Overview of Workers' Compensation Insurance (WCI)

Environmental Health, Safety and Risk Management

Celia Saenz,
Claims & Insurance Analyst

What is Workers' Compensation Insurance?

- A state-regulated insurance program that pays medical bills and lost wages for employees with work-related injuries and/or occupational illnesses. *** UT System employees for all of our institutions have specific guidelines that are governed by Texas Labor Code, Chapter 503.**

- Workers' compensation will replace a percentage of the lost wages if the injury or illness caused the employee to lose some or all income for more than seven days.

Who is the Insurance Carrier?

- UT System is the insurance carrier.
- UT System is “Self-Insured” as a matter of law.

The Workers’ Compensation Insurance (WCI)
program is administered by Cannon Cochran Management Services, Inc. (**CCMSI**).

Tri-Partnership working together for UTRGV's injured employees

UT System

Role: WCI Carrier with UTS Claim Supervisors' management & oversight

CCMSI

Role: Adjusters investigating and managing claims for carrier (UTS)

IMO

Role: Network Mgmt, Nurses, Treatment & Bill Review for Medically Necessary & Related Treatment

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CCMSI

CCMSI has three offices with staff providing services
for all UT System injured employees. (Adjusters & Claim Assistants)
Main phone number to reach all staff: 888.802.0692

Dallas - CCMSI corporate Office

Austin - CCMSI staff in same office as UT System Supervisors

Houston - CCMSI field Office

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IMO = Injury Management Organization

IMO has two main offices with staff providing services for all UT System injured employees. (Network Management, Telephonic Case Managers – Nurses, Preauthorization Review for some types of medical treatment or RX, and Bill Review)

Network Customer Care and to reach all staff: 877.870.0638 and 214.217.5936

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WHAT WCI BENEFITS APPLY TO AN INJURED EMPLOYEE?

Medical Benefits

- Medical benefits necessary to treat a compensable work-related injury or illness. NOTE: WCI does not pay for treatment of unrelated injuries or personal illnesses, even if treatment was provided at the same time as treatment for the injury at work.

  [A dispute letter (PLN-11) may be filed by WCI.]

- Treatment for work-related injuries must be with a doctor who is in the **IMO Med-Select Network**. To find participating providers, please check the IMO website: http://injurymanagement.com/imo-med-select-network/
  Your WCI rep can also assist with this.

Income Benefits

- Income benefits, other than impairment benefits, replace a portion of lost wages due to a work-related injury or illness.

The **most common** types of income benefits are:

  - Temporary Income Benefits (TIBs) – if unable to work, with a valid excuse from a doctor

  - Impairment Income Benefits (IIBs) – depending on severity; after completion of treatment and resolution of the work-related injury

Types of Claims

- Incident Only – Employee reports a minor injury, is not planning on seeing a doctor and has not lost time from work.

  These claims are NOT sent to UT System/CCMSI.

- Medical Only – Employee reports an injury and decides to seek medical treatment but has not lost any time from work. This could include an occupational disease claim.

- Lost Time/Reportable – Employee reports an injury and informs their supervisor that they are off work due to the injury or occupational disease.

Notice of Injury and Timely Reporting

- The employer (UTRGV) is required to file an **Employer's First Report of Injury or Illness** with the insurance carrier and the injured employee within **eight (8)** days after the employee's absence from work or notice of an occupational disease. [DWC-1 form]

Good idea to keep in mind: *File right away or you could pay*

- Failure to report a lost time or occupational disease claim may result in monetary penalties assessed by TDI/DWC to the employer. Per the Texas Labor Code Sec. 415.021, a violation is subject to a maximum penalty of $25,000 per day, per occurrence.

Definition of an "Injury" per the Texas Statute (Sec. 401.011)

INJURY means damage or harm to the physical structure of the body and disease naturally resulting from damage or harm.

- All work-related incidents must be reported to **Celia Saenz, UTRGV WCI Rep** with Environmental Health, Safety & Risk Management
- A claim will be forwarded to UT System/CCMSI when there has been an absence of more than one day, if the employee sought medical treatment, if the claim is for an occupational disease, or if there is a fatality.

