check for all possible current mail.
10. Paid bills must be filed on the next diary date.
11. If you must do something on somebody else's file, please document it and give it to the adjuster so they will know what has been done in their absence.
12. All files **MUST** be maintained as if they are going to trial the next day. All files must be handled as if they are in litigation.
13. Anyone should be able to determine claim status by reviewing STARS.

## **Claims Council**

Refer to ORM-C800 Adj. 1-4 General Procedure, Claims Council section.

## **Recorded Statements**

Recorded statements are an invaluable investigative tool. Recorded statements can and should be taken from the injured worker, supervisor, and any witnesses to an accident. Statements can be taken either in person or by phone. Statements will be allowed at the agency or by phone for extenuating circumstances with supervisor approval. For witness or supervisory statements, those can be taken at the agency or by phone. Statements must be taken from the injured worker as soon as the adjuster is aware of the accident. The longer the wait before a statement is recorded, the more likely that the information will be distorted and the chances increase for the injured worker to seek representation from an attorney. If the injured worker is represented by an attorney, permission to take a recorded statement must be obtained from the attorney. No statements are to be taken in the hospital.

Note: For obtaining recorded statements the following are needed:

- Tape recorder
- Tape
- Batteries
- Adapter backups
- Questions/checklist

## **Value of Recorded Statements**

- Tie down facts
- Refresh the memory at a later date
- Use in litigation
- Substantiate details of claim or origin of loss
- Determine lack of knowledge of involved person (negative comment)
- Preserve testimony
- Obtain previous loss history

## **Record the Statement**

1. Contact the person (usually by telephone), inform them that you need a recorded statement, obtain their permission, and record the statement.
2. Ensure the person (injured worker, supervisor, witness, etc.) is well aware that you are recording their statements and obtain their approval as part of the recorded statement.
3. Use a checklist of questions and statements to obtain the information.

**NOTE:** A checklist is used to ensure consistency in what is recorded and information to be obtained.

4. After obtaining the information on the checklist and additional information, as needed, thank the person for their assistance.
5. Remove the tape from the tape recorder and write the injured worker's claim number and/or name on the tape as a means of identification.
6. Use the recording to complete claim information (if needed).
7. Keep the tape as part of the claim investigation. Include in the file a written summary of the statement.
8. Provide the information to supervisor or attorney(s) as needed.
9. Determine if the injured worker is to be represented by an attorney; if so, get the phone number of the attorney.

### **Widow/Widower's Affidavit**

1. On compensable death claims, check on the status of the widow and/or the dependent children.
2. Use the Widow/Widower's Affidavit form to properly document this status.
3. Send the Widow/Widower's Affidavit form to the compensated widow/widower once every six to twelve months. If there are dependant children, send the Widow/Widower's Affidavit twice a year.

### **Thirty (30) Day Captioned Report**

1. Complete a thirty (30) day captioned report upon the first diary to ensure the claim is progressing properly (see report form for details).
2. Attach report to STARS Attachment/Notes.

### **Contract Performance Evaluation**

Refer to ORM-C800 General procedure – Contracts section

### **Record of Corrections**

Claim corrections must be made by the Administrative Program Manager I for claims.

### **Weekly Field Travel**

Field travel is required except in extenuating circumstances. The purpose of field travel is to investigate claims, gather documentation, and establish rapport with agency personnel. Field travel is also necessary to attend mediation conferences, court appearances, depositions, meeting, with attorneys, and training seminars. Claims investigation shall include recorded statements from the injured worker, the immediate supervisor, and/or witnesses. The amount of investigation required depends on the depth of the claim. If you

feel confident that the claim is legitimate, then only the injured worker's statement is needed. Pictures of the accident scene may be needed or to document scarring.

