Texas Workers' Compensation

Return to Work

TDI Division of Workers' Compensation

What is workers' compensation insurance in Texas?

A state-regulated, no fault, no blame insurance program for employees who are injured at work or have work-related diseases or illnesses, that pays for:

- Medical bills.
- Replaces some lost wages.

Is workers' compensation insurance required?

It's **not required** for most private employers.

The law requires certain governmental entities, educational institutions, and certain private employers to provide workers' compensation coverage.

Texas Labor Code §406.002, Coverage Generally Elective

Division of Workers' Compensation (DWC) Overview

Source: DWC Biennial Report to the 88th Texas Legislature, December 2022

Non-Covered Employers (Non-subscribers)

Other insurance programs available:

- They are NOT the same as workers' compensation coverage.

Not likely to pay for litigation costs:

- Court costs.
- Legal fees.
- Punitive damages.
- Pain and suffering.

Non-Covered Employers Required Reporting

Annual	Notify DWC if:
• Notice of non-coverage to employees. • DWC Form-005 (*Employer Notice of No Coverage or Termination of Coverage*).	• Employer drops coverage. • Injury results in lost time or death (DWC Form-007, Employer's report of noncovered employee's work-related injury or illness).

May be fined for not filing.

Forms and notices available at: www.tdi.texas.gov/forms/form20.html

Labor Code §406.004, Employer Notice to the Division

General Definitions

Injury is damage or harm to the physical structure of the body and a disease or infection naturally resulting from the damage or harm. The term includes an occupational disease.

Labor Code §401.011, General Definitions

General Definitions

Compensable injury is an injury or illness that happened while the injured employee was performing duties related to their employment.

Course and scope of employment is an injury that happens while an employee is doing activities related to the business of their employer and while furthering the interests of their employer.

Labor Code §401.011, General Definitions

Exceptions to Liability

Sometimes, the workers' compensation insurance carrier may not be responsible.

Some examples of when the workers' compensation insurance carrier won't pay is when the employee:

- Intentionally caused their own injuries.
- Was injured while playing around or while intoxicated.
- Was injured outside of work or while voluntarily participating in an off-duty sports or social event.

More exceptions in Labor Code §406.032, Exceptions

Covered Employers (Subscribers)

Employers who provide coverage gain legal protections by paying premiums to insurance carriers or self insuring.

Insurance carriers or certified self-insured employers pay benefits to injured employees or families of employees killed on the job.

What Workers' Compensation Does

Employers that provide workers' compensation insurance limit their liability.

Workers' compensation:
• Provides lifetime reasonable and necessary medical treatment for the compensable injury. • Pays weekly income replacement benefits. • Pays death and burial benefits to beneficiaries.

What Workers' Compensation Does

Workers' compensation:

- Pays impairment and lifetime benefits.
- Limits the employer's liability for work-related injuries or illnesses by:
  - Protecting the employer.
  - Protecting the employees.
- Provides dispute resolution.

Your Workers' Compensation Premium

- Industry
- Payroll
- Past 3 years of experience (cost)

Your experience modifier

Fewer injuries and eliminating unnecessary lost time mean lower cost.

Controlling Your Costs

Costs	Solutions
1. Severity and frequency of injuries and illnesses.	• Safety culture and training. • Enforcement and accountability.
2. Medically unnecessary lost time.	• Stay at work (SAW). • Return to work (RTW).

