February 20, 2014

South Carolina Workers' Compensation

Workers' Compensation Compliance Poster

We are operating under and subject to the South Carolina Workers' Compensation Act

In case of accidental injury or death to an employee, the injured employee, or someone acting in his or her behalf, must give immediate notice to the employer or general authorized agent. Failure to give such immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her dependents and may result in failure to receive any compensation benefits under the law.

Workers' Compensation:

1. Pays 100% of your medical bills and some other expenses.
2. Compensates you for 66 2/3% of your salary, limited to the maximum wage set by law, if you are unable to work for more than seven (7) calendar days.

If you are injured on the job, you should:

1. Notify your employer at once. You cannot receive benefits unless your employer knows you are injured.
2. Tell the doctor your employer sends you to that you are covered by workers' compensation.
3. Notify the Workers' Compensation Provider listed on this poster or the South Carolina Workers' Compensation Commission at 803.737.5700 if you experience undue delays or problems with your claim.

South Carolina
Workers' Compensation Commission
P.O. Box 1715, 1333 Main Street, Suite 500
Columbia, S.C. 29202-1715
803-737-5700
www.wcc.sc.gov

Workers' Compensation Provider Name

South Carolina State Accident Fund

Mailing Address

P.O. Box 102100
Columbia, SC 29221

Claims Telephone Number

803-896-5800

South Carolina Department of Mental Health
Workers' Compensation Cover Page

Please read and complete all applicable information in this packet

Supervisor's Name: _____

Date of Injury: _____

Employee's Name: _____

Facility/Center/Lodge: _____

Timekeeper: _____

Org Unit Facility Code: _____

Checklist:

	Instruction Sheets	Do ***not*** scan back to us.
	HRS 16- Report of Injury	1st page due in 24 hours 2nd page due in 72 hours
	HRS 147- Election Form	Scan and send ***only*** a completed page 3 after ***both employee and supervisor*** have signed
	HRS 148- ESN	Scan and send ***only*** after each doctor visit ***with the medical notes attached***
	HRS 178- Witness Form	The ***injured employee*** must complete and sign one also, restating what happened in ***full*** detail

Notes:

1. Copy employee's timekeeper on all paperwork
2. Do ***not*** fax Compendium. Do ***not*** fax to our office
3. Do ***not*** call Compendium if no ***medical*** treatment is needed (i.e. first aid is ***not*** medical treatment)
4. Submit packet in ***PDF*** format only after ***all signatures have been obtained*** to 10workcompemail@scdmh.org

WC Contacts:

Program Coordinator	Ph: (803) 935-5442
Risk Assessment Officer	Ph: (803) 898-8592
Via Email	10workcompemail@scdmh.org

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH DIRECTIVE NO. 491-79 (5-100) requires that the SUPERVISOR complete all required forms

Instructions

1. The supervisor must review to see if the injury occurred (1) by accident, (2) was caused by work, and (3) because of work. All three elements must be present for a claim to be filed. If it is not an emergency call 803-898-8600 for Central Administration and Community Mental Health Center employees, or 803-935-6030 for Division of Inpatient Services employees.

    a. If the injury is a "report only", i.e. the employee does not want to seek medical treatment, or the injury can be treated with first aid as defined by OSHA, do not call Compendium.

    b. For mental health, repetitive motion, and occupational diseases call (803) 898-8600 before making any claims. ***All three must be supported by medical evidence***

2. Once all forms are ***completed and turned in*** to 10workcompemail@scdmh.org, contact the Nurse Case Manager at Compendium to authorize treatment if you are ready to assert that this is in fact work related and requires medical attention @1-877-709-2667.

    a. Doing so is the ***supervisor authorizing, affirming, and asserting*** that the claim is (1) by accident, (2) was caused by work, and (3) because of work. ***Do not call unless all three conditions are met***

    b. OSHA defines medical treatment as "the management and care of a patient to combat disease or disorder"

        i. This does not include "diagnostic procedures, such as x-rays and blood tests, including the administration of prescription medications used solely for diagnostic purposes (e.g., eye drops to dilate pupils), or first aid"

