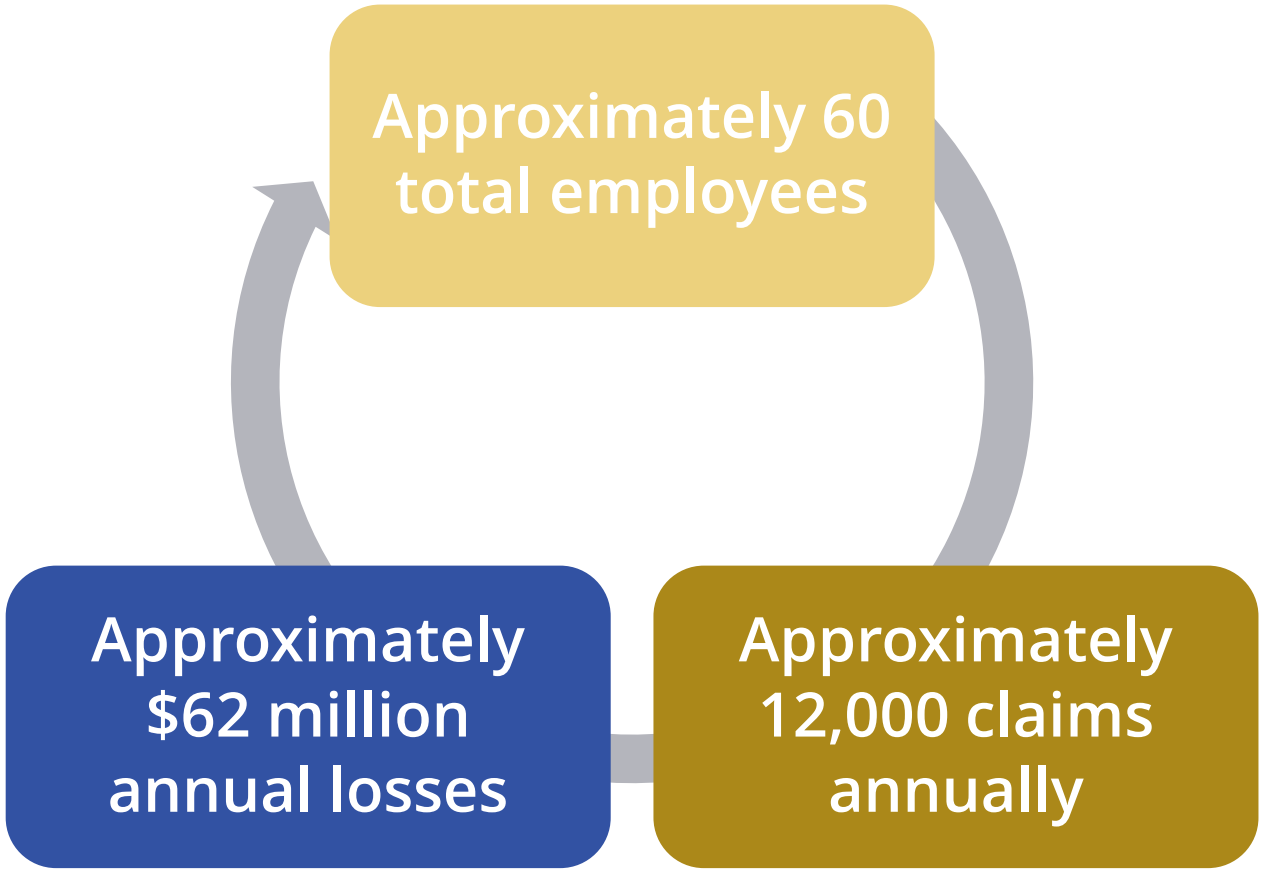
Workers' Compensation

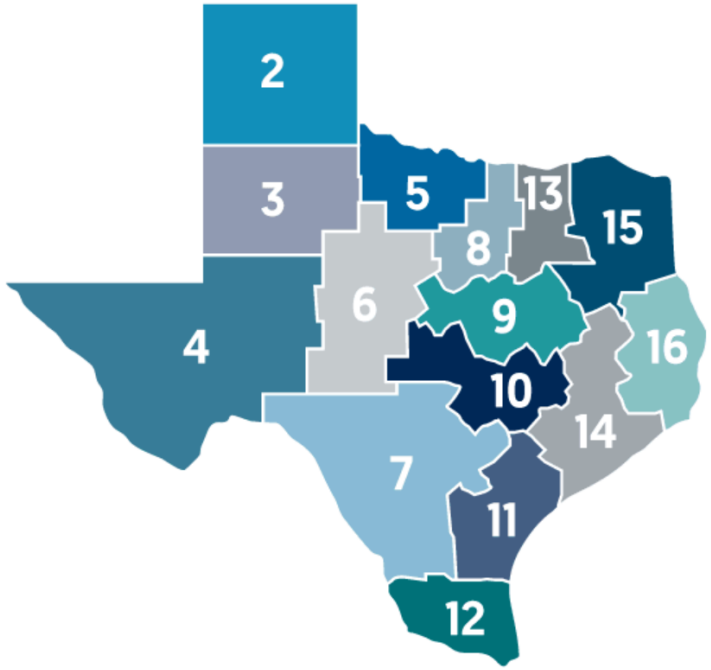
Navigating the Process

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	Occupational Disease	Repetitive Trauma
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.	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.	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?

