Clark County Fire Department

Workers Compensation

Quick Reference

August

2016

575 E. Flamingo Road, Las Vegas, NV 89119

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INJURIES

If you are potentially injured at work, you must contact your supervisor and/or Battalion Chief (BC) immediately.

Your supervisor or BC will direct you to the Training website to complete a C-1 form. ***You have seven (7) days counting injury date to complete and submit this form***.

INJURED, BUT MAY NOT NEED TO BE SEEN:

If you do not leave work to see a doctor, you must complete the C-1, located on the Fire Training Information page, within seven (7) days of the injury.

Upon completing the C-1 form, e-mail it to your supervisor/BC. Make sure you keep a copy for yourself.

You have 90 days from injury to determine if you need to be seen.

INJURED AND NEED TO BE SEEN:

Contact the Employee Injury Call Center at (877) 764-3574 unless an emergency.
If you leave work to seek medical care ***you must go to a UMC Quick Care or Concentra Medical Center*** unless the severity of the injury requires emergency treatment. You have 90 days from the date of the injury to seek treatment.

INITIAL CARE TREATMENT CENTERS:

UMC QUICK CARES

Enterprise Quick Care – 1700 Wheeler Peak Drive
Rancho Quick Care – 4231 N. Rancho Drive
Spring Valley Quick Care – 4180 S. Rainbow Blvd, Ste. 810
Sunset Quick Care – 525 Marks St, Henderson
These UMC Quick Cares will be utilized for the first visit ONLY.

UMC HOSPITAL – 1800 W Charleston Blvd

CONCENTRA MEDICAL CENTERS

Henderson – 149 N. Gibson Rd, Ste. H
Las Vegas Paradise – 3900 Paradise Rd, Ste. V
Las Vegas Polaris – 5850 Polaris Ave, Ste. 100 (Open 24 hours)

ALL FOLLOW-UP APPOINTMENTS WILL BE AT:

ENTERPRISE QUICK CARE OR W/C PPO LIST

WHEN SEEN BY PHYSICIAN

Three (3) forms must be completed:

C1 – link located on the Training website home page.

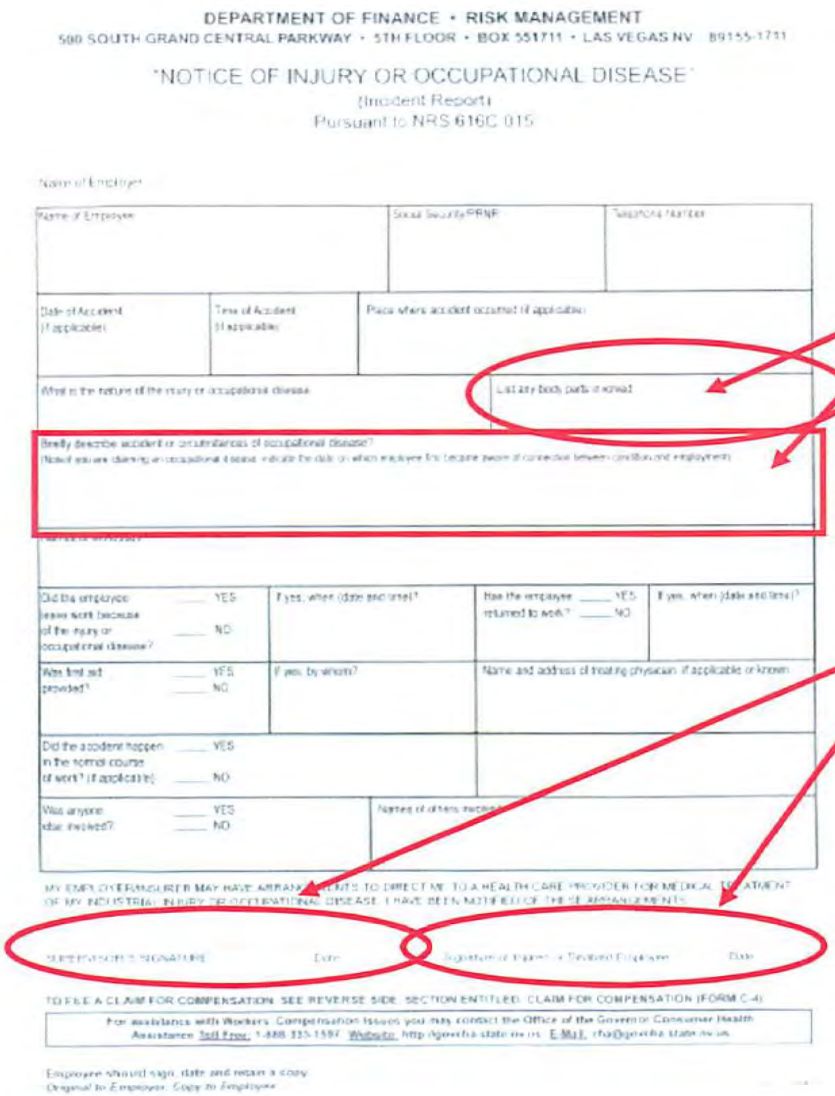
C4 – located at the hospital or Quick Care.