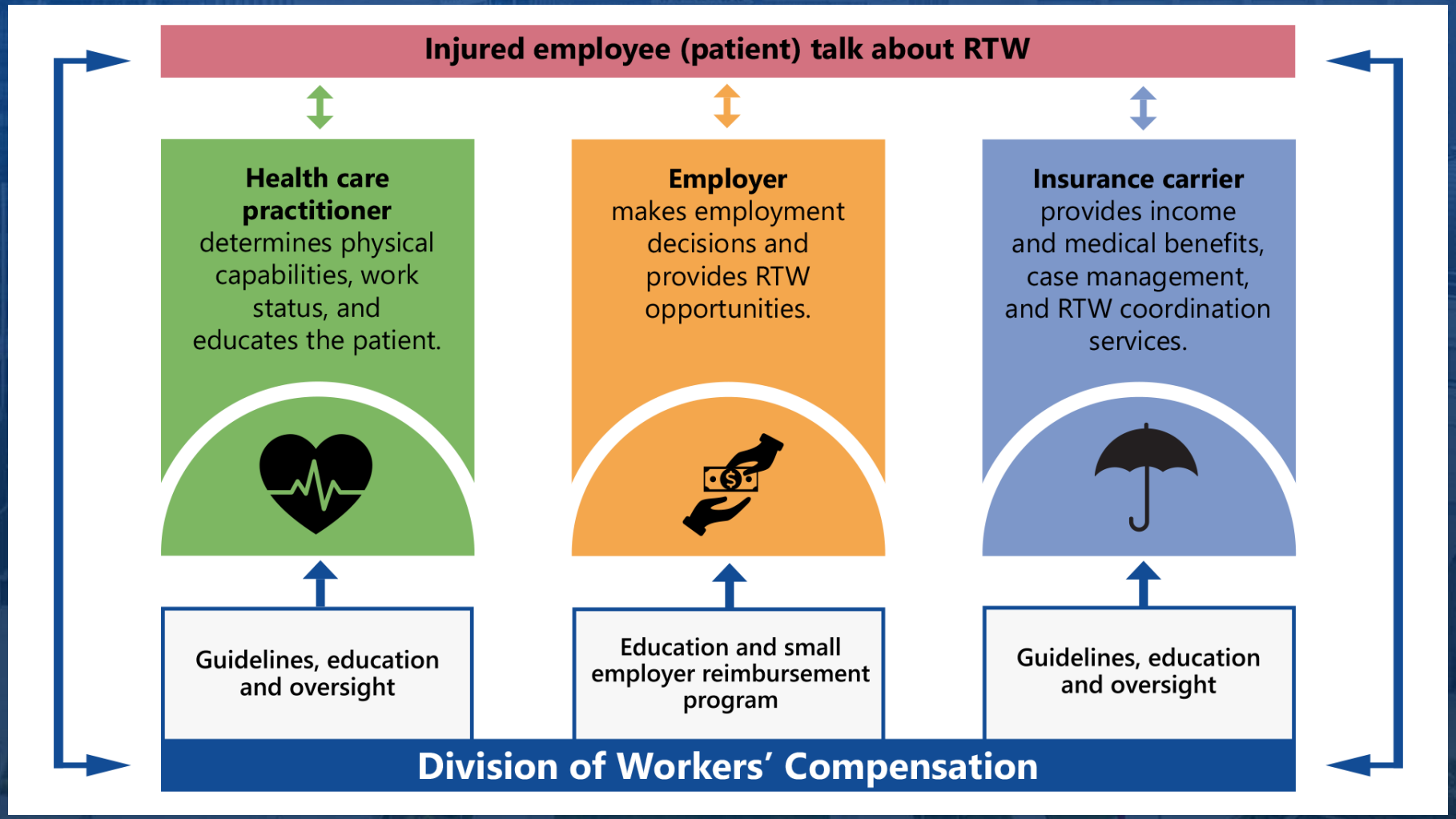
What is your safety culture?

The Goal

Help injured employees recover and get back to work as soon as possible after an injury or illness.

All system participants, including the injured employee, share this responsibility.

RTW is a Shared Responsibility



Medically Unnecessary Lost Time

Costs	Solutions

• Absences =
  • Income benefits.
  • Medical bills.
  • Staff turnover.
  • Training costs.
  • Delays.
  • Premiums.
	• SAW.
	• RTW.

Your trained and experienced employee continues to work and contribute to your business while recovering.

Benefits to Employers

- Reduce costly turnover and training costs.
- Reduce absences.
- Maintain quality and production standards.
- Reduce workers' compensation and business costs.
- Pay wages for work – not benefits.
- **Employees heal better and faster.**

Benefits to Employees

- More likely to retain job-related benefits.
- Avoid financial difficulty.
- Keep job skills up to date.
- Stay in better physical and mental condition.
- More likely to stay employed.
- Avoid becoming isolated, depressed.

Medically Unnecessary Absences

- Family or personal problems.
- Fear.
- Just don’t wanna.
- My job.
- **Work environment.**

Employers Can Contribute to Unnecessary Lost Time

- Not 100% well.
- No work available.
- Too busy.
- Insurance carrier’s job.
- Supervisors and managers.

