WORKERS' COMPENSATION

MEDICAL SERVICES

AND

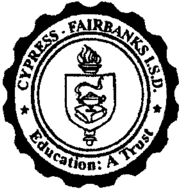
INFORMATION PACKET

Revised: October, 2012

IMPORTANT NOTE: The first page of this packet, the **Accumulated Paid Leave Election Form** MUST BE SUBMITTED to the Insurance Department AT THE SAME TIME AS THE EMPLOYEE INJURY REPORT.

Cypress-Fairbanks I.S.D.
Insurance Department – Workers' Compensation
10300 Jones Road, Suite 136
Houston, TX 77065

Tel: (281) 897-4135
Fax: (281) 807-8652



Cypress-Fairbanks Independent School District

Insurance Department — *Workers' Compensation*
(281) 897-4135

WORKERS' COMPENSATION
ACCUMULATED PAID LEAVE ELECTION FORM

TO AUTHORIZE THE USE OF AVAILABLE PAID TIME FOR A WORK-RELATED INJURY ABSENCE

(Required if you are ELECTING TO USE AVAILABLE PAID TIME while absent for a work-related injury.)

USE OF PAID LEAVE
If eligible, workers' compensation insurance will begin paying a percentage (not more than 70%; to a current maximum of $773) of the employee's current wages on the eighth calendar day of a work-related disability if an extended absence is required. An employee will receive workers' compensation wage benefits only, which may not equal his or her pre-injury or illness wage; unless the injured/ill employee elects to receive his/her accumulated paid leave instead.

DATE: ____________________

RETURN TO: Your Campus Secretary or Department Payroll Clerk

This form MUST BE SUBMITTED TO THE INSURANCE DEPARTMENT at the same time as the Employee Injury Report.

Employee's Name: ____ **Employee Number:** ________________

Department/Campus: ______________________________________ **Date of Injury:** ________________

Position: ____

I have approximately __________ **accumulated paid leave days currently available.**

First Day of Absence for this job-related injury: ____________________

Employee Choice:

If I am absent from duty because of a job-related illness or injury I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I choose the following option:

- ☐ **I CHOOSE TO USE MY AVAILABLE PAID LEAVE DAYS** for all my absences resulting from this injury/illness. An employee choosing to use paid leave will not receive workers' compensation weekly income benefits until all paid leave is exhausted or to the extent that paid leave does not equal the pre-injury or illness wage.

- ☐ **I CHOOSE NOT TO USE ANY OF MY AVAILABLE PAID LEAVE.** I understand that I will not receive any regular salary payments from Cypress-Fairbanks ISD while receiving workers' compensation weekly income benefits for this injury/illness. No available paid leave will be deducted from my leave balance. I understand that I will be responsible for the payment of my employee benefits under the FMLA or COBRA leave policies if I elect to have them continue during my absence. I further understand that .Workers' Compensation wage compensation is not reported to the Teachers Retirement System of Texas (TRS) as income. As such, this decision could have an impact on my future TRS benefits.

____ ____________________
Employee Signature — Date

Complete and fax to the Insurance Department at (281) 807-8652

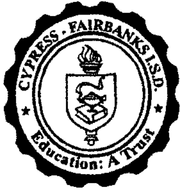
For Insurance & Payroll Use Only

INSURANCE DEPARTMENT: Date sent to Human Resources Dept.: ____________________ By: ______________

URGENT: This completed form must be returned to the Insurance Department within 2 days of receipt.

HR DEPT: Last day of Accumulated Paid Leave: ________________ Payroll: __Semi-M __Bi-Weekly * HPD ______

HR DEPARTMENT: Date returned to Insurance Dept.: ____________________ By: ______________



Cypress-Fairbanks Independent School District

Insurance Department *Workers' Compensation*
(281) 897-4135

MEDICAL SERVICES FORM

FIRST FILL® CARD (Prescription Card) follows

District Employee: ______________________ **Employee Number:** ______________

School or Department: ______________________ **Date of Injury:** ______________

Supervisor/Principal ______________________ **Today's Date:** ______________

If initial medical treatment is being sought more than 30 days after the date of injury please call the district's Insurance Department Workers' Compensation Specialist for special instructions at(281) 897-4135, during regular business hours Monday - Friday, 7:30 am - 4:30pm.