1. Conduct the following activities when traveling. Combine activities on one trip as appropriate. Activities include but are not limited to:
  - Meet with injured workers
  - Meet with assigned state agency personnel
  - Attend mediations and/or trials
  - Attend DRL staffing
  - Investigate accident scene
2. If trying to establish compensability or denial, obtain as much information in the recorded statement and documentation as possible.
3. Include in the field travel, reviewing and/or securing court records, especially in subrogation claims or if trying to establish existence of a pre-existing condition; obtain marriage records in the case of a widow or widower in a death claim.
4. Consider mediation conferences as part of required travel if they are done in conjunction with other activities such as statements, agency visits, etc., as most mediation conferences usually do not take all day.
5. Provide supervisor your itinerary on Friday for the following week. Notify the receptionist's desk dates of travel.
6. Change voicemail message indicating out of office.
7. Ensure all field travel is done in a state-owned vehicle unless the Transportation Coordinator indicates no state-owned vehicle is available. In such cases, personal vehicles may be used.
8. If both the supervisor and the adjuster make the same trip, only the supervisor is required to complete a trip report.
9. Upon return, complete any necessary travel expense, trip report, and/or any other required documents.

## RETIREMENT BENEFITS – ORM-C212

### Responsibility

The assigned Workers' Compensation State Risk (SRA) Adjuster performs activities for retirement benefits associated with workers' compensation as described in this procedure

### Forms or Reference Material Required

LDOL 1002 form

Benefits Reduction Tape

### Procedure

### Disability Retirement

If an injured worker is receiving disability retirement, the insurer/employer is entitled to a reduction of benefits in proportion to the employer's contribution to the injured worker's retirement benefits.

#### Obtain information and complete benefits reduction sheet

1. Obtain an employer/employee contribution history from the retirement system. When this is received, request an actuarial study.
2. Send to DRL via transmittal to file a motion to take disability offset.
3. When the actuarial study is received, reduce the benefits using the following criteria:
  - Multiply the monthly disability retirement amount times 12 (months).
  - Divide the product by 52 (weeks) to get the disability retirement per week.
  - Multiply the disability retirement per week times the actuarial percentage to obtain the allowable credit amount.
  - Subtract the allowable credit amount from 66 2/3 % of the AWW to obtain the new comp rate. Do not worry about the maximum comp rate.

Monthly D. R.	865.62	x
	12	=
	10 387.44	*
	10 387.44	÷
	52	=
Weekly D. R.	199.76	*
	199.76	x
54% Cred.	107.87	=
	107.87	-
AWW	392.75	x
don't worry about max	6667	=
	261.85	*
	261.85	+
	107.87	-
New Comp rate	153.98	*

Example benefits reduction tape

4. Complete benefits reduction tape to show calculations.
5. Enter note in STARS to show step by step calculations.

**Receive OWCA approval and adjust indemnity benefit record**

**NOTE:** Effective January 1, 2000, any reductions for disability retirement benefits must have the approval of the Office of Workers' Compensation hearing officer.

1. Receive OWCA approval.
2. Adjust the indemnity benefit record in STARS.
3. Notify the injured worker (attorney, if represented), OWCA, and the agency with a new LDOL 1002 form.

**NOTE:** Injured worker is still entitled to 520 weeks of benefits. Entitlement to indemnity will be for life expectancy if totally and permanently disabled.

**Regular Retirement**

An injured worker who is receiving regular retirement is entitled to no less than 104 weeks of benefits.

Enter STARS note that the injured worker is receiving regular retirement.

1. If the injured worker is receiving regular retirement, notify the injured worker that benefits may stop after 104 weeks of payments. Notification is by LDOL 1002 form.

**NOTE: Do not take reduction for regular retirement.**

2. Monitor 104 weeks to ensure benefits are not paid in excess of 104 weeks.
3. Before the 104 weeks expire, establish through rehabilitative services that the injured worker is capable of gainful employment.
4. Obtain supervisory approval to discontinue benefits once 104 weeks is reached.
5. Notify injured worker in writing that benefits have stopped and attach completed LDOL 1003 form.

**Note:** If injured worker is permanently and totally disabled, payments cannot be stopped at 104 weeks. If permanently and totally disabled, payments are for life.

## SUPPLEMENTAL EARNING BENEFITS (SEB) REDUCTIONS – ORM- C213

### Responsibility

The assigned Workers' Compensation State Risk (SRA) Adjuster performs activities associated with supplemental earning benefits as described in this procedure.