Employer's Role

Ensure a safe workplace.

Employers must take all actions reasonably necessary to ensure a safe workplace and take all steps reasonably necessary to protect the life, health, and safety of employees.

Occupational Safety and Health Act of 1970

Employer's Role

Before another injury, change your culture.

- Post notices of coverage (Notice 6, *Notice to Employees Concerning Workers' Compensation in Texas*).
- Educate, inform, and remove surprises.
- Know what to expect and what to do.
- Involve your employees.
- Designate and train a contact.
- Hold supervisors and managers accountable.

Employer's Role

After an injury or illness, the employer:

- Reports an injury to your insurance carrier using DWC Form-001, *Employer's First Report of Injury and Illness* and DWC Form-003, *Employer's Wage Statement*.
- Investigates.
- Maintains continuous positive communication with injured employees.
- Monitors claims regularly.
- Attends hearings.
- Provides RTW and SAW opportunities.

28 Texas Administrative Code (TAC) Chapter 120

Employer's Role

Employers don't:

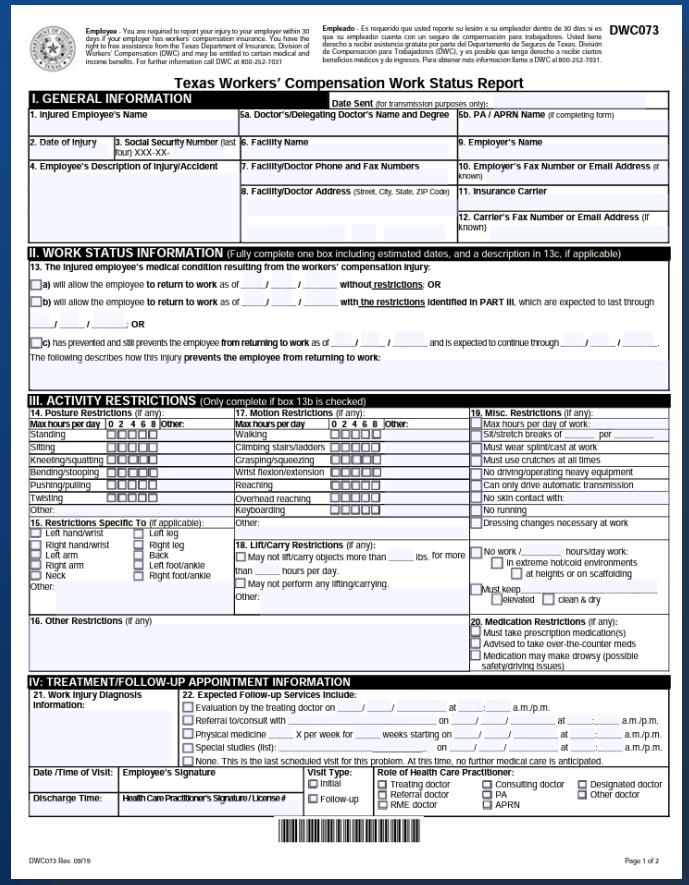
- Retaliate.
- Direct medical care.
- Determine compensability.

Insurance Carrier's Role

- Follow all rules and laws.
- Investigate to determine compensability.
- Monitor claim activities.
- Maintain communication with the injured employee, employer, doctor, and other providers.
- Provide information and education.
- Use treatment and lost time (RTW) guidelines.
- Provide RTW coordination services.
- Possibly assign a case manager.

Treating Doctor's Role

- Provide medical care for an injury and determine when it is safe for the employee to RTW.
- Communicate to the employer and others by completing DWC Form-073, *Work Status Report*.
- Identify any restrictions and what the injured employee **can** do.
- Support and encourage SAW and RTW.



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 (DWC) and may be entitled to certain medical and income benefits. For further information call DWC at 800-252-7031.

Empleado - Es requerido que usted reporte su lesión a su empleador dentro de 30 días si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte del Departamento de Seguros de Texas, División de Compensación para Trabajadores (DWC), y es posible que tenga derecho a recibir ciertos beneficios médicos y de ingresos. Para obtener más información llame a DWC al 800-252-7031.