The district's Workers' Compensation Administrator is:

TASB
Att: Workers' Compensation Claims Division
P.O. Box 2010
Austin, TX 78768-2010
Phone: (800) 482-7276 **Fax: 1-800-580-6720**

INJURED EMPLOYEE*:* <u>You must choose a treating doctor from The Alliance list of doctors</u> designated as primary care physicians for all non-urgent medical services for work related injuries.

The Alliance Provider Directory is available at:
<u>www.pswca.org</u>

For your convenience we've listed a few of the local ALLIANCE primary care providers below. Many others are available on the Political Subdivision Workers' Compensation Alliance provider network.

Excel Immediate Medical Care	Cypress Fairbanks Occupational Medicine	US Healthworks
NO APPOINTMENT NECESSARY	NO APPOINTMENT NECESSARY	NO APPOINTMENT NECESSARY
25801 Highway 290 @ Spring-Cypress Rd	9110 Barker Cypress Rd (North of West Rd)	17420 Highway 290 @ Jones Rd
Cypress, TX 77429	Cypress, TX 77433	Houston, TX 77040
Phone: (281) 304-1100	Phone: (281) 463-9696	Phone: (713) 466-0044
Monday – Sunday: 9:00 am – 9:00 pm	7 Days a Week 9:00 am – 9:00 pm	Monday – Friday: 8:00 am – 5:00 pm
On Site X-ray and Lab	On Site X-ray	On Site X-ray, Lab and Physical Therapy

We will be receiving the information from your campus/department concerning your recently reported injury. We will be processing all the necessary claims data to assure that your workers' compensation benefits are delivered to you in a timely manner.

Workers' compensation benefits for qualified job-related injuries/illnesses include medical costs required for recovery and, if eligible, income compensation, as allowed according to the Texas Workers' Compensation Division's authorized guidelines. The Texas Association of School Boards (TASB) is the district's workers' compensation claim administrator. TASB claim adjusters manage the injury claims, including authorizing all medical costs and wage compensation payments.

REQUIREMENTS OF THE INJURED EMPLOYEE

FOR MEDICAL SERVICES ONLY INJURIES: An employee that seeks medical attention due to a job-related injury must, BEFORE RETURNING TO WORK, present a Texas Workers' Compensation Work Status Report, DWC Form-73 (attached), signed by the attending physician, releasing the employee to return to work. **ANY RESTRICTIONS NOTED IN PART III OF THE FORM MUST BE APPROVED BY THE *INSURANCE DEPARTMENT* PRIOR TO THE EMPLOYEE RETURNING TO HIS/HER ASSIGNMENT.**

FOR LOST TIME INJURIES: If you are absent from work for more than 1 day as a result of your injury **YOU ARE REQUIRED to provide the district's Insurance Department**, at the Instructional Support Center-North (ISC-N), Suite 136, with the following:

1) Texas Workers' Compensation Work Status Report, DWC Form-73, attached, signed by the attending physician, releasing the employee to return to work. **ANY restrictions noted in Part III of the form MUST BE APPROVED by the Insurance Department prior to the employee returning to his/her assignment.**

2) Employee Accumulated Paid Leave Election Form. If this form is not submitted at the time of the injury/illness the injured/ill employee **will receive workers/ compensation wage benefits ONLY**, which may not equal his or her pre-injury or illness wage.

3) A DWC Form-73 after EACH medical visit.

4) During an absence of 5 days or more - A phone call from you between the hours of 8:00 am and 4:00 pm Monday through Friday, AT LEAST ONCE A WEEK during your absence (281) 897-4135. **This phone call is required** in addition to any communication required by your supervisor.

5) A DWC Form-73 must be presented by you to the district's Insurance Department before 4:00 pm of the business day prior to your return to work.

First Fill® Prescription Medication Card

On Next Page

PROGRESSIVE
Medical, Inc.

Progressive Medical, Inc. has been chosen to manage your workers' compensation prescription plan on behalf of your insurer or employer.

Below is your First Fill® card that allows you to fill your initial workers' compensation prescriptions at your local pharmacy at no extra cost to you.

Questions?
888.908.6337

Instructions for the Company

- Fill in the ID/Auth# per the First Fill card below along with the name, date of birth and gender.
- Instruct the injured worker to take the First Fill card and their prescription to the pharmacy.
- Report the claim to the appropriate insurance company/TPA.

Note: If additional medications are required, the claims professional should contact Progressive Medical to use our Retail Drug Card program. If additional First Fill cards are needed or if you have any questions about the use of this program, please contact Progressive Medical at 888.908.MEDS and ask for the Pharmacy Services Coordinator.

