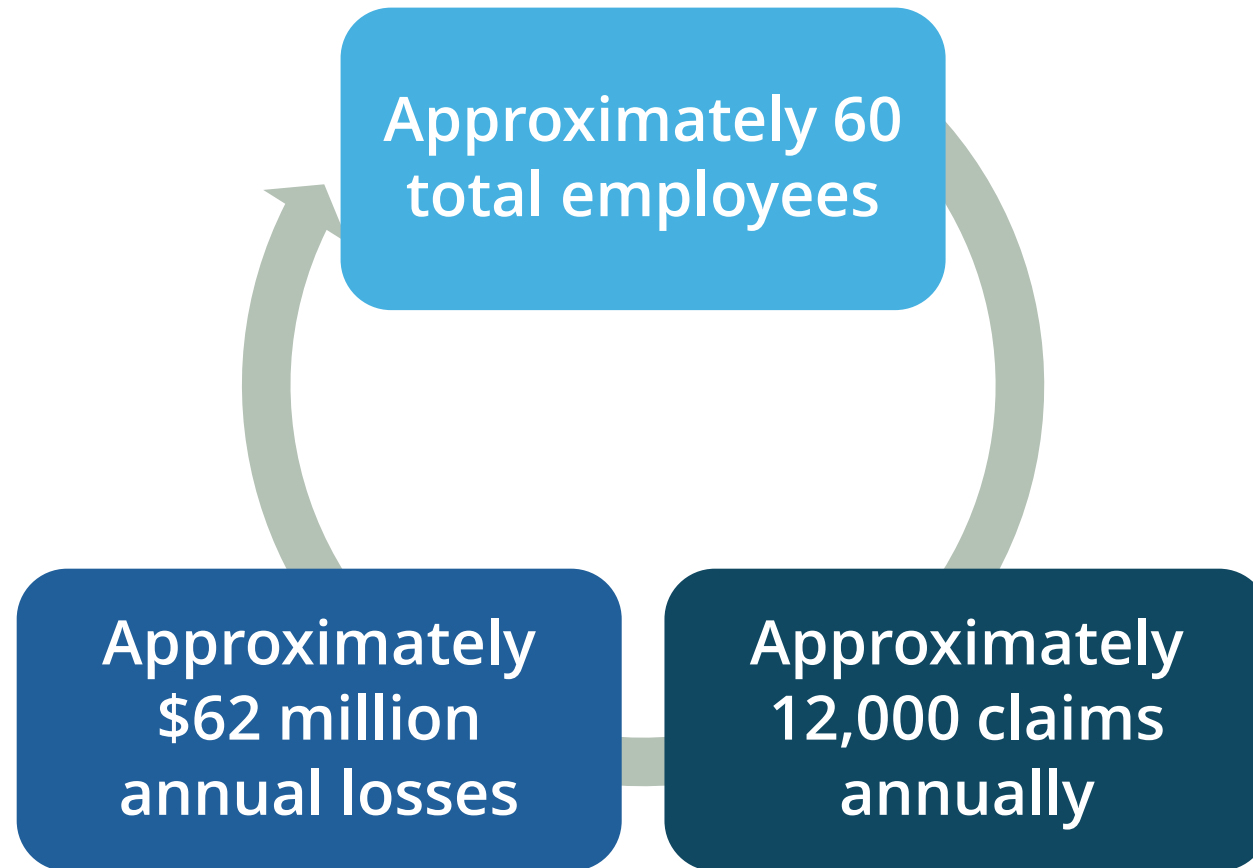


Workers' Compensation

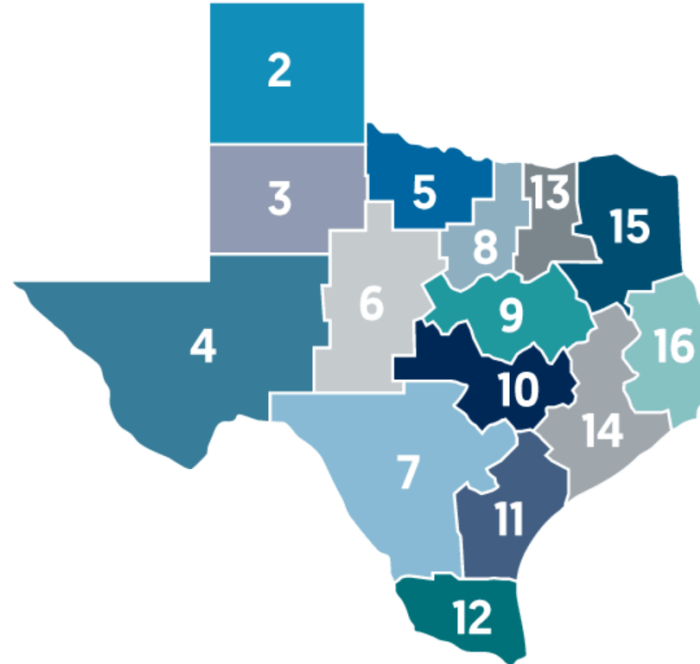


Workers' Compensation Department Overview



Regions

- [Region 2: Amarillo Area](#)
- [Region 3: Caprock-Lubbock Area](#)
- [Region 4: Permian Basin Region-Odessa Area](#)
- [Region 5: Red River Valley-Wichita Falls Area](#)
- [Region 6: Hub of Texas-Abilene Area](#)
- [Region 7: Alamo Region-San Antonio Area](#)
- [Region 8: Where the West Begins-Fort Worth Area](#)
- [Region 9: Heart of Texas Region-Waco Area](#)
- [Region 10: Highland Lakes Region-Austin Area](#)
- [Region 11: Coastal Bend Region-Corpus Christi Area](#)
- [Region 12: Lower Rio Grande Valley-Rio Grande Valley Area](#)
- [Region 13: North Central Texas Region-Dallas Area](#)
- [Region 14: San Jacinto Region-Houston Area](#)
- [Region 15: Tyler-Longview Area](#)
- [Region 16: Golden Pine and Oil Region-Beaumont-Lufkin Area](#)



(800) 537-6655

What?

When?

How?

Who?

Minor Injuries?

Consequences?

What?

Injury

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 occupational disease.

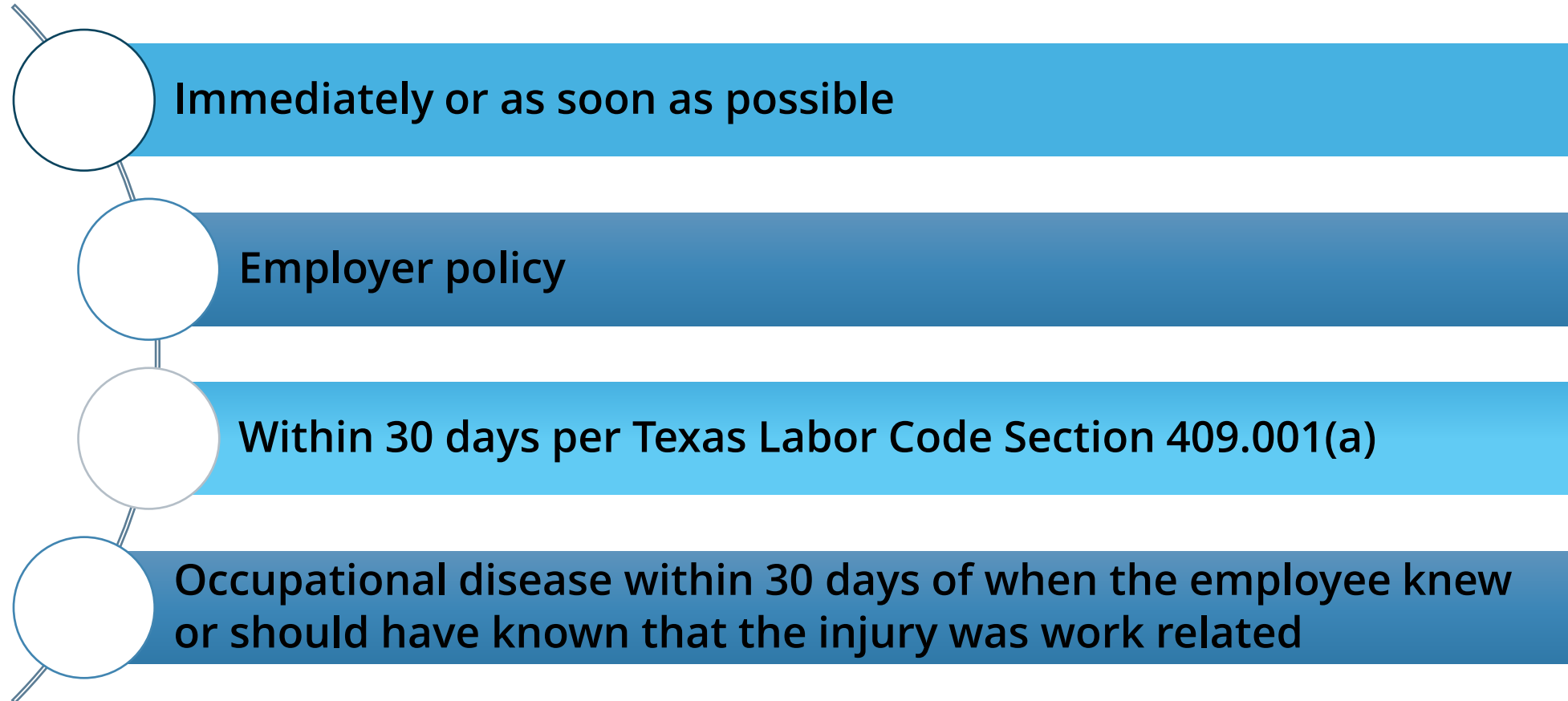
Occupational Disease

A disease arising out of and in the course and employment that causes damage or harm to the physical structure of the body, including a repetitive trauma injury.