DWC073

Texas Workers' Compensation Work Status Report

I. GENERAL INFORMATION — Date Sent (for transmission purposes only):

1. Injured Employee's Name
5a. Doctor's/Delegating Doctor's Name and Degree
5b. PA / APRN Name (if completing form)
2. Date of Injury
3. Social Security Number (last four XXX-XX-
6. Facility Name
9. Employer's Name
4. Employee's Description of Injury/Accident
7. Facility/Doctor Phone and Fax Numbers
10. Employer's Fax Number or Email Address (if known)
8. Facility/Doctor Address (Street, City, State, ZIP Code)
11. Insurance Carrier
12. Carrier's Fax Number or Email Address (if known)

II. WORK STATUS INFORMATION (Fully complete one box including estimated dates, and a description in 13c, if 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 ____/____/____ **without restrictions**; **OR**

☐ b) will allow the employee **to return to work** as of ____/____/____ **with the restrictions identified in PART III**, which are expected to last through ____/____/____; **OR**

☐ c) has prevented and still prevents the employee **from returning to work** as of ____/____/____ and is expected to continue through ____/____/____.

The following describes how this injury **prevents the employee from returning to work**:

III. ACTIVITY RESTRICTIONS (Only complete if box 13b 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:						

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:						

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 skin contact with:
☐ No running
☐ Dressing changes necessary at work

15. Restrictions Specific To (if applicable):
☐ Left hand/wrist ☐ Left leg
☐ Right hand/wrist ☐ Right leg
☐ Left arm ☐ Back
☐ Right arm ☐ Left foot/ankle
☐ Neck ☐ Right foot/ankle
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:

☐ No work / _____ hours/day work:
☐ In extreme hot/cold environments
☐ at heights or on scaffolding
☐ Must keep _____
☐ elevated ☐ clean & dry

16. Other Restrictions (if any)

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)

IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

22. Expected Follow-up Services Include:
☐ Evaluation by the treating doctor on ____/____/____ at ____:____ a.m./p.m.
☐ Referral to/consult with _____ on ____/____/____ at ____:____ a.m./p.m.
☐ Physical medicine ____ X per week for ____ weeks starting on ____/____/____ at ____:____ a.m./p.m.
☐ Special studies (list): _____ on ____/____/____ at ____:____ a.m./p.m.
☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date /Time of Visit:	Employee's Signature	Visit Type:	Role of Health Care Practitioner:
Discharge Time:	Health Care Practitioner's Signature / License #	☐ Initial ☐ Follow-up	☐ Treating doctor ☐ Consulting doctor ☐ Designated doctor ☐ Referral doctor ☐ PA ☐ Other doctor ☐ RME doctor ☐ APRN

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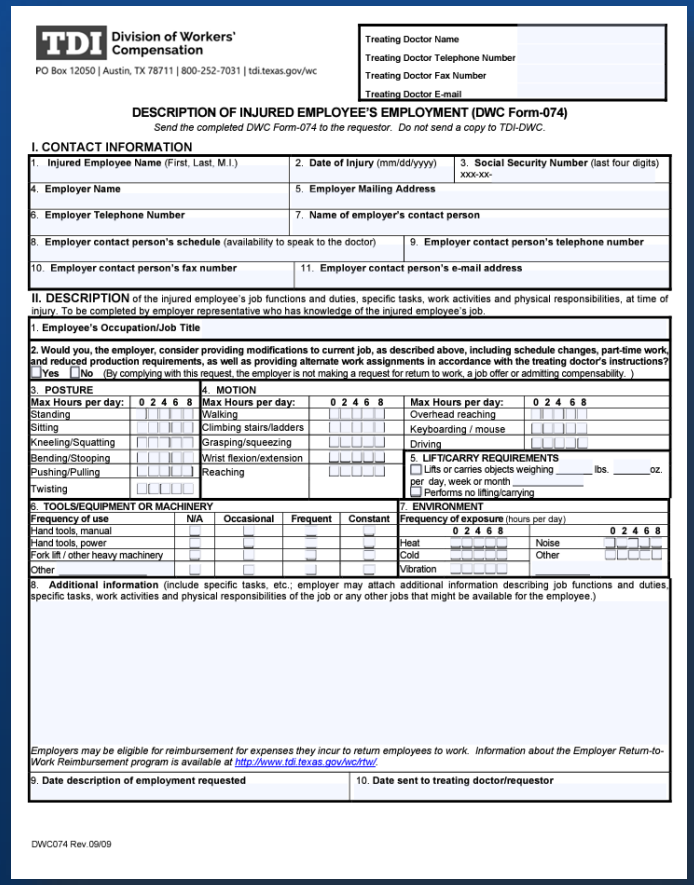
Explaining the Injured Employee's Job to the Treating Doctor

Employer may assist the treating doctor by explaining the tasks and duties related to the injured employee's job.