PDS (Physicians Disability Statement) – located at the hospital or Quick Care and also available on link on Training website home page.

1. The attending physician will complete the C-4 and the PDS.

2. Upon completion of all forms, submit or e-mail the forms to your supervisor and/or BC.

3. Make sure you keep a copy for yourself.



DEPARTMENT OF FINANCE • RISK MANAGEMENT

500 SOUTH GRAND CENTRAL PARKWAY • 5TH FLOOR • BOX 551711 • LAS VEGAS NV 89155-1711

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

Briefly describe accident or circumstances of occupational disease?

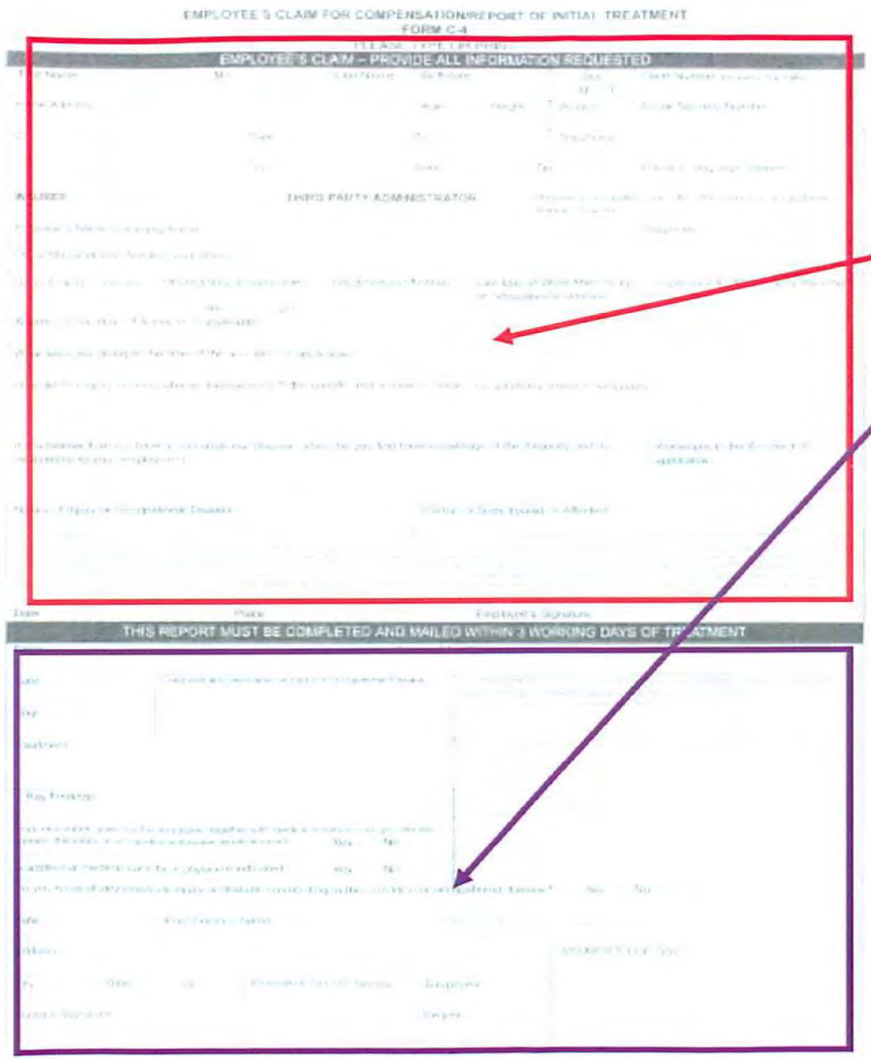
TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED: CLAIM FOR COMPENSATION (FORM C-4)

For assistance with Workers' Compensation issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Website: http://govcha.state.nv.us E-Mail: cha@govcha.state.nv.us