Repetitive Trauma

Damage or harm to the physical structure of the body occurring as the result of repetitious, physically traumatic activities that occur over time and arise out of and in the course and scope of employment.

When?



How?

Notice may be verbal or in writing

Reporting may be vague

What

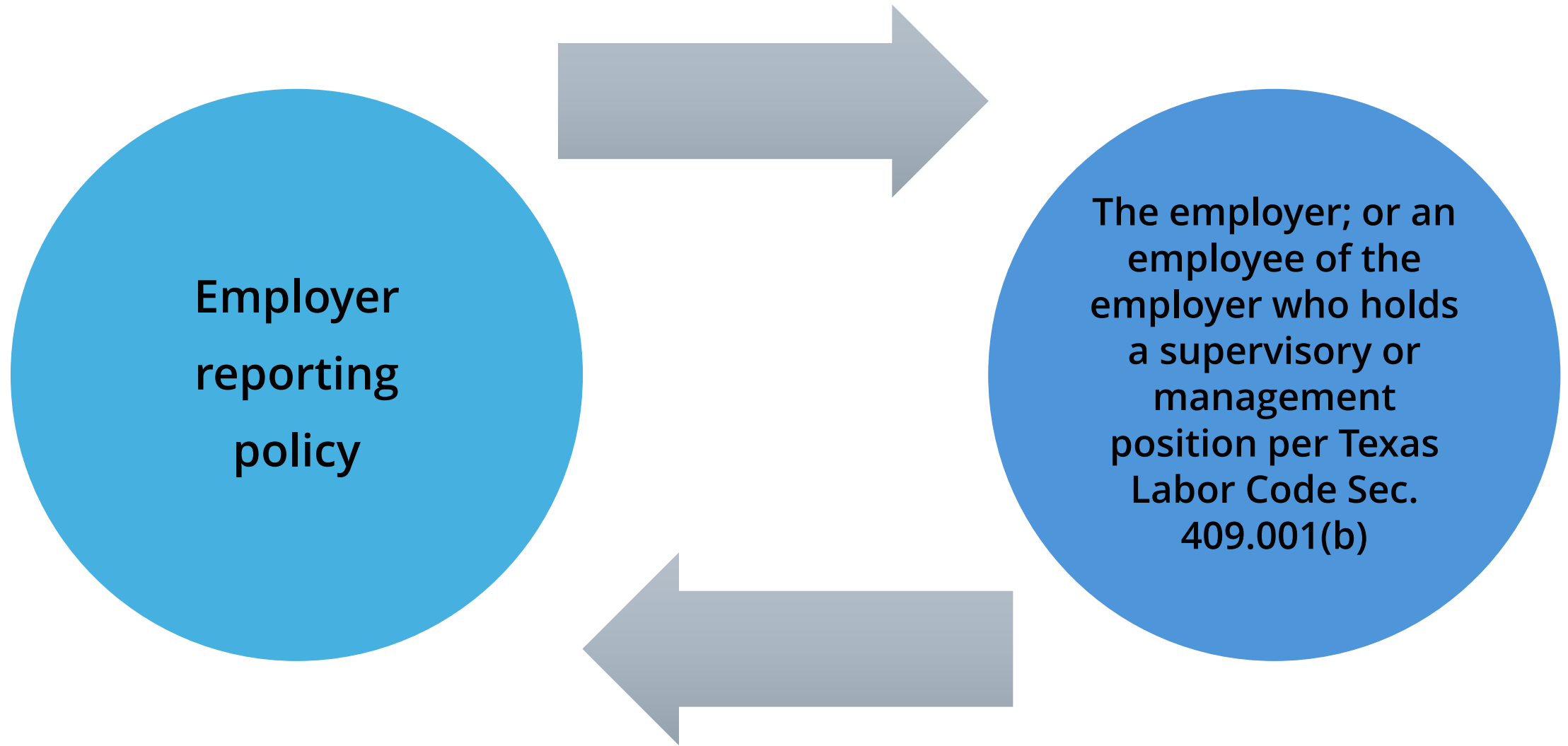
When

Where


Why

How

Who?

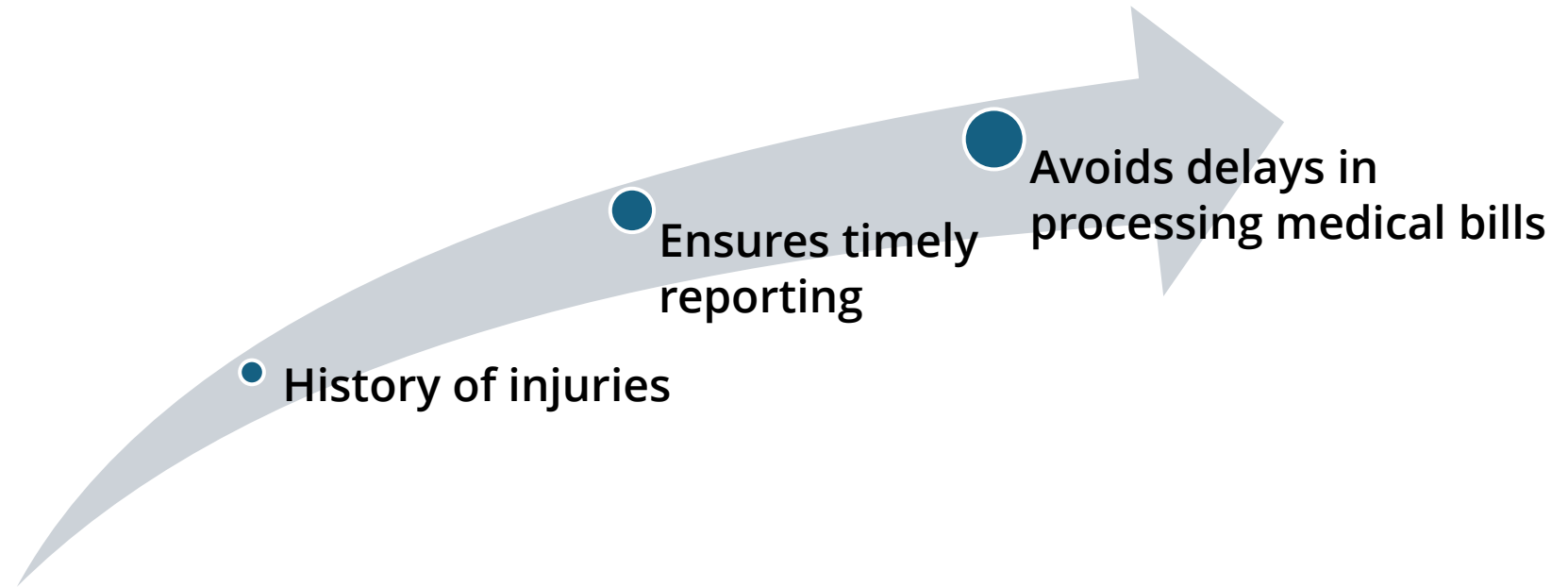


Should All Injuries be Reported?



All injuries should be reported - to the member
Injuries that do not require medical attention such as exposure should be reported
Injuries that require medical treatment with The Alliance should be reported
Minor injuries can develop into major problems
All occupational illnesses must be reported

Advantages of Reporting Injuries



Reporting of all injuries helps identify trends and target areas where preventive measures may be beneficial

Reporting a Workers' Comp Claim



- Preferred method - Member Portal - (www.tmlirp.org)
- Email (workerscompensation@tmlirp.org).
- Fax (512) 491-2481
- Phone (only if other methods aren't working).

After Hours Emergency Number: (800) 537-6655

Reporting a Workers' Comp Claim – Major Injury or Fatality



Any injury in which the employee's life could be in danger or that could result in the amputation of a hand, arm, foot, leg, or the loss of an eye. These injuries must be reported by phone immediately.

If you aren't sure - call!

Consequences?