Employer may use DWC Form-074, *Description of Injured Employee Employment*, to help explain:

- Job functions and duties.
- Specific tasks.
- Work activities.
- Physical responsibilities.



TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Treating Doctor Name
Treating Doctor Telephone Number
Treating Doctor Fax Number
Treating Doctor E-mail

DESCRIPTION OF INJURED EMPLOYEE'S EMPLOYMENT (DWC Form-074)

Send the completed DWC Form-074 to the requestor. Do not send a copy to TDI-DWC.

I. CONTACT INFORMATION

1. **Injured Employee Name** (First, Last, M.I.) | 2. **Date of Injury** (mm/dd/yyyy) | 3. **Social Security Number** (last four digits) xxx-xx-
4. **Employer Name** | 5. **Employer Mailing Address**
6. **Employer Telephone Number** | 7. **Name of employer's contact person**
8. **Employer contact person's schedule** (availability to speak to the doctor) | 9. **Employer contact person's telephone number**
10. **Employer contact person's fax number** | 11. **Employer contact person's e-mail address**

II. DESCRIPTION of the injured employee's job functions and duties, specific tasks, work activities and physical responsibilities, at time of injury. To be completed by employer representative who has knowledge of the injured employee's job.

1. **Employee's Occupation/Job Title**

2. **Would you, the employer, consider providing modifications to current job, as described above, including schedule changes, part-time work, and reduced production requirements, as well as providing alternate work assignments in accordance with the treating doctor's instructions?** ☐ **Yes** ☐ **No** (By complying with this request, the employer is not making a request for return to work, a job offer or admitting compensability.)

3. **POSTURE**

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

4. **MOTION**

Max Hours per day:	0 2 4 6 8
Walking	
Climbing stairs/ladders	
Grasping/squeezing	
Wrist flexion/extension	
Reaching	

Max Hours per day:	0 2 4 6 8
Overhead reaching	
Keyboarding / mouse	
Driving	

5. **LIFT/CARRY REQUIREMENTS**
☐ Lifts or carries objects weighing _____ lbs. _____oz. per day, week or month _____
☐ Performs no lifting/carrying

6. **TOOLS/EQUIPMENT OR MACHINERY**

Frequency of use	**N/A**	**Occasional**	**Frequent**	**Constant**
Hand tools, manual				
Hand tools, power				
Fork lift / other heavy machinery				
Other _____				

7. **ENVIRONMENT**

Frequency of exposure (hours per day)	0 2 4 6 8		0 2 4 6 8
Heat		Noise	
Cold		Other	
Vibration		_____	

8. **Additional information** (include specific tasks, etc.; employer may attach additional information describing job functions and duties, specific tasks, work activities and physical responsibilities of the job or any other jobs that might be available for the employee.)

Employers may be eligible for reimbursement for expenses they incur to return employees to work. Information about the Employer Return-to-Work Reimbursement program is available at http://www.tdi.texas.gov/wc/rtw/.

9. **Date description of employment requested** | 10. **Date sent to treating doctor/requestor**

DWC074 Rev.09/09

Description of Injured Employee's Employment (DWC Form-074)

II. DESCRIPTION of the injured employee's job functions and duties, specific tasks, work activities and physical responsibilities, at time of injury. To be completed by employer representative who has knowledge of the injured employee's job.

1. **Employee's Occupation/Job Title**

2. Would you, the employer, consider providing modifications to current job, as described above, including schedule changes, part-time work, and reduced production requirements, as well as providing alternate work assignments in accordance with the treating doctor's instructions?
☐ **Yes** ☐ **No** (By complying with this request, the employer is not making a request for return to work, a job offer or admitting compensability.)