### Forms or Reference Material Required

### Procedure

#### Calculate SEB

The purpose of SEB is to compensate the injured employee for the wage earning capacity lost as a result of his/her injury. The benefits are determined by comparing the wages earned at the time of the injury with the wages the employee earns or able to earn after the injury, and pay the employee 66 2/3% of loss.

The employee is entitled to SEB benefits **only** if the post-injury wages or earning capacity calculates to be less than 90% of the wages at the time of injury.

1. Divide the employee's annual income **before** the accident by 12 to determine employee's average monthly wage,
2. Multiply the employee's hourly wage earning capacity or actual wages the employee is earning after the injury by 40 hours for full time or number of hours for part time as indicated by treating physician to determine post-injury AMW.
3. Multiply the pre-injury wages by 90%.
4. If the post-injury wages are 90% or more of the pre-injury wages, no benefits are paid.
5. If the post-injury wages are less than 90% of the pre-injury wages, determine pre-injury wages and post-injury wages. Multiply the difference between the pre-injury wages and post-injury wages by 66 2/3% to determine monthly SEB.
6. Enter a STARS note giving step by step calculations.
7. Attempt to settle based on remaining weeks of SEB discounted.

## CHILD SUPPORT – ORM- C214

### Responsibility

The assigned Workers' Compensation State Risk (SRA) Adjuster performs activities for handling child support payments deducted from workers' compensation checks as described in this procedure

### Forms or Reference Material Required

Copy of court order for child support payment

LDOL 1002

### Procedure

#### Deduct Child Support Payments

If an injured worker has been assessed child support payments, these may be deducted from the workers' compensation check if the injured worker is no longer employed with the State.

1. Obtain a copy of the court order or notice from the Department of Social Services for the claimant's file.
2. Verify whether or not injured worker is still employed with the State. If the injured worker is still employed, please notify the Office of Uniform Payroll of the Order.
3. If the injured worker is no longer employed, determine the weekly amount due for child support.
4. Complete the STARS Adjustment tab in the Indemnity Benefit Record to have a check cut; designate the place where the check should be mailed.
5. Reduce the compensation rate by the weekly amount paid for child support.
6. Complete a new LDOL 1002. Send the original to the Department of Labor and copies to the injured worker, attorney (if applicable), and the employer.

**NOTE:** Once the compensation benefits for the injured worker stops, so do the benefits for child support.

At time of injury, if there is a current child support order being withheld through payroll, then Workers Compensation does not withhold child support.

Once injured worker is terminated from state employment, then child support order reverts to workers' compensation deduction.

## **SECONDARY CLAIMS – ORM- C215**

### **Responsibility**

The assigned Workers' Compensation State Risk (SRA) Adjuster performs activities relating to secondary claims as described in this procedure.

### **Forms or Reference Material Required**

### **Procedure**

### **Employers' Liability**

When a lawsuit is received in which the employer is sued in tort because of gross negligence, the suit falls under Part B Workers' Compensation, Employers' Liability for Intentional Tort.

1. Request an attorney to defend the suit through the Attorney General's office (DRL).
2. Change STARS coverage to indicate Employers' Liability.

### **Excess Carriers**

Refer to ORM-C800 General procedure – Miscellaneous Activities / Excess Carrier section

## **HANDLING TRANSFERRED FILES – ORM-C216**

### **Responsibility**

The assigned Workers' Compensation State Risk (SRA) Adjuster performs activities for handling transferred files as described in this procedure

### **Forms or Reference Material Required**

ORM-C800 General procedure – Case Management and Miscellaneous Activities sections

Transferred claim file

Adjuster's Checklist Upon Receipt of Transferred File form

### **Procedure**

### **File Review**

If a claim is transferred from another adjuster, it must be thoroughly reviewed by the new adjuster. Any information, investigation, and/or documentation that is lacking will be the responsibility of the new adjuster.