Details Needed When Reporting a Claim

- The supervisor and the injured employee must provide specific details of the injured body parts (**including which side:** left, right, both?) and the location of where the accident occurred. (On campus? Building? Off campus?)

- Obtain a written statement from any witness(es), if applicable.

- Obtain name of network doctor the employee has seen or if the employee went to a hospital emergency room.

- All of the injury information NEEDS TO BE PROVIDED to the WCI Rep, Celia Saenz, **immediately after you know a work-related injury has occurred or is being reported by an employee.**

CCMSI Claim Investigation & Determination

All claims that are reported to WCI are investigated by the CCMSI Adjuster prior to making a compensability determination.

- As part of a new claim investigation the CCMSI Adjuster is required to contact **ALL** parties, especially the supervisor and the injured employee.
- If contractors or 3rd parties are a factor in the accident, the contractor information or insurance information needs to be reported to the Adjuster so CCMSI can recover UT System losses due to the contractor negligence.

❖ **PLEASE REPORT CORRECT PHONE NUMBERS AND EMAILS** for the injured employee, supervisor receiving the notice of injury, witnesses to the injury and medical provider (if known).

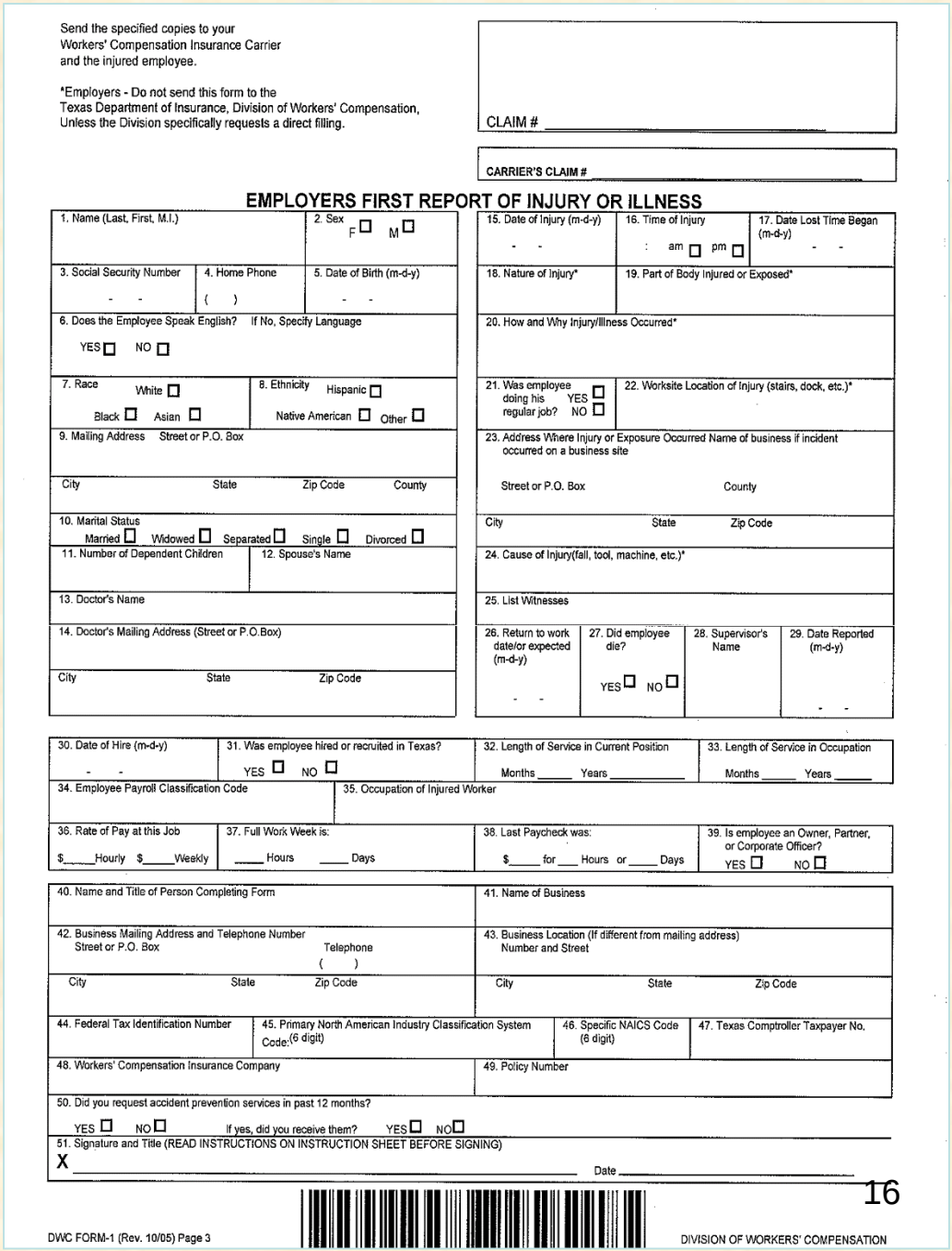
Employer Reporting Responsibilities

For Medical Only or Lost Time claims, these forms are to be filed electronically by entering them into CCMSI's web-based program (iCE) for review by WCI staff:

- Employer's First Report of Injury -- DWC-1
- Supplemental Report of Injury -- DWC-6 (for a lost time claim)
- Employee's Request for Paid Leave -- WCI Form-23 (if lost time)
- Wage Statement -- DWC-3 (if lost time)

DWC-1 Employer's First Report of Injury

*** This is the official injury report form that is attached to the claim record (iCE) and transmitted to TDI/DWC if there is any lost time.**



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

1. Name (Last, First, M.I.) | 2. Sex F ☐ M ☐
3. Social Security Number - - | 4. Home Phone ( ) | 5. Date of Birth (m-d-y) - -
6. Does the Employee Speak English? If No, Specify Language — YES ☐ NO ☐
7. Race White ☐ Black ☐ Asian ☐ | 8. Ethnicity Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box — City State Zip Code County
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children | 12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O.Box) — City State Zip Code

15. Date of Injury (m-d-y) - - | 16. Time of Injury : am ☐ pm ☐ | 17. Date Lost Time Began (m-d-y) - -
18. Nature of Injury* | 19. Part of Body Injured or Exposed*
20. How and Why Injury/Illness Occurred*
21. Was employee doing his regular job? YES ☐ NO ☐ | 22. Worksite Location of Injury (stairs, dock, etc.)*
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
24. Cause of Injury(fall, tool, machine, etc.)*
25. List Witnesses
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 _____