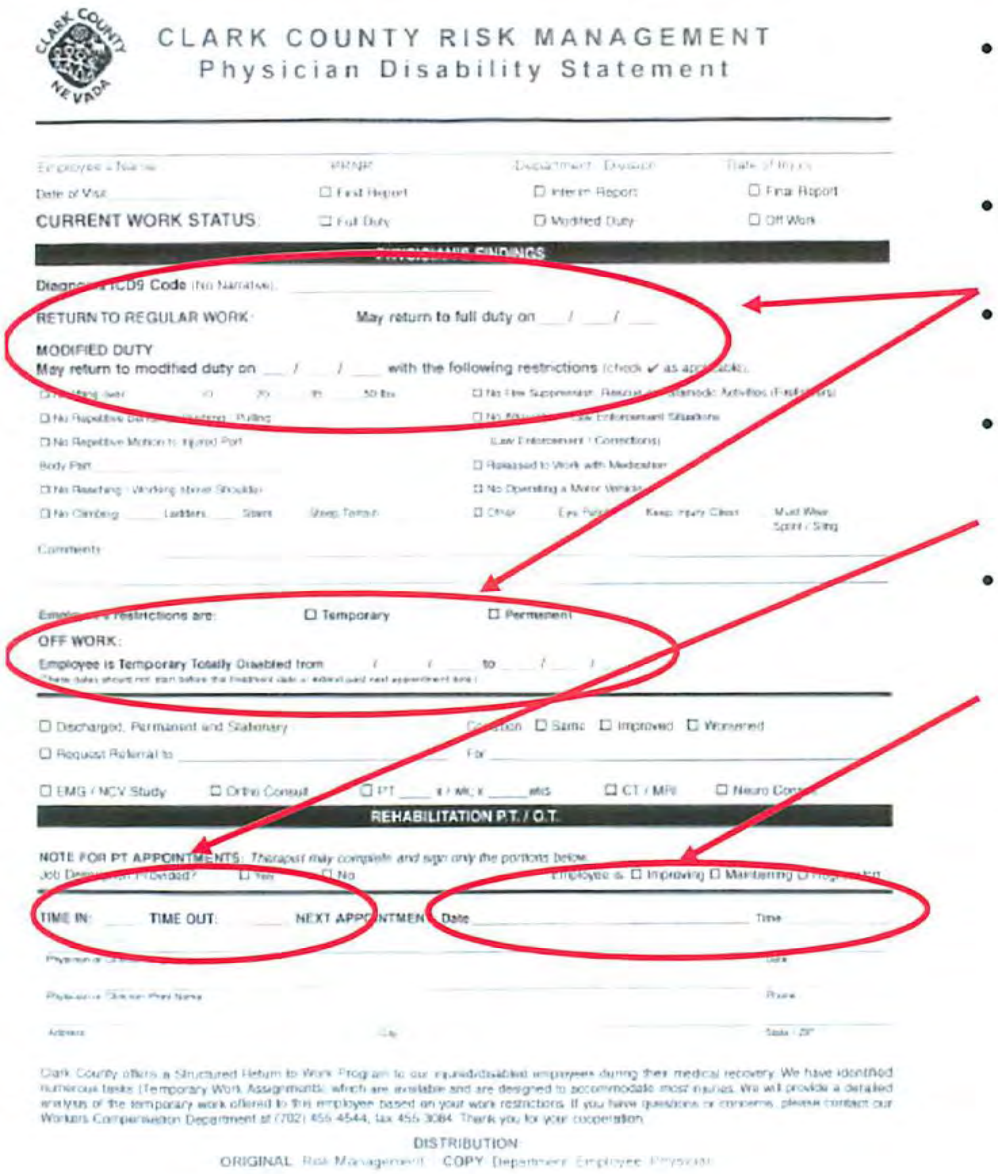
Employee should sign, date and retain a copy.

Original to Employer. Copy to Employee

- The C1
- This must be completed for each injury/exposure, even if you don't go to the Doctor
- Be VERY detailed with the description of the injury and how it occurred
- **Explain the accident: how it happened, where, mechanism, object**
- It must be signed by the employee and his/her supervisor
- Fill out the entire form
- The form must be submitted within seven (7) days of the injury



- The C4
- This is completed ONLY if you go to see a Doctor.
- This form is available at the treating facility and the CCFD training site.
- The treating facility will ask you for the information on the top of the form
- The attending physician will sign the bottom of the form
- **Please be sure there is a *DIAGNOSIS not symptoms*.**



CLARK COUNTY RISK MANAGEMENT
Physician Disability Statement

Date of Visit ☐ First Report ☐ Interim Report ☐ Final Report

CURRENT WORK STATUS: ☐ Full Duty ☐ Modified Duty ☐ Off Work

RETURN TO REGULAR WORK: May return to full duty on ___/___/___

MODIFIED DUTY
May return to modified duty on ___/___/___ with the following restrictions (check ✔ as appropriate)

Comments:

Employee's restrictions are: ☐ Temporary ☐ Permanent

OFF WORK:
Employee is Temporary Totally Disabled from ___/___/___ to ___/___/___

☐ Discharged, Permanent and Stationary

☐ Request Referral to ___ For ___

☐ EMG / NCV Study ☐ Ortho Consult ☐ PT ___ x / wk x ___ wks ☐ CT / MRI ☐ Neuro Consult

REHABILITATION P.T. / O.T.

NOTE FOR PT APPOINTMENTS: *Therapist may complete and sign only the portions below.*

Job Description Provided? ☐ Yes ☐ No Employee is: ☐ Improving ☐ Maintaining ☐ Regressing

TIME IN: ___ TIME OUT: ___ NEXT APPOINTMENT: Date ___ Time ___

Physician's Signature ___ Date ___

Physician's Printed Name ___ Phone ___

Address ___ City ___ State / ZIP ___

Clark County offers a Structured Return to Work Program to our injured/disabled employees during their medical recovery. We have identified numerous tasks (Temporary Work Assignments), which are available and are designed to accommodate most injuries. We will provide a detailed analysis of the temporary work offered to this employee based on your work restrictions. If you have questions or concerns, please contact our Workers Compensation Department at (702) 455-4544, fax 455-3084. Thank you for your cooperation.