Failure to
notify
relieves
employer
and carrier
of liability
unless:

Employer / carrier have actual
knowledge

DWC determines “good cause” exists

Employer / carrier does not contest

Loss Prevention Accident Investigations

Purpose &
Intent

Considerations

Process

Keys to
Success

Resource
TMILR Pool -
Accident
Prevention
Plan
Development
Guide

Texas Communities are **STRONGER TOGETHER**



Loss Prevention

Example of Investigation Process



Red Flags

Compensability issues
/ Course and Scope

Newly hired
employees

Spite claims

Monday claims

Pre-existing
conditions

Unwitnessed
injuries

Late reporting
claims

Exposure claims

Ordinary diseases of
life

Other

Texas Communities are **STRONGER TOGETHER**



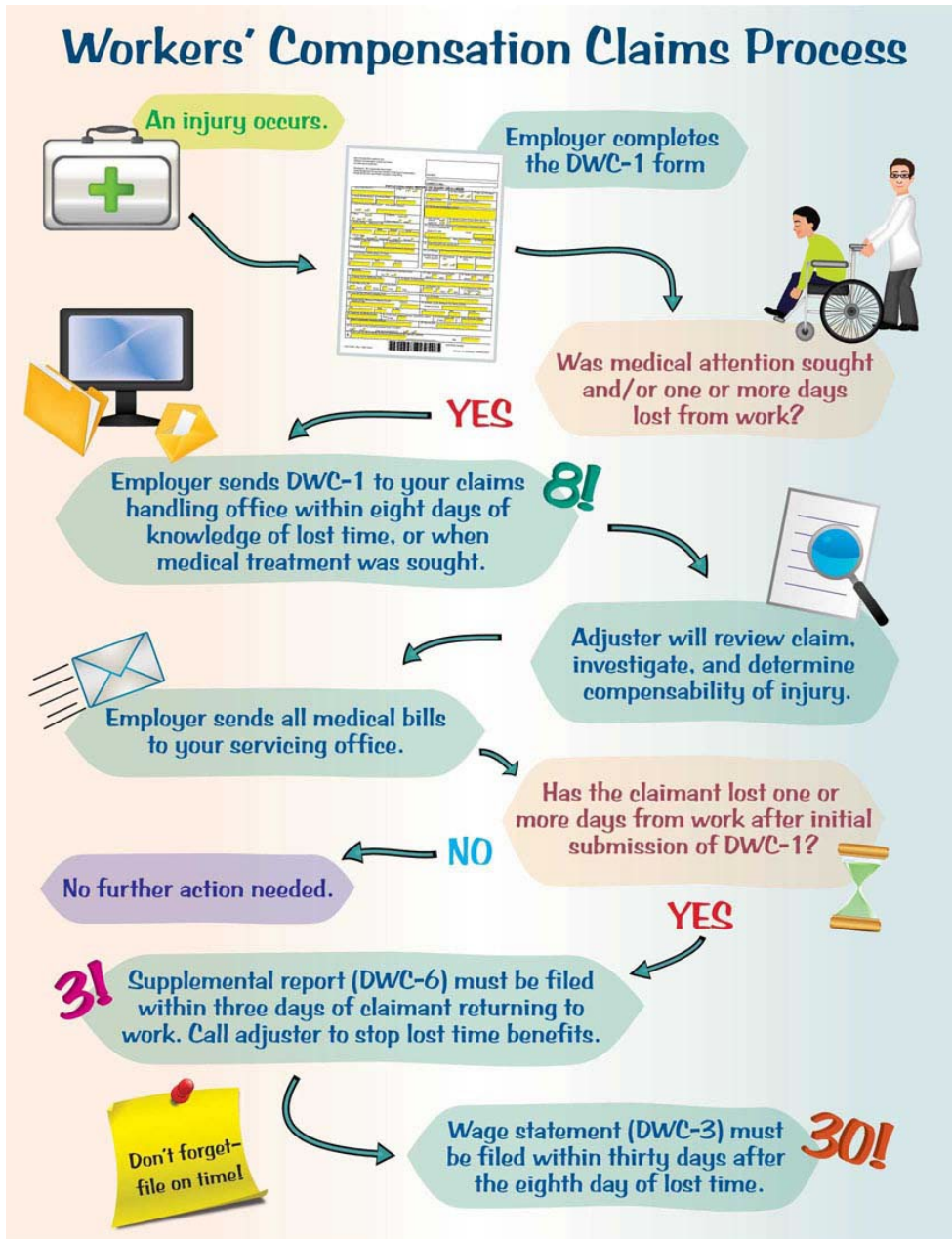
Claims Process

Assignment, Investigation & Claim Documentation

Course and Scope/Compensability Determination

Timely Payments and Disputes

Return to Work and modified duty members



Assignment, investigation, and claims documentation

All claims are reviewed for course and scope, compensability

Medical only claims are handled routinely after initial screening to notify of requirements and pay the bills timely

Lost time claims require detailed investigations depending on the nature of the claim. May require statements, witness contact and discussion with supervisor or coworkers



Employer role...



OPTUM[®]

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

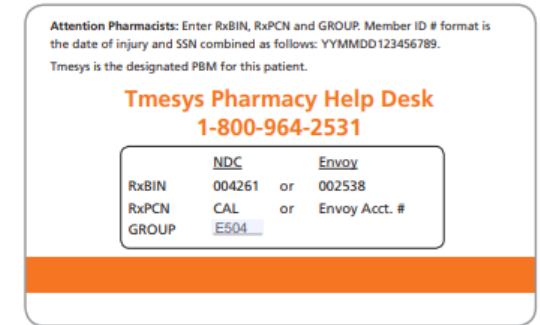
CARRIER/TPA _____ EMPLOYER _____

INJURED PERSON NAME _____

Please provide directly to Pharmacist _____

SOCIAL SECURITY NUMBER _____ DATE OF INJURY (YYMMDD) _____

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.



Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.
Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	<u>NDC</u>		<u>Envoy</u>
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	E504		

Provide the injured employee:

Copy of the Employer's First Report of Injury

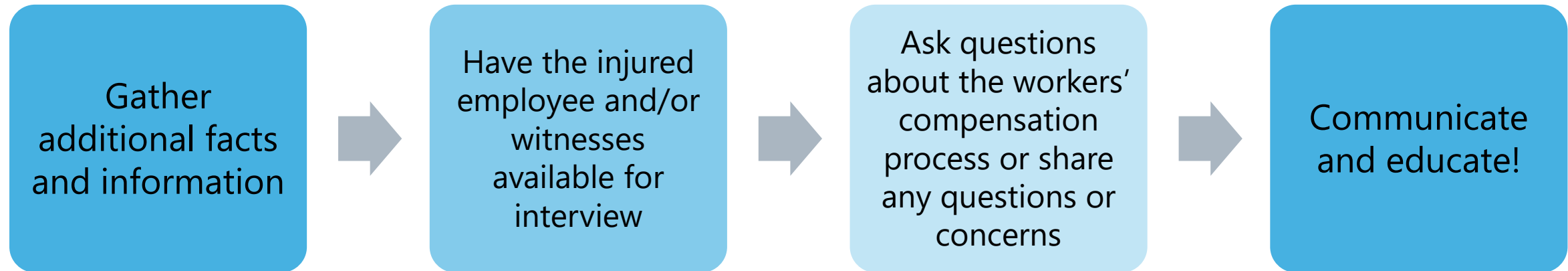
Injured Employee's Rights and Responsibilities letter

First Fill Card

Information for primary care physician selection in the Alliance

Communicate with the injured worker – phone calls, visits. Don't create an adverse environment. Let the injured employee know that he is needed back at work.

What can you do to help?



Compensability Determination

Compensable injury - an injury that arises out of and in the course and scope of employment

Review the claim, gather necessary information and make a determination on compensability

Administer medical and income benefits for compensable injuries pursuant to the Texas Labor Code



Medical Attention

Select a primary treating physician through Political Subdivision Workers' Compensation Alliance (PSWCA/The Alliance)

Treating physician will make any referrals

Emergency treatment

Utilization Review / Preauthorization - Genex

Pharmacy Benefit Manager - Optum

The Political Subdivision Workers' Compensation Alliance (PSWCA/The Alliance) website: www.pswca.org

Lost Time

If the injured employee is taken off work or placed on light duty, income benefits may be owed



**Notify TMLIRP of any
changes in the work status
and submit the appropriate
forms**

Temporary Income Benefits (TIBs)

Lost time > 7 days of disability

Paid based on Average Weekly Wage (AWW)

Paid at either 70% or 75% of the AWW

< \$10.00 an hour 75% the first 26 weeks then to 70% for remaining weeks

> \$10.00 an hour 70%

Limited to 104 weeks from the accrual date

Impairment Income Benefits (IIBs)

- Maximum Medical Improvement (MMI) if certified
- Impairment Rating (IR) is given
- 3 weeks of IIBs paid for each percent of the IR
- 70% of the AWW

Supplemental Income Benefits (SIBs)

Qualifications

IR must be 15% or higher

Injured employee is earning less than 80% of pre-injury wages

Initial determination by DWC

Paid monthly

Apply every quarter

Lifetime Income Benefits (LIBs)

Possible Circumstances

- Total and permanent loss of sight in both eyes
- Loss of both feet at or above the ankle
- Loss of both hands at or above the wrist
- Loss of 1 foot at or above the ankle, and loss of one hand at or above the wrist
- Spine injury that causes permanent and complete paralysis of both arms, both legs or one arm and one leg

75% of AWW with a 3% increase annually

Lifetime Income Benefits (LIBs)

Before Sept 1, 1997

- An injury to the skull resulting in incurable insanity or imbecility

After Sept 1, 1997, but before Sept 1, 2013

- A physically traumatic injury to the brain resulting in incurable insanity or imbecility.

After Sept 1, 2023

- A physically traumatic injury to the brain that, as determined using evidence-based medicine, results in a permanent major neurocognitive disorder
 - Which requires occasional supervision of routine daily tasks or self-care and
 - Render permanently unemployable

Lifetime Income Benefits (LIBs)

After June 17, 2001, but before Sept 1, 2023

- Third-degree burns that cover at least 40% of the body and require grafting or
- Third-degree burns covering the majority of either both hands or one hand and the face.

After Sept 1, 2023

- Third-degree burns that cover at least 40% and require grafting or
- Third-degree burns covering the majority of
 - Both hands;
 - One hand and one foot; or
 - One hand or one foot and the face.

Death Benefits (DB)

Possible Beneficiaries

Surviving spouse

Minor children

Children <25 who are enrolled in college

Dependent grandchildren

Other dependent family members

Non-dependent parents

75% of AWW

Surviving spouse of a first responder who remarries is still able to get DBs for the rest of their life

Funeral Benefits

Expenses for the burial may be paid if the employee died because of a work-related injury

Request must be made within 12 months of the date of death

Copies of bills

Timely Payments and Disputes


Initial TIB payment due within 15 days of first notice received



IIBs due within 5 days of receiving MMI and IR



SIBs due within 7 days of the beginning of the monthly period



DBs due no later than the 60th day from notice or within 15 days after receiving claim for death benefits



Disputes must be filed by the 15th day or benefits are still due until dispute is filed. The claim must be disputed by the 60th day.