DWC FORM-1 (Rev. 10/05) Page 3 — DIVISION OF WORKERS' COMPENSATION

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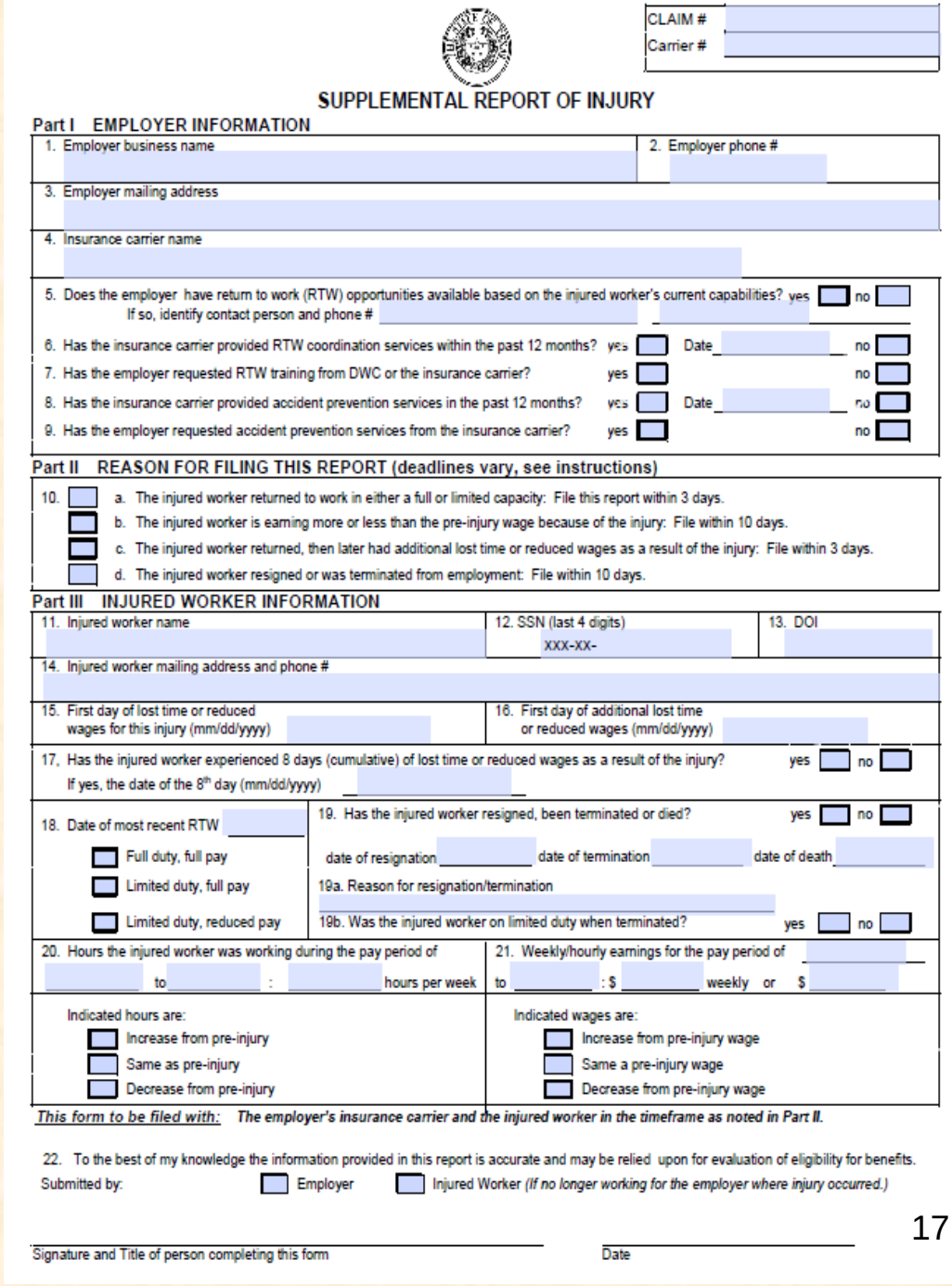
DWC-6 Supplemental Report of Injury

*** This form is important as it's used to track lost time, return to work, resignation/termination and an injured employee's wages.**



CLAIM #
Carrier #

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name
2. Employer phone #
3. Employer mailing address
4. Insurance carrier name
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes ☐ no ☐
   If so, identify contact person and phone #
6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes ☐ Date ____ no ☐
7. Has the employer requested RTW training from DWC or the insurance carrier? yes ☐ no ☐
8. Has the insurance carrier provided accident prevention services in the past 12 months? yes ☐ Date ____ no ☐
9. Has the employer requested accident prevention services from the insurance carrier? yes ☐ no ☐