1. Review the file using the Adjuster's Checklist Upon Receipt of Transferred File form.
2. Obtain answers to questions that include but not limited to the following:
  - Is this an Old Law or New Law claim?
  - Were benefits properly calculated?
  - Is this a compensable claim?
  - Was contact made with the injured worker, agency, treating physician?
  - Who is the injured worker's doctor(s) and specialties?
  - Are benefits properly classified: TTB, SEB, Survivors' Benefits? If SEB, reason for the classification.
  - Investigation completed?
  - Sufficient medical documentation? Does medical documentation support continued disability? When was the last time the injured worker saw the doctor?
  - Has the injured worker reached MMI? Can injured worker return to work? Previous work? Other work?
  - Rehabilitation/medical management involved? Firm? Has the treating physician signed off on jobs if unable to return to previous work?
  - Is injured worker represented by an attorney? If so, who?
  - Is ORM represented by an attorney? If so, who?
  - Litigation involvement? Why? Resolved?
  - Legal tracking completed and up-to-date?

- Is there Excess Carrier liability? Have procedures been followed? Refer to ORM-C800 General procedure – Miscellaneous Activities / Excess Carrier section.
  - Second injury fund involvement? Was claim filed with Second Injury Board?
    - SIF properly coded?
    - Reserves accurate?
    - Recovery on regular intervals?
  - Subrogation involvement? Notice of Lien sent? Intervention filed if in suit? Turned over to Subrogation unit? Who is the subrogation adjuster?
  - Are medical records current in the file?
  - Are medical payments related to the accident?
  - Rehabilitation/medical management involvement? Results?
  - How has the file progressed?
  - Can benefits be stopped or reduced?
  - Can the file be settled? What are the remaining weeks? What is the discounted value?
  - If the file is settled, is a copy of the receipt and release in the file? Has the indemnity benefit record been stopped in STARS?
  - Can the file be closed?
3. Review the file for accuracy of information.

## **GENERAL INFORMATION – ORM- C217**

### **Responsibility**

The assigned Workers' Compensation State Risk (SRA) Adjuster performs activities to provide general information to adjusters under their supervision as described in this procedure.

### **Forms or Reference Material Required**

General guidelines for workers' compensation

### **Procedure**

### **General Guidelines**

Listed below are some general guidelines that the supervisor may provide to adjusters regarding workers' compensation. The supervisor provides this information in addition to regular updates and laws as needed to keep the adjusters current on information for investigating and handling workers' compensation.

1. Ensure adjusters are kept current on new laws and mandates affecting workers' compensation.
2. Provide guidelines which may include but are not limited to the following to adjusters for performing their jobs.

### **General Workers' Compensation Information**

- Benefits are not payable for the first seven (7) days of disability unless the injured worker misses more than forty-two (42) days from work (see R. S. 23:1224).
- Compensation rates are subject to a maximum and a minimum amount by law (see R. S. 23:1202). Compensation rates are based on 66 2/3 of the injured worker's average weekly wage (AWW) up to a maximum amount.
- Maximum and minimum comp rates are established by the Department of Labor. Comp rates are subject to change each September first.
- Once the comp rate has been established, it does not change when injured workers receive promotions or merit increases.

#### **EXCEPTIONS:**

SEB reductions based on job identification

Disability retirement offsets

NOTE: If disability results from an OCCUPATIONAL DISEASE, the AWW is not governed by the date of the exposure. Comp rate for these claims shall be established based on the comp rate in effect on the date of the last injurious exposure or the date disability began, whichever is later.(Please refer to R. S. 23:1021.10.g

- If loss time results from occupational injury or disease, the comp rate is governed by the comp rate at the time of the last injurious exposure.