Return to Work

Full Duty/Full Pay

Modified Duty/Full Pay

Modified Duty/Reduced Pay



Bona Fide Offer of Employment

Loss Prevention – Return to Work

Purpose & Intent

Considerations

Benefits

Potential Negatives

Keys to Success

Resources

TMILR Pool - Establishing an Effective Return to Work Program

Texas Department of Insurance – Division of Workers' Compensation

<https://www.tdi.texas.gov/wc/rtw/index.html>

Special Claims



Volunteers – 7 types of covered volunteers

Presumptions Claims – Firefighters, EMTs, Peace Officers

Multiple Employment – payment of benefits can include wages from multiple employers - Subsequent Injury Fund allows for reimbursement upon request

Optional Volunteer Coverages

37240 Outside Volunteers

7704V Volunteer Firefighters

7720E Volunteer Ambulance/EMS

7720V Police Reserves

8742E Elected/Appointed Officials-Governing Board Only

8742F Elected/Appointed Officials-All Boards/Comms

8742| Inside Volunteers

8888V Police Reserves-Motorcycle



Presumption Claims

Chapter 607 of the Government Code

Firefighters and EMTs

Heart Attacks

Cancers effective June 10, 2019:

testicular, prostate, non-Hodgkin's
lymphoma, stomach, colon, rectum,
skin, brain, multiple myeloma,
malignant melanoma, renal cell
carcinoma

Strokes

Other respiratory illnesses

Certain preventative immunizations

COVID

Peace Officers

Heart attacks

Strokes

Other respiratory illnesses

Certain preventative immunization

COVID

Presumption Claims

Chapter 607 of the Government Code

Exclusions

Employed as a firefighter, EMT or peace officer for:

5 years or more

Tobacco user

Spouse is a smoker

Prior physical exam showing no disease

COVID expired
09/01/2023

Multiple Employment

Applies to all employees and not just volunteers

Wages from injury and non-injury employer are added together to calculate AWW

Reimbursement sought from Subsequent Injury Fund (SIF) for benefits paid based upon non-injury employer

If the non-claim employer does not have WC coverage the wages do not get added and the AWW does not increase

Paid out of unallocated expenses – does not affect member rates

Secondary Employment

Activity

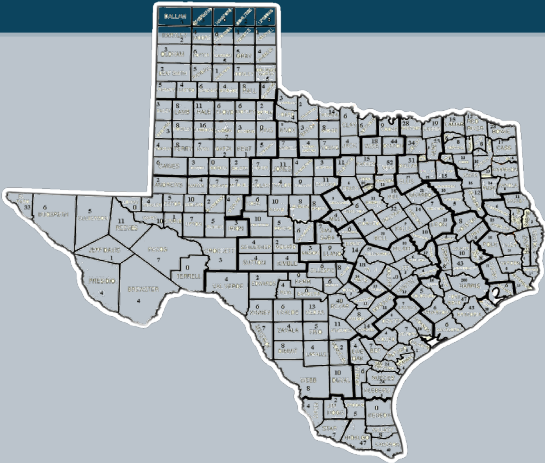
Jurisdiction

Approved

1st Responders
may or may
not be covered

Division of Workers' Compensation (DWC)

Oversees Workers'
Compensation in
Texas



Handles Workers'
Compensation
disputes

- Benefit Review Conference (BRC)
- Contested Case Hearing (CCH)
- Appeal Process

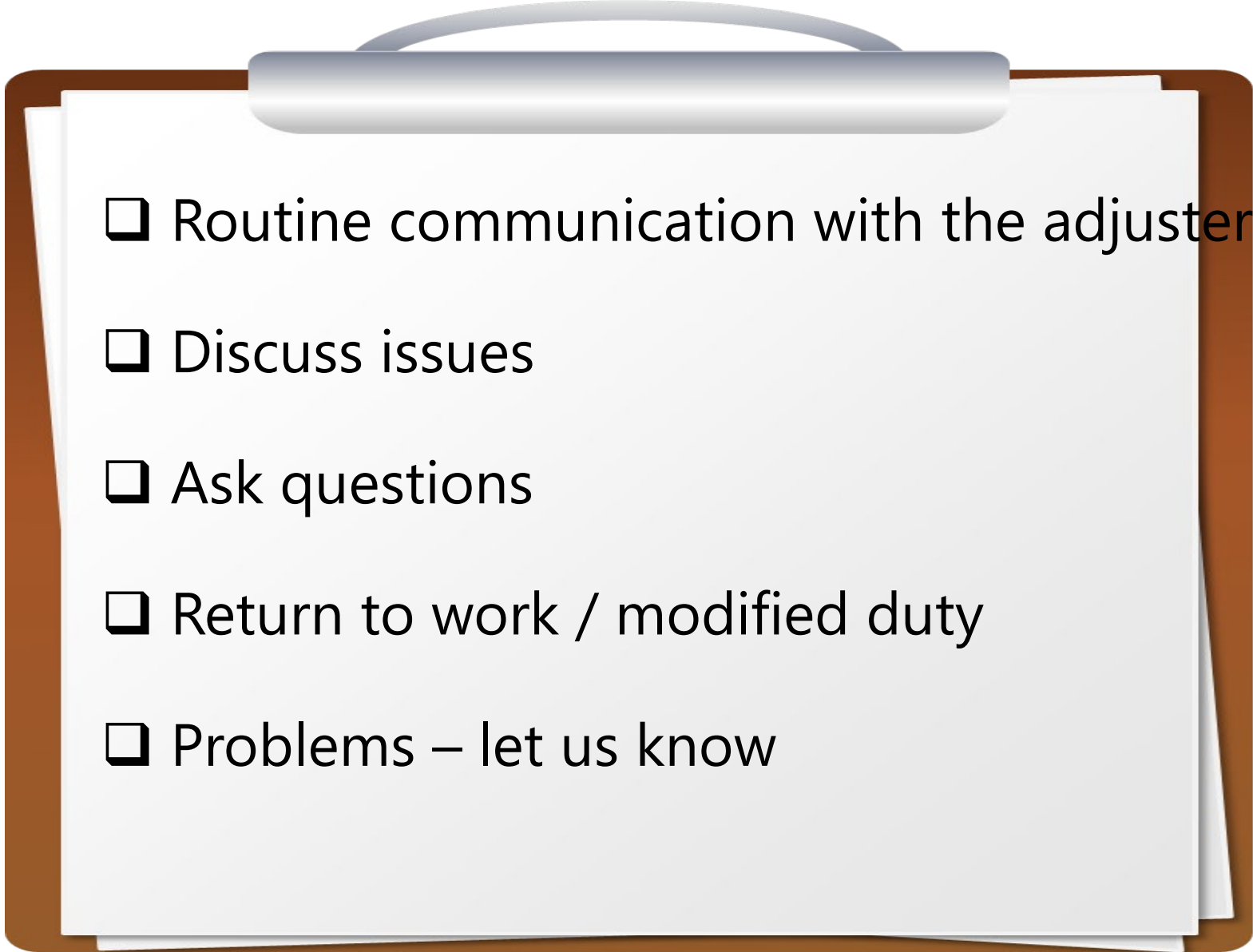
Assists injured
workers (via OIEC)



Yolanda Garcia (512) 804-4173

firstresponderhelp@oiec.Texas.gov

Important Reminders!

- 
- ☐ Routine communication with the adjuster
 - ☐ Discuss issues
 - ☐ Ask questions
 - ☐ Return to work / modified duty
 - ☐ Problems – let us know

