WORKERS' COMP

BOOT CAMP

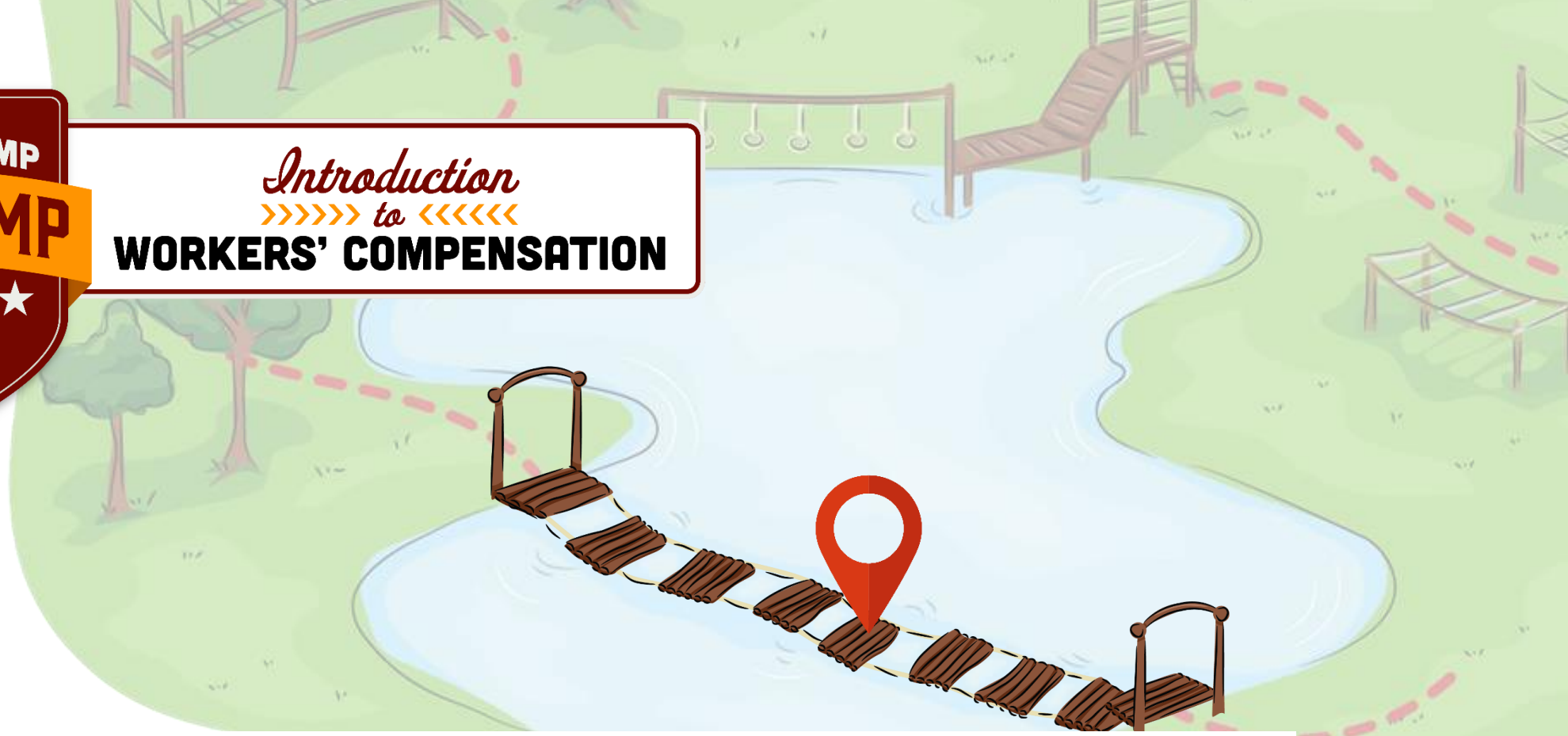
Training

PART 2

2025

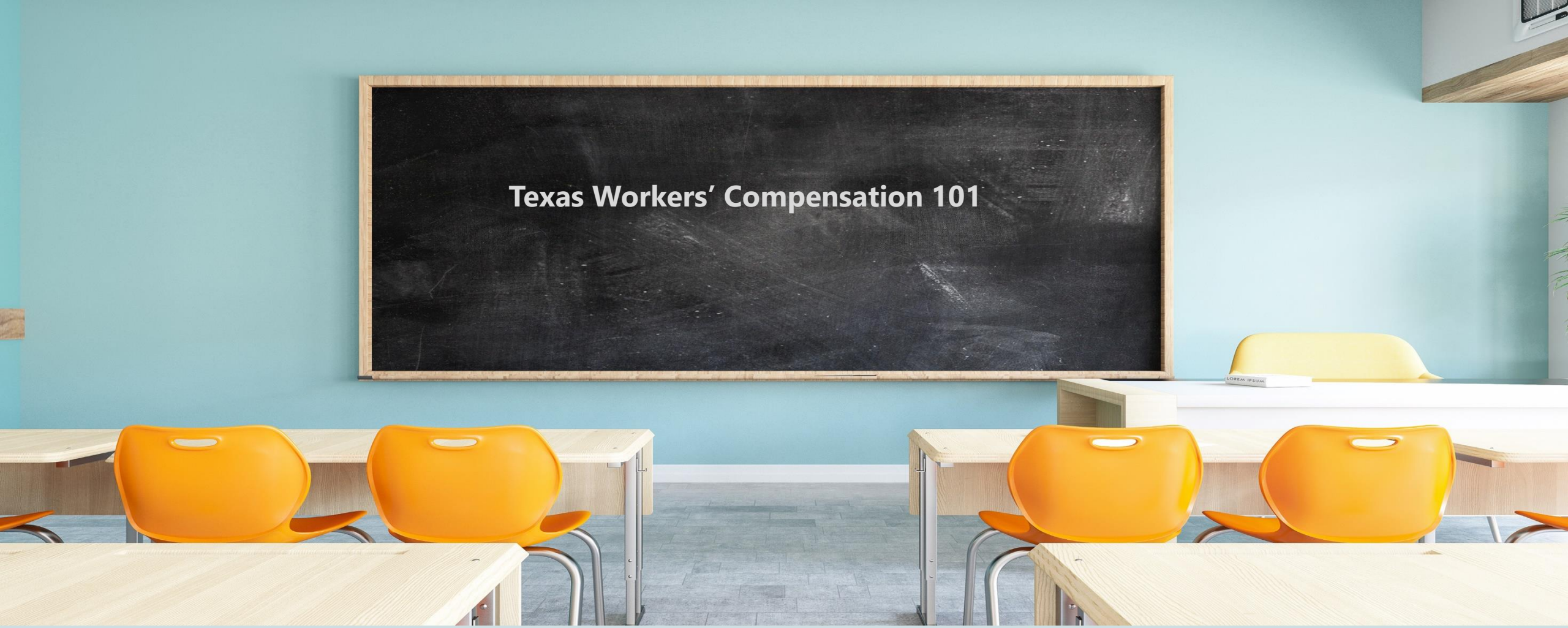
Introduction to WORKERS' COMPENSATION

TDI Division of Workers' Compensation



Learning Objectives

- Know the DWC website, using the workers' compensation A-Z tool.
- Understand how Texas workers' compensation coverage works for employers.
- Learn about the required forms and notices.



Introduction to the Texas Workers' Compensation System

Division of Workers' Compensation
2025

Disclaimer

This presentation is for educational purposes only and provides general information. It is not a substitute for a full review of statutes and rules.

System participants are responsible for knowing and complying with the applicable sections of the Texas Insurance Code (Insurance Code), Texas Labor Code (Labor Code), and Texas Administrative Code (TAC).

Any opinions expressed by the speakers are personal and do not constitute or reflect any statement of policy by the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Overview

- Texas Workers' Compensation Regulation.
- Goals, Legislative Intent, and Mission of the Workers' Compensation System.
- Texas Workers' Compensation Coverage.
- Required Forms.
- Providing Health Care to Injured Employees.
- Official Notices.

Texas Workers' Compensation Regulation

What is Texas workers' compensation?

A state-regulated insurance program that pays medical benefits and income benefits for employees with **compensable** work-related illnesses or injuries.

Compensable injury:

"An injury that arises out of and in the course and scope of employment for which compensation is payable under this subtitle."

Labor Code Sec. 401.011. General Definitions

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"An injury that arises out of and in the course and scope of employment for which compensation is payable under this subtitle."

Texas Labor Code Sec. 401.011. General Definitions

Course and scope of employment -

"An activity… that is performed by an employee while engaged in or about the furtherance of the affairs or business of the employer… [including] on the premises of the employer or at other locations."

Texas Labor Code Sec. 401.011. General Definitions

… regardless of fault

Regardless of fault does **not** mean:

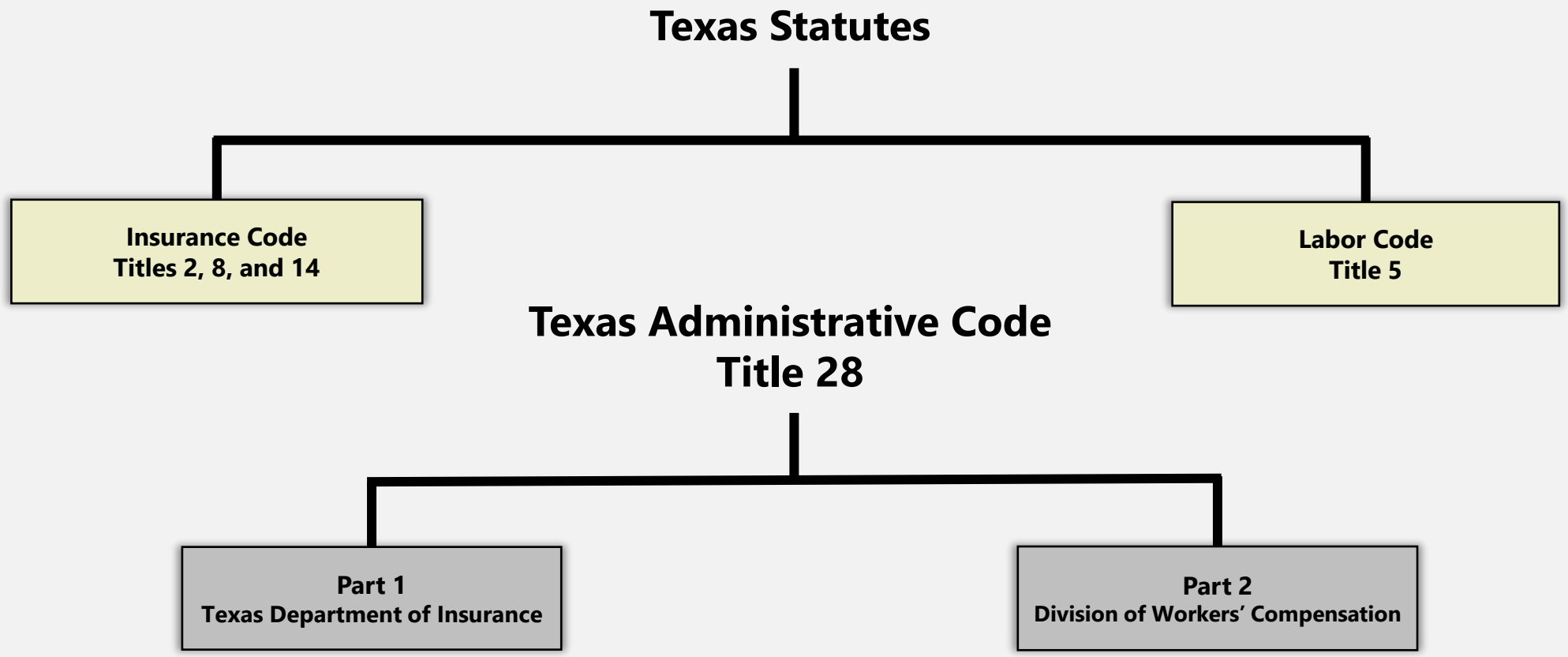
- Intoxication;
- Willful attempt to injure themself or another person;
- Caused by a third person for a personal reason, unless the reason was related to employment;

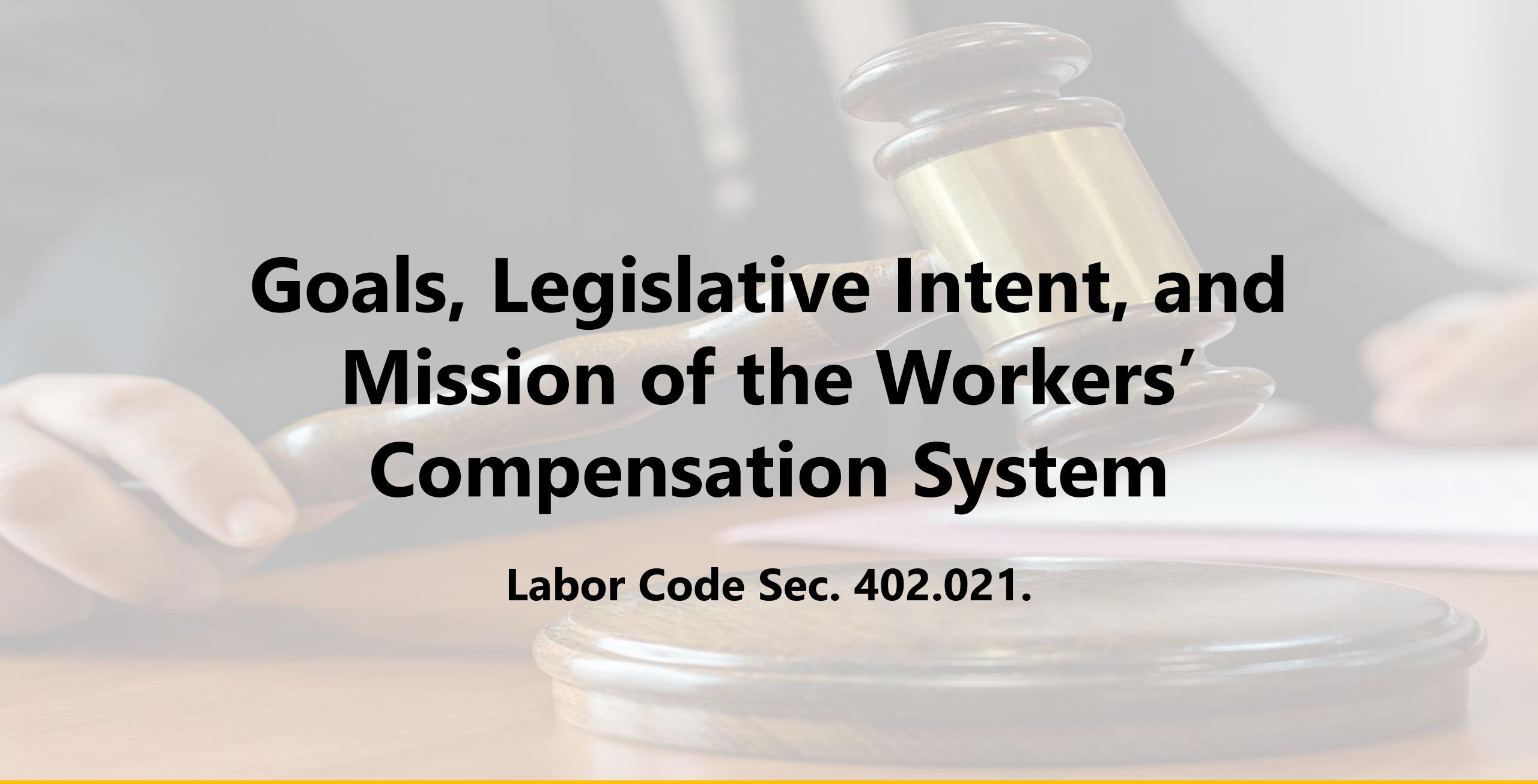
Regardless of fault does **not** mean:

- Intoxication;
- Willful attempt to injure themself or another person;
- Caused by a third person for a personal reason, unless the reason was related to employment;

- Participation in an off-duty activity not related to job duties, unless explicitly or implicitly required by employer;
- An act of God, unless job exposed the employee to a greater risk of injury; or
- Engaging in horseplay.

Texas Workers' Compensation Regulation





Goals, Legislative Intent, and Mission of the Workers' Compensation System

Labor Code Sec. 402.021.

Mission of the Texas Workers' Compensation System

The timely return of injured employees to productive roles in the Texas workforce is one of the key components of DWC's mission.

Some Basic Goals of the Texas Workers' Compensation System

Each injured employee shall have access to prompt, high quality medical care supporting restoration of the injured employee's physical condition and earning capacity.

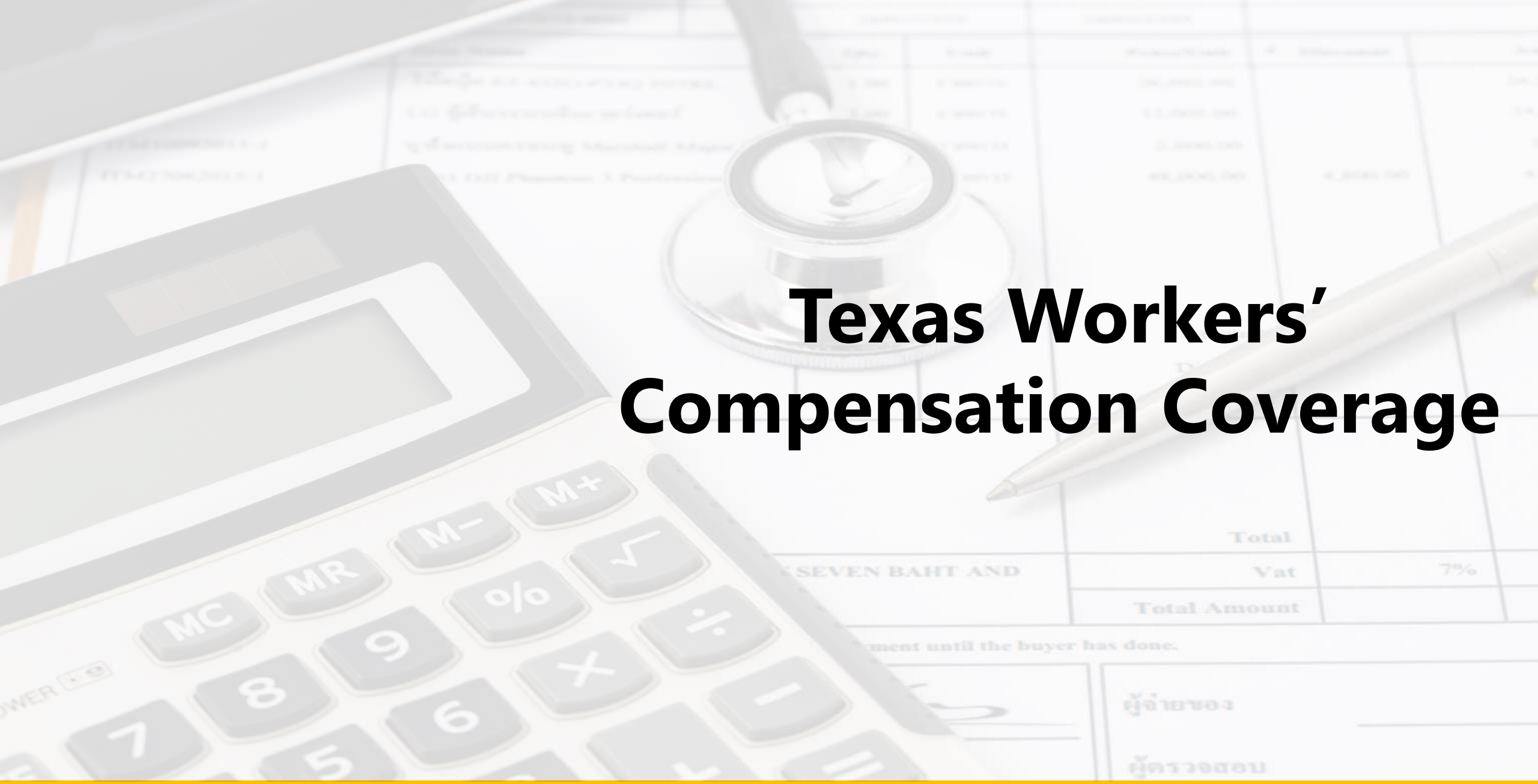
Some Basic Goals of the Texas Workers' Compensation System

Each injured employee shall have access to prompt, high quality medical care supporting restoration of the injured employee's physical condition and earning capacity.