3. Follow the instructions of the Nurse Case Manager at Compendium. They are the contracted company that will schedule a first appointment with an ***approved*** Occupational Therapist or other approved health care provider.

    a. ***Any employee who schedules and attends an appointment without authorization from Compendium will NOT be covered by their Workers' Comp insurance and will be paying for the appointment out of pocket.***

NOTES:

1. Emergency or life –threatening means that it requires ***immediate*** intervention to save life or limb

2. Medical restrictions and referrals are ***only*** accepted from ***approved*** Occupational Health Specialists. They ***will not be accepted*** from private or not previously approved medical providers

3. Employees are ***not*** to leave work for non-emergency situations unless authorized by their supervisor. Personal leave may be approved at the supervisor's discretion

South Carolina Department of Mental Health

WORKERS COMPENSATION INCIDENT REPORT HRS-16

INSTRUCTIONS

SECTION 42-1-160 (A). "INJURY" AND "PERSONAL INJURY" DEFINED (SC STATE LAW)

(A) "Injury" and "personal injury" mean only injury by *accident arising out of and in the course of employment* and shall not include a disease in any form, except when it results naturally and unavoidably from the accident and except such diseases as are compensable under the provisions of Chapter 11 of this title.

All on-the-job injuries must be reported to the Supervisor immediately. Even if not seeking medical attention

US DEPARTMENT OF LABOR—OCCUPATIONAL SAFETY AND HEALTH ACT (OSHA). 29 CFR 1904.7

First Aid: Under the OSHA recordable occupational injuries and illnesses or any injury or illness which results in a fatality, regardless of the time between injury and death or length of illness; lost workday cases; or injuries or illnesses which result in transfer to another job or termination; or require medical treatment (*other than first aid*), loss of consciousness or restriction of work or motion. Medical treatment as used here does not include first aid, one-time treatment and subsequent observations of minor scratches, cuts, burns, splinters, and so forth which do not ordinarily require medical treatment even though provided by a physician or registered professional personnel.

First Aid incidents are "Report Only"

EMERGENCIES and NON-EMERGENCIES

- Emergency treatment is needed if there are open wounds requiring stitches, lacerations, broken bones unconsciousness, or to save life or limb
- Non emergencies can be scheduled as appointments with approved licensed occupational health provider. A sprain two-weeks ago is not an emergency today
- Unapproved or unauthorized work excuses will not be accepted from private, unlicensed, or other non-acceptable medical facilities

POTENTIAL EXPOSURE TO BLOODBORNE PATHOGENS

TWO CONDITIONS MUST EXIST:

1. **FIRST**: The source must be positive prior to the incident
2. **SECOND**: The recipient must have had an opening to receive exposure prior to the incident

PAGE ONE

To be completed by Employee and signed by the Employee and Supervisor

Enter personal data for record keeping and statistical analysis

NORMAL DUTY ASSIGNMENT CIRCLE ONE:

- Select the facility in which the incident occurred
- Select the facility to which you are assigned to if the incident occurred away from the facility. For example: Traveling to or from

(17) Enter information about other employment

(24) Explain if there was a delay between the incident and the reporting date. Why the delay?

(25) Who was the incident reported to? Date? Time?

(33) Is there a history of similar symptoms?

(34) Did you receive assistance in-house for First Aid?

(37) A witness is anyone who perceived an incident by any of their five senses. Witnesses must be identified and their statements submitted with the initial report

PAGE TWO

To be completed by the Employee's Supervisor and reviewed by the chain of command

Page Two stresses accountability and incident review with an eye towards prevention

(40) Was the Employee authorized to perform the activities?

(42) Are there Rules, Regulations, Policies, etc., in place covering the alleged activity?

(43) Was there a breach of these rules? Explain

(44) Was the incident avoidable?

(45) What were contributing factors? i.e., Walking on wet floors, disregarding rules, not asking for assistance, etc.

(46) Was the Employee working within the scope of their duties or doing something outside of their job description?