Workers' Compensation



Forms

Employer's Record of Injuries

Texas Labor Code Sec. 409.006 / DWC Rule 120.1

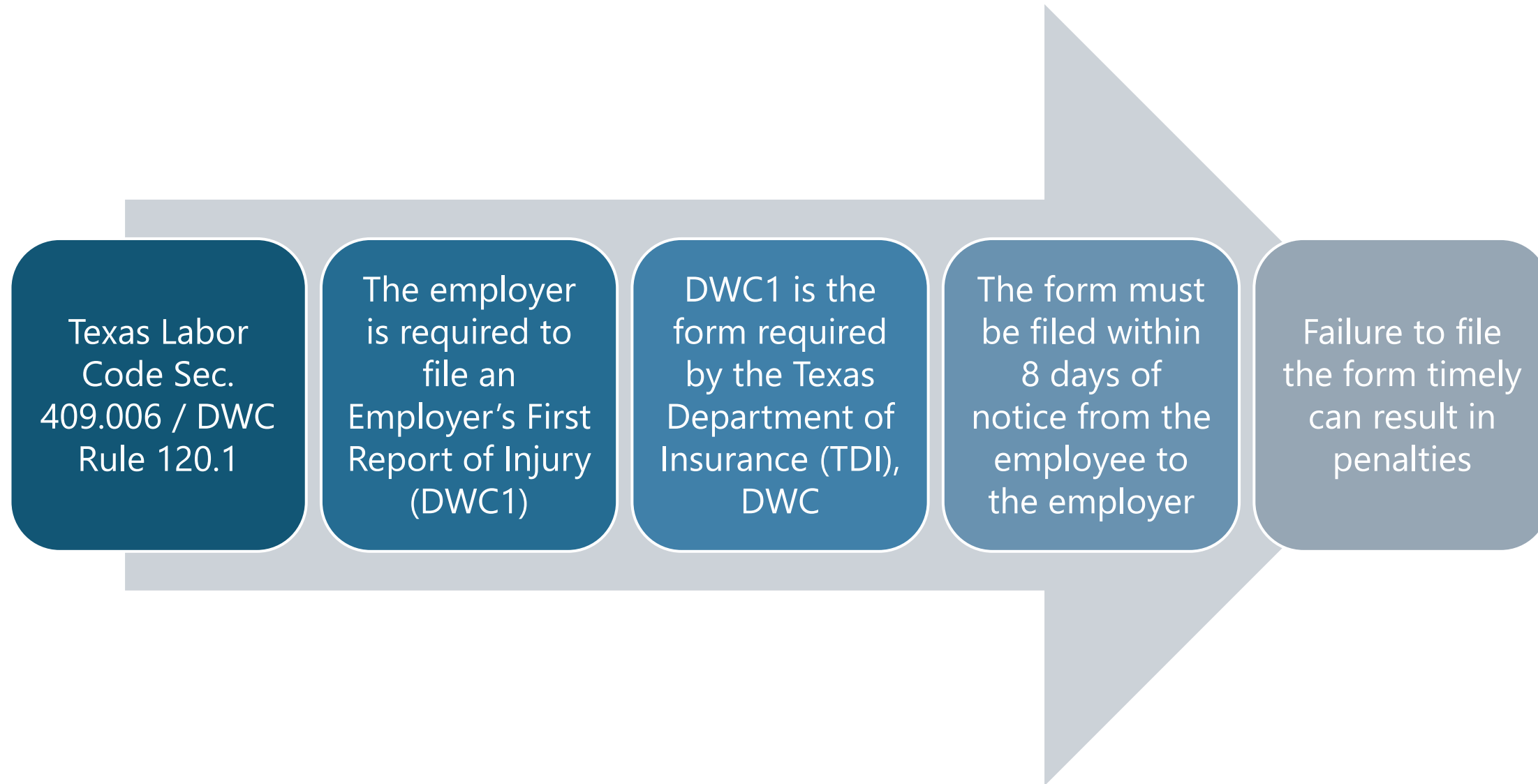
Employer shall keep record of ALL injuries

At least for 5 years

Available for DWC inspection

Possible fines

How is the injury reported?



Texas Labor
Code Sec.
409.006 / DWC
Rule 120.1

The employer
is required to
file an
Employer's First
Report of Injury
(DWC1)

DWC1 is the
form required
by the Texas
Department of
Insurance (TDI),
DWC

The form must
be filed within
8 days of
notice from the
employee to
the employer

Failure to file
the form timely
can result in
penalties

Supervisor Role

Gather information from the injured employee and any witnesses.

Complete any internal employer accident investigation forms

Complete the DWC1

Review any employer policies

Review injury site and/or secure any faulty or broken equipment, third party involvement, photos, recordings, etc.

If there are any questions/concerns, bring those forward as early as possible.

First Report of Injury - DWC1

Information:

Employee
Injury



Division of Workers'
Compensation

DWC001

Complete if known:

DWC claim #

Insurance carrier claim #

Employer's first report of injury or illness

Part 1: Injured employee information

1. Name (first, middle, last)		2. Address (street or PO box, city, state, ZIP code)	
3. Phone number	4. Email address	5. Social Security number (XXX-XX-XXXX)	6. Date of birth (mm/dd/yyyy)
7. Marital status		8. Sex <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown	
9. Spouse's name (first, middle, last)			10. Number of dependent children
11. Does the employee speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, specify language			
12. Doctor's name (first, last)		13. Doctor's mailing address (street or PO box, city, state, ZIP code)	

Part 2: Injury information

14. Date of injury or illness (mm/dd/yyyy)	15. Time of injury : <input type="checkbox"/> a.m. or <input type="checkbox"/> p.m.	16. First day absent from work (mm/dd/yyyy)
17. Supervisor's name (first, last)		18. Date injury reported (mm/dd/yyyy)
19. Nature of injury or illness (Examples: cut, burn, bruise, fracture, sprain, chemical burn. For more than one injury, list the most serious injury.)		20. Body parts affected
21. Describe in detail how and why the injury, illness, or death occurred (Include the events leading up to the injury or illness, state the actual injury, and list the reasons why the accident or injury occurred.)		
22. Reported cause of injury (Examples: overexertion due to lifting or pushing, slip, trip, fall.)		
23. Was the employee doing their regular job? <input type="checkbox"/> Yes <input type="checkbox"/> No		
24. Address and name of the location where the injury, exposure, or death occurred (business name, street or PO box, city, state, ZIP code)		
25. List all witnesses (first, last names)		



First Report of Injury - DWC1

Information:

Employment
Employer

DWC001

26. Number of days absent from work, not including the day of injury or the day of return to work <input type="checkbox"/> One day or less (work-related illness only) <input type="checkbox"/> Two to seven days <input type="checkbox"/> Eight days or more	
27. Return-to-work date (mm/dd/yyyy) <input type="checkbox"/> Actual date or <input type="checkbox"/> Expected date	28. Did the employee die? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the date of death. (mm/dd/yyyy)

Part 3: Employment information

29. Date of hire (mm/dd/yyyy)	30. Occupation of injured employee
31. Length of service in current position Years Months	32. Length of service in current occupation Years Months
33. Employee payroll classification code	34. Was the employee hired or recruited in Texas? <input type="checkbox"/> Yes <input type="checkbox"/> No
35. Rate of pay at this job \$ Hourly \$ Weekly	36. Full work week is Hours Days
37. Last paycheck was \$ for Hours or Days	
38. Is the employee an owner, partner, or corporate officer? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Part 4: Employer information

39. Name and title of person completing form (first, middle, last, title)		40. Business name	
41. Business mailing address (street or PO box, city, state, ZIP code)		42. Phone number	43. Email address
44. Business location (if different from mailing address)		45. Federal employer identification number	
46. Primary North American Industry Classification System (NAICS) code (six digits)	47. Specific NAICS code (six digits)	48. Texas comptroller taxpayer number	
49. Workers' compensation insurance carrier		50. Policy number	
51. Did you request accident prevention services in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did you receive them? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Part 5: Certification

52. Certify with your signature: I certify the information in this form is true and correct.	
Signature _____	Date _____



Employee and Medical Information

Employee and Medical Information	Injury Information	Employment Information	Employer Information
Use legal name Contact information Medical provider	Date of the injury Specific information reported Date lost time began (NLT) Actual date injury was reported	Complete all boxes Date of hire/join date volunteer Payroll classification code	Complete all boxes Primary classification code Specific NAICS code List no and note Self-Insured Sign and date

DWC1 – Payroll Classification Code



4-digit codes are assigned based on job duties.

- Department may point to the correct code but consider the actual job.
- Employees whose duties fall under more than one classification should be assigned to the classification where they spend the most time.
- Most Housing Authority employees are assigned to one of two codes: 9033 for employees other than clerical; or 8810H for clerical employees.
- Volunteer classifications apply only if your entity has elected volunteer coverage.

Wage Statement DWC3

Information:
Employee
Employer
Employment Status
Same/Similar
Pecuniary
Nonpecuniary

Work status, sign and date, wages
BEFORE the injury, amount of Non-
Pecuniary and if they will continue.

Employer's wage statement

Section 1: Injured employee information

1. Name (first, middle, last)	2. Social Security number (last four digits) XXX-XX-
3. Address (street or PO Box, city, state, ZIP code)	4. Phone number
5. Date of injury (mm/dd/yyyy)	6. Date of hire (mm/dd/yyyy)
7. First day of missed work (mm/dd/yyyy)	8. Returned to work on (mm/dd/yyyy) <input type="checkbox"/> Has not returned to work

Section 2: Employer information

9. Name	10. Address (street or PO box, city, state, ZIP code)
11. Phone number	12. Federal tax ID number
13. Printed name (person submitting form)	14. Job title (person submitting form)

Section 3: Employment status at the time of injury

15. Check all that apply:

<input type="checkbox"/> Full-time: The employee regularly works 30 hours or more per week.
<input type="checkbox"/> Part-time regular course of conduct: The employee regularly works less than 30 hours per week.
<input type="checkbox"/> Part-time not regular course of conduct: The employee's work history for the 12-month period before the date of injury shows part-time and full-time work.
<input type="checkbox"/> Seasonal: The employee does temporary work to meet the employer's needs during certain times of the year.
<input type="checkbox"/> Apprentice: The employee is learning a new skilled trade by on-the-job training and studies.
<input type="checkbox"/> Minor: The employee is under 18 years of age and not married or emancipated by court action.
<input type="checkbox"/> Student: The employee is enrolled in a course of study (such as high school, college, or technical training).
<input type="checkbox"/> Trainee: The employee is being trained for the job they were originally hired to do.



Wage Statement DWC3

Information:

Employee

Employer

Employment Status

Same/Similar

Pecuniary

Nonpecuniary

Work status, sign and date, wages
BEFORE the injury, amount of Non-
Pecuniary and if they will continue.