DISTRIBUTION
ORIGINAL: Risk Management/IL COPY: Department/ Employee/ Physician

- It MUST indicate if you are FULL duty, MODIFIED duty, or OFF WORK
- It must indicate a TIME IN and TIME OUT
- It must indicate date and time of next appointment
- *If these items are missing, you will have to go back and have them filled in*
- Upon completion of all forms, submit to your supervisor and/or BC. Make sure you keep a copy for yourself.

AFTER SEEING THE PHYSICIAN

The attending physician will complete the PDS and determine what work status applies to your injury.

The work status categories are:

Modified Duty

Off Work

Full Duty

MODIFIED DUTY

If you are released to modified duty, you will notify your supervisor/BC of your status and report to Fire Station 18 the day you are released. If you are released to modified duty on a Saturday or Sunday, you will go home and report to Fire Station 18 on Monday at 08:00.

NOTE: If the modified duty date is not a normal shift date (such as a 6-day), you will still report to Fire Station 18 on the day you are released to modified duty.

Arrive at Fire Station 18 in Class B uniform with the PDS, C-1 and C-4 forms.

OFF WORK

If the injured employee is placed in "Off Work" status they need to:

1. Contact their supervisor/BC immediately.
2. Forward their PDS and C-4 to their supervisor/BC immediately.

FULL DUTY

If the employee is returned to full duty on their actual duty day, they need to contact their supervisor/BC immediately and report for duty.

If the employee is returned to full duty on their off day, they will report to duty the first shift back.

Daily Health Newsletter for Firefighter Health Week

Skin Cancer Paperwork Part I

C-1 form information:
Please fill in all areas to the best of your ability.

If there is a blank enter N/A.

Call Adele at (455-7376) with any questions.

Below are some areas on the C1 form that often have questions:

Date of injury: This is the first date that you were seen for skin cancer; e.g. January 10th. (Please see timeline and filling in forms example to the right.)

Briefly describe accident: Incident date, employee awareness - this is the date of knowledge (e.g. January 18th). You also need to describe how it happened or what increased your risk. You may wish to include contributing factors, i.e. how long you were a firefighter or what you were exposed to such as carcinogens, diesel fuel, and sun during FF duties.

Example:

On January 18th, Dr. X informed me I have skin cancer. My first appointment was on January 10th. As a firefighter for the last 27 years, I have been exposed to carcinogens and the sun while on scene. This is what I believe contributed to my skin cancer.

(You must state what you believe contributed to your skin cancer.)

If you are diagnosed with skin cancer, it is a worker's compensation claim and should be covered.

The agreement between Risk Management and 1908 is that claims with correct paperwork will be accepted. You need to go to Risk Management on your own time.

<u>Incident Timeline</u>

January 1 - you and your doctor (optometrist, GYN, dentist, etc.) see something odd and you are referred to a specialist for further diagnosis.

January 10 – the specialist sends you for a biopsy.

January 18 – the specialist goes over the results and informs you that you have skin cancer or basal cell carcinoma, etc.

January 25 – follow-up appointment for more treatment.

<u>When to Fill In Forms</u>

January 1 – you do nothing because at this point you know nothing. This is not the physician who will be addressing the issue.

January 10 – you still do nothing. You do not know the results of the biopsy. Remember this date; it is the first appointment to deal with the issue.

January 18 – this is the most important date. This is the date you have KNOWLEDGE. Fill out the C-1 form within 7 days of this appointment.

January 25 – have physician fill out the C-4 and PDS forms.

C1 FORM EXAMPLE FOR DISEASE

DEPARTMENT OF FINANCE • RISK MANAGEMENT
500 SOUTH GRAND CENTRAL PARKWAY • 5TH FLOOR • BOX 551711 • LAS VEGAS NV 89155-1711

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)
Pursuant to NRS 616C.015

Skin Cancer Sample

Name of Employer SAMPLE ***Remember skin cancer appointments are on YOUR time***

Name of Employee	Social Security/PRNR	Telephone Number

Date of Accident (if applicable)	Time of Accident (if applicable) ☐ am ☐ pm	Place where accident occurred (if applicable)
		The date of accident is the date of the FIRST APPT. for diagnosis.

What is the nature of the injury or occupational disease:	List any body parts involved:
Skin cancer; basal cell carcinoma etc.	Skin not ear nose etc.

Briefly describe accident or circumstances of occupational disease?
(Note:if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)

1. Describe what you feel contributed to skin cancer. This may include how long you were a firefighter and/or exposure to carcinogens etc.
2. The day you had KNOWLEDGE you had cancer AND its relationship to your employment. This is often they day they said it IS cancer.

Please remember the C1 must be fill-in and signed within 7 days of knowledge.