(47) Most incidents are avoidable and follow a chain of events were opportunities for intervention are present. How could this have been prevented?

(51, 52, 53) A review by someone in supervision above the immediate Supervisor. This is an opportunity for correction, accountability, and/or oversight. The best way to establish a community of safety is to be aware of the big picture.

(55) SC Workers Compensation Commission and Occupational Safety And Health Administration recording and tracking

South Carolina Department of Mental Health

EMPLOYEE INJURY INCIDENT REPORT HRS-16A

***** INCOMPLETE FORMS WILL NOT BE ACCEPTED. N/A ALL NON-APPLICABLE AREAS *****

REPORT OF INJURY. HRS-16A. TO BE COMPLETED BY EMPLOYEE AND SUBMITTED IMMEDIATELY

EMPLOYEE INFORMATION: INITIAL HERE IF "REPORT ONLY":

1. LAST NAME:	2. FIRST NAME:	3. DOB:	4. SSN: XXX-X-

MALE ☐ FEMALE ☐	5. EMPLOYEE #	6. JOB TITLE:	7. DATE HIRED:

8. PHYSICAL HOME ADDRESS: *(NO PO BOXES)*		9. CITY:	10. ZIP:

11. REGULAR DAYS OFF:	12. WORK PHONE #:	13. PERSONAL PH #:

NORMAL DUTY ASSIGNMENT: CIRCLE ONE	DIS/HQ	BPH-A	BPH	CMT-S	CMT-R	PBH	MV	Nutri	SVPTP	DOAS/HQ	PPS	PSO	DOS/HQ	A-B	A-O-P
	BECK	BERK	CAT	C-D	C E	COLA	GVL	LEX	OBG	P D	PIED	S-W	SPTB	TRI	WAC

INCIDENT LOCATION (EX. WGB, LODGE-X, KITCHEN):	14. FACILITY:	15. UNIT:	16. AREA:

17. ARE YOU EMPLOYED SOMEWHERE ELSE? ☐ Yes ☐ No WHERE?	18. POSITION:	19. HOW LONG?

20. TIME WORKDAY BEGAN:	☒A.M. ☐P.M.	21. TIME OF INJURY:	☒A.M. ☐P.M.	22. DATE INCIDENT OCCURRED:	23. DATE INCIDENT REPORTED:

24. WHY DELAYED IN REPORTING?

25. INJURY REPORTED TO (PRINT NAME):	26. DATE:	27. TIME:

28. WHAT WERE YOU DOING?

29. WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED YOU?	30. PATIENT#

31. HOW DID INCIDENT OCCUR? GIVE ALL FACTS REGARDING THE INCIDENT:

32. TYPE AND LOCATION OF INJURY ON THE BODY:	33. HISTORY OF SIMILAR SYMPTOMS? ☐ YES ☐ NO

EXPLAIN:

34. IN-HOUSE FIRST AID TREATMENT:

35. ATTENDED BY (PRINT NAME):	36. DATE:

EMERGENCY TREATMENT NEEDED IF THERE ARE OPEN WOUNDS REQUIRING STITCHES, LACERATIONS, UNCONSCIOUSNESS OR BROKEN BONES

NON EMERGENCIES CAN BE SCHEDULED AS APPOINTMENTS WITH A LICENSED OCCUPATIONAL HEALTH PROVIDER

UNAPPROVED OR UNAUTHORIZED WORK EXCUSES WILL NOT BE ACCEPTED FROM PRIVATE OR OTHER NON ACCEPTABLE MEDICAL FACILITIES

37. **WITNESSES MUST COMPLETE STATEMENTS BEFORE THE END OF SHIFT AND MUST ACCOMPANY THIS FORM**

WITNESS 1:	NAME:	WK PH#	CONTACT PH#
WITNESS 2:	NAME:	WK PH#	CONTACT PH#

THE ABOVE IS TRUE, CORRECT, AND AN ACCURATE REPRESENTATION OF THE FACTS	38. EMPLOYEE SIGNATURE:	TODAY'S DATE:

39. PRINT SUPERVISOR/CHARGE PERSON:	**SUPERVISOR/CHARGE PERSON SIGNATURE:**	**PHONE#:**	**TODAY'S DATE:**

South Carolina Department of Mental Health

EMPLOYEE INJURY INCIDENT REPORT HRS-16B

HRS-16B TO BE COMPLETED BY SUPERVISOR, CHARGE PERSON, OR INDEPENDENT REVIEWER

HRS-16B. TO BE FORWARDED VIA EMAIL AS A PDF DOCUMENT WITH SIGNATURES TO WORKERS COMPENSATION WITHIN THREE (3) DAYS OF THE DATE OF ANY INCIDENT

NAME OF INJURED PERSON:	DATE OF INCIDENT:	TIME:	☐AM ☐PM
LOCATION OF INCIDENT:			

40. IF APPLICABLE. WAS THE PERSON INVOLVED APPROPRIATELY TRAINED AND AUTHORIZED?	☐YES	☐NO

41. GIVE BRIEF DETAILS OF RELEVANT TRAINING AND AUTHORIZATION:

42. ARE THERE ANY RULES OR OTHER INSTRUCTIONS APPLICABLE TO THE WORK? (POST ORDERS, POLICIES, ETC.)	☐YES	☐NO

a) IF SO GIVE BRIEF DETAILS:

43. WAS THERE ANY APPARENT BREACH OF RULES OR INSTRUCTIONS, OR ANY APPARENT MALPRACTICE?	☐YES	☐NO

a) IF SO GIVE BRIEF DETAILS:

44. WAS THE INCIDENT AVOIDABLE? ☐**YES** ☐**NO WHY?**

45. WHAT CONTRIBUTED TO INCIDENT (I.E. CARELESSNESS, WET FLOOR, POOR LIGHTING, DISREGARDING RULES, WARDROBE, ETC.)?

46. WAS THE EMPLOYEE ENGAGED IN WORK REQUIRED BY THEIR JOB DESCRIPTION/DUTIES?	☐YES	☐NO

47. WHAT COULD HAVE PREVENTED THIS INCIDENT:

48. PRESENT SUPERVISOR'S ADDITIONAL COMMENTS OR OBSERVATIONS:

49. PERSON COMPLETING #41—48 (**PRINT**)	SIGNATURE:	TODAY'S DATE:

TO BE COMPLETED BY AREA MANAGER, DIRECTOR, DIVISION DIRECTOR OR ASSISTANT DIVISION DIRECTOR

50. DO YOU ENDORSE THE SUPERVISOR'S REPLIES TO PARTS 41 TO 48?	☐YES	☐NO
51. HAS THE INVESTIGATION IDENTIFIED ANY TRAINING, MANAGEMENT, OR PERSONNEL AREAS FOR IMPROVEMENT?	☐YES	☐NO

52. WHAT ACTION(S) HAS BEEN TAKEN IN RESPONSE TO THIS INCIDENT (DISCIPLINARY, TRAINING, ETC.)?

53. PERSON COMPLETING #50—52 (**PRINT**)	SIGNATURE:	TODAY'S DATE:

54. OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

EMPLOYER'S 12-A, SC WORKERS COMPENSATION COMMISSION		**OSHA 300 LOG**	
☐	SHOULD **NOT** BE FILED. ONLY FIRST AID	☐	SHOULD **NOT** BE RECORDED ON OSHA 300 LOG
☐	SHOULD BE FILED. ADDITIONAL MEDICAL TREATMENT REQUIRED	☐	SHOULD BE RECORDED IN OSHA 300 LOG
☐	NO TIME LOST FROM WORK	☐	TIME LOST (OTHER THAN DAY OF INJURY)
☐	TIME LOST RECOMMENDED BY MEDICAL PROFESSIONAL	☐	MODIFIED DUTY ASSIGNED
☐	MEDICAL TREATMENT BEYOND FIRST AID	☐	OSHA 300 LOG #
NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL IF OFFSITE		☐ **YES** ☐ **NO**	WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM?
FACILITY NAME, STREET ADDRESS, CITY, STATE, ZIP		☐ **YES** ☐ **NO**	WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN INPATIENT?