DWC003

Section 4: Wages and benefits (complete parts one and two)

Part 1: Wage information

16. The wage information on this form is for ☐ the injured employee **or** ☐ a similar employee.

17. Salary amount (if applicable) \$	18. Hourly rate (if applicable) \$	19. Daily pay (if applicable) \$	20. Other (if applicable) \$
---	---	---	---

Week	21. Number of hours worked	22. Pay period dates (mm/dd/yyyy-mm/dd/yyyy)	23. Gross wage amount
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
24. Total gross wages			

Wage Statement - DWC3

Complete and send within 30 days on lost time claims and/or when requested

Retain copy and supply a copy to the injured employee

Complete all boxes and use 13 weeks prior to the date of injury

Ensures that the injured employee is receiving the correct benefit

Complete if known:
 DWC claim # _____
 Insurance carrier claim # _____

Supplemental report of injury

Part 1: Employer information

1. Name		2. Address (street or PO box, city, state, ZIP code)	
3. Phone number	4. Email address	5. Insurance carrier name	
6. Does the employer have return-to-work (RTW) opportunities available based on the injured employee's current capabilities? If yes, give a contact name and phone number: _____		Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Has the insurance carrier provided RTW coordination services within the past 12 months? If yes, give the date: (mm/dd/yyyy) _____		<input type="checkbox"/>	<input type="checkbox"/>
8. Has the employer requested RTW training from DWC or the insurance carrier?		<input type="checkbox"/>	<input type="checkbox"/>
9. Has the insurance carrier provided accident prevention services in the past 12 months? If yes, give the date: (mm/dd/yyyy) _____		<input type="checkbox"/>	<input type="checkbox"/>
10. Has the employer requested accident prevention services from the insurance carrier?		<input type="checkbox"/>	<input type="checkbox"/>

Part 2: Reason for filing this report

11. ☐ a. The injured employee returned to work in either full or limited capacity: file this report within three days.

☐ b. The injured employee returned, then later had more lost time or reduced wages because of the injury: file this report within three days.

☐ c. The injured employee is earning more or less than the pre-injury wage because of the injury: file this report within 10 days after each pay period that the injured employee's earnings changed.

☐ d. The injured employee resigned or was terminated from employment: file this report within 10 days.

Part 3: Injured employee information

12. Name (first, middle, last)	13. Address (street or PO box, city, state, ZIP code)	14. Phone number
15. Email address	16. Date of injury (mm/dd/yyyy)	17. Social Security number (last four digits) XXX-XX-_____
18. First day absent from work or had reduced wages because of the injury (mm/dd/yyyy)	19. First day of additional absence from work or reduced wages because of the injury (mm/dd/yyyy)	
20. Has the injured employee experienced eight days (cumulative) of lost time or reduced wages because of the injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what is the date of the eighth day? (mm/dd/yyyy)		
21. Date of most recent RTW (mm/dd/yyyy) : <input type="checkbox"/> Full duty, full pay <input type="checkbox"/> Limited duty, full pay or <input type="checkbox"/> Limited duty, reduced pay		
22. Has the injured employee resigned, been terminated, or died? Yes <input type="checkbox"/> No <input type="checkbox"/>		
22a. If yes, was it a resignation, termination, or death? On what date? (mm/dd/yyyy)		
22b. What was the reason for the resignation or termination?		
22c. Was the injured employee on limited duty when terminated? Yes <input type="checkbox"/> No <input type="checkbox"/>		
23. How many hours did the injured employee work during the most recent pay period of: (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____ ? _____ hours per week.		
23a. Are these hours the same as pre-injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		
23b. If no, are these hours less than or more than pre-injury hours? <input type="checkbox"/> Less than <input type="checkbox"/> More than		
24. What were the injured employee's weekly or hourly earnings for the most recent pay period of: (mm/dd/yyyy) _____ to (mm/dd/yyyy) _____ ? \$ _____ weekly or \$ _____ hourly		
24a. Are these wages the same as pre-injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		
24b. If no, are these wages less than or more than pre-injury wages? <input type="checkbox"/> Less than <input type="checkbox"/> More than		

Part 4: Certification

25. Certify with your signature:

- To the best of my knowledge, the information in this report is accurate and may be used to evaluate eligibility for benefits.
- Submitted by: ☐ Employer or ☐ Injured employee (If no longer working for the employer where the injury occurred)

Signature _____ Date _____

Supplemental Report of Injury DWC6

- Employer and employee information
- Work status
- Other sections as they apply

Supplemental Report of Injury – DWC6

Complete and send within 3 days after return to work or additional lost time

File within 10 days of a change in pay related to the injury, resignation or termination

Retain copy and send a copy to the injured employee

Possible fines for late filing

**Call TMLIRP to advise of
return to work prior to
sending the form**

Work Status - DWC73

General Information

Work status

Restrictions

Treatment/Follow-up



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:	
<input type="checkbox"/> a) will allow the employee to return to work as of ___/___/___ without restrictions; OR	
<input type="checkbox"/> 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	
<input type="checkbox"/> 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):		17. Motion Restrictions (if any):	19. Misc. Restrictions (if any):
Max hours per day 0 2 4 6 8 Other:		Max hours per day 0 2 4 6 8 Other:	Max hours per day of work:
Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Walking <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sit/stretch breaks of ___ per ___
Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Climbing stairs/ladders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Must wear splint/cast at work
Kneeling/squatting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Grasping/squeezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Must use crutches at all times
Bending/stooping <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Wrist flexion/extension <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	No driving/operating heavy equipment
Pushing/pulling <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Can only drive automatic transmission
Twisting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Overhead reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	No skin contact with:
Other:		Keyboarding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	No running
15. Restrictions Specific To (if applicable):		Other:	Dressing changes necessary at work
<input type="checkbox"/> Left hand/wrist <input type="checkbox"/> Left leg		18. Lift/Carry Restrictions (if any):	<input type="checkbox"/> No work / ___ hours/day work:
<input type="checkbox"/> Right hand/wrist <input type="checkbox"/> Right leg			
<input type="checkbox"/> Left arm <input type="checkbox"/> Back			
<input type="checkbox"/> Right arm <input type="checkbox"/> Left foot/ankle			
<input type="checkbox"/> Neck <input type="checkbox"/> Right foot/ankle		<input type="checkbox"/> May not lift/carry objects more than ___ lbs. for more than ___ hours per day.	<input type="checkbox"/> In extreme hot/cold environments
Other:		<input type="checkbox"/> May not perform any lifting/carrying.	<input type="checkbox"/> at heights or on scaffolding
		Other:	<input type="checkbox"/> Must keep ___
			<input type="checkbox"/> elevated <input type="checkbox"/> clean & dry
16. Other Restrictions (if any)		20. Medication Restrictions (if any):	
		<input type="checkbox"/> Must take prescription medication(s)	
		<input type="checkbox"/> Advised to take over-the-counter meds	
		<input type="checkbox"/> 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:			
		<input type="checkbox"/> Evaluation by the treating doctor on ___/___/___ at ___:___ a.m./p.m.			
		<input type="checkbox"/> Referral to/consult with ___ on ___/___/___ at ___:___ a.m./p.m.			
		<input type="checkbox"/> Physical medicine ___ X per week for ___ weeks starting on ___/___/___ at ___:___ a.m./p.m.			
		<input type="checkbox"/> Special studies (list): ___ on ___/___/___ at ___:___ a.m./p.m.			
		<input type="checkbox"/> 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 #	<input type="checkbox"/> Initial	<input type="checkbox"/> Treating doctor	<input type="checkbox"/> Consulting doctor	<input type="checkbox"/> Designated doctor
		<input type="checkbox"/> Follow-up	<input type="checkbox"/> Referral doctor	<input type="checkbox"/> PA	<input type="checkbox"/> Other doctor
			<input type="checkbox"/> RME doctor	<input type="checkbox"/> APRN	



Submitting Medical Bills

- When submitting medical bills on claims already been filed – don't send a copy of the DWC1. If you send it for identification purposes, note - that it is a DUPLICATE or COPY. This will eliminate the creation of duplicate files.
- If you are submitting only a bill, check that the name is the same on the bill as on the DWC1. If the names differ, write the name on the DWC1 across the top.



Submitting Medical Bills

MAIL: PO Box 2894 Clinton IA 52733

FAX: 732-813-1345

Electronic Billing: Jopari Payer ID #A0245 (866) 269-0554

Provider Filing Deadlines:

- Medical bill - 95 days from the date of service to file, or it will be denied for timely filing.
- Reconsideration or Appeal - 11 months from the date of service.

All bills that comply with the DWC Fee Schedule and/or the Alliance Contractual Agreements will be paid if the treatment is related to a compensable injury.

Workers' Compensation

Medical Treatment and

 **The Alliance**



POLITICAL SUBDIVISION
WORKERS' COMPENSATION
ALLIANCE

What is the Alliance?

Political Subdivision Workers' Compensation Alliance (The Alliance)

Joint Contracting Partnership (5 Pools)

Medical Network



TEXAS ASSOCIATION *of* COUNTIES



What is the Alliance?