Questions?
888.908.6337

Instructions for the Injured Worker

- Report your injury to the appropriate staff.
- Below is a First Fill card that will allow you to obtain the "initial" prescriptions needed upon injury with no out-of-pocket expense.
- A sample list of participating pharmacy chains that accept this First Fill card is on the back of this sheet.
- Present your First Fill card and your prescription to the pharmacist.
- This card is for a one time use to receive your medications per your company benefits. Use of this card is only for your workers' compensation injury for which this claim was made.
- If you have any questions, call Progressive Medical toll-free at 888.908.MEDS. Our Client Services Specialists are available 24-hours a day to take care of your needs.

PLEASE NOTE: IF YOUR WORKERS' COMPENSATION CLAIM IS ACCEPTED, YOU WILL RECEIVE A RETAIL DRUG CARD IN THE MAIL. PRESENT THAT CARD WHEN FILLING OTHER INJURY-RELATED PRESCRIPTIONS.

FIRST FILL® CARD

BIN#: Restat 600471

PCN: 7777

Company Name: Cypress-Fairbanks ISD

Group/Plan#: T154

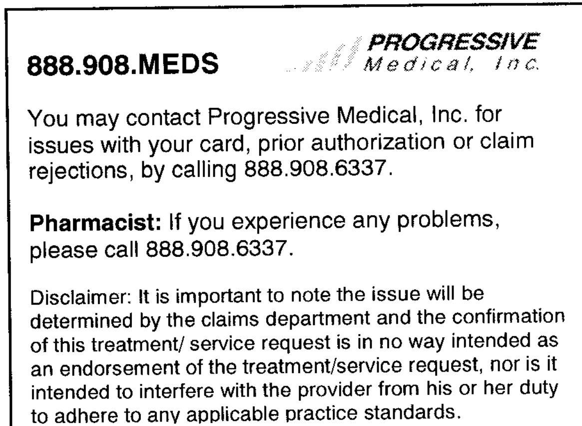
Person Code: 00 (zero, zero)

ID/Auth#: ____________

SSN (9 digits, no dashes) Date (6 digits, no dashes) E.g. if the SSN is 000-00-0000 and today's date is May 21, 2007, the ID/Auth# is 000000000052107.

Injured Worker's Name: ____________

Date of Birth: ____________ **Gender:** ______



888.908.MEDS **PROGRESSIVE** *Medical, Inc.*

You may contact Progressive Medical, Inc. for issues with your card, prior authorization or claim rejections, by calling 888.908.6337.

Pharmacist: If you experience any problems, please call 888.908.6337.

Disclaimer: It is important to note the issue will be determined by the claims department and the confirmation of this treatment/ service request is in no way intended as an endorsement of the treatment/service request, nor is it intended to interfere with the provider from his or her duty to adhere to any applicable practice standards.

PROGRESSIVE
Medical, Inc.

Cuando una persona lesionada necesita medicamentos de inmediato, la opción con la tarjeta First Fill (Surtir primero) le permite autorizar estas recetas y ayudarle a recuperarse.

¿Preguntas?
888.908.6337

Instrucciones para la compañía

- Anote el número de identificación/autorización en la tarjeta First Fill al verso junto con el nombre, la fecha de nacimiento y el sexo.
- Indique al trabajador lesionado que lleve la tarjeta First Fill y su receta a la farmacia.
- Reporte la reclamación a la aseguradora/TPA apropiada.

Nota: Si se requiere recibir medicamentos adicionales continuamente, el profesional de reclamaciones debe ponerse en contacto con Progressive Medical para utilizar nuestro programa de Tarjeta de Medicamentos al por Menor. Si se necesitan tarjetas First Fill adicionales, o si tiene alguna pregunta sobre cómo usar este programa, llame a Progressive Medical al 888.908.MEDS y pida hablar con el Coordinador de Farmaceuta.

Instrucciones para el trabajador lesionado:

¿Preguntas?
888.908.6337

- Reporte la lesión al personal apropiado.
- En la parte inferior de este formulario aparece una tarjeta First Fill que le permitirá obtener los medicamentos "iniciales" necesarios para la lesión sin costo de su propio bolsillo.
- A continuación se encuentra una lista de muestra de las cadenas de farmacias participantes que aceptan esta tarjeta First Fill.
- Presente su tarjeta First Fill y su receta al farmacéutico.
- Esta tarjeta sólo se puede usar una vez para recibir sus medicamentos de acuerdo con los beneficios de su compañía. Utilícela únicamente para la lesión que cubre el seguro de compensación a los trabajadores para la cual se presente el reclamo.
- Si tiene alguna pregunta, llame gratis a Progressive Medical al 888.908.MEDS. Nuestros Especialistas de Servicios al Cliente están disponibles las 24 horas del día.