3. **POSTURE**

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

4. **MOTION**

Max Hours per day:	**0 2 4 6 8**	**Max Hours per day:**	**0 2 4 6 8**
Walking		Overhead reaching	
Climbing stairs/ladders		Keyboarding / mouse	
Grasping/squeezing		Driving	
Wrist flexion/extension			
Reaching			

5. **LIFT/CARRY REQUIREMENTS**
☐ Lifts or carries objects weighing _____ lbs. _____oz. per day, week or month _____
☐ Performs no lifting/carrying

6. **TOOLS/EQUIPMENT OR MACHINERY**

Frequency of use	**N/A**	**Occasional**	**Frequent**	**Constant**
Hand tools, manual	☐	☐	☐	☐
Hand tools, power	☐	☐	☐	☐
Fork lift / other heavy machinery	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

7. **ENVIRONMENT**

Frequency of exposure (hours per day)

	0 2 4 6 8		**0 2 4 6 8**
Heat		Noise	
Cold		Other	
Vibration		_____	

8. **Additional information** (include specific tasks, etc.; employer may attach additional information describing job functions and duties, specific tasks, work activities and physical responsibilities of the job or any other jobs that might be available for the employee.)

Work Status Form (DWC Form-073)

II. WORK STATUS INFORMATION (Fully complete one box including estimated dates, and a description in 13c, if applicable)

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☐ **b)** will allow the employee **to return to work** as of _____/ _____ / _____ **with the restrictions identified in PART III**, which are expected to last through _____/ _____ / _____; **OR**

☐ **c)** has prevented and still prevents the employee **from returning to work** as of _____/ _____ / _____ and is expected to continue through _____/ _____ / _____.

The following describes how this injury **prevents the employee from returning to work:**

III. ACTIVITY RESTRICTIONS (Only complete if box 13b is checked)

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Sitting	☐	☐	☐	☐	☐	
Kneeling/squatting	☐	☐	☐	☐	☐	
Bending/stooping	☐	☐	☐	☐	☐	
Pushing/pulling	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	
Other:						

15. Restrictions Specific To (if applicable):

☐ Left hand/wrist ☐ Left leg
☐ Right hand/wrist ☐ Right leg
☐ Left arm ☐ Back
☐ Right arm ☐ Left foot/ankle
☐ Neck ☐ Right foot/ankle
Other:

16. Other Restrictions (if any)

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 skin contact with:
☐ No running
☐ Dressing changes necessary at work
☐ No work /_____ hours/day work:
☐ in extreme hot/cold environments
☐ at heights or on scaffolding
☐ Must keep_____
☐ elevated ☐ clean & dry

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)

SAW & RTW Employer Offering Work Assignments

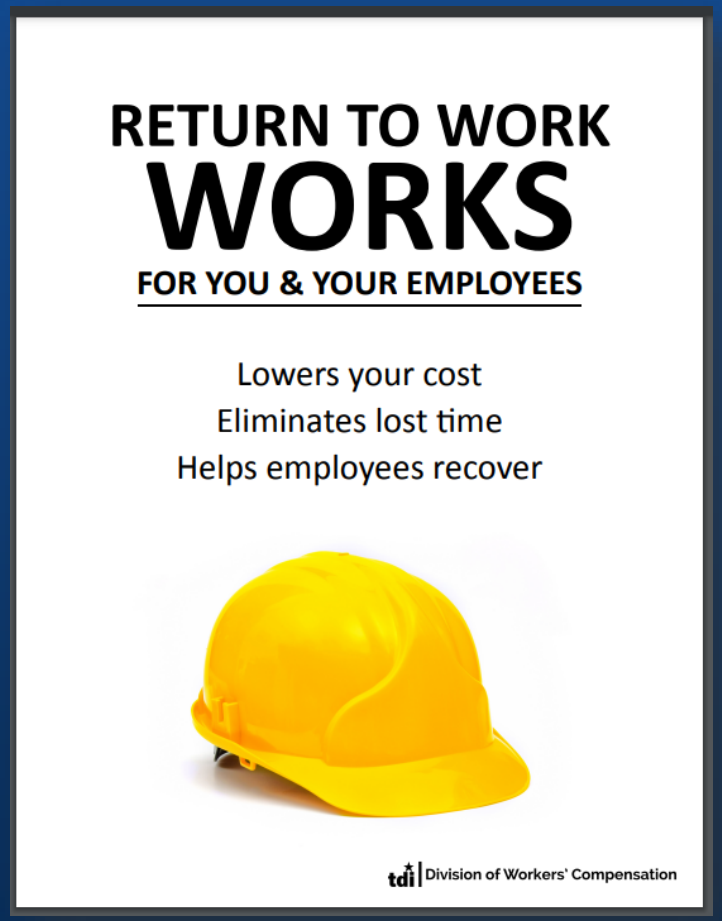
NOT: “Light Duty” – REAL WORK!