Chapter 504.053

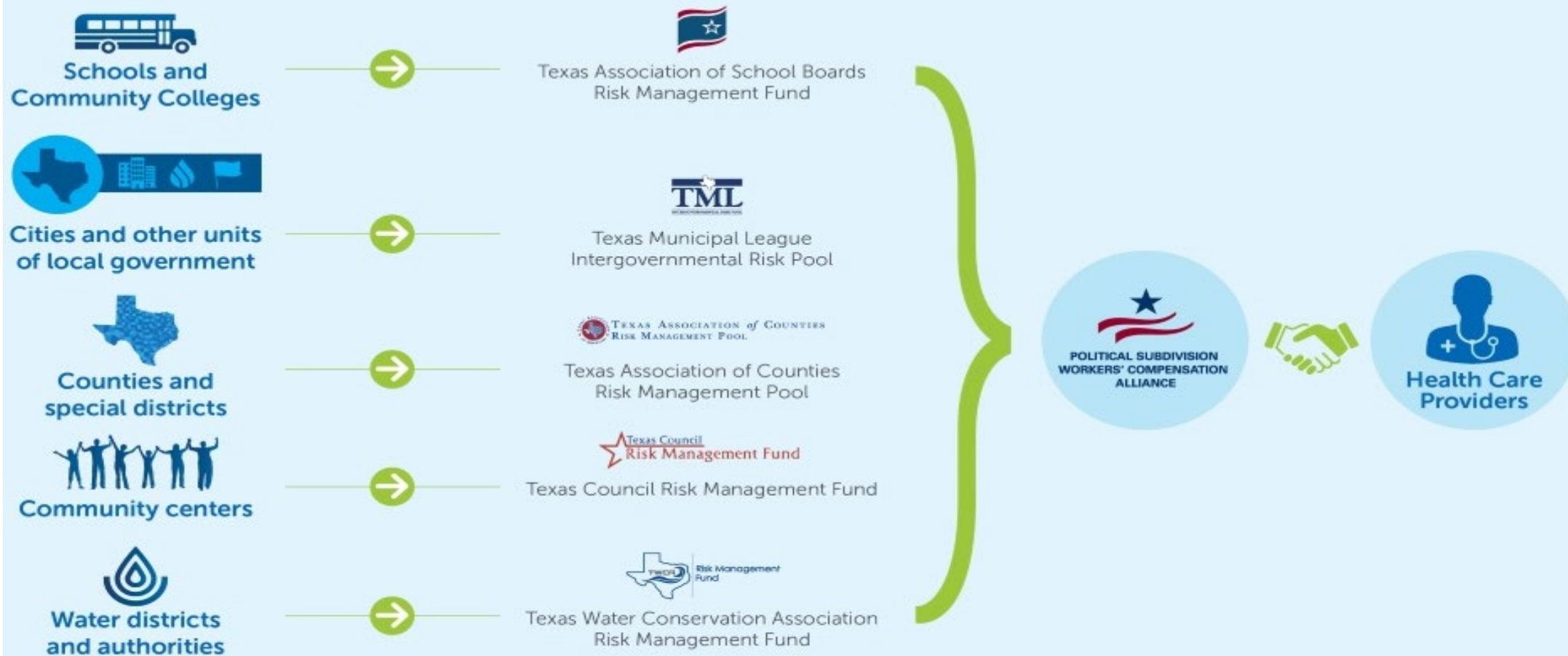
2005 workers' compensation reforms allowed Texas public entities to directly contract with health care providers to deliver care to injured employees

5 Pools represent the
2nd largest coverage
provider in the state

Serves more than
3,000 public
employers (500,000
employees)

Providers treat
approximately
22,000 injured
employees per year

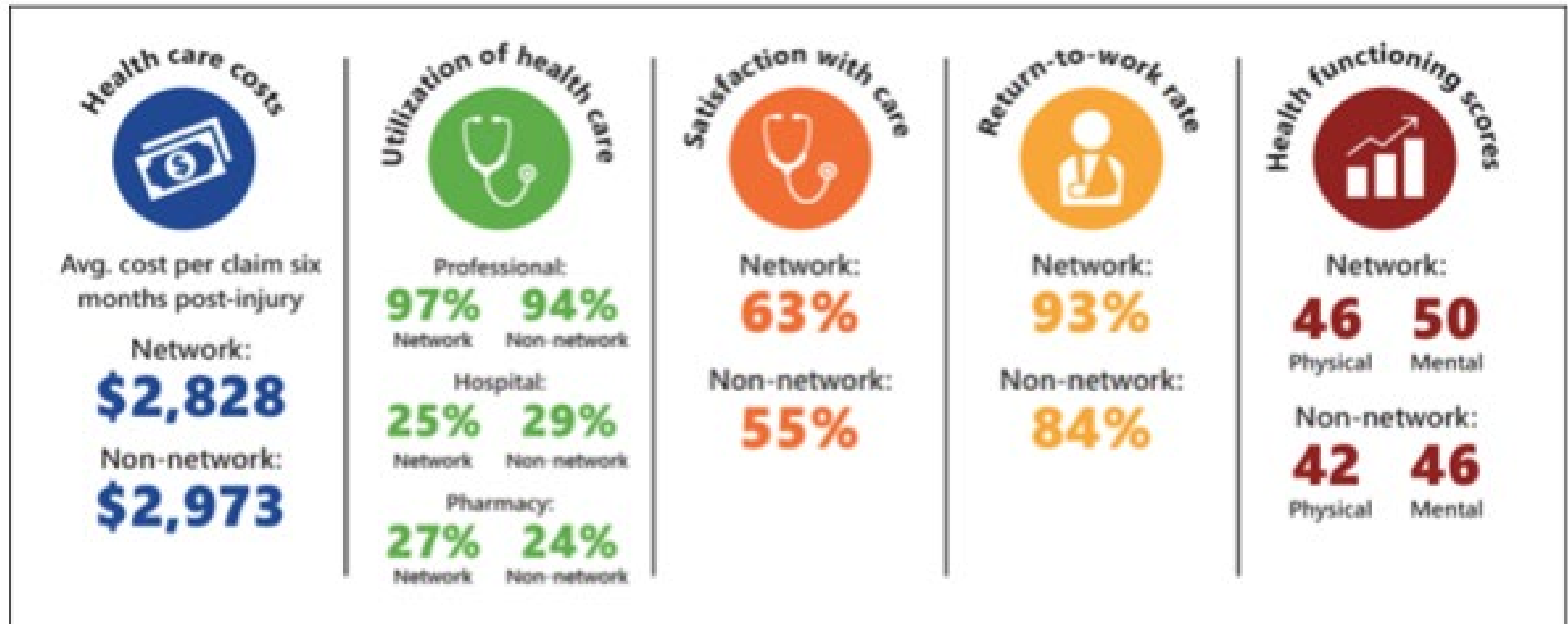
The Alliance structure



Some Alliance risk pools cover several types of public entities.

Success in the Alliance

2024 Workers' Comp Network Report Card



Medical Benefits


Texas Labor Code Sec. 408.021. Entitlement to Medical Benefits

Healthcare reasonably required by the nature of injury

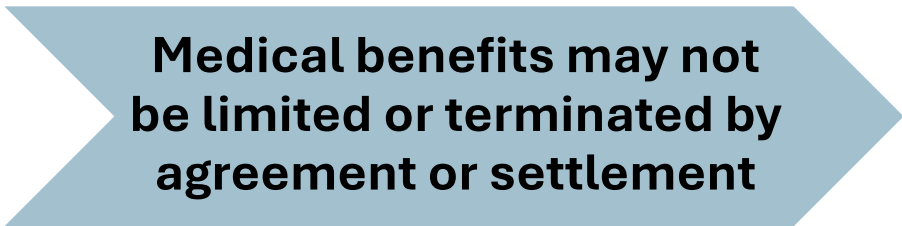
Cures or relieves the effects naturally resulting from injury

Promotes recovery

Enhances ability of employee to retain or return to employment



Except in emergency, all health care must be through the treating doctor



Medical benefits may not be limited or terminated by agreement or settlement

Member Role and Influence

Provide employee paperwork, ensure posting is current and have employee acknowledgement signed if at all possible

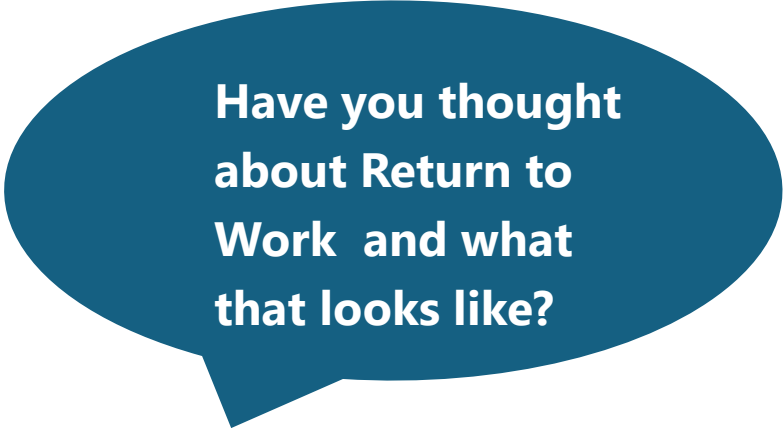
Guide injured employees to the website: www.pswca.org

Can nominate providers to participate

Keep employees connected

Call periodically and just check on them

Advocacy-based workers' compensation is real



**Have you thought
about Return to
Work and what
that looks like?**

TMLIRP

 Portal



STP Podcast



File a Claim



Portal Submissions



Annual Partnership Summit





STP Podcast



File a Claim



Portal Submissions



Change Schedule



Provider Bill Status



Training

STP Podcast

File a Claim

Portal Submissions

Change Schedule

Provider Bill Status

Training



Login

User Name

Password



If you're having issues logging in, please contact your Fund Contact or Contact Us

[Forgot User Name?](#)

[Forgot Password?](#)

Login

This website is best used with the following browsers



[WHO WE ARE](#)

[RISK MANAGEMENT](#)

[TRAINING](#)


[NEWS](#)


[CONTACT US](#)

[LOGOUT](#)




 [EOBs](#)

 [Member Dashboard](#)

 [Portal Submissions](#)



 [Manage](#) ▾



TMLIRP Portal

To access - submit an online New User Registration form. Once approved, account information will be sent within 24 to 48 hours. <https://www.tmlirp.org/new-user-registration/>

Access the TMLIRP Member Portal.
<https://members.tmlirp.org/login>

NOTE: Employer Forms can be found at <https://www.tmlirp.org/> or on the DWC website at <https://www.tdi.texas.gov/wc/index.html>.