Names of witnesses:

Did the employee leave work because of the injury or occupational disease?	If yes, when (date and time)?	Has the employee returned to work?	If yes, when (date and time)?
☐ YES ☑ NO	Date / Time ☐ am ☐ pm	☑ YES ☐ NO	Date / Time ☐ am ☐ pm

Was first aid provided?	If yes, by whom?	Name and address of treating physician, if applicable or known
☐ YES ☑ NO		

Did the accident happen in the normal course of work? (if applicable)	
☑ YES ☐ NO	

Was anyone else involved?	Names of others involved
☐ YES ☐ NO	

MY EMPLOYER/INSURER MAY HAVE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature Date

Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Website: http://govcha.state.nv.us E-Mail: cha@govcha.state.nv.us

Employee should sign, date and retain a copy.
Original to Employer, Copy to Employee

C-1 (Rev. 10/08)

Daily Health Newsletter for Firefighter Health Week

Skin Cancer Paperwork Part II

C-4 form information:

You have 90-days from the date of KNOWLEDGE (January 18th, in the example provided to the right) of an occupational disease or injury, to file the C-4 form. The C-4 is the legal form that starts a claim in the State of Nevada.

Your physician should have the C-4 form in their office, but if they do not, you will find it on the Training Centers' website.

Filling in the C-4 form for a disease is a bit different than filling it in for an injury.

On the example form, located on the next page, a box is highlighted with the word "date". That is the date you first went to the physician. The claims adjuster uses that date to pay the bills.

For this example it would be January 10th. Any appointments prior to the date listed will be denied.

For questions please contact Adele at 455-7376.

If you are diagnosed with skin cancer, it is a worker's compensation claim and should be covered.

<u>Incident Timeline</u>

January 1 - you and your doctor (optometrist, GYN, dentist, etc.) see something odd and you are referred to a specialist for further diagnosis.

January 10 – the specialist sends you for a biopsy.

January 18 – the specialist goes over the results and informs you that you have skin cancer or basal cell carcinoma, etc.

January 25 – follow-up appointment for more treatment.

The agreement between Risk Management and 1908 is claims that are completed correctly will be accepted.

You need to go to Risk Management on your own time.

<u>When to Fill In Forms</u>

January 1 – you do nothing because at this point you know nothing. This is not the physician who will be addressing the issue.

January 10 – you still do nothing. You do not know the results of the biopsy. Remember this date; it is the first appointment to deal with the issue.

January 18 – this is the most important date. This is the date you have KNOWLEDGE. Fill out the C1 form within 7 days of this appointment.

January 25 – have the physician fill out the C4 and PDS forms.

C4 FORM EXAMPLE FOR DISEASE

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

First Name	M.I.	Last Name	Birthdate	Sex ☐ M ☐ F	Claim Number (Insurer's Use Only)
Home Address			Age / Height	Weight	Social Security Number
City	State	Zip		Telephone	
Mailing Address	City	State	Zip		Primary Language Spoken

INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred
Employer's Name/Company Name		Telephone
Office Mail Address (Number and Street)		

Date of Injury (if applicable)	Hours Injury (if applicable)	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
N/A Jan 10th	am pm	Date you complete the C-1 form Jan 18th		

Address or Location of Accident (if applicable)

What were you doing at the time of the accident? (if applicable)

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?
This is the date the doctor advised you had cancer. Jan 18th

Witnesses to the Accident (if applicable)

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER, OR OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

Date Place Employee's Signature

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place Name of Facility

Date This is the date you first sought medical care Jan 10th / Hour	Diagnosis and Description of Injury or Occupational Disease	Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? ☐ No ☐ Yes (if yes, please explain)
Treatment:		Have you advised the patient to remain off work five days or more? ☐ Yes Indicate dates: from _____ to _____ ☐ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty If modified duty, specify any limitations/restrictions: _____
X-Ray Findings:		
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☐ Yes ☐ No		
Is additional medical care by a physician indicated? ☐ Yes ☐ No		

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ No (Explain if yes)

Date	Print Doctor's Name	I certify that the employer's copy of this form was mailed to the employer on:
Address		INSURER'S USE ONLY
City State Zip	Provider's Tax I.D. Number	Telephone
Doctor's Signature		Degree

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev.10/07)

HEARING CLAIMS

Clark County Fire Department, Clark County Risk Management and UMC Enterprise Physicals have collaborated to improve the hearing test process.

If on your annual physical it is found that you have a “Significant Change” in your hearing you will be referred to an audiologist.

Significant Change: Standard Threshold Shift (STS) is a change of more than 10dB in the average thresholds of 2000, 3000, and 4000 in Hz.

When to file a claim: if you are informed that you have industrial hearing loss you have the right ***(it is recommended)*** to file a worker's comp claim.

Filling in the C1 form: this is very similar to how disease forms are filled in.