Each injured employee shall receive services to facilitate the employee's return to employment as soon as it is considered safe and appropriate by the employee's health care provider.

Promoting Safe and Timely Return of Injured Employees to Productive Roles in the Workforce Includes:

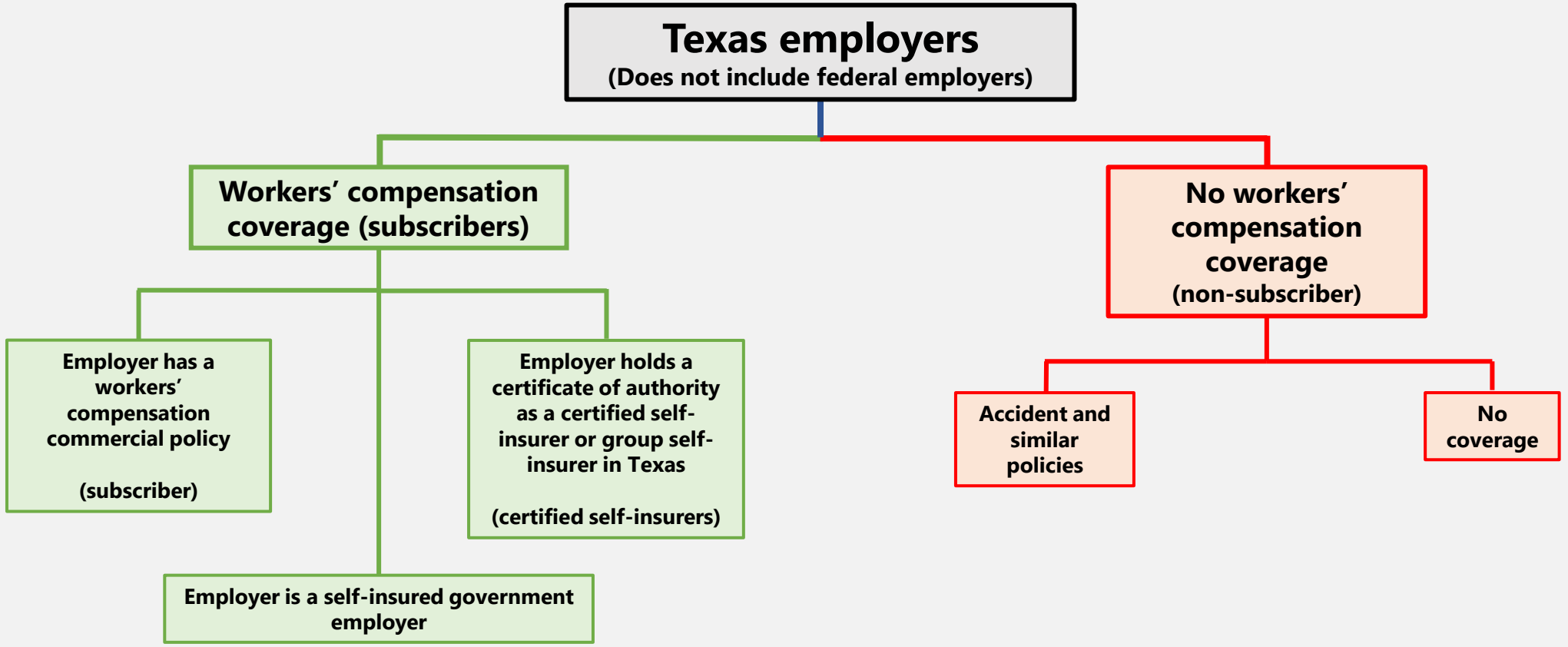
- Treatment guidelines;
- Return-to-work guidelines;
- Employer return-to-work programs; and
- Case management.



Texas Workers' Compensation Coverage

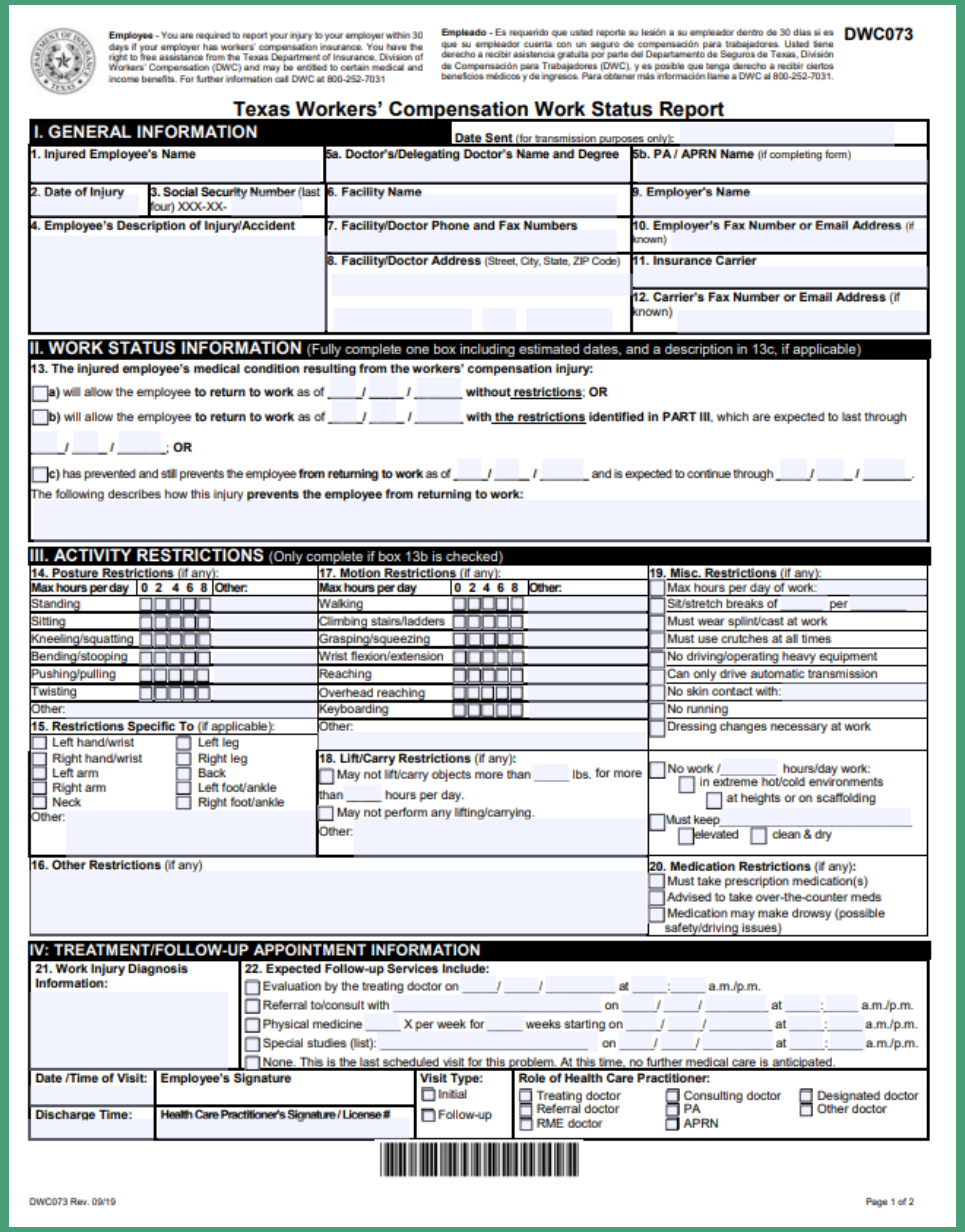
Texas Workers' Compensation Coverage

Labor Code Sec. 406.002 Coverage Generally Elective



Required Forms

Work Status Report
DWC Form-073



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	☐	☐	☐	☐	☐	

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

DWC073 Rev. 09/19

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Work Status Report
DWC Form-073

Used to inform the insurance carrier, employer, and injured employee of the injured employee's functional abilities and whether the injured employee is able to work, with or without restrictions, or is unable to work.

Work Status Report
DWC Form-073

Submitted by:

- Injured employee's treating doctor;
- Treating doctor's delegated physician assistant or advanced practice registered nurse;
- Referral doctor;
- Designated doctor; or
- Required medical exam doctor.

Work Status Report
DWC Form-073

Submitted:

- After the initial examination of the employee, regardless of the employee's work status; and
- When the employee experiences a change in their work status or a substantial change in their activity restrictions.