STP Podcast

Episode 8

"First Responders and COVID-19 Vaccines"

Posted August 19, 2021

Provides COVID-19 statistics and the story of Roger Dean – as told by his surviving healthy 31-year-old Seguin firefighter who passed away after a months-long battle with COVID-19.

Further information:

[Texas Department of State Health Services Vaccine Information Web Page](#)



Listen Now

Episode 7

"Disciplining and Terminating Employees: Liability and the 'Call Before You Fire' Hotline"

Posted July 28, 2021

Explains: (1) that you may be liable for improper employment actions; and (2) that you should consult one of the Pool's attorneys prior to taking action.

Further information:

[TML Risk Pool's "Call Before You Fire Program"](#)
[Employment Law Manual for Texas Cities](#)
[Texas Municipal Human Resources Association](#)
[Ask a Texas Municipal League Attorney](#)

Listen Now



Listen Now

Episode 10a - Part 1

"Workers' Comp: Taking Care of Your Employees"

Posted October 14, 2021

The TML Risk Pool provides workers' compensation coverage for more than 200,000 local government employees, and receives around 10,000 claims per year. The Workers' Compensation Department is the largest of all the Pool's departments, largely because the workers compensation process is highly-regulated by the Workers' Compensation Division of the Texas Department of Insurance. In this episode, you'll hear from key Pool staff about the process and how it's administered, most importantly how we partner with Members to help guide them through the complex process.

Further information:

[Texas Political Subdivision Workers' Compensation Alliance](#)
[Texas Department of Insurance - Division of Workers' Compensation](#)
[Division of Worker's Compensation – Performance-Based Oversight Results](#)

Lubbock Firefighter Matt Dawson Receiving Risk Pool Worker's Compensation Benefits:

[Everything Lubbock](#)
[KCBD](#)



Texas Communities are **STRONGER TOGETHER**



File a Claim or Send additional Forms

File a Claim or Submit Additional Forms to Existing Claims

Auto, Liability & Property

- ☐ Was Member property damaged (Property)?
- ☐ Was a vehicle involved (Auto liability and/or physical damage)?
- ☐ Did this incident affect a 3rd party or Member employee (All liability claims other than auto)?
- ☐ Cyber claim?

Workers' Compensation

- ☐ Was an employee or volunteer injured (DWC-1)?
- ☐ Wage Statement to submit (DWC-3)?
- ☐ Supplemental Report of Injury to submit (DWC-6)?

Next

Portal Submissions

Portal Submissions

Date Range

10/18/2021

to

11/02/2021

GO

Filter

All Submissions

Search

Export Options

	Submission Type	Date of Loss	Date Submitted	Scheduled ID	Submitted By	Member	Adjuster	Claim Number
	DWC-1	10/27/2021	11/2/21, 11:56 AM	N/A				
	Vehicle Add Form	N/A	11/2/21, 11:02 AM	N/A				
	DWC-1	10/31/2021	11/2/21, 9:20 AM	N/A				
	Vehicle Add Form	N/A	11/1/21, 2:50 PM	N/A				
	Auto Claim	09/27/2021	10/28/21, 11:32 AM	N/A				
	DWC-1	10/26/2021	10/26/21, 3:03 PM	N/A				
	DWC-1	10/20/2021	10/26/21, 9:04 AM	N/A				
	Property Claim	10/09/2021	10/21/21, 1:57 PM	N/A				
	Liability Claim	09/29/2021	10/21/21, 11:15 AM	N/A				
	Liability Claim	10/21/2021	10/21/21, 9:58 AM	N/A				
	Vehicle Add Form	N/A	10/21/21, 9:43 AM	N/A				
	Auto Claim	10/18/2021	10/21/21, 8:36 AM	N/A				

To assist in training and education efforts, the Pool provides programs in electronic formats.

The Pool's Media Library has DVDs that members can check out at no charge, except for return shipping. The materials provide support for safety meeting and training.

Webinars are presented each month throughout the year and are recorded for later viewing. Please contact Loss Prevention for the password. Upcoming webinars are found on the [Education and Training Calendar](#).

The [Online Learning Center](#) allows employees to gain valuable knowledge and take classes at work or anywhere they have access to a computer or an internet connection.

Media Library

The Loss Prevention Media Library is divided into categories. This listing is currently [available as a PDF](#). To order videos, go to our [Order Form](#). A password is not necessary to request a video, but videos are available only to TMLIRP member employees.

[MEDIA LIBRARY ORDER FORM](#)

View Media List



Online Learning Center

Member employees may take online courses at work or anywhere they have access to a computer and an internet connection. Online courses are provided at no cost to TMLIRP members.

Go to Learning Center



Virtual Events

Recorded webinars are posted on the Pool's YouTube channel. The Pool also provides live virtual events to individual members via web conferencing. Please contact your Loss Prevention Representative for scheduling.

View Webinars



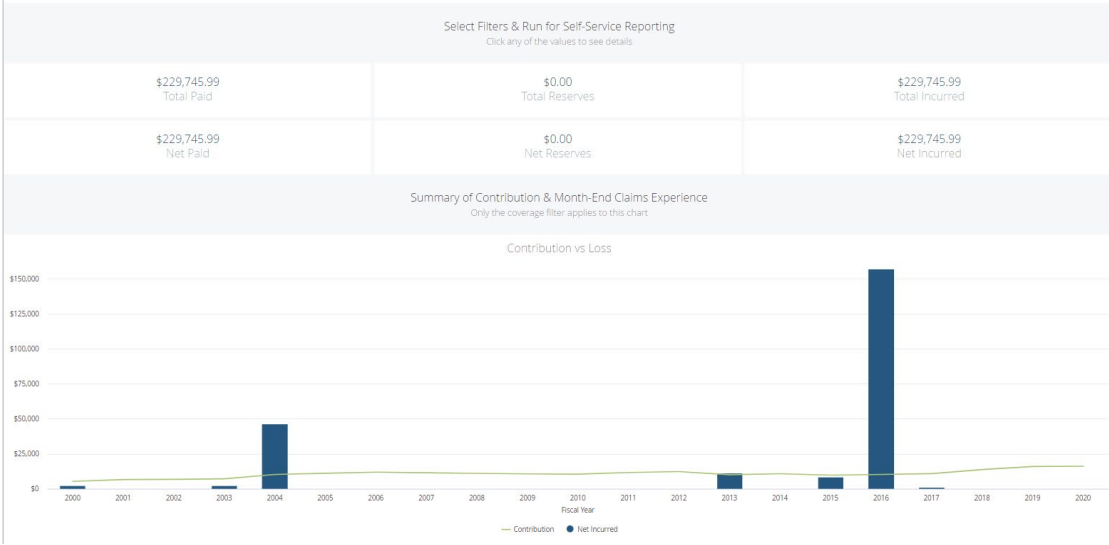
YouTube Video Library

Member employees can view Youtube videos at work or anywhere they have access to a computer or phone and an internet connection.

Go to YouTube Video Library



Member Dashboard





REPORT A BREACH

GET TRUSTED HELP
WHEN YOU NEED IT



TOOLS & CALCULATORS

UNDERSTAND YOUR
EXPOSURE



CYBERSECURITY TRAINING

INCREASE YOUR
SECURITY AWARENESS



RANSOMWARE RESOURCES

BE A TOUGHER TARGET
LEARN HOW

Featured Content

- The Economic Impact of Cyber Attacks on Municipalities
- NetDiligence 2020 Cyber Claims Study
- A Guide to Securely Working from Home
- Integrating Incident Response and Business Continuity Programs
- Data Breach Response Handbook
- Cybersecurity Tips to Prevent Your Business from Becoming COVID-19's Virtual Victim

Dark Reading



How Hackers Are Targeting Cryptocurrency
11/02/2021

How AI-Driven Security Analytics Speeds Up
Enterprise Defense
11/01/2021






















CISA and Partners Coordinate on Security,
Combatting Misinformation for Election Day
11/01/2021

Manage

Documents & Forms

Stay tuned....
More to come!

Workers' Compensation Forms

-  [DWC-1 Employers First Report of Injury or Illness.pdf](#)
-  [DWC-156 Prospective Employment Authorization & Certification.pdf](#)
-  [DWC-3 Employers Wage Statement.pdf](#)
-  [DWC-3ME Employees Multiple Employment Wage Statement.pdf](#)
-  [DWC-6 Supplemental Report of Injury.pdf](#)
-  [DWC048 Request for Travel Reimbursement.pdf](#)
-  [DWC074 Description of Injured Employees Employment.pdf](#)
-  [Employee Rights Responsibilities English.pdf](#)
-  [Employee Rights Responsibilities Spanish.pdf](#)
-  [First Responder Liaison English.pdf](#)
-  [First Responder Liaison Spanish.pdf](#)
-  [Notice of Ombudsman Program English.pdf](#)
-  [Notice of Ombudsmand Program Spanish.pdf](#)
-  [notice10.pdf](#)
-  [notice10s.pdf](#)
-  [notice8.pdf](#)
-  [notice8s.pdf](#)
-  [notice9.pdf](#)
-  [notice9s.pdf](#)
-  [Page 36 Requirements for Building Contractors.pdf](#)
-  [...](#)

Thank you!