HOW TO FILL IN A C1 FORM FOR HEARING LOSS

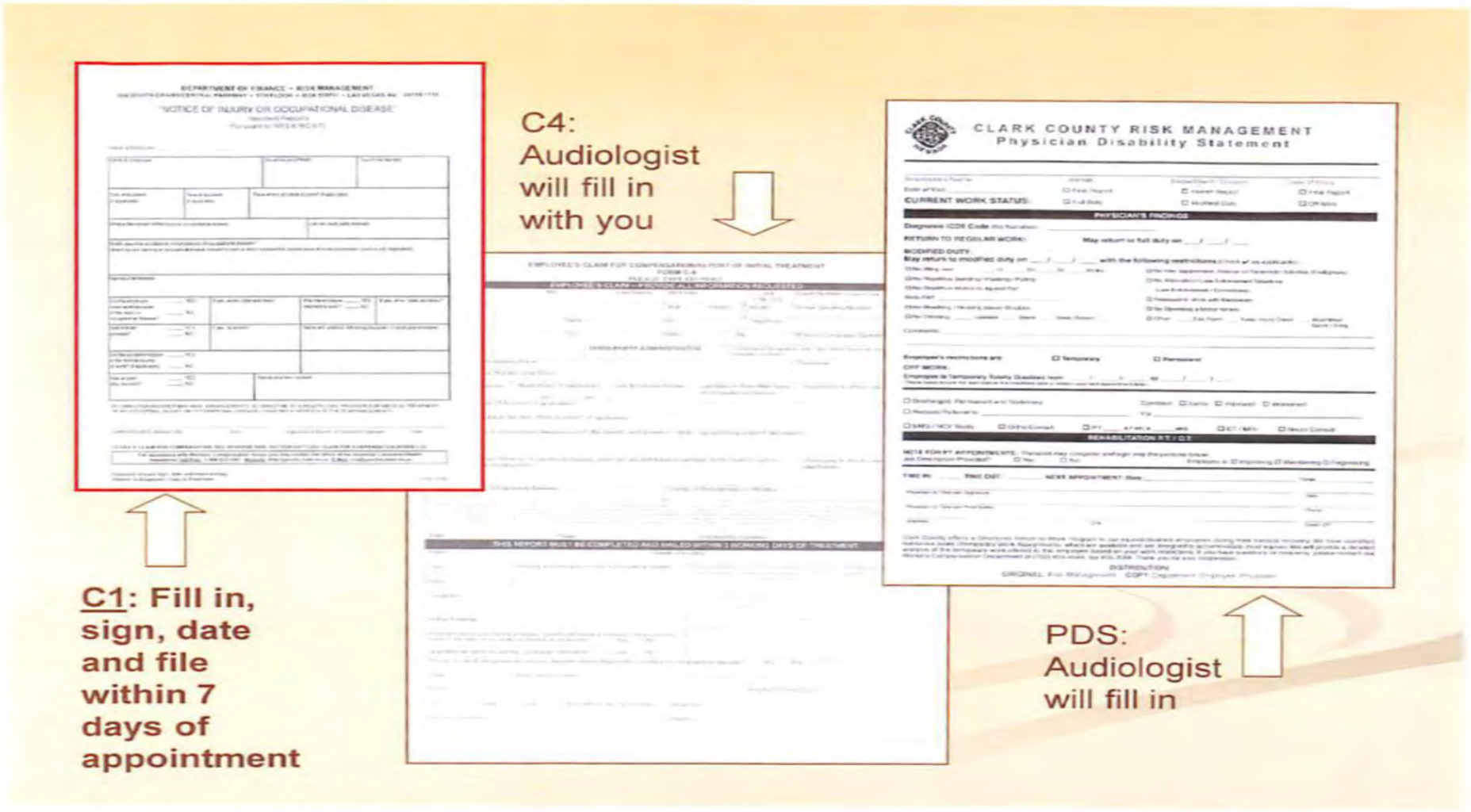
Date of injury: N/A

Briefly describe: you need to put what you feel contributed to your hearing loss, i.e. exposure to loud noise, sirens, the number of years as a firefighter, e.g. “I was advised by (name of audiologist) I have industrial hearing loss”.

Be sure you fill in date and sign within 7 days of the physician telling you that you have industrial hearing loss due to being a firefighter and that it shows an STS>10. (Please see examples on next page.)

If you have any questions please contact CCFD nurse at 455-7309 or Sandra Swickard 455-5524

HEARING LOSS FORMS



HEART AND LUNG

PURPOSE:

The purpose is to help explain the benefits available to you under the “Heart and Lung Bill”, along with the process and responsibilities of the parties involved. This benefit is governed by Chapter 617 of the Nevada Revised Statutes and Nevada Administrative Code.

These laws and regulations are for police officers, firefighters, and arson investigators (as defined by the NRS) who develop:

Heart or lung disease after five (5) years of full-time continuous uninterrupted salaried service in Nevada to a conclusive presumption that the disease is work-related, provided that the employee submits to required physical examinations and tests and takes action to correct predisposing conditions that lead to these diseases when ordered to do so by the examining physician.

ANNUAL HEART AND LUNG PHYSICAL EXAMINATIONS

EMPLOYER RESPONSIBILITIES

NAC 617 requires employers to provide, schedule and pay for physical examinations and tests related to the heart and lung. The heart and lung benefit is for employees who are covered under this statute.

Employers are also required to discuss with the employee any warning from the examining physician indicating that the employee has a predisposition to the contraction of a disease of the heart or lungs. This will be communicated to the employee in the form of a letter or email which reiterates the medical conditions identified by the physician requiring corrective steps to be taken and outlines the requirements of the employee.

EMPLOYEE RESPONSIBILITIES

NAC 617 requires employees to submit to the physical examinations and tests related to the heart and lung benefits at the time scheduled by the employer unless a reasonable excuse for missing the scheduled examination is provided to Risk Management. Missing your annual examination may exclude you from benefits.

