MUNICIPAL
WORKERS
COMP



Workers Compensation 101

WHAT THE EMPLOYER SHOULD KNOW

EMPLOYERS MUST HAVE WC COVERAGE AND SHOULD PROVIDE NOTICE TO EMPLOYEES

Employers in Arkansas with three or more employees are required by law to have workers' compensation insurance coverage for their employees and must display a poster of instructions (Form P) in a conspicuous location in the workplace. If the Form P is posted, employers have the right to expect injured workers to give written notice (Form N) of the injury according to the instructions on the poster.

INJURIES THAT ARISE OUT OF AND IN THE COURSE OF EMPLOYMENT ARE GENERALLY COVERED

Typically, compensable work-related injuries occur in the context of a specific incident, time, and place. However, covered injuries or illnesses can also take other forms such as rapid repetitive motion injuries (i.e., carpal tunnel), gradual on-set injuries, occupational diseases, hearing loss, mental injuries, and aggravations or accelerations. Even if it is questionable whether an injury or illness is work-related, have the employee file a claim. AML's team of experienced insurance representatives will evaluate the facts and determine compensability. It is important to keep in mind that the employee bears the burden of proving his or her injury is compensable.

ENSURE PROMPT REPORTING AND RESPONSE TO WORKPLACE INJURIES

Encourage employees to report all injuries, no matter how slight. Even a minor laceration can become serious if an infection develops. When an employer learns of an employee's injury, the employer should take the following steps.

First, offer medical treatment to the injured worker. Second, have the employee fill out and sign three forms: the **Form N**, the Municipal Report of Accident (ROA), and the Pharmacy First Fill Letter of Intent. The Form N (Notice of Injury) is an Arkansas State form that allows a worker to report their injury to their employer. It also informs the employee of their rights and responsibilities and provides legal protection for both parties. You must have the injured worker sign the front and back of the Form N and provide the injured worker with a copy of the signed form.

The Municipal ROA allows the injured worker to provide more detailed information about the injury. The Pharmacy First Fill Form allows the injured worker to fill an initial prescription without having to pay for it out of his or her own pocket. You can find a copy of these forms at the end of this pamphlet or on our website.

Third, notify AML immediately by filing a claim online via the AML/Origami Risk software program accessible from the MWC page on the AML website. Fourth, conduct and document an investigation to determine witnesses, how the injury occurred, and/or any suspicious circumstances and report that information to AML. Finally, attempt to make reasonable accommodations to get your injured workers back to work promptly.

INJURED WORKERS SHOULD BE PROVIDED ALL REASONABLE AND NECESSARY MEDICAL CARE

Employers are obligated to provide injured workers with all reasonably necessary medical care. Although employees may seek emergency treatment without prior approval, employers or their insurance representatives have the right to choose the initial doctor(s) and direct care. However, employees must be notified of these rights via the Form N, which is why it is imperative employees sign both the front and back of the Form.

Employees should ensure that they have the approval of the workers' compensation carrier before seeking treatment. This allows AML's insurance representatives a chance to evaluate the reasonableness and necessity of any recommended treatment and thus approve or deny the recommendation. If the employer receives a bill from a medical provider for treatment of a work-related injury, send it immediately to their AML insurance representative for prompt handling. Delays in forwarding these bills may interfere with the treatment or services due an injured worker.

WHAT ARE INDEMNITY BENEFITS?

If an employee has to miss work because of a work-related injury or illness, the employee may be eligible to receive some cash benefits, also known as indemnity benefits. These payments can help an employee through a period of time he or she is disabled from the workplace injury or illness. Indemnity payments are calculated based on the employee's average weekly wage (not to exceed a maximum rate as set by state law).

Often employers will be required to provide a wage statement (Form W) if requested by the insurance representative in order to calculate the employee's average weekly wage. The waiting period for these benefits is seven (7) calendar days and must be at the direction of the authorized treating doctor. The employee will be paid for the first seven (7) days only if he or she is disabled for more than fourteen (14) days. (They do not have to be continuous calendar days.) Most often, cash payments are made to injured workers in the form of temporary total disability benefits.

These payments are made while an employee is healing and suffers a total incapacity to earn wages. If the injury results in a permanent impairment, such as the amputation of a finger or loss of use of the shoulder, the employee can be paid permanent partial disability benefits once their treatment is complete. If an employee's impairment has affected his or her pre-injury wages, the employee may be entitled to wage loss benefits. If the injury resulted in death, payments may be made to surviving
dependents.