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. ☐ a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
    ☐ b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
    ☐ c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
    ☐ d. The injured worker resigned or was terminated from employment: File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name
12. SSN (last 4 digits) XXX-XX-
13. DOI
14. Injured worker mailing address and phone #
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)
16. First day of additional lost time or reduced wages (mm/dd/yyyy)
17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes ☐ no ☐
    If yes, the date of the 8th day (mm/dd/yyyy)
18. Date of most recent RTW
    ☐ Full duty, full pay
    ☐ Limited duty, full pay
    ☐ Limited duty, reduced pay
19. Has the injured worker resigned, been terminated or died? yes ☐ no ☐
    date of resignation ____ date of termination ____ date of death ____
    19a. Reason for resignation/termination
    19b. Was the injured worker on limited duty when terminated? yes ☐ no ☐
20. Hours the injured worker was working during the pay period of ____ to ____ : ____ hours per week
    Indicated hours are:
    ☐ Increase from pre-injury
    ☐ Same as pre-injury
    ☐ Decrease from pre-injury
21. Weekly/hourly earnings for the pay period of ____ to ____ : $ ____ weekly or $ ____
    Indicated wages are:
    ☐ Increase from pre-injury wage
    ☐ Same a pre-injury wage
    ☐ Decrease from pre-injury wage

This form to be filed with: ***The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.***

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: ☐ Employer ☐ Injured Worker *(If no longer working for the employer where injury occurred.)*

Signature and Title of person completing this form ____ Date ____

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REQUEST FOR PAID LEAVE (WCI Form-23)

Texas Labor Code Sec. §503.041

Exhaustion of Accrued Leave

- An employee may elect to use sick leave before receiving income benefits. WCI benefits do not begin until ALL sick leave is exhausted.

  * Once an employee selects this option, they cannot change their mind later on.

- AFTER all sick leave is exhausted, an employee may use all or a portion of "other" leave to remain on the payroll.

- OR - an employee may elect to go on Leave Without Pay (LWOP) immediately. ***IMPORTANT TO KNOW: There is a 7-day waiting period until any income benefits would be paid by WCI to the injured employee.***

Consequences of Untimely Reporting an Injured Employee's Leave

- Employee may be overpaid receiving 170% pay:
  - 100% for remaining on payroll
  - 70% for TIBS from WCI

- UT System may overpay income benefits which could result in penalties levied by TDI/DWC.

Work Status Report /DWC-73

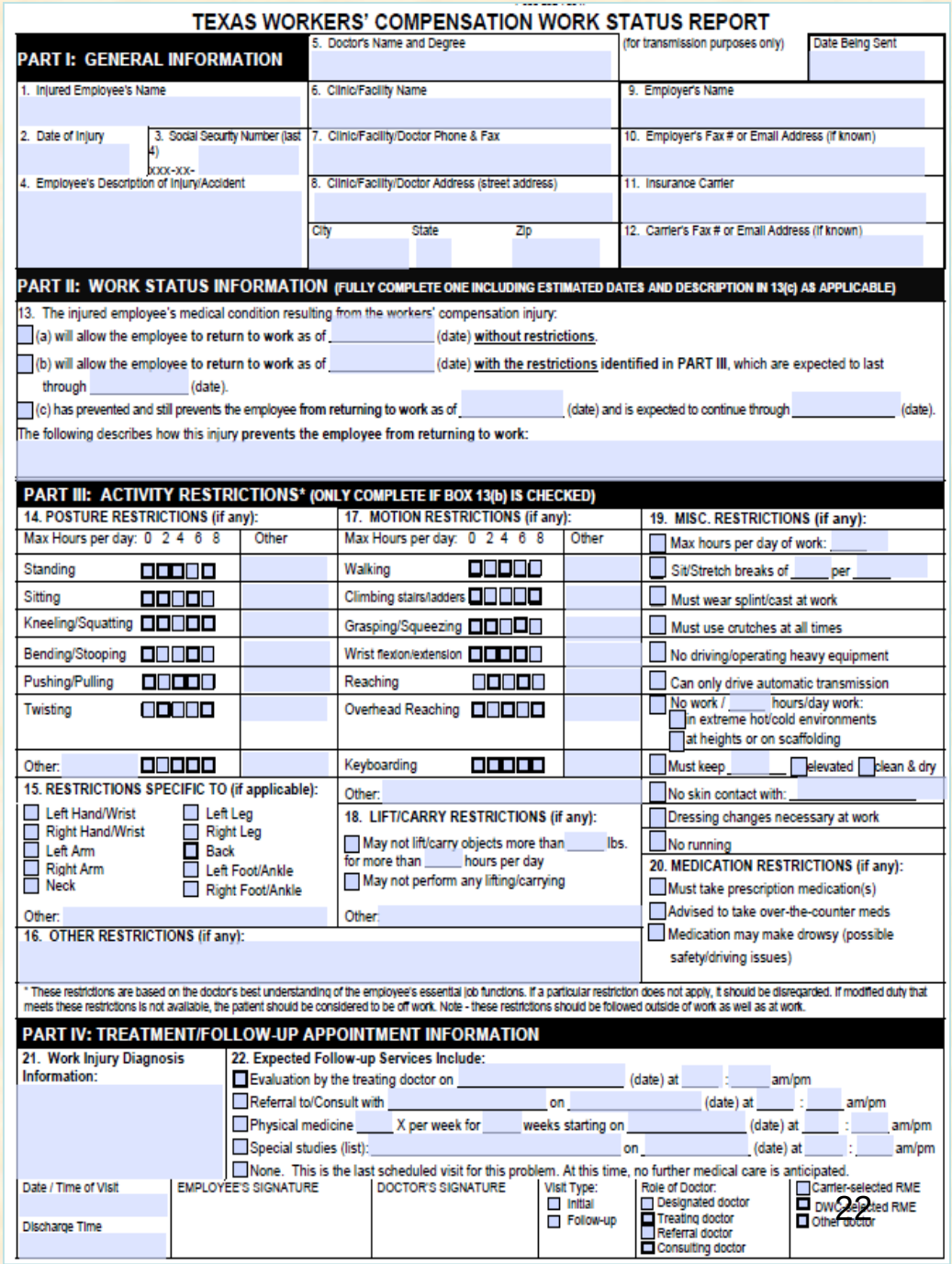
The DWC-73 (work status) form is completed by doctors involved in treating injured workers to communicate the employee's current work capability to the employee, employer, and insurance carrier.