The Collective Bargaining Agreement, Article 14, states that these examinations must be completed upon employment and every year thereafter. Examinations must be completed within a 30 day time frame around your birth month (the month prior to your birth month, your birth month, or the month after your birth month).

You will receive an email from the nurse when it is time to schedule your appointments. The email will include instructions on scheduling these examinations (how, when, where, etc.) along with access to the paperwork and forms required for them. Please print out the paperwork and take it with you to your first appointment.

PHYSICIAN RESPONSIBILITIES

NAC 617 requires physicians to complete the forms as prescribed by the Division of Industrial Relations and provide the employer and the employee with a copy of these forms. Please be sure to get a copy of your examination packet at the completion of your second visit.

ABNORMAL RESULTS OR FALSE POSITIVE

During your examination, you may have what the physician describes as an abnormal result. In these cases, the physician may recommend that you obtain further testing to determine if these results are a false positive, if the results are normal, or if you have a condition that warrants filing a workers' compensation claim.

If you are currently eligible for benefits under NRS 617, the County will pay for additional testing relating to the heart and lung to determine the reason for the abnormal result. NOTE: in order for the additional testing to be paid by the County, the testing must be pre-approved by Risk Management.

RISK FACTORS IDENTIFIED BY THE PHYSICIAN

The physician will review the results of these examinations and tests with you during your second office visit. During this review the physician will go over any potential risk factors that you may have which could lead to heart or lung disease.

Per NRS 617.455 and NRS 617.457, "…failure to correct predisposing conditions which lead to (heart or lung) disease when so ordered in writing by the examining physician after the annual examinations excludes the employee from the benefits of this section if the correction is within the ability of the employee."

Please document your compliance with the physician's order in the event you do have to file a related workers' compensation claim in the future. The inability to provide such documentation, if asked to do so, will be viewed as non-compliance with the physician's orders and may cause you to lose your benefits under the heart and lung statutes. If you receive additional documentation that you would like to include in your CCFD physical file, you may send a copy to the Infection Control Nurse. (Please retain the original for your personal records.)

FILING A WORKERS COMP CLAIM UNDER HEART AND LUNG BILL

WHEN TO COMPLETE A CLAIM

If there is an indication that you may have heart or lung disease, you may file a claim under workers' compensation. This may become apparent during your heart and lung exam (annual physical) or you may have symptoms outside of the examination room that require treatment or diagnosis.

If you have reason to believe that you may have heart or lung disease, notify your supervisor immediately. Your supervisor will give you a workers' compensation packet or direct you to the CCFD Training site which will contain the forms and guidelines on how to file a claim.

C-1 NOTICE OF INJURY OR OCCUPATIONAL DISEASE

This is to be filled in within 7 days of knowledge of the disease. The supervisor may fill it in if the employee is incapable.

FILLING IN THE C-1 FORM WHERE IT STATES

- Date of accident: please put the first date you sought treatment for the heart/lung disease.

- Briefly describe accident or circumstances: please put what you felt contributed to your developing heart/lung disease ***AND*** the date you had knowledge of the disease and its relation to your employment.

C-4 EMPLOYEE'S CLAIM FOR COMPENSATION/ REPORT OF INITIAL TREATMENT

You and your physician will be responsible for completing the Employee's Claim for Compensation/ Report of Initial Treatment (C-4). Physicians should have the forms at their office or they can download the form from the Division of Industrial Relations website. If you wish to file a workers' compensation claim, you must have this form completed and submit it to Risk Management.

FILLING IN THE C-4 FORM WHERE IT STATES

- Date of Injury: please put the first date you sought treatment for the heart/ lung disease.

- How did this injury occur: please put what you felt contributed to your developing heart/lung disease.

- If you believe that you have…. When did you first…: please put the date you first had knowledge of the disease and its relation to your employment.

WORKERS COMP CLAIM PROCESS

CLAIM REVIEW AND INVESTIGATION

Once the C-1 and C-4 forms are received by Risk Management, the claims process will begin. CCFD will provide all relevant documentation to Risk Management. This may include copies of your annual examinations. A claims representative will be assigned to your claim and will be responsible for reviewing your claim and managing your care.

Your claims representative will contact you to review your claim, discuss corrective actions you have taken to correct predisposing conditions (if applicable), and discuss your treatment.

CLAIM DETERMINATION

Risk Management will send you a letter indicating whether your injury or disease has been accepted or denied as an industrial claim. This determination will be made within 30 working days of their receipt of a completed C-4 form from your treating physician.

If Risk Management requires further information to make the final claim determination, your claim may be denied pending completion of the medical and factual investigation. This is not always the case, but can happen when a claim is complicated or detailed; (e.g. there is a delay in receiving information or medical records from the physician or further medical testing is needed to determine the final diagnosis or cause of the illness). This is why it is best to start the form when there is a diagnosis (see how to fill in forms, for further information). In the event the claim is denied pending completion of the medical and factual investigation, Risk Management will continue to gather information until a new determination can be made.