ADDITIONAL INFORMATION

Although the Workers' Compensation Law provides that an employer cannot discharge or discriminate against an employee for exercising his or her rights under the Workers' Compensation Law, there is no specific requirement that an employer keep a job open while an employee is off work.

Also, an employer is responsible for Workers' Compensation benefits to the injured employee for two years from the date of injury or, if it is a longer period of time, one year from the date of the last payment of benefits. If you have any questions or would like more information, please contact the Arkansas Municipal League Workers' Compensation Program.

Form AR-N	ARKANSAS WORKERS' COMPENSATION COMMISSION	N
Ark. Code Ann. §§11-9-701, 508, 514 AWCC Rule 099.33 Revised: 1-1-2001 Updated: 8-1-2006	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

EMPLOYEE'S NOTICE OF INJURY

EMPLOYEE INFORMATION (Please Print in Ink)

Employee's Last Name	First Name	M I	Social Security Number	Home Phone No.

Street Address or P.O. Box	City	State	Zip Code

Child Support Obligation: ❑ Current ❑ Past Due Payable to:

EMPLOYER INFORMATION (Please Print)

Employer's Name	Supervisor's Name

Employer's Street Address or P.O. Box	Employer's City	State	Zip Code

ACCIDENT INFORMATION (Please Print)

Place of Accident	Date of Accident	Time of Accident	Date /Time Employer Notified of Accident

What part of your body was injured? _____

_____

_____

Briefly discuss the cause of injury: _____

_____

_____

Name/address of witness(es): _____

_____

_____

_____

_____

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, written or oral, including, but not limited to, copies of medical records concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician- and psychotherapist-patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original. My signature below also indicates that I have been provided with my rights regarding change-of-physician. (See additional information on back side of form)

Date _____ Signature _____

Assistance with AWCC Form N is available from the AWCC Legal Advisor Division (1-800-250-2511 or 501-682-3930). Information is supplied by the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

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EMPLOYER'S NOTICE TO EMPLOYEE

NOTICE TO EMPLOYEE - Fill out this form to give to your employer immediately. Employer: Be sure the employee receives a copy of this form [Ark. Code Ann. § 11-9--514 (c)]

Ark. Code Ann. § 11-9-701. Notice of injury or death.

(a)(1) Unless an injury either renders the employee physically or mentally unable to do so, or is made known to the employer immediately after it occurs, the employee shall report the injury to the employer on a form prescribed or approved by the Workers' Compensation Commission and to a person or at a place specified by the employer, and the employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's report of injury.

(2) All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements.

(3) The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

(b)(1) Failure to give the notice shall not bar any claim:
(A) If the employer had knowledge of the injury or death;
(B) If the employee had no knowledge that the condition or disease arose out of and in the course of the employment; or
(C) If the commission excuses the failure on the grounds that for some satisfactory reason the notice could not be given.

(2) Objection to failure to give notice must be made at or before the first hearing on the claim.

CHOICE/CHANGE OF PHYSICIAN

Rights and responsibilities. Treatment or services furnished or prescribed by any physician other than the ones selected according to the provisions below, except emergency treatment, shall be at the claimant's/employee's expense.

Ark. Code Ann. § 11-9-508. Medical services and supplies.

"(e). . . [T]he injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions."

1. Your employer shall have the right to select the initial primary care physician from among those associated with certified MCOs.

2. You may request a change-of-physician. You should initially request a change from the insurance carrier or employer. Within five business days of your initial request for a change-of-physician, the insurance carrier or employer should notify you of its decision to grant or deny the change-of-physician.

3. If your request for change of physician is denied you may send a petition to the Clerk of the Arkansas Workers' Compensation Commission for a one (1) time only change-of-physician.

4. **If your employer has contracted with a certified MCO,** you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must also either be associated with the certified MCO chosen by your employer or who is your regular treating physician. (Your "regular treating physician" is one who maintains your medical records and with whom you have a history of regular treatment before the onset of your compensable injury.) The health care provider to whom you change must agree to refer you to the certified MCO chosen by your employer for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by the MCO initially chosen by your employer.