NOTA: SI SE ACEPTA SU RECLAMO DE SEGURO DE COMPENSACIÓN A LOS TRABAJADORES, RECIBIRÁ POR CORREO UNA TARJETA DE FARMACIA AL POR MENOR. PRESENTE ESA TARJETA AL SURTIR RECETAS SUBSECUENTES RELACIONADAS CON EL TRABAJO.

Sample Listing of Participating Pharmacies

The below is a sampling of pharmacies that honor our program:

Albertsons	Longs Drug Stores	Costco
Safeway	Giant Eagle Pharmacy	Winn Dixie Pharmacy
Meijer Pharmacy	Publix Pharmacy	CVS Pharmacy
Walgreens	Rite Aid Pharmacy	Discount Drug Mart
K-Mart	Fred Meyer	Target Pharmacy
Tops Markets	Medicine Shoppe	Wal-Mart Pharmacy

For additional pharmacies within your area call Progressive Medical's Client Services department at 888.908.6337 or visit our website at www.progressive-medical.com. Go to Workers' Compensation, Tools and Resources, Pharmacy Look-Up and enter your city, state or zip code and click on "Submit". You will see a listing of pharmacies in your area.

OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel. This assistance is offered at local offices across the State. These local offices also provide other workers' compensation system services from the Texas Department of Insurance (TDI). TDI is the state agency that administers the system through the Division of Workers' Compensation.

You can contact the Office of Injured Employee Counsel by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Also, more information is available on the Internet at: **www.oiec.state.tx.us** **<http://www.oiec.state.tx.us>**.

You can contact the Division of Workers' Compensation by calling the toll-free telephone number 1-800-252-7031. More information about the Division of Workers' Compensation is available on the Internet at: **<http://www.tdi.state.tx.us/wc/indexwc.html>**.

Your Rights in the Texas Workers' Compensation System:

1. **You may have the right to receive benefits.**

You may receive benefits regardless of who was at fault for your injury with certain exceptions, such as:

- You were intoxicated at the time of the injury;
- You injured yourself on purpose or while trying to injure someone else;
- You were injured by another person for personal reasons;
- You were injured by an act of God;
- Your injury occurred during horseplay; or
- Your injury occurred while voluntarily participating in an off-duty recreational, social, or athletic activity.

2. **You have the right to receive medical care to treat your workplace injury or illness. There is no time limit to receive this medical care as long as it is medically necessary and related to the workplace injury.**

3. **Choosing a treating doctor:**
    - If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list.
    - If you are not in a network, you may choose any doctor who is willing to treat your workers' compensation injury.
    - If you are employed by a political subdivision (e.g. city, county, school district), you must follow its rules for choosing a treating doctor.

It is important to follow all the rules in the workers' compensation system. If you do not follow these rules, you may be held responsible for payment of medical bills.

4. **You have the right to hire an attorney at any time to help you with your claim.**

5. **You have the right to receive information and assistance from the Office of Injured Employee Counsel at no cost.**

Staff is available to answer your questions and explain your rights and responsibilities by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432) or visiting any Division of Workers' Compensation/Office of Injured Employee Counsel local field office.

6. **You have the right to receive ombudsman assistance if you do not have an attorney and a dispute resolution proceeding about your claim has been scheduled.**

An ombudsman is an employee of the Office of Injured Employee Counsel. Ombudsmen are trained in the field of

workers' compensation and provide free assistance to injured employees who are not represented by attorneys. At least one Ombudsman is located in each local field office to assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot sign documents for you, make decisions for you, or give legal advice.

7. You have the right for your claim information to be kept confidential.
In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from the Division of Workers' Compensation.

Your Responsibilities in the Texas Workers' Compensation System

1. You have the responsibility to tell your employer if you have been injured at work or in the scope of your employment.
You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work-related.

2. You have the responsibility to know if you are in a Workers' Compensation Health Care Network (network).
If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. Your employer must give you a copy of the TDI network rules. Read the rules carefully. If there is something you do not understand, ask your employer or call the Office of Injured Employee Counsel. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at **<http://www.tdi.state.tx.us/consumer/complfrm.html#wc>**

3. If you worked for a political subdivision (e.g. city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment. Your employer should be able to provide you with the information you will need in order to determine which health care provider can treat you for your workplace injury.