WHO PAYS THE BILLS FOR A WORKERS COMPENSATION CLAIM

ACCEPTED CLAIM

Direct all your treating physicians, hospitals, and other providers to send their billings and reports to Clark County Risk Management. Risk Management is responsible for payment of all authorized medical bills resulting from treatment on accepted claims for occupational disease.

CLAIMS DENIED PENDING MEDICAL INVESTIGATION

NRS allows 30 days to approve or deny medical bills and 30 days from the date of the approval to process the payment. If your claim determination has not been made prior to the deadlines provided under the statutes, your bills should be submitted to the claims administrator handling your workers compensation case until the final determination is rendered.

If you receive a bill from a provider, please forward it to Risk Management and the Claims Administrator. Please note: if these bills have not yet been submitted to Risk Management and your claim is later denied, please refer to the denied claims section below.

DENIED CLAIMS

If your claim has been denied, you will receive a letter from the Claims Administrator with this information. Contact a member of the Local 1908 Worker's Compensation Committee for further assistance in addressing denied claims.

WORK TIME

TIME CODING

Any time taken for treatment appointments during regularly scheduled work days (including travel time up to the time stated in Article 21 of the CBA) and time you have taken "off work" by the physicians request will be coded to **"WC" (time off work due to an industrial injury**) in TeleStaff. You will not be reimbursed or compensated for appointments which occur during non-working hours. If you are given restrictions from the physician, your modified duty time should be charged to **"WCM"** (**worked hours under modified/restricted duty**). You have the option to deny modified duty and use sick time but you must sign paperwork with payroll in order to deny a modified duty assignment. Employees on temporary modified duty will not be eligible for overtime or callback. If your claim is denied under workers' compensation, any time charged to WC for this incident will be re-coded by Central Time and charged to the employee's sick time.

> **An employee *will not be paid* workers' compensation hours for staying home from work without the treating physician providing documentation that they should do so. If the treating physician does not provide such documentation, the time off will be charged to the employee's sick time.**

A PHYSICIANS DISABILITY STATEMENT (PDS)

A Physician's Disability Statement is required for every physician/specialist visit. Please have the physician's office indicate the time you arrived for your appointment and the time you left the office. If your visit and travel time occur during regular work hours, your time will be coded to WC for the time spent at the office and travel time to and from the office up to the time allowed in Article 21 of the CBA. Time coded to workers compensation will be coded as FMLA up to the allowable number of hours on a rolling 12 month calendar (480 hours for 8 and 10 hour employees and 672 for 24 hour employees).

When placed on modified duty by your treating physician, you must contact Irene Davidson or Chief Blackmon at 702-455-7311 to determine when you must report. If they are unavailable, report to Fire Station 18 on the next business day at 08:00. You will receive your modified duty assignment at that time within the restrictions of your modified duty release.

BENEFITS AFTER RETIREMENT OR SEPARATION FROM CLARK COUNTY FIRE DEPARTMENT

Some benefits under the Heart and Lung Bill may be available to you even after you leave your employment at CCFD. Although you will not receive employer-paid physicals, we encourage you to continue following up with your primary care physician on an annual basis to maintain optimal health. In the event you do develop heart or lung disease you may file a workers compensation claim with Clark County. This benefit is available to prior employees who completed five (5) years of full-time continuous uninterrupted salaried service in Nevada as a police officer, firefighter, or arson investigator (as defined by the NRS) and develop heart or lung disease after that time regardless of whether you remain employed with the County.

Should you leave CCFD and obtain employment with another Nevada employer in a position that is covered under the Heart and Lung Bill, you would file any heart or lung claim with your new employer once you have met the statutory five years of full continuous service with your new employer. If you have not met the statutory timeframe, you should file your claim with Clark County.

RESOURCES AND LINKS

DIABETES
www.diabetes.org

WEIGHT MANAGEMENT
www.nutrition.gov
www.choosemyplate.gov

CONTROLLING YOUR CHOLESTEROL
www.americanheart.org

SMOKING CESSATION
www.lungusa.org
www.livingtobaccofree.com

OTHER HEALTH INFORMATION
www.healthfinder.gov
www.ama-assn.org/ama/pub/patients/patients.page
www.nhlbi.nih.gov/health
www.heart.org/MyLifeCheck

NEVADA REVISED STATUE 617
www.leg.state.nv.us/nrs/NRS-617.html

NEVADA ADMINISTRATIVE CODE 617
www.leg.state.nv.us/NAC/NAC-617.html

DISCLAIMER

The benefits for heart and lung disease and employee/ employer responsibilities are established by Nevada law and are set forth in Chapters 617 of the Nevada Revised Statutes and the Nevada Administrative Code, both of which may be amended from time to time. This education provides an overview of those benefits and responsibilities and the related procedures used by the County. It does not address all the relevant provisions of Nevada law. Each case is different, and the employee is responsible for managing his/her case and claim.

The benefits, responsibilities, and procedures included in this education are current as of the date indicated. Nevada law is subject to change, and the County may modify its procedures at its discretion. This handbook does not create any contractual or other right to the benefits, responsibilities, or procedures set forth herein. In the event of any conflict between Nevada law and the contents of this education, Nevada law will apply.