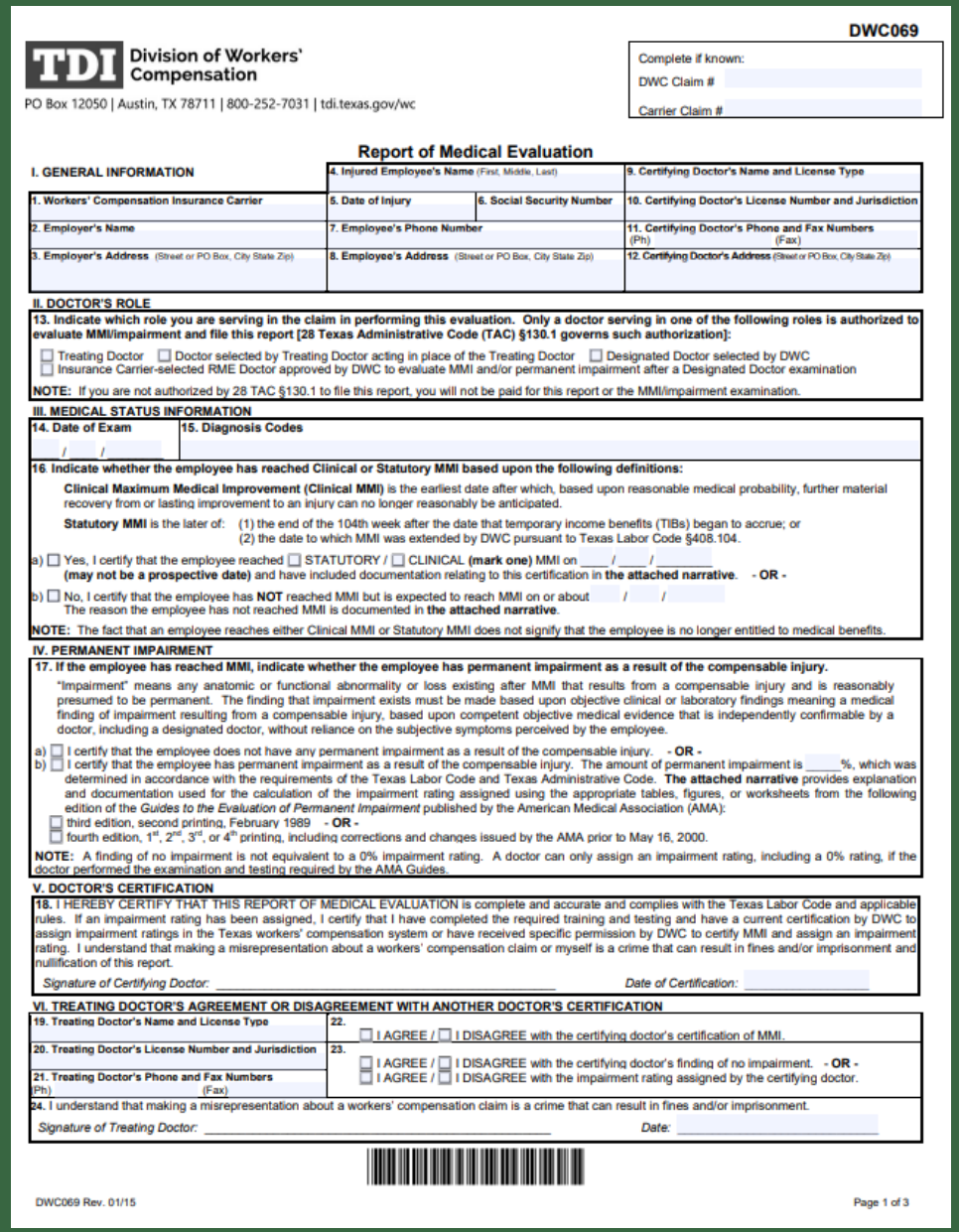
Work Status Report
DWC Form-073

On the scheduled request by the insurance carrier, its agent, or the employer requesting the report through its insurance carrier:

- Not to exceed one report every two weeks; and
- Based on the scheduled appointments with the injured employee.

Work Status Report
DWC Form-073

Report of Medical Evaluation DWC Form-069



DWC069

TDI Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Complete if known:
DWC Claim #
Carrier Claim #

Report of Medical Evaluation

I. GENERAL INFORMATION

1. Workers' Compensation Insurance Carrier
2. Employer's Name
3. Employer's Address (Street or PO Box, City State Zip)
4. Injured Employee's Name (First, Middle, Last)
5. Date of Injury
6. Social Security Number
7. Employee's Phone Number
8. Employee's Address (Street or PO Box, City State Zip)
9. Certifying Doctor's Name and License Type
10. Certifying Doctor's License Number and Jurisdiction
11. Certifying Doctor's Phone and Fax Numbers (Ph) (Fax)
12. Certifying Doctor's Address (Street or PO Box, City State Zip)

II. DOCTOR'S ROLE

13. Indicate which role you are serving in the claim in performing this evaluation. Only a doctor serving in one of the following roles is authorized to evaluate MMI/impairment and file this report [28 Texas Administrative Code (TAC) §130.1 governs such authorization]:

☐ Treating Doctor ☐ Doctor selected by Treating Doctor acting in place of the Treating Doctor ☐ Designated Doctor selected by DWC
☐ Insurance Carrier-selected RME Doctor approved by DWC to evaluate MMI and/or permanent impairment after a Designated Doctor examination

NOTE: If you are not authorized by 28 TAC §130.1 to file this report, you will not be paid for this report or the MMI/impairment examination.

III. MEDICAL STATUS INFORMATION

14. Date of Exam ___ / ___ / ___
15. Diagnosis Codes

16. Indicate whether the employee has reached Clinical or Statutory MMI based upon the following definitions:

Clinical Maximum Medical Improvement (Clinical MMI) is the earliest date after which, based upon reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated.

Statutory MMI is the later of: (1) the end of the 104th week after the date that temporary income benefits (TIBs) began to accrue; or (2) the date to which MMI was extended by DWC pursuant to Texas Labor Code §408.104.

a) ☐ Yes, I certify that the employee reached ☐ STATUTORY / ☐ CLINICAL **(mark one)** MMI on ____ / ____ / _____ **(may not be a prospective date)** and have included documentation relating to this certification in **the attached narrative**. **- OR -**

b) ☐ No, I certify that the employee has **NOT** reached MMI but is expected to reach MMI on or about ___ / ___ / ___ The reason the employee has not reached MMI is documented in **the attached narrative**.

NOTE: The fact that an employee reaches either Clinical MMI or Statutory MMI does not signify that the employee is no longer entitled to medical benefits.

IV. PERMANENT IMPAIRMENT

17. If the employee has reached MMI, indicate whether the employee has permanent impairment as a result of the compensable injury.

"Impairment" means any anatomic or functional abnormality or loss existing after MMI that results from a compensable injury and is reasonably presumed to be permanent. The finding that impairment exists must be made based upon objective clinical or laboratory findings meaning a medical finding of impairment resulting from a compensable injury, based upon competent objective medical evidence that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee.

a) ☐ I certify that the employee does not have any permanent impairment as a result of the compensable injury. **- OR -**
b) ☐ I certify that the employee has permanent impairment as a result of the compensable injury. The amount of permanent impairment is _____%, which was determined in accordance with the requirements of the Texas Labor Code and Texas Administrative Code. **The attached narrative** provides explanation and documentation used for the calculation of the impairment rating assigned using the appropriate tables, figures, or worksheets from the following edition of the *Guides to the Evaluation of Permanent Impairment* published by the American Medical Association (AMA):
☐ third edition, second printing, February 1989 **- OR -**
☐ fourth edition, 1st, 2nd, 3rd, or 4th printing, including corrections and changes issued by the AMA prior to May 16, 2000.

NOTE: A finding of no impairment is not equivalent to a 0% impairment rating. A doctor can only assign an impairment rating, including a 0% rating, if the doctor performed the examination and testing required by the AMA Guides.

V. DOCTOR'S CERTIFICATION

18. I HEREBY CERTIFY THAT THIS REPORT OF MEDICAL EVALUATION is complete and accurate and complies with the Texas Labor Code and applicable rules. If an impairment rating has been assigned, I certify that I have completed the required training and testing and have a current certification by DWC to assign impairment ratings in the Texas workers' compensation system or have received specific permission by DWC to certify MMI and assign an impairment rating. I understand that making a misrepresentation about a workers' compensation claim or myself is a crime that can result in fines and/or imprisonment and nullification of this report.

Signature of Certifying Doctor: _____ *Date of Certification:*

VI. TREATING DOCTOR'S AGREEMENT OR DISAGREEMENT WITH ANOTHER DOCTOR'S CERTIFICATION

19. Treating Doctor's Name and License Type
20. Treating Doctor's License Number and Jurisdiction
21. Treating Doctor's Phone and Fax Numbers (Ph) (Fax)

22. ☐ I AGREE / ☐ I DISAGREE with the certifying doctor's certification of MMI.
23. ☐ I AGREE / ☐ I DISAGREE with the certifying doctor's finding of no impairment. **- OR -**
☐ I AGREE / ☐ I DISAGREE with the impairment rating assigned by the certifying doctor.

24. I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature of Treating Doctor: _____ *Date:*

DWC069 Rev. 01/15 Page 1 of 3

Report of Medical Evaluation DWC Form-069

Report of Medical Evaluation

- Used to indicate whether the injured employee has reached maximum medical improvement (MMI).
- Used to indicate whether the injured employee has permanent impairment as a result of the compensable injury.

Report of Medical Evaluation DWC Form-069

Maximum Medical Improvement

Clinical
The earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer be anticipated.

Statutory
The expiration of 104 weeks from the date on which income benefits begin to accrue.

Report of Medical Evaluation DWC Form-069

Maximum Medical Improvement

The commissioner may extend the date of statutory MMI if the employee has had spinal surgery, or has been approved for spinal surgery, within 12 weeks before the expiration of the 104-week period.

Report of Medical Evaluation DWC Form-069

Impairment Rating

Impairment

Any anatomic or functional abnormality or loss existing after MMI that results from a compensable injury and is reasonably presumed to be permanent.

IR

The percentage of permanent impairment of the whole body resulting from a compensable injury.

Based on the rating criteria contained in the ***American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th Edition. 1st, 2nd, 3rd, or 4th printing***.

Report of Medical Evaluation DWC Form-069

Only a Doctor Who is Certified by DWC may assign an IR:

- ✓ Designated doctors;
- ✓ Required medical examination doctors;
- ✓ Some treating doctors; and
- ✓ Some referral doctors.

Report of Medical Evaluation DWC Form-069

Providing Health Care to Injured Employees

Systems of Reimbursement for Health Care Services Provided to Injured Employees

Certified Workers' Compensation Health Care Network Contracts

Texas Insurance Code Sec.1305.

(Network Claims)

Systems of Reimbursement for Health Care Services Provided to Injured Employees

Public Employers Intergovernmental Risk Pools

Texas Labor Code, Sec. 504.053.

(Network; Non-Network; or Direct contracts with HCPs)

Certified Workers' Compensation Health Care Network Contracts

Texas Insurance Code Sec.1305.

(Network Claims)

DWC Non-Network Health Care

Texas Labor Code, Sec. 408. and Sec. 413.

(Non-Network Claims)

Providing Health Care to Injured Employees Subject to a Network

- Must apply to the network to be an approved network provider;
- Medical reimbursement is determined by contract;
- Must make referrals to other network providers; **and**
- Referrals to out-of-network providers must be approved by the network.

Providing Health Care to Injured Employees *not* Subject to a Network (non-network)

- No application requirement to provide non-network health care;
- Medical reimbursement is determined by DWC medical fee guidelines; and
- Generally, follow Medicare payment policies.

Providing Health Care to Injured Employees of Political Subdivisions

Provide workers' compensation medical benefits:

- Through a network (follow network rules);
- In the manner provided by Labor Code Chapter 408 (follow non-network rules); or
- By directly contracting with health care providers or by contracting through a health benefits pool established under Local Government Code Chapter 172.

What happens when an injury occurs?