5. **If your employer does not have a contract with a certified MCO,** you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must either be associated with any certified MCO or who is your regular treating physician. (See definition above.) The health care provider to whom you change must agree to refer you to a physician associated with any certified MCO for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by any certified MCO.

Back side / Two-sided form

Date _____ Signature _____

MUNICIPAL EMPLOYEE'S REPORT OF ACCIDENT

Mail to: Municipal League Workers' Compensation Trust

P.O. Box 37

North Little Rock, AR 72115

To be completed by employee:

PERSONAL: Name: _____,_____,_____ Phone: _____ Birth Date:_____
Last First Middle

Address: _____ _____ Marital Status:_____Sex _____
Street City State Zip

EDUCATION: Check highest grade level completed. ☐☐☐☐☐☐☐☐ High School ☐ ☐ ☐ ☐ College ☐☐☐☐
1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4

Vocational Tech_____Other _____

EMPLOYMENT: Present Employer _____ Job Title _____ WagesWk _____

Length of Employment _____ If less than 5 years with present employer, list employers of past 5 Years:

_____

ACCIDENT: Date of Accident _____ Time _____ Place _____

Describe fully how the accident happened _____

_____

Who did you report the accident to? _____ When? _____

_____

Who witnessed the accident? _____

Who is your supervisor? _____

Injury: Nature and location of injury (describe part(s) of body): _____

_____

Name and address of Doctor(s) _____

Who selected Your Doctor? _____ Date of First Visit _____

1st day unable to work: _____ Are you still under doctor's treatment? _____

DISABILITY: How long does your doctor anticipate you will be off? _____

Are your wages continuing? _____ If so, from what source? _____

Regular wages _____ Sick Leave _____ Vacation _____

Have you ever collected compensation for a prior injury? ☐ yes ☐ no

If yes, give details _____

Have you ever had any other condition or injury involving this part of your body prior to this injury?

☐ yes ☐ no. If yes give details _____

_____

_____

Name and Address of Family Physician _____

I _____, received this day, a copy (front and back) of the Arkansas Workers' Compensation Form AR-N.

_____ _____
Employee Signature Date

_____ _____
Witness Witness

Pharmacy First Fill Letter of Intent

Injured Employee:		Employee Social Security Number:	
Employee Phone:		Employee Date of Birth:	
Pharmacy Name:		Pharmacy Phone Number:	

Date of Injury:	
Description of Injury:	

Employer:		State of Jurisdiction:	Arkansas
Employer Rep:		Employer Rep Phone:	

Employer: **Arkansas Municipal League** has selected Preferred Medical to administer the prescription drug program for your injured employee's workers' compensation claim. Please complete the top portion of this Letter of Intent and present it to your injured employee when you receive first notice of the injury. **Please email** intake@thepreferredmedical.com **or fax 502-489-5045 a copy of this letter to Preferred Medical.**

Employee: Please present this Letter of Intent to a participating pharmacy. Preferred Medical provides an extensive network of pharmacies, both large and small and a full list of our network pharmacies are available on our website at www.thepreferredmedical.com. You may also contact Preferred Medical on their toll-free line at **888-586-4650 Option 1** for a list of local participating pharmacies.

This Letter of Intent is to be used for your **initial** medication fills only. This letter will provide your pharmacist electronic access to information regarding your eligibility for workers' compensation Rx benefits.

If your claim is accepted, in approximately ten business days you will receive a permanent Rx card from Preferred Medical.

Use of this Letter of Intent is limited to medications associated with your workers' compensation injury. The payer reserves the right to restrict or suspend the use of your benefits associated with this program at any time.

Pharmacist: Preferred Medical administers this workers' compensation prescription drug program through the ProCare Rx network. For immediate online billing information, contact Preferred Medical at **888-586-4650 Option 1**. *Please Note: You may be required to fax or email a copy of the Letter of Intent to 502-489-5045 for verification purposes.

Pharmacy processing steps:

1. Call Preferred Medical at **888-586-4650 Option 1** to obtain the Member ID Number.
2. Enter BIN number: **023237**
3. Enter Processor Control Number (PCN): **PMN**
4. Group Number: **PREF3000**
5. Enter the Member ID provided by Customer Service.
6. Enter Person Code **01**

Municipal Workers Comp

P.O. Box 37

North Little Rock, AR 72115

amlcomp@arml.org