



Workers' Compensation

We Are
Here To
Support You!

Be Involved!
Be Proactive!
Ask Questions!

Coming soon



Administrative Policy 3-23
City of Houston
Workers' Compensation Program

*Which will replace the
Executive Oder 1-33 Workability Guidelines*

What Is Workers' Compensation?

Workers' Compensation is a state-regulated insurance program that provides you with income and medical benefits after you've sustained a work-related injury or illness. Workers' Compensation pays your medical bills and replaces a portion of your lost wages.

Workers' Compensation Partners



P.O. Box 2805
Clinton, Iowa 52733-2805
Office #: 832 -710-4444
Fax #: 832-710-4440

The City's Third Party Administrator (TPA) investigates and administers the City's workers' compensation claims.

The TPA utilizes other partners to review medical bills for compliance and payment as well as other cost containment functions.



Employee Rights

- Right to initial choice of doctor
- Right to receive reasonable and necessary medical care to treat work-related injury or illness
- Right to receive income benefits
- Right to confidentiality
- Right to receive a copy of the entire Supervisor Accident Packet
- Right to Office of Injured Employee Council services
- Right to hire an attorney to help get benefits or resolve disputes
- Right to judicial review of disputed claims

Employee Responsibilities

State

- Tell employer about injury or occupational disease
- Complete & send Employee's Claim for Compensation for a Work-Related Injury or Occupational Disease form to Division of Workers' Compensation
- Tell Division of Workers' Compensation and the City's Third Party Administrator whenever income or employment changes
- Tell Division of Workers' Compensation and the City's Third Party Administrator whenever address changes

City of Houston

- Must be available daily to receive phone calls from DDR, Supervisor, Workers' Compensation Coordinator or adjuster. And also home visits with 24 hour notice
- Notify Supervisor about injury or occupational disease
- Complete Supervisor Accident Packet
- If medical treatment is required, it must be with a doctor that accepts Workers' Compensation
- Must notify the DDR and/or Supervisor of any changes in work status.
- Refer to E.O. 1-33 for complete list of responsibilities.

We Can Help

DESIGNATED DEPARTMENT REPRESENTATIVE (DDR)

Individual(s) appointed by each department head to coordinate Workers' Compensation and related procedures for the department. The DDR interacts with the Workers' Compensation Coordinator and adjuster.

CLAIMS COORDINATOR

A representative of the HR Workers' Compensation Division. They are responsible for the coordination of salary continuation benefits for our recovering employee

WORKERS' COMPENSATION COORDINATOR

The Workers' Compensation Coordinator is a licensed adjuster who is an advocate for the injured employee on behalf of the COH and interacts with the department representative and adjuster.

ADJUSTER / EXAMINER

An employee of the Third Party Administrator (Tristar Risk Mgmt.) who investigates and adjudicates workers' compensation claims. The adjuster also initiates payments to recovering employees and health care providers in compliance with the law

What Type of Benefits Can You Receive?

Medical

Salary Continuation (Paid by City)

Workers' Comp Payment (Paid by City)

Income (Paid by Adjuster / Examiner)

Medical Treatment

Types of treatment commonly covered under Workers' Compensation

Office Visits

Prescriptions

Diagnostics (i.e. X-Rays, MRIs)

Therapy (Physical, Occupational)

Surgery

Pain Management

These may require Pre-Authorization

Select A Treating Doctor...

It's Your Choice!

A Treating Doctor is an individual, group or facility licensed to practice medicine in Texas, accepts workers' compensation and is chosen by the recovering employee to direct his medical treatment.

An emergency room doctor would not be considered your first choice of treating doctor.

A doctor recommended by your employer is also not considered your first choice of treating doctor.