Tasks

Duties

Activities

Employer RTW Guide



DWC
Division of Workers' Compensation

Real Work Assignments within Restrictions

- All assignments should be within restrictions.
- Transitionary or temporary.
- Functions or duties of their regular job.
- New assignment.
- Other tasks usually done by coworkers.
- Might be a different way of doing something.

The Value of Part Time Work, Everybody Wins!

At Home Full Time

Employer gets:

- No work, OT/Temp costs.
- Pays $350 income benefits.
  (AWW $500 x .70= $350)

Employee gets:

- $350 income benefits.
- Slower recovery.

Working Half Time

Employer gets:

- Real work, may not need OT/Temp.
- Pays $175 income benefits.
  (1/2 AWW $250 x .70= $175)

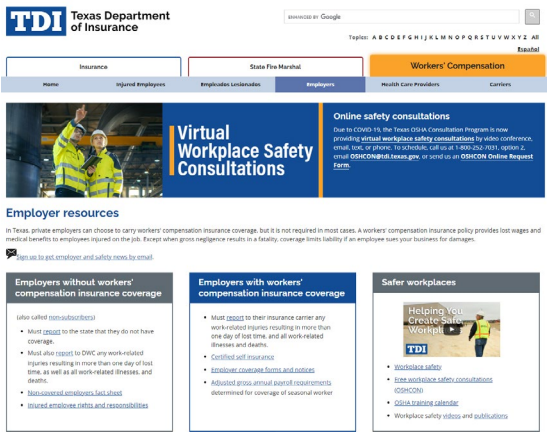
Employee gets:

- $250 for real work.
- $175 income benefits.
  ($250 + $175 = $425)
- Heals faster.

DWC Resources

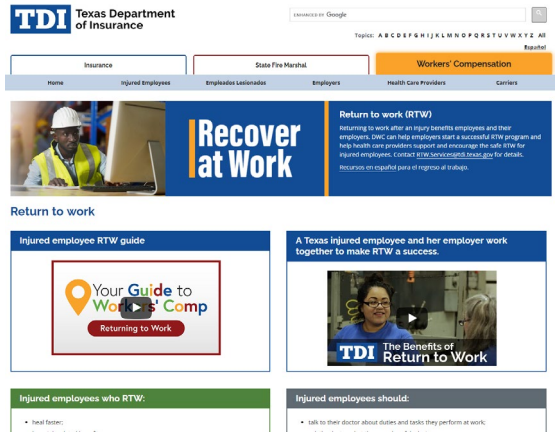
Employer webpage with responsibilities and forms:

www.tdi.texas.gov/wc/employer/index.html



RTW webpage for all system participants, including the employer's RTW guide:

www.tdi.texas.gov/wc/rtw/index.html



RTW training for:

- Employers.
- Health care providers.
- Professional associations.

Occupational Safety and Health Consultations (OSHCON)

- Free confidential workplace safety consultations for OSHA compliance.
- Resources, videos, safety training, and courses.
- Lone Star Safety Program recognizes safe employers.
- Field offices across Texas.

800-252-7031, option 2

OSHCON@tdi.texas.gov

www.tdi.texas.gov/oshcon/index.html

Office of Injured Employee Counsel (OIEC)

Free assistance for injured employees who:

- Have a workers' compensation claim.
- Are not represented by an attorney.

Services include assisting, educating, and advocating for the injured employee.

866-393-6432

OIECInbox@oiec.texas.gov

www.oiec.texas.gov

DWC RTW Contact Information

Amy Rich

RTW Outreach and Education

Amy.Rich@tdi.texas.gov

512-804-4809

Email:

RTW.services@tdi.texas.gov

Website:

www.tdi.texas.gov/wc/rtw/index.html

Thank you!

TDI Division of Workers' Compensation