Notice of Injury

28 Texas Administrative Code

Chapter 120 Compensation Procedure – Employers

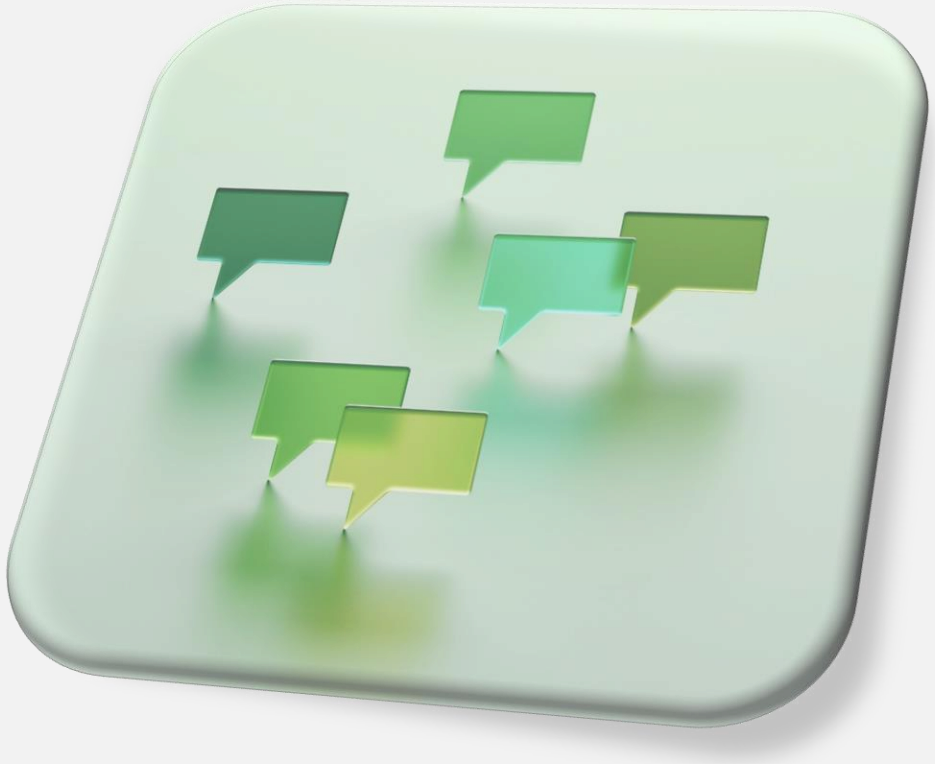
Chapter 122 Compensation Procedure – Claimants

Chapter 124 Insurance Carriers: Notices, Payments, and Reporting

Employee's Notice of Injury or Occupational Disease

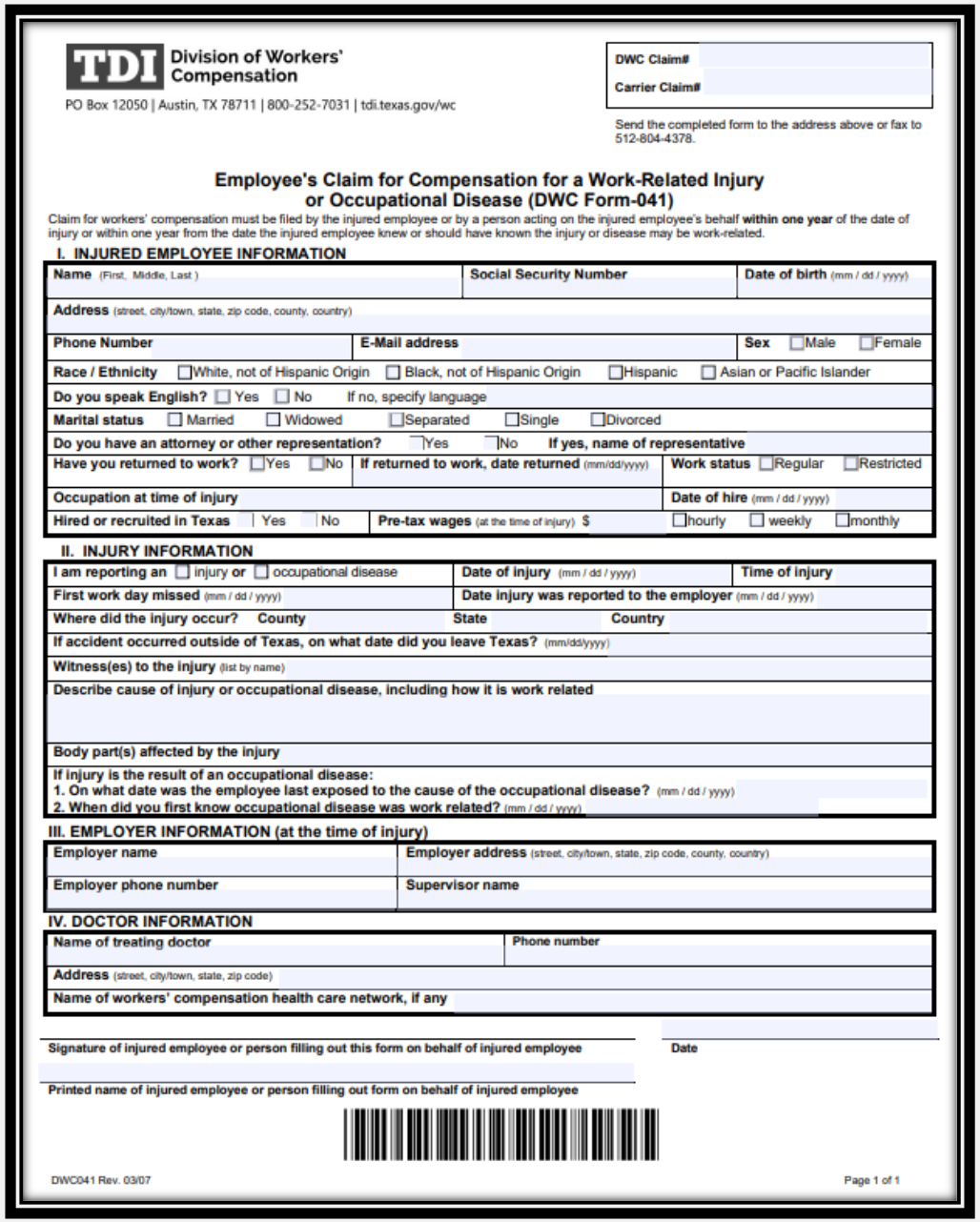
The employee:

- Notifies employer within **30 days** of the date:
  - The injury occurred; or
  - The employee knew or should have known of an occupational disease that may be related to the employment.
- Selects a treating doctor and informs the doctor how the injury occurred.



Employee's Notice of Injury or Occupational Disease

- Keeps in touch with the employer and the insurance carrier.
- Files **Employee's Claim for Compensation for a Work-Related Injury or Occupational Disease (DWC Form-041)** with DWC within one year.



TDI Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

DWC Claim#

Carrier Claim#

Send the completed form to the address above or fax to 512-804-4378.

Employee's Claim for Compensation for a Work-Related Injury or Occupational Disease (DWC Form-041)

Claim for workers' compensation must be filed by the injured employee or by a person acting on the injured employee's behalf **within one year** of the date of injury or within one year from the date the injured employee knew or should have known the injury or disease may be work-related.

I. INJURED EMPLOYEE INFORMATION

Name (First, Middle, Last)	Social Security Number	Date of birth (mm / dd / yyyy)
Address (street, city/town, state, zip code, county, country)		
Phone Number	E-Mail address	Sex ☐ Male ☐ Female
Race / Ethnicity ☐ White, not of Hispanic Origin ☐ Black, not of Hispanic Origin ☐ Hispanic ☐ Asian or Pacific Islander		
Do you speak English? ☐ Yes ☐ No If no, specify language		
Marital status ☐ Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced		
Do you have an attorney or other representation? ☐ Yes ☐ No If yes, name of representative		
Have you returned to work? ☐ Yes ☐ No	If returned to work, date returned (mm/dd/yyyy)	Work status ☐ Regular ☐ Restricted
Occupation at time of injury		Date of hire (mm / dd / yyyy)
Hired or recruited in Texas ☐ Yes ☐ No	Pre-tax wages (at the time of injury) $	☐ hourly ☐ weekly ☐ monthly

II. INJURY INFORMATION

I am reporting an ☐ injury or ☐ occupational disease	Date of injury (mm / dd / yyyy)	Time of injury
First work day missed (mm / dd / yyyy)	Date injury was reported to the employer (mm / dd / yyyy)	
Where did the injury occur? County	State	Country
If accident occurred outside of Texas, on what date did you leave Texas? (mm/dd/yyyy)		
Witness(es) to the injury (list by name)		
Describe cause of injury or occupational disease, including how it is work related		
Body part(s) affected by the injury		
If injury is the result of an occupational disease: 1. On what date was the employee last exposed to the cause of the occupational disease? (mm / dd / yyyy) 2. When did you first know occupational disease was work related? (mm / dd / yyyy)		

III. EMPLOYER INFORMATION (at the time of injury)

Employer name	Employer address (street, city/town, state, zip code, county, country)
Employer phone number	Supervisor name

IV. DOCTOR INFORMATION

Name of treating doctor	Phone number
Address (street, city/town, state, zip code)	
Name of workers' compensation health care network, if any	

Signature of injured employee or person filling out this form on behalf of injured employee — Date

Printed name of injured employee or person filling out form on behalf of injured employee