Texas Department of Insurance
 Division of Workers' Compensation
 7561 Metro Center Drive, Suite 100 • MS-84
 Austin, TX 78744-1645
 (800) 252-7031 phone • (512) 804-4378 fax

DWC053

Complete if known:

DWC Claim #

Carrier Claim #

Employee Request to Change Treating Doctor

For use ONLY by Employees NOT in Workers' Compensation Health Care Networks or Certain Political Subdivision Health Care Plans
 Type (or print in black ink) each item on this form

I. EMPLOYEE/EMPLOYEE'S ATTORNEY INFORMATION

1. Employee's Name (First, Middle, Last)		2. Employee's Social Security Number	
3. Employee's Mailing Address (Street or PO Box, City, State, Zip Code)			
4. Employee's Telephone Number	5. Alternate Telephone Number (if available)	6. Date of Injury (mm/dd/yyyy)	
7. Attorney/Representative's Name (if applicable)		8. Attorney/Representative's Address (Street or PO Box, City, State, Zip Code)	

II. EMPLOYER INFORMATION (at the time of the Injury)

9. Employer's Name	10. Employer's Address (Street or PO Box, City, State, Zip Code)
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III. INSURANCE CARRIER INFORMATION

11. Insurance Carrier's Name		12. Insurance Carrier's Address (Street or PO Box, City, State, Zip Code)	
13. Adjuster's Name	14. Adjuster's Telephone Number ext.	15. Adjuster's Fax Number	

IV. TREATING DOCTOR INFORMATION

Current Treating Doctor			
16. Current Treating Doctor's Name (First, Middle, Last) and Title (MD, DO, DC, etc.)		17. Current Treating Doctor's Telephone Number ext.	
18. Current Treating Doctor's Mailing Address (Street or P.O. Box, City, State, Zip Code)			
19. Current Treating Doctor's License Number (if known)		20. Current Treating Doctor's Fax Number	

Reason for Requesting a Change of Treating Doctor

21. Explain Why You Are Requesting to Change Your Treating Doctor (Attach additional sheets if necessary.)

Requested Treating Doctor			
22. Requested Treating Doctor's Name (First, Middle, Last) and Title (MD, DO, DC, etc.)		23. Requested Treating Doctor's Telephone Number ext.	
24. Requested Treating Doctor's License Number		25. Requested Treating Doctor's Fax Number	
26. Requested Treating Doctor's Mailing Address (Street or P.O. Box, City, State, Zip Code)			
27. Requested Treating Doctor's Signature (required)		28. Date (mm/dd/yyyy)	

V. EMPLOYEE'S AUTHORIZATION TO CHANGE TREATING DOCTORS AND RELEASE MEDICAL RECORDS

By signing this form I confirm that I wish to change my treating doctor, and I authorize my current treating doctor to furnish records pertaining to my workers' compensation claim to the requested treating doctor.		For TDI-DWC Use Only	
29. Employee's Signature (required)			
30. Date			

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).



How to Change Your Treating Doctor – DWC 53

In the event you want to change Treating Doctor, submit this form to the Division of Workers' Compensation.

Your adjuster can also help answer questions.

Texas Workers' Compensation Work Status Report (DWC-73)

The Texas Workers' Compensation Work Status Report (DWC-73) is required by the Adjuster to maintain Income Benefit Payments and it is required by the City to maintain your current work ability.

The DWC-73 must be delivered, to you, by the Treating Doctor at the time of your examination.

**Before leaving the physician's office
always verify that your work status and treatment
information is documented on this form.**

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)252-7131.

Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos e monetarios. Para mayor información comuníquese con el oficina local de la División al teléfono 1-800-252-7131.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

1. Injured Employee's Name
 2. Date of Injury
 3. Social Security Number (last 4)
 4. Employee's Description of Injury/Accident

5. Doctor's Name and Degree (for transmission purposes only) Date Being Sent
 6. Clinic/Facility Name
 7. Clinic/Facility/Doctor Phone & Fax
 8. Clinic/Facility/Doctor Address (street address)
 City State Zip

9. Employer's Name
 10. Employer's Fax # or Email Address (if known)
 11. Insurance Carrier
 12. Carrier's Fax # or Email Address (if known)

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(a) AS APPLICABLE)

13. The injured employee's medical condition resulting from the workers' compensation injury:
 (a) will allow the employee to return to work as of _____ (date) without restrictions.
 (b) will allow the employee to return to work as of _____ (date) with the restrictions identified in PART III, which are expected to last through _____ (date).
 (c) has prevented and still prevents the employee from returning to work as of _____ (date) and is expected to continue through _____ (date).
 The following describes how this injury prevents the employee from returning to work:

PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):		17. MOTION RESTRICTIONS (if any):		19. MISC. RESTRICTIONS (if any):	
Max Hours per day: 0 2 4 6 8	Other	Max Hours per day: 0 2 4 6 8	Other	<input type="checkbox"/> Max hours per day of work:	
Standing <input type="checkbox"/>		Walking <input type="checkbox"/>		<input type="checkbox"/> Sit/Stretch breaks of _____ per _____	
Sitting <input type="checkbox"/>		Climbing stairs/ladders <input type="checkbox"/>		<input type="checkbox"/> Must wear splint/cast at work	
Kneeling/Squatting <input type="checkbox"/>		Grasping/Squeezing <input type="checkbox"/>		<input type="checkbox"/> Must use crutches at all times	
Bending/Stooping <input type="checkbox"/>		Wrist flexion/extension <input type="checkbox"/>		<input type="checkbox"/> No driving/operating heavy equipment	
Pushing/Pulling <input type="checkbox"/>		Reaching <input type="checkbox"/>		<input type="checkbox"/> Can only drive automatic transmission	
Twisting <input type="checkbox"/>		Overhead Reaching <input type="checkbox"/>		<input type="checkbox"/> No work / _____ hours/day work: <input type="checkbox"/> In extreme hot/cold environments <input type="checkbox"/> At heights or on scaffolding	
Other: <input type="checkbox"/>		Keyboarding <input type="checkbox"/>		<input type="checkbox"/> Must keep _____ elevated <input type="checkbox"/> Clean & dry	
15. RESTRICTIONS SPECIFIC TO (if applicable):		18. LIFT/CARRY RESTRICTIONS (if any):		20. MEDICATION RESTRICTIONS (if any):	
<input type="checkbox"/> Left Hand/Wrist	<input type="checkbox"/> Left Leg	<input type="checkbox"/> May not lift/carry objects more than _____ lbs. for more than _____ hours per day		<input type="checkbox"/> Must take prescription medication(s)	
<input type="checkbox"/> Right Hand/Wrist	<input type="checkbox"/> Right Leg	<input type="checkbox"/> May not perform any lifting/carrying		<input type="checkbox"/> Advised to take over-the-counter meds	
<input type="checkbox"/> Left Arm	<input type="checkbox"/> Back			<input type="checkbox"/> Medication may make drowsy (possible safety/driving issues)	
<input type="checkbox"/> Right Arm	<input type="checkbox"/> Left Foot/Ankle				
<input type="checkbox"/> Neck	<input type="checkbox"/> Right Foot/Ankle				
Other: _____		Other: _____			
16. OTHER RESTRICTIONS (if any):					
* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.					

Part I: General Information

Part II: Work Status Information

Part III: Activity Restrictions

Part IV: Treatment/ Follow-Up Appointment Information

Employee Request for Travel Authorization

A recovering employee must follow the procedure below to obtain authorization for travel when recovering medical treatment.

- Obtain an authorization form from your DDR. You must have your treating physician complete the form stating that travel will not negatively impact the recovering employee's medical recovery or cause you to miss scheduled appointments.
- Provide the completed authorization form to the Workers' Compensation Coordinator, DDR and TPA.
- Obtain final written authorization from the DDR a minimum of (10) days prior to travel unless the travel is deemed an emergency by the DDR.

What Is Pre-Authorization?

By State Law, Preauthorization is required at a minimum for the items listed below and is processed through Injury Management Organization (IMO). IMO has **3 business days from the date of receipt** to approve or disapprove preauthorization requests.

- Spinal Surgery
- Work Hardening or Work Conditioning services provided by a health care facility that is not credentialed.
- Inpatient hospitalization, including any procedure and length of stay.
- Physical and occupational therapy
- Outpatient or ambulatory surgical services
- Any investigational or experimental services or devices
- Treatment that is outside of the Official Disability Guidelines Treatment in Workers' Comp (ODG).