The employer may use the information provided on the DWC-73 to offer a light / modified duty position to an injured employee. This is also called a bona fide offer of employment (BFOE). NOTE: A light duty assignment is temporary, and the restrictions are determined only by the treating doctor.

DWC-73

TX Workers' Compensation WORK STATUS Report

A copy of this form must be provided to the UTRGV Supervisor and/or the WCI Rep whenever the employee sees the doctor.



TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

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

(for transmission purposes only) Date Being Sent

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:	

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 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

15. RESTRICTIONS SPECIFIC TO (if applicable):
- Left Hand/Wrist
- Right Hand/Wrist
- Left Arm
- Right Arm
- Neck
- Left Leg
- Right Leg
- Back
- Left Foot/Ankle
- 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:

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)

* 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: Initial; Follow-up
Role of Doctor: Designated doctor; Treating doctor; Referral doctor; Consulting doctor
Carrier-selected RME; DWC-selected RME; Other doctor

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Filing Requirements of the DWC-73

- The doctor is required to file this form with the injured employee, the insurance carrier (Adjuster), and the **Employer**.

- This form must be sent by the doctor to both the employer and the carrier within two (2) working days from the date of exam.

For more information: DWC Rule 129.5 (e)

http://www.tdi.texas.gov/wc/rules/documents/129.pdf

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What if an employee rejects light duty?

If an employee rejects an offer of light duty given to them either verbally or mailed to their home, WCI can **suspend** temporary income benefits (TIBs) if the employee does not respond by the 5th calendar day after receiving the offer.

***** Please immediately inform Celia Saenz at UTRGV and the Adjuster of a refusal of an offer, especially if you know the employee is off work and receiving WCI income benefits (TIBs).**

For more information: DWC Rule 129.6

http://www.tdi.texas.gov/wc/rules/documents/129.pdf

TIP: **Help resolve the employee's on the-job injury with constant <u>communication</u>!**

Thank you!!

Celia M. Saenz, UTRGV, Environmental Health, Safety & Risk Management

Claims & Insurance Analyst

956.665.3690 (main)

956.665.2902 (direct)

celia.saenz@utrgv.edu