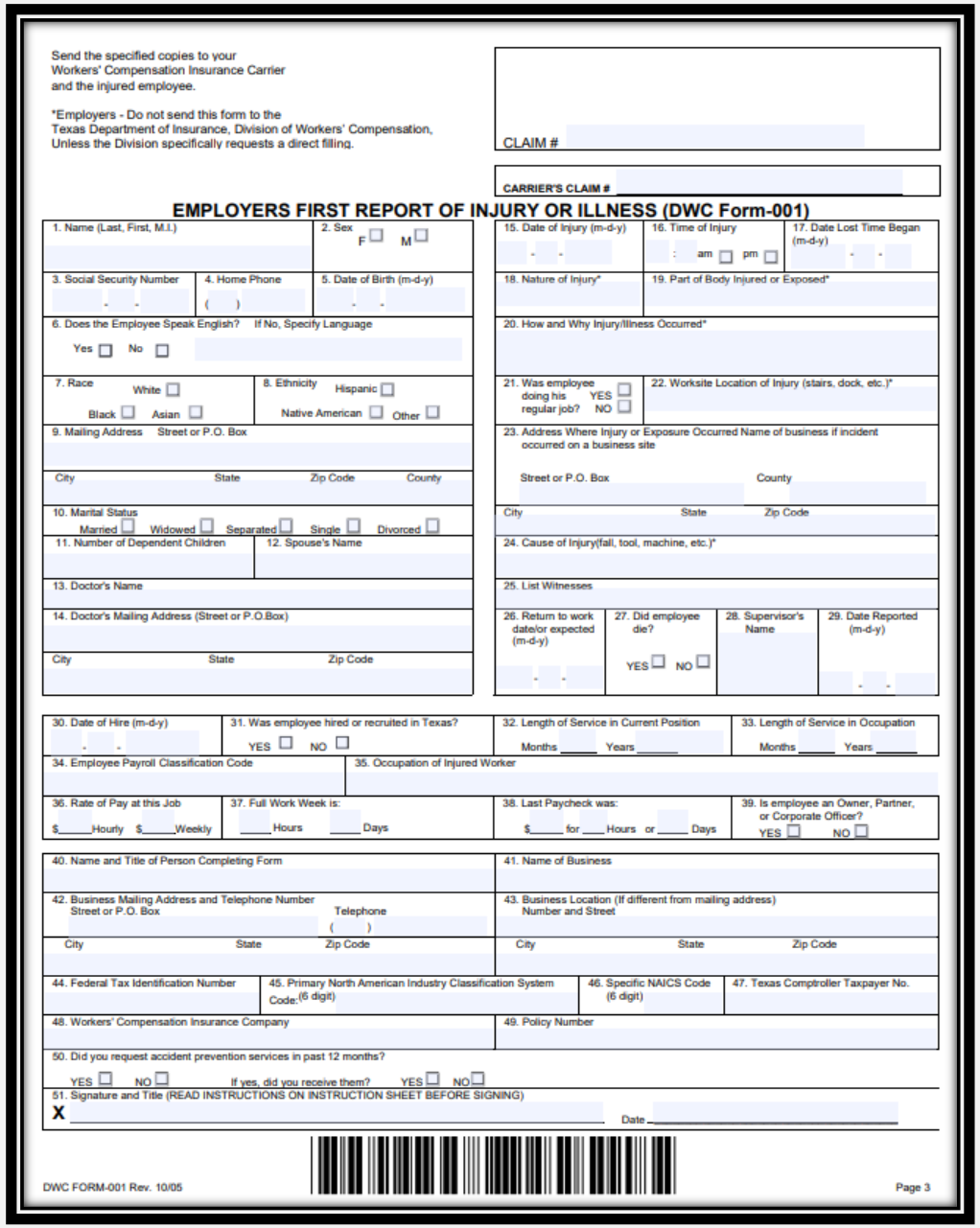
DWC041 Rev. 03/07 — Page 1 of 1

Employer's First Report of Injury

The employer:

- Gives the employee a written copy with a summary of rights and responsibilities, including notification of network requirements, if applicable; and

- Files **Employer's First Report of Injury or Illness (DWC Form-001)** with the insurance carrier if the employee loses more than one day of work.



Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, Unless the Division specifically requests a direct filing.

CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC Form-001)

1. Name (Last, First, M.I.) | 2. Sex F M | 15. Date of Injury (m-d-y) | 16. Time of Injury am pm | 17. Date Lost Time Began (m-d-y)

3. Social Security Number | 4. Home Phone | 5. Date of Birth (m-d-y) | 18. Nature of Injury* | 19. Part of Body Injured or Exposed*

6. Does the Employee Speak English? If No, Specify Language — Yes No | 20. How and Why Injury/Illness Occurred*

7. Race White Black Asian | 8. Ethnicity Hispanic Native American Other | 21. Was employee doing his regular job? YES NO | 22. Worksite Location of Injury (stairs, dock, etc.)*

9. Mailing Address Street or P.O. Box — City State Zip Code County | 23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site — Street or P.O. Box County — City State Zip Code

10. Marital Status Married Widowed Separated Single Divorced

11. Number of Dependent Children | 12. Spouse's Name | 24. Cause of Injury(fall, tool, machine, etc.)*

13. Doctor's Name | 25. List Witnesses

14. Doctor's Mailing Address (Street or P.O.Box) — City State Zip Code | 26. Return to work date/or expected (m-d-y) | 27. Did employee die? YES NO | 28. Supervisor's Name | 29. Date Reported (m-d-y)

30. Date of Hire (m-d-y) | 31. Was employee hired or recruited in Texas? YES NO | 32. Length of Service in Current Position Months Years | 33. Length of Service in Occupation Months Years

34. Employee Payroll Classification Code | 35. Occupation of Injured Worker

36. Rate of Pay at this Job $ Hourly $ Weekly | 37. Full Work Week is: Hours Days | 38. Last Paycheck was: $ for Hours or Days | 39. Is employee an Owner, Partner, or Corporate Officer? YES NO

40. Name and Title of Person Completing Form | 41. Name of Business

42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone — City State Zip Code | 43. Business Location (If different from mailing address) Number and Street — City State Zip Code

44. Federal Tax Identification Number | 45. Primary North American Industry Classification System Code:(6 digit) | 46. Specific NAICS Code (6 digit) | 47. Texas Comptroller Taxpayer No.

48. Workers' Compensation Insurance Company | 49. Policy Number

50. Did you request accident prevention services in past 12 months? YES NO If yes, did you receive them? YES NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

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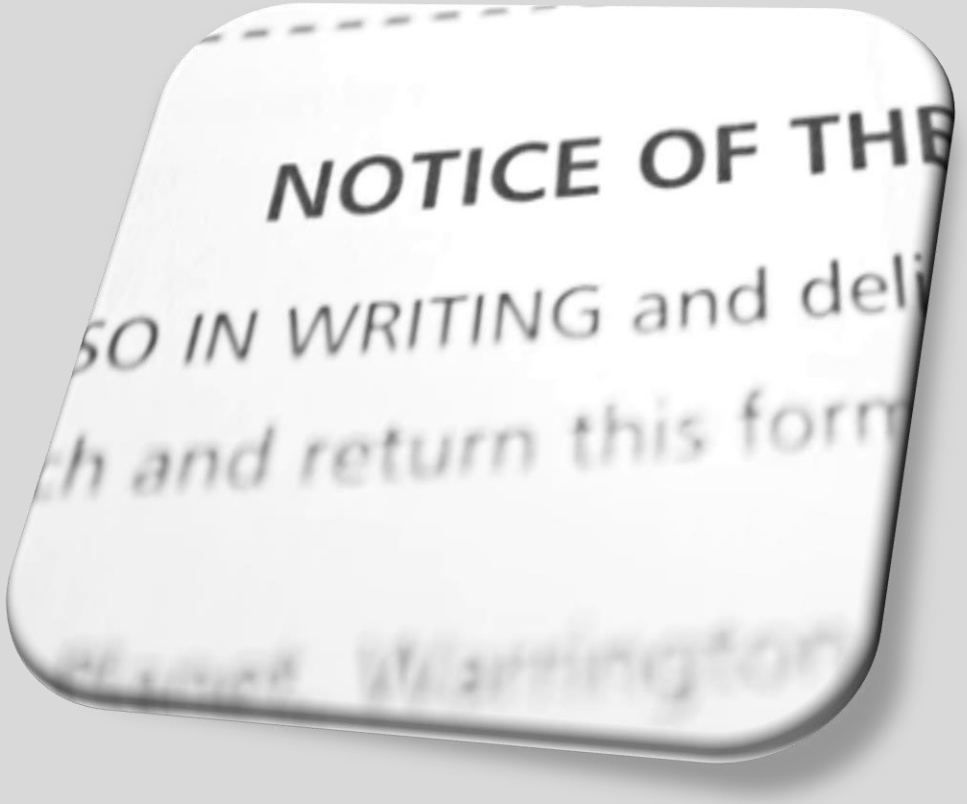
Insurance Carrier's Notice of Injury

Written notice of the injury is the insurance carrier's earliest receipt of:

- The employer's first report of injury (FROI);
- Notification from DWC; or



Insurance Carrier's Notice of Injury

Any other written communication regardless of source, which fairly informs the insurance carrier of:

- Name of the injured employee and identity of the employer;
- Approximate date of the injury; and
- Information that asserts the injury is work related.

NOTE: If no FROI, the carrier shall contact the employer regarding the injury within seven days of notification.