Denial of Medical Treatment

In the event that medical treatment is denied there are alternatives or means to appeal. Please contact your Adjuster and/or Workers' Compensation Coordinator.

You may also contact an Ombudsman with the Texas Department of Insurance - Division of Workers' Compensation, whose role is to assist, in lieu of an attorney, in the dispute process.

Ombudsman Services are
free

TRANSITIONAL DUTY PROGRAM

Transitional Duty is available in all departments and it allows a recovering employee, with restrictions, to return to gainful and productive employment with the goal of returning to full duty.

Classified Employees are allowed up to 360 calendar days of transitional duty per injury.

Bona Fide Offer of Employment



CITY OF HOUSTON

Annise D. Parker
Mayor
P.O. Box 1001
Houston, Texas 77251-1001
Telephone - 281-311
www.houston.gov

July 5, 2014

Employee Name:
Employee Address:
City, State Zip:

Re: **Bona Fide Offer of Employment/Transitional Duty Assignment**
Date of Injury: [Click here to enter a date.](#) Claim #: [Enter claim #.](#)

Dear Employee Name,

This letter will serve as our offer of a Transitional Duty Assignment that meets the physical restrictions imposed by a medical provider. I have attached a copy of the medical report from Doctor's Name, dated [Click here to enter a date.](#) upon which this offer is based. The Transitional Duty Assignment being offered to you will not exceed the restrictions stated in the attached medical report. The City will only assign tasks consistent with your physical abilities, knowledge, and skills and will provide training if necessary.

You are being offered a Transitional Duty assignment at Location and Physical Address, beginning [Click to select date.](#) and continue for as long as possible. Selected on item days or until you are released by your doctor to full duty. You will be earning the same hourly and weekly rate of pay, \$0.00 per hour and 0.00 per week. This Transitional Duty Assignment is for Number of hours, hours per week # of hours hours per day, # of days, days per week. We are asking that you report to work enter first day of week, at start time through last day of week and end time.

This position will not require you to exceed the restrictions as stated on the work status report dated [Click to select date.](#) This Transitional Duty Assignment requires you to perform the following tasks:

Task and description of duty, for approximately # of hours or percentage of day.
Task and description of duty, for approximately # of hours or percentage of day
.

You will be reporting to Name of supervisor, or their designee.

During this Transitional Duty Assignment, you will be required to attend any and all medical appointments as prescribed by your treating physicians. You will be responsible for your own transportation to and from all medical appointments.

A written offer of a transitional duty assignment that abides by the work restrictions given by your treating doctor or a designated doctor appointed by the DWC.

Should you **ACCEPT** this Transitional Duty Assignment, you will begin work on [Click to select date.](#)

Employee's Signature

Date Accepted:

Should you **DECLINE** this Transitional Duty Assignment, you are subjected to loss of benefits.

Employee's Signature

Date Declined:

Designated Department Representative

Date:

Witness

Date:

If you have any questions during your assignment, please direct them to Name of DOR, your Designated Department Representative at DOR's phone number..

Enclosure: Choose an item, [Click](#) from [Enter doctor's name.](#) dated [Click to select date.](#)

Cc: Adjudicator

Income Benefits

(other than impairment income benefits) replace a portion of any wages you lose due to **disability** resulting from a work-related injury or illness.

Paid by Adjuster	Paid by City of Houston payroll
Impairment Income Benefits (IIBs)	Salary Continuation
	Workers' Comp Payment

Amount of Workers' Comp Payment

- Workers' Comp Payments are based upon your wages earned over the 14 complete weeks before your work-related injury or illness occurred.
- Workers' Comp Payments are equal to 70% of the difference between your average weekly wage (includes overtime) and the wages you are able to earn after your work-related injury. The amount of Workers' Comp Payments is subject to maximum and minimum benefit amounts.
- For example, if your average weekly wage was \$550, and your injury or illness caused you to lose all of your income, your Workers' Comp Payments would be \$385 a week:

70% X \$550= **\$385** in Workers' Comp Payments

Workers' Comp Payments are non-taxable

Salary Continuation

- You may be paid Salary Continuation, up to 52 weeks for classified employees, if your work-related injury or illness causes you to lose all or some of your City paid wages. This can be extended in increments of 90 days, for up to an additional 52 weeks, and is offset by the amount of Workers' Comp Payments.
- Salary Continuation continues as long as you are receiving Workers' Comp Payments or you exhaust your maximum Salary Continuation allowed, whichever comes first.
- After exhausting Salary Continuation, the City will automatically use your accrued time; however, you have the right to Opt Out of the automatic usage of your time.