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- If an injured worker is earning less than the minimum comp rate, then the comp rate is the injured worker's actual wages.
- If the injured worker is earning more than the minimum comp rate, however, after calculation of  $66 \frac{2}{3}$  of the AWW, the comp rate comes out less than the minimum comp rate, then the minimum comp rate is due.
- Comp checks are always mailed to the agency unless the injured worker and/or his/her attorney requests mailing of the comp check to another location (see R. S. 23:1201.0). All requests for change of address for comp checks from the agency directly to the injured worker must be received in writing. Notify the agency by phone and follow-up with a copy of the request to change the address. Comp checks are sent to the agency to buy back leave as an injured worker cannot receive both workers' comp and regular paycheck at the same time.
- Benefits are not payable when an injured worker is incarcerated unless the injured worker can prove he/she has family who is dependent on the comp check for support (see R. S. 23:1201.4).
- The only deductions from benefits other than SEB reductions are for court ordered child support (see R. S. 23:1205A).
- Medical benefits prescribe one (1) year from the date of the accident if there is no payment on the claim. Medical benefits prescribe three (3) years from the date of the last payment (date of check) once payments have begun (see R. S. 23:1209).
- Comp benefits prescribe one (1) year from the date of the accident if there is no comp payment on the file. Comp benefits prescribe three (3) years from the date of the last payment once benefits have begun (see R. S. 23:1209). **EXCEPTION:** Compensation benefits on claims for developmental disability (manifestation) shall prescribe one (1) year from the date the disability manifests itself but no more than two (2) years from the date of the accident.
- SEB benefits prescribe two (2) years from the date of the last payment or if no SEB is paid within 13 consecutive weeks.
- No benefits are payable if the injury results from intoxication (see R. S. 23:1081.1.b) – intoxication can be from drugs and/or alcohol.
- No benefits are payable if the injury results from the injured worker's willful intention to injure him/herself or another employee (see R. S. 23:1081.1.a).
- No benefits are payable if the injury results from the injured worker's deliberate failure to use adequate guard are protection provided to protect against accident or injury (see R. S. 23:1081.1.c).
- No benefits are payable to the initial physical aggressor in an unprovoked physical altercation (see R. S. 23:1081.1.d).
- If medical information indicates the claimant is unable to return to regular duty but gives restrictions or indicates other work, request rehabilitation services.
- Ideal claims handling is to work the file to a close as quickly as possible: RTW, Settlement, and Closure.

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- Each diary date worked should include a thorough effort to close applicable files so that caseloads remain down and manageable.
- Only Claims Council can make a decision to accept a court decision or appeal it.
- Adjusters and supervisors may waive subrogation rights within their authority however no one can waive more than 50% of the State's interest in a claim without the approval of claims council regardless of the amount.
- All subrogation liens in excess of 50% of our interest must be presented to claims council for approval regardless of the amount.
- Workers' Comp is a non-taxable income. Injured workers do not have to disclose it on income tax returns.
- Commissioners-of-Elections in charge of voting sites are not State employees and therefore are not covered under workers' comp. They are considered to be public officials and not employees.
- Volunteers are not covered under workers' compensation. The Office of Risk Management will reimburse medical benefits but not pay any compensation benefits.
- Members of National Guard are not covered under workers compensation except when called to State Active Duty (see R. S. 23:1211).

## **CLOSE A FILE – ORM-C218**

### **When and how to close a file**

1. Close a file when:
  - No compensation is due
  - No unpaid medical bills in file
  - No pending litigation
  - No pending second injury funds reimbursements
  - No pending subrogation issues: recovery, receipt, and release
  - Settlement documents have been received from the attorney
2. Once a file is settled, be sure to stop the indemnity benefit record once the settlement has been court approved.
3. Complete LDOL 1003 and forward to OWC. Place copy in claim file.
4. Mark the activity sheet to show closure.
5. Ensure all material in the file is pronged and placed in the proper claim section; do not leave loose materials in the file.
6. Mark the outside of the file folder to show date file was closed.
7. If the file is in litigation the supervisor must verify that litigation management is in proper order.

### **What NOT to do**

- Do not reopen a file in the computer without pulling the file.
- Do not reopen a file in the computer and then NOT close it back once all work is completed.
- Do not leave loose material in a file that is being closed; make sure all materials are pronged and placed in the proper claim section.

## **LITIGATION MANAGEMENT**

- D – Litigation flag for initial mediation or ORM filed 008.
- L – Litigation flag once the citation is received.
- Docket #'s must be in both OWCA / Litigation and in the correct format.
- Track Appeals in the State Level tab
- Docket number format in OWCA tab:
  - Take out the dash that's on OWCA notice
  - Example: 08-04822 should be 0804822
- Docket number format in Litigation tab:
  - Take out the dash that's on OWCA notice

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Example: 09/0804822

Please refer to the Litigation Management section in the General Claims Section.