4. You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.

5. You have the responsibility to send a completed claim form (DWC-41) to the Division of Workers' Compensation. You have one year to send the form after you were injured or first knew that your illness might be work related.
Send the completed DWC-41 form even if you already are receiving benefits. You may lose your right to benefits if you do not send the completed claim form to the Division of Workers' Compensation. Call 1-800-252-7031 or 1-866-393-6432 for a copy of the DWC-41 form.

6. You have the responsibility to provide your current address, telephone number, and employer information to the Division of Workers' Compensation and the insurance carrier.

7. You have the responsibility to tell the Division of Workers' Compensation and the insurance carrier any time there is a change in your employment status or wages. Examples include:

- **You stop working because of your injury;**
- **You start working; or**
- **You are offered a job.**

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)-252-7031.

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 y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

	5. Doctor's Name and Degree	(for transmission purposes only) / Date Being Sent
1. Injured Employee's Name	6. Clinic/Facility Name	9. Employer's Name
2. Date of Injury / 3. Social Security Number (last 4) XXX-XX-	7. Clinic/Facility/Doctor Phone & Fax	10. Employer's Fax # or Email Address (if known)
4. Employee's Description of Injury/Accident	8. Clinic/Facility/Doctor Address (street address)	11. Insurance Carrier
	City State Zip	12. Carrier's Fax # or Email Address (if known)

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

Max Hours per day:	0	2	4	6	8	Other
Standing	☐	☐	☐	☐	☐	______
Sitting	☐	☐	☐	☐	☐	______
Kneeling/Squatting	☐	☐	☐	☐	☐	______
Bending/Stooping	☐	☐	☐	☐	☐	______
Pushing/Pulling	☐	☐	☐	☐	☐	______
Twisting	☐	☐	☐	☐	☐	______
Other:	☐	☐	☐	☐	☐	______

15. RESTRICTIONS SPECIFIC TO (if applicable):

☐ Left Hand/Wrist ☐ Right Hand/Wrist
☐ Left Arm ☐ Right Arm
☐ Left Leg ☐ Right Leg
☐ Left Foot/Ankle ☐ Right Foot/Ankle
☐ Neck ☐ Back

Other: ______________

17. MOTION RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Walking	☐	☐	☐	☐	☐	______
Climbing stairs/ladders	☐	☐	☐	☐	☐	______
Grasping/Squeezing	☐	☐	☐	☐	☐	______
Wrist flexion/extension	☐	☐	☐	☐	☐	______
Reaching	☐	☐	☐	☐	☐	______
Overhead Reaching	☐	☐	☐	☐	☐	______
Keyboarding	☐	☐	☐	☐	☐	______
Other:	☐	☐	☐	☐	☐	______

18. LIFT/CARRY RESTRICTIONS (if any):

☐ May not lift/carry objects more than ______ lbs. for more than ______ hours per day

☐ May not perform any lifting/carrying

Other: ______________

19. MISC. RESTRICTIONS (if any):

☐ Max hours per day of work: ______
☐ Sit/Stretch breaks of ______ per ______
☐ Must wear splint/cast at work
☐ Must use crutches at all times
☐ No driving/operating heavy equipment
☐ Can only drive automatic transmission
☐ No work / ______ hours/day work:
 ☐ in extreme hot/cold environments
 ☐ at heights or on scaffolding
☐ Must keep ______________
 ☐ elevated ☐ clean & dry
☐ No skin contact with: ______________
☐ Dressing changes necessary at work
☐ No running

20. MEDICATION RESTRICTIONS (if any):

☐ Must take prescription medication(s)
☐ Advised to take over-the-counter meds
☐ Medication may make drowsy (possible safety/driving issues)

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 IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

22. Expected Follow-up Services Include:

☐ Evaluation by the treating doctor on ______________ (date) at ____ : ____ am/pm
☐ Referral to/Consult with ______________ on ______________ (date) at ____ : ____ am/pm
☐ Physical medicine ______ X per week for ______ weeks starting on ______________ (date) at ____ : ____ am/pm
☐ Special studies (list): ______________ on ______________ (date) at ____ : ____ am/pm
☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit / Discharge Time	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type:	Role of Doctor:	
			☐ Initial ☐ Follow-up	☐ Designated doctor ☐ Treating doctor ☐ Referral doctor ☐ Consulting doctor	☐ Carrier-selected RME ☐ DWC-selected RME ☐ Other doctor