Amount of Salary Continuation

Classified Employees may receive up to 100% of their Salary Continuation AWW, this includes base salary, longevity, other permanent pay and Workers' Comp Payments.

For example, if your Salary Continuation AWW was \$1300 and your injury or illness caused you to lose all of your income, your Salary Continuation would be \$900 a pay period:

Your Salary Continuation AWW	\$1300
Multiplied by 2 weeks	\$2600
100% of \$2600 equals	\$2600 in Salary Continuation/ Accruals Owed

Salary Continuation/ Accruals Owed	\$ 2600.00
Minus wages for hours worked	-\$ 0
Minus Workers' Comp Payments	-\$ 1700.00
Salary Continuation / Accruals Owed	\$ 900.00

Maximum Medical Improvement

The earliest date after which, based on reasonable medical probability,

- further medical recovery or
- lasting improvement to an injury can no longer be anticipated; or
- the expiration of 104 weeks from the date on which income benefits begin to accrue.

Impairment Rating and Impairment Income Benefits

Impairment Rating: The percentage of permanent physical damage to your body that resulted from a work-related injury or illness.

Impairment Income Benefits: A form of payment the Adjuster pays an injured employee who reaches MMI with an impairment rating.

Do You Disagree with an MMI Determination?

In the event you disagree with an MMI determination there are alternatives or means to appeal. Please contact your Adjuster and/or Workers' Compensation Coordinator.

You may also contact an Ombudsman with the Texas Department of Insurance - Division of Workers' Compensation, whose role is to assist, in lieu of an attorney, in the dispute process.

Ombudsman Services are
free

Overpayment

What is a considered an Overpayment?

Any payment of Salary Continuation, Workers' Comp Payments, accrued leave balances, city funds or benefits which, when added to Workers' Compensation benefits paid, results in the recovering employee being paid more than allowed.

How is an Overpayment recovered?

If you're off work, this is automatically recovered through the payroll system.

If you've returned to work, the DDR and/or payroll representative will communicate with you to establish a payment plan or a one-time deduction.

Family Medical Leave (FMLA)

FMLA runs concurrently with Workers' Compensation for qualifying employees.

- Qualifications
 - If you have worked for the City of Houston for at least one year,
 - have been physically present at work at least 1,250 hours during the previous twelve months,
 - and your injury/impairment is considered a serious health condition

Once a determination is made on your status, your Family Medical Leave Coordinator will contact you with additional information.

Possible Outcomes....

Medical Questionnaire

A document used to query a treating physician regarding the medical status of a recovering employee as it relates to the performance of essential functions.

Medical Separation

The non-punitive, non-disciplinary process of removing an employee from a position of employment with the City pursuant to Section 14-185 of the Code of Ordinances or Section 143.1115 of the Texas Local Government Code.

If upon receipt and evaluation of the medical questionnaire it is determined that there is no potential for a recovering employee to return to perform the full essential functions of his job, there will be a referral to the Work Referral Program. If job opportunities cannot be found, then the medical separation process may be taken in to consideration.

Speak Up

.. if you have questions or concerns, and if you don't understand, ask again. You have a right to know.

... if you don't understand something that your health care professional tells you.

.. concerning pain relief and pain management. Discuss pain relief options with your health care team.

.. if you do not understand a subject. Ask for additional explanation.

.. when there is a delay or non- approval of your recommended treatment.



QUESTIONS





You are our most important asset and we are here to ensure you receive the benefits you are entitled to, that you are treated respectfully and fairly...

every step of the way!