DISTRIBUTION:

DMH EMPLOYEE RISK ASSESSMENT (WC Coordinator)
INFECTION CONTROL
RISK MANAGER
IMMEDIATE SUPERVISOR
DMH SAFETY
FACILITY SAFETY

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
WITNESS STATEMENT OF INJURY OR ILLNESS

This Form Must Be Completed And Submitted With The Initial Report Of Injury

Witness Name:		**Today's Date:**
Injured Employees Name:		
Contact #:	**Date of alleged incident:**	**Time of incident:**
Supervisor's Name:		**Contact #:**

Witness Description of Incident:

Please include date, time and place of incident along with the activity that you were engaged in at the time of incident. State exactly what happened to cause the injury. Specifically, list all body parts affected (Example – right index finger, lower/mid/upper back, etc.). Do **NOT** Include patient name(s) but do include patient/client number(s) and the names of others present, if applicable. Use extra sheets of paper if necessary.

DIRECTIVE NO. 856-06, Employee Disciplinary Standards and attachments, requires every employee, including supervisors, to assist in the performance of any investigations.

List any other witnesses to the incident:

The incident as described is true and complete to the best of my knowledge.

Employee Signature **Date**

South Carolina Department of Mental Health

WORKERS' COMPENSATION EMPLOYEE/SUPERVISOR NOTIFICATION

INSTRUCTIONS

The Employee/Supervisor Notification (ESN) HRS-148 form places the employee at work or out of work following a Workers Compensation claim. The form must be completed by the Supervisor each time an employee is placed out of work or placed in a temporary modified duty position, and/or returned to work by the Supervisor. This form must also be completed after each medical appointment.

All leave taken under Worker's Compensation must be supported by an ESN form HRS-148 authorizing the employee to be out of work. If the employee is out of work without authorization, that employee will be charged LWOP.

Employee/Supervisor Notification HRS-148 Form is a legal document that **starts** and/or **stops** Pay Benefits from the SC State Accident Fund to the employee. Failure to submit this form in a timely manner will cause a delay in benefits, overpayment, or underpayment.

Section I

Enter vital statistics surrounding this event. Employees may have multiple claims with different dates and or locations.

Section II

MEDICAL RECOMMENDATIONS:

A. **Section II is reserved for the recommendations of the medical provider**
B. Supervisors will **not** add or take away from the recommendations. **Section IV** is reserved for the Supervisor
C. Medical recommendations are only accepted from approved licensed medical providers. Recommendations from unapproved personal doctors, physical therapists, masseuses, chiropractors, spiritual healers, clergy, etc. are not acceptable
D. Enter the recommendations verbatim from the medical provider
E. Check the box that corresponds to the medical provider's recommendations
F. Enter dates and times as applicable
G. The word "RECOMMENDATION" is used in this form in deference to SCDMH
    1. A medical provider may prescribe work restrictions that are entirely inapplicable to the employee, their duties, or available Temporary Modified Duty position that accommodates the temporary restrictions. **For example:** *"Remain out of work. Avoid sun exposure at work for more than 30-minutes"*. In this scenario the employee does not work outside and therefore the medical "Recommendations" to "*Remain out of work*" is clearly not taking into account the actual work conditions
    2. A medical provider may give instructive recommendations to the employee. **For example:** "*Avoid activities that aggravate injury*". Those are instructions to the employee and the employee is responsible for not aggravating their injury on or off duty
H. Medical Providers are to make recommendations only about the employee's ability to physically perform their duties. Recommendations involving cosmetics or unapproved mental health claims do not affect ability to physically perform duties
I. SCDMH will be the final arbiter as to when an employee should stay out of work or can be accommodated in a Temporary Modified Duty position

Section III

NOTICE TO EMPLOYEE:

A. The employee must read and initial all three areas indicating that they understand
B. The employee must sign the form
C. However, in the event the employee is not available immediately due to circumstances beyond their control the Supervisor must notify them of the decision in **Section IV** and the employee can sign the ESN on their next workday or shift

Section IV

SUPERVISOR RESPONSE:

A. The Supervisor must read the medical recommendations carefully
B. In conjunction with the medical recommendations and analyzing the work related duties and available modified duties the Supervisor will determine whether the employee…
    1. ***Can be accommodated immediately***: The employee will remain at work performing regular duties or modified duties under the same Supervisor
    2. ***Cannot be Accommodated***: The employee's medical restrictions cannot be accommodated and the employee will either stay out of work or be referred to a Temporary Modified Duty Position and accommodated. See "Referred to another Dept.
    3. ***Referred to another Dept., Facility, or Location for accommodation***: The employee has been placed in a Temporary Modified Duty Position. Explain in the Comments of **Section V**
    NOTE: An employee can be accommodated on any shift and at any SCDMH facility within a 30-mile commute from their residence of record
    4. ***Can be accommodated but not until***: The employee will be accommodated after released to light duty; usually after surgery
    5. ***No Restrictions were prescribed***: The previous restrictions will remain in effect until further clarification is obtained. Contact the DMH Workers Compensation Coordinator. An attempt will be made to receive clarifications from the medical provider

Section V

COMMENTS:

A. In the event there are special instruction or circumstances please add comments
B. When an employee is placed into a Temporary Modified Duty position comments will be placed explaining the arrangement such date and time to report and to whom and location

South Carolina Department of Mental Health

COMPENSATION EMPLOYEE/SUPERVISOR NOTIFICATION

I. DMH Facility: _____ **Date of Injury:** _____

EMPLOYEE: _____
(Last) (First) (MI) (Last 5 Digits of SSN)

II. MEDICAL RECOMMENDATIONS:

Date of Medical/Clinic Visit: _____ Medical Provider: _____
(Name of Physician)

MEDICAL WORK STATUS AND RECOMMENDED RESTRICTIONS:

NOTE: SCDMH only accepts medical recommendations from approved State Accident Fund medical providers assigned to the claim.

The work restrictions for Modified Duty are: _____

_____

_____

☒ Back to work Full Duty immediately ☐ Out of Work until _____, then to Work Full Duty

☒ Back to work with Restrictions ☐ Out of Work until _____, then to Work with Restrictions

☐ Out of work until medical visit on _____ at _____ ☐ AM ☐ PM

☒ Return for follow-up appointment on _____ at _____ ☐ AM ☐ PM

III. NOTICE TO EMPLOYEE:

INITIALS:

_____ I understand that I must report to my Supervisor for a work assignment when placed on Full Duty or Work Restrictions. If I am unable to return to work as instructed by the Medical Provider, I will immediately notify my Supervisor. I understand that an unauthorized absence can result in a Leave Without Pay status and/or Disciplinary Action.

_____ I understand that I must attend all appointments and turn in a "Return to Work Statement" from the medical provider on the same day of each appointment.

_____ I understand that I may be placed in a Temporary Modified Duty position on any shift, facility, or location that will comply with my medical recommendations within 30-commuting miles from my residence at the discretion of SCDMH.

Employee Signature: Date:

IV. SUPERVISOR RESPONSE:

I have read and discussed with the employee the above work status prescribed by the healthcare provider and any recommended work restrictions. Based on the recommendations, I have decided that the employee: (check one of the following)

☐ Can be accommodated immediately ☐ Can be accommodated, but not until _____

☐ Cannot be accommodated ☐ No Restrictions were prescribed

☐ Referred to another Dept, Facility, or Location for accommodation

V. COMMENTS:

Use Comments/Update Section to notify of any changes that occur in the work status of this employee. Write in the dates and times of the changes

(Supervisor Print)	(Supervisor Signature)	(Telephone)	(Date)	(Time)

Distribution: DMH Workers' Comp Coordinator, Immediate Supervisor, State Accident Fund, Timekeeper, Employee, OSHA