DWC FORM - 73
WORK STATUS REPORT INSTRUCTIONS

PART I: GENERAL INFORMATION - Contains space to record general information about the employee and the doctor/clinic. This section includes space to record a high-level generic description of the injury or condition (e.g. broken right arm, strained left knee, etc) and how it occurred. Also contains space to record the name and facsimile number or email address of the insurance carrier (carrier) and the employer, as well as the date of transmission. This space is intended to eliminate the need for a separate facsimile cover page. **Because this information is intended primarily for transmission purposes, the report may be provided to the injured employee (employee) at the time of the examination, even if the information required in this section is not yet available.**

PART II: WORK STATUS INFORMATION - The doctor is required to indicate the employee's current work status. There are three choices: able to work without restrictions; able to work with restrictions; and prevented from returning to work.

If the doctor believes that the employee can only work with restrictions or is prevented from returning to work, the doctor is **required** to provide an estimated date of expiration for the restrictions. These estimates are required to enhance claims management and to provide the employer with information that can be used to plan work coverage and plan for the employee's return to work (whether with or without restrictions). **An estimated expiration is speculative in nature. The further the date is projected, the less accurate it may be. Estimations are not binding and may be changed as needed based upon the condition and progress of the employee by filing a subsequent Work Status Report. Doctors need to provide reasonable estimates based upon the nature of the employee's injury.**

In addition, a doctor who believes that an employee is prevented from returning to work is required to provide a specific explanation of how the condition prevents the employee from returning to work. One of the goals of the Texas Workers' Compensation Act is to ensure a speedy return to employment which is safe, meaningful, and commensurate with the abilities of the employee. **It is the responsibility of the doctor treating or examining an injured employee to identify what the employee may be able to safely perform. It is not the doctor's responsibility to ensure that the employer has a modified duty position that meets those restrictions - that is the employer's responsibility if the employer chooses to try to accommodate the restrictions.**

PART III: ACTIVITY RESTRICTIONS - If the doctor indicates that the employee is able to work with restrictions, the doctor is to indicate those restrictions in this section. **The doctor is only supposed to indicate what restrictions are in place because of the workers' compensation injury.** Any restrictions that may have existed due to other conditions are assumed to remain and should not be duplicated here. The doctor should go over the restrictions with the employee at the time the report is provided.

The section was designed to include check boxes for common restrictions that may apply to the employee. If a box is not checked, it is assumed that there is no restriction on that activity. Also, if no specific body part is indicated in box #15, then it should be understood that the restrictions are whole body restrictions.

PART IV: DIAGNOSIS/FOLLOW-UP INFORMATION - Provides general diagnosis information and provides upcoming appointment information (if known at time of filing report) so that the carrier can better manage the claim and the employer can be aware of time where the employee might not be available for work. In addition, providing this information may reduce calls from carriers and employers seeking the information. **However, doctors need ensure that the diagnosis information provided to the employer is at a general level and does not violate any confidentiality laws relating to the employee's privacy rights.**

The Work Status Report is primarily designed to be filed by the treating or referral doctor. However, other doctors can and will occasionally need to file this report. The following describes the various roles that doctors can play within the system:

Treating: Doctor chosen by and primarily responsible for employee's injury-related health care.	***Referral***: Doctor who was selected by the treating doctor to treat one or more aspects of the employee's medical condition.
Consulting: Doctor who was selected by the treating doctor to provide an opinion on the employee's medical condition.	***Carrier-selected RME:*** Doctor selected by the insurance carrier.
Designated: Doctor selected by the Division to evaluate whether the employee's medical condition has improved sufficiently to allow a return to work (only for Supplemental Income Benefits claims).	***DWC-selected RME:*** Doctor selected by DWC.
	Other: Doctor who fits none of the other descriptions.

Basic Instructions - Provide to injured employee at time of examination and fax or electronically transmit to: insurance carrier and employer by the end of the second working day following the date of the examination. Report must be filed after initial visit, when there is a change in work status or a substantial change in activity restrictions, and on the schedule requested by or through the carrier (not to exceed one report every two weeks). Also file within 7 days of receiving functional job descriptions from the employer or a Work Status Report from a Required Medical Examination doctor that indicates that the employee is able to return to work with or without restrictions.

Rules 126.6, 129.5, and 130.110 lay out the complete requirements for filing this report (in addition, Rule 129.6 provides information on how the report might be used). The complete text to these rules is available on the Division's web site at www.tdi.state.tx.us.