Insurance Carrier's Notice of Injury

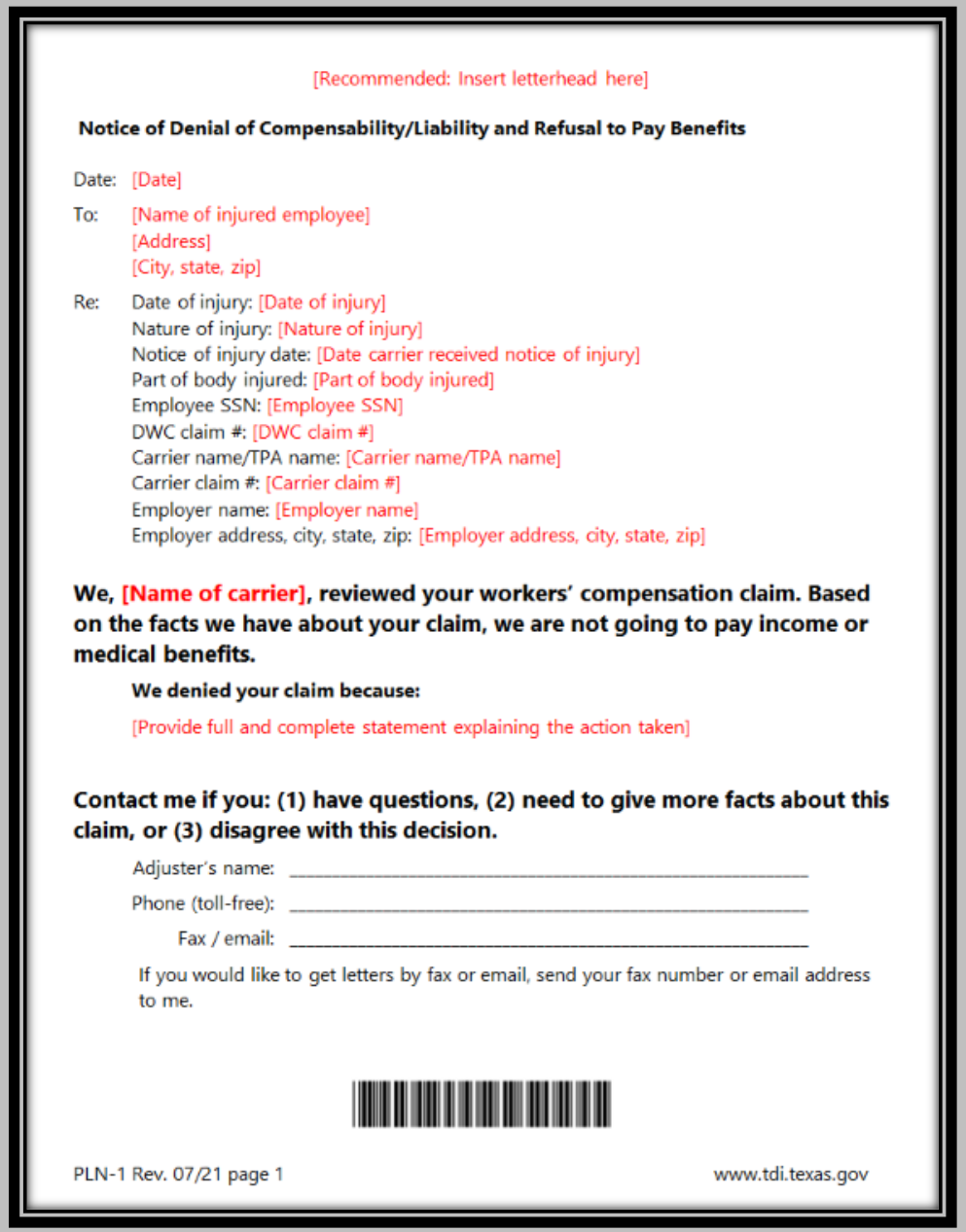
On receipt of a written notice of injury, the insurance carrier:

- Creates a record of each reportable injury;
- Conducts an investigation relating to the compensability and insurance carrier's liability for the injury; and
- Notifies DWC and the injured employee if there is a denial of a claim based on non-compensability or lack of coverage.

Insurance Carrier's Notice of Denial

Notice of Denial of Compensability/Liability and Refusal to Pay (PLN01)

If the PLN01 is filed between the 15th and 60th day after receipt of written notice of injury, the insurance carrier is liable and must pay all medical services provided **before** filing the PLN01.



[Recommended: Insert letterhead here]

Notice of Denial of Compensability/Liability and Refusal to Pay Benefits

Date: [Date]

To: [Name of injured employee]
[Address]
[City, state, zip]

Re: Date of injury: [Date of injury]
Nature of injury: [Nature of injury]
Notice of injury date: [Date carrier received notice of injury]
Part of body injured: [Part of body injured]
Employee SSN: [Employee SSN]
DWC claim #: [DWC claim #]
Carrier name/TPA name: [Carrier name/TPA name]
Carrier claim #: [Carrier claim #]
Employer name: [Employer name]
Employer address, city, state, zip: [Employer address, city, state, zip]

We, [Name of carrier], reviewed your workers' compensation claim. Based on the facts we have about your claim, we are not going to pay income or medical benefits.

We denied your claim because:

[Provide full and complete statement explaining the action taken]

Contact me if you: (1) have questions, (2) need to give more facts about this claim, or (3) disagree with this decision.

Adjuster's name: _____

Phone (toll-free): _____

Fax / email: _____

If you would like to get letters by fax or email, send your fax number or email address to me.

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Notice to Network Provider

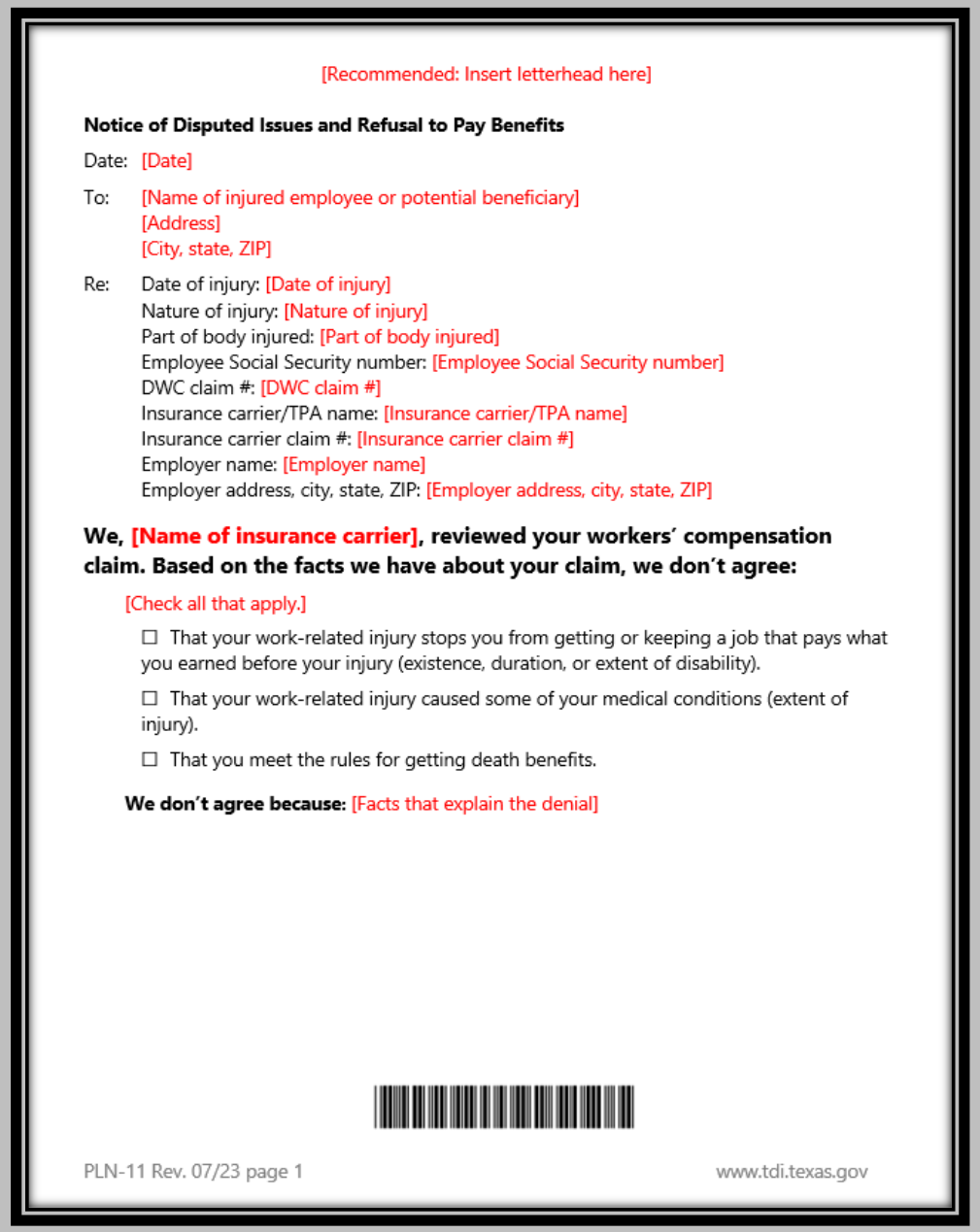
Before providing written notification to the network health care provider, the insurance carrier:

- May not deny payment for medically necessary health care services based on compensability; and
- Is liable for up to a maximum of $7,000 for medically necessary health care services provided before notification.

Notice of Disputed Issues

If the insurance carrier receives medical bills for conditions, treatments or services that the insurance carrier believes are not related to the compensable injury, it will file a **Notice of Disputed Issues and Refusal to Pay Benefits** (PLN11) to:

- The injured employee.
- DWC.



[Recommended: Insert letterhead here]

Notice of Disputed Issues and Refusal to Pay Benefits

Date: [Date]

To: [Name of injured employee or potential beneficiary]
[Address]
[City, state, ZIP]

Re: Date of injury: [Date of injury]
Nature of injury: [Nature of injury]
Part of body injured: [Part of body injured]
Employee Social Security number: [Employee Social Security number]
DWC claim #: [DWC claim #]
Insurance carrier/TPA name: [Insurance carrier/TPA name]
Insurance carrier claim #: [Insurance carrier claim #]
Employer name: [Employer name]
Employer address, city, state, ZIP: [Employer address, city, state, ZIP]

We, [Name of insurance carrier], reviewed your workers' compensation claim. Based on the facts we have about your claim, we don't agree:

[Check all that apply.]

☐ That your work-related injury stops you from getting or keeping a job that pays what you earned before your injury (existence, duration, or extent of disability).

☐ That your work-related injury caused some of your medical conditions (extent of injury).

☐ That you meet the rules for getting death benefits.

We don't agree because: [Facts that explain the denial]

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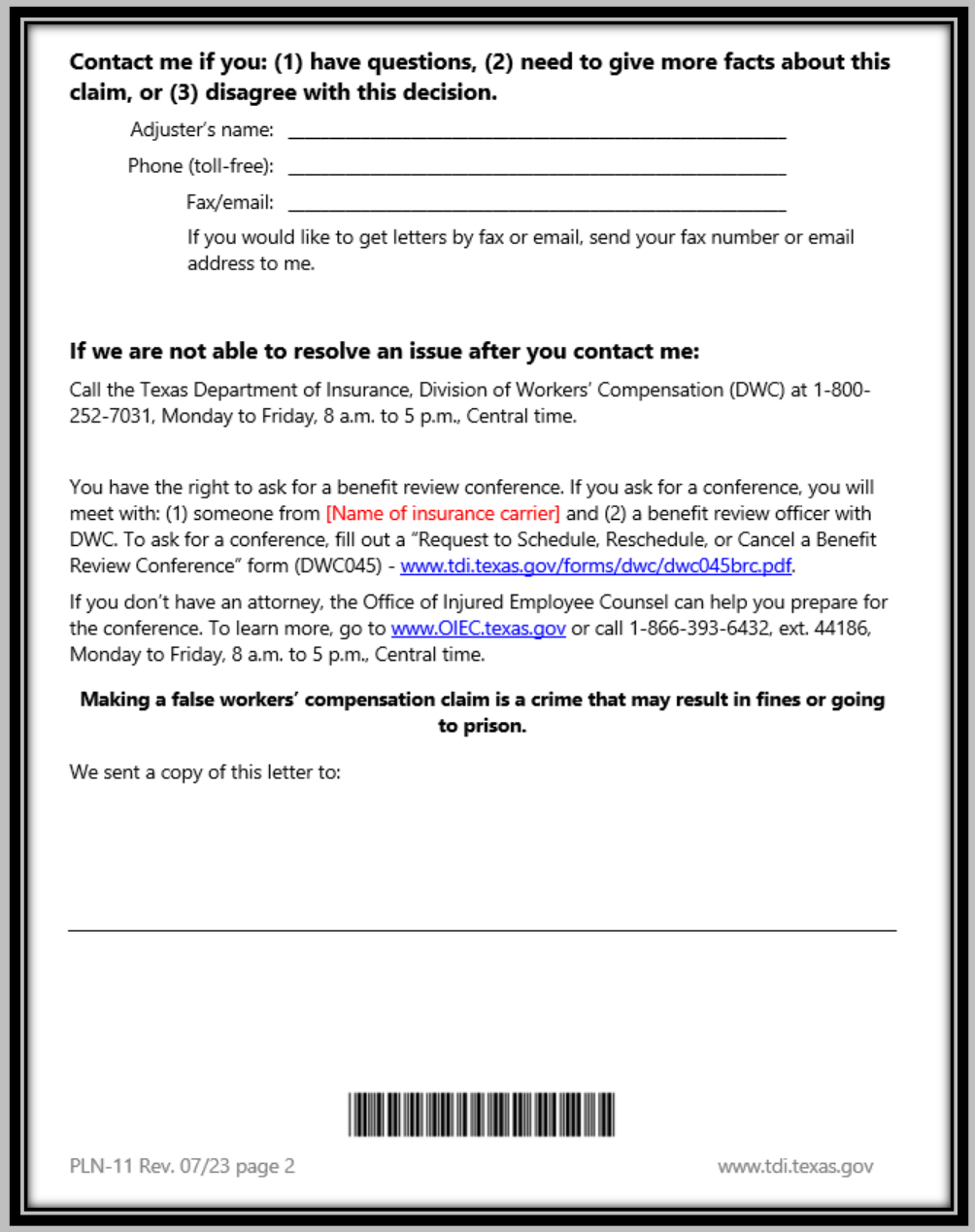
Notice of Disputed Issues

The PLN11 must be filed no later than:

- The date the insurance carrier denied the medical bill; or
- The due date for the insurance carrier to pay or deny the medical bill.



Contact me if you: (1) have questions, (2) need to give more facts about this claim, or (3) disagree with this decision.

Adjuster's name: _____

Phone (toll-free): _____

Fax/email: _____

If you would like to get letters by fax or email, send your fax number or email address to me.

If we are not able to resolve an issue after you contact me:

Call the Texas Department of Insurance, Division of Workers' Compensation (DWC) at 1-800-252-7031, Monday to Friday, 8 a.m. to 5 p.m., Central time.

You have the right to ask for a benefit review conference. If you ask for a conference, you will meet with: (1) someone from [Name of insurance carrier] and (2) a benefit review officer with DWC. To ask for a conference, fill out a "Request to Schedule, Reschedule, or Cancel a Benefit Review Conference" form (DWC045) - www.tdi.texas.gov/forms/dwc/dwc045brc.pdf.

If you don't have an attorney, the Office of Injured Employee Counsel can help you prepare for the conference. To learn more, go to www.OIEC.texas.gov or call 1-866-393-6432, ext. 44186, Monday to Friday, 8 a.m. to 5 p.m., Central time.

Making a false workers' compensation claim is a crime that may result in fines or going to prison.

We sent a copy of this letter to:

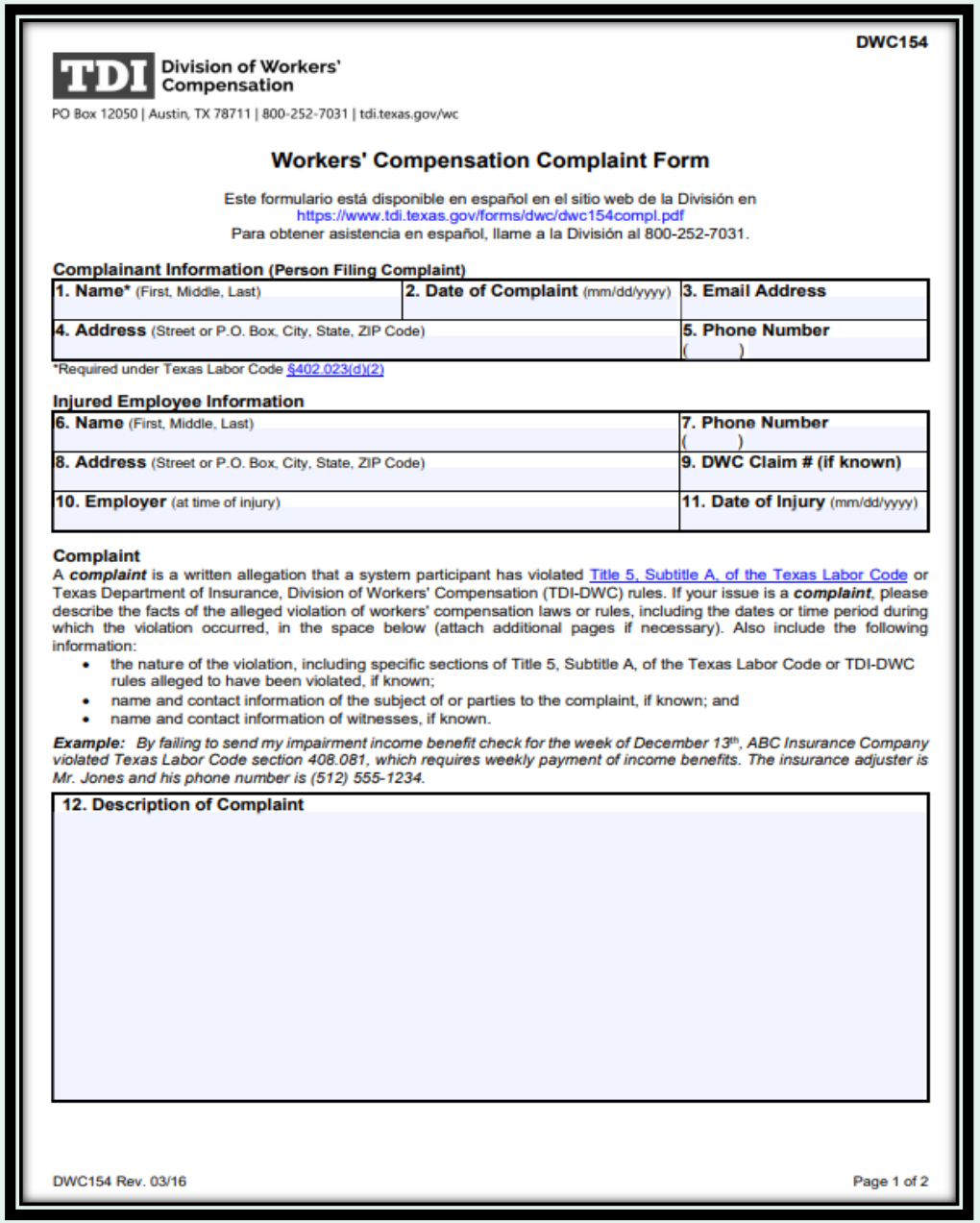
PLN-11 Rev. 07/23 page 2 www.tdi.texas.gov

Workers' Compensation Complaints

Must be submitted in writing. Ways to do it:

- Complaint Form (DWC Form-154);
- Email: DWCCOMPLAINTS@tdi.texas.gov;
- Fax: 512-490-1030;
- In person at a DWC field office; or
- Mail to the Texas Department of Insurance, Division of Workers' Compensation.

Workers' compensation complaint webpage:
tdi.texas.gov/wc/ci/wccomplaint.html



DWC154

TDI Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Workers' Compensation Complaint Form

Este formulario está disponible en español en el sitio web de la División en
https://www.tdi.texas.gov/forms/dwc/dwc154compl.pdf
Para obtener asistencia en español, llame a la División al 800-252-7031.

Complainant Information (Person Filing Complaint)

1. Name* (First, Middle, Last)	2. Date of Complaint (mm/dd/yyyy)	3. Email Address
4. Address (Street or P.O. Box, City, State, ZIP Code)		5. Phone Number ( )

*Required under Texas Labor Code §402.023(d)(2)

Injured Employee Information

6. Name (First, Middle, Last)	7. Phone Number ( )
8. Address (Street or P.O. Box, City, State, ZIP Code)	9. DWC Claim # (if known)
10. Employer (at time of injury)	11. Date of Injury (mm/dd/yyyy)

Complaint

A ***complaint*** is a written allegation that a system participant has violated Title 5, Subtitle A, of the Texas Labor Code or Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) rules. If your issue is a ***complaint***, please describe the facts of the alleged violation of workers' compensation laws or rules, including the dates or time period during which the violation occurred, in the space below (attach additional pages if necessary). Also include the following information:

- the nature of the violation, including specific sections of Title 5, Subtitle A, of the Texas Labor Code or TDI-DWC rules alleged to have been violated, if known;
- name and contact information of the subject of or parties to the complaint, if known; and
- name and contact information of witnesses, if known.

Example: *By failing to send my impairment income benefit check for the week of December 13th, ABC Insurance Company violated Texas Labor Code section 408.081, which requires weekly payment of income benefits. The insurance adjuster is Mr. Jones and his phone number is (512) 555-1234.*

12. Description of Complaint

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Recap

- Texas Workers' Compensation Regulation.
- Goals, Legislative Intent, and Mission of the Workers' Compensation System.
- Texas Workers' Compensation Coverage.
- Required Forms.
- Providing Health Care to Injured Employees.
- Official Notices.

Contact Us

CompConnection:
800-252-7031, option 3

compconnection@tdi.texas.gov