- Immediately or as soon as possible
- Employer policy
- Within 30 days per Texas Labor Code Section 409.001(a)
- Occupational disease within 30 days of when the employee knew or should have known that the injury was work related

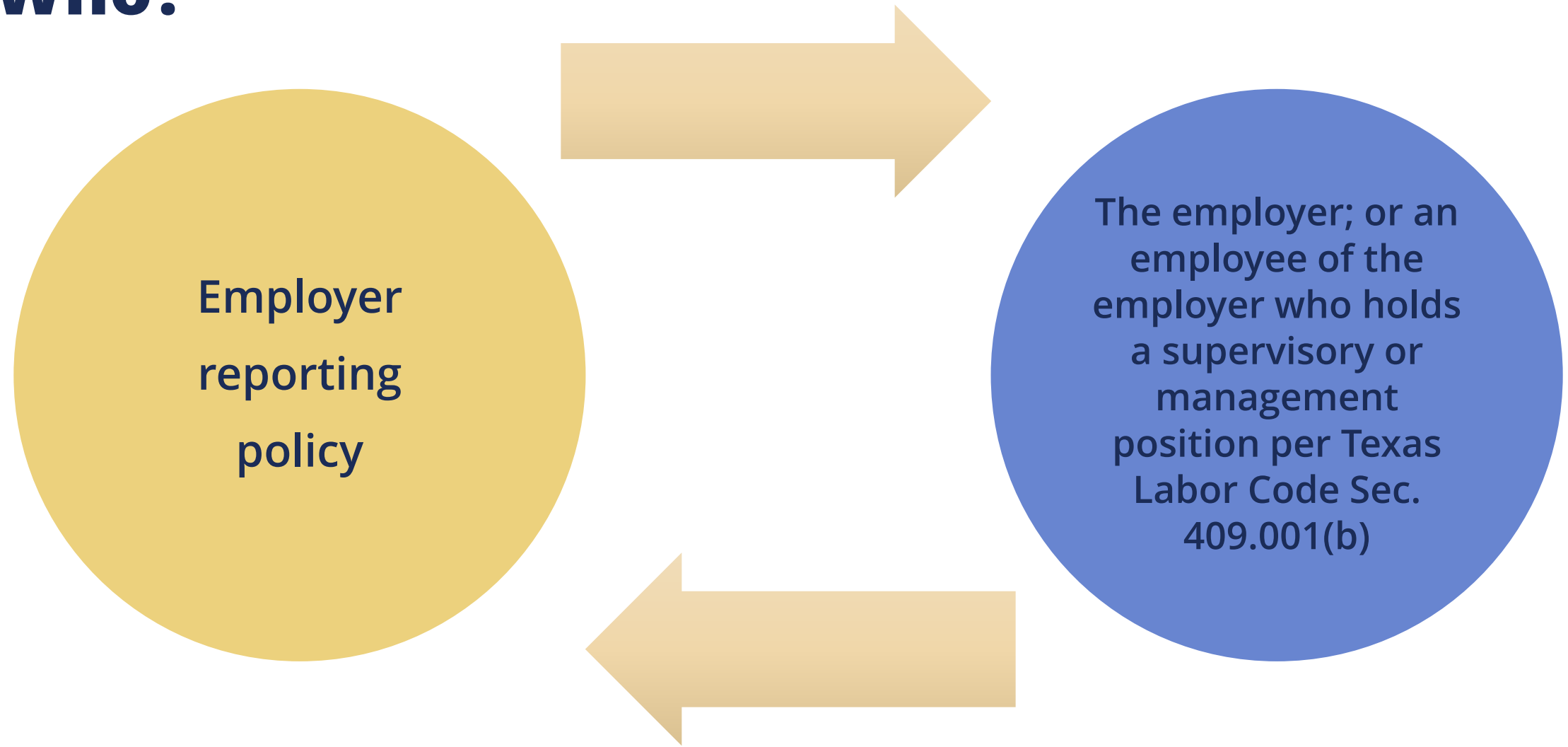
How?

Notice may be verbal or in writing

Reporting may be vague

- What
- When
- Where
- Why
- How

Who?


Employer reporting policy
The employer; or an employee of the employer who holds a supervisory or management position per Texas Labor Code Sec. 409.001(b)

Should All Injuries be Reported?

All injuries should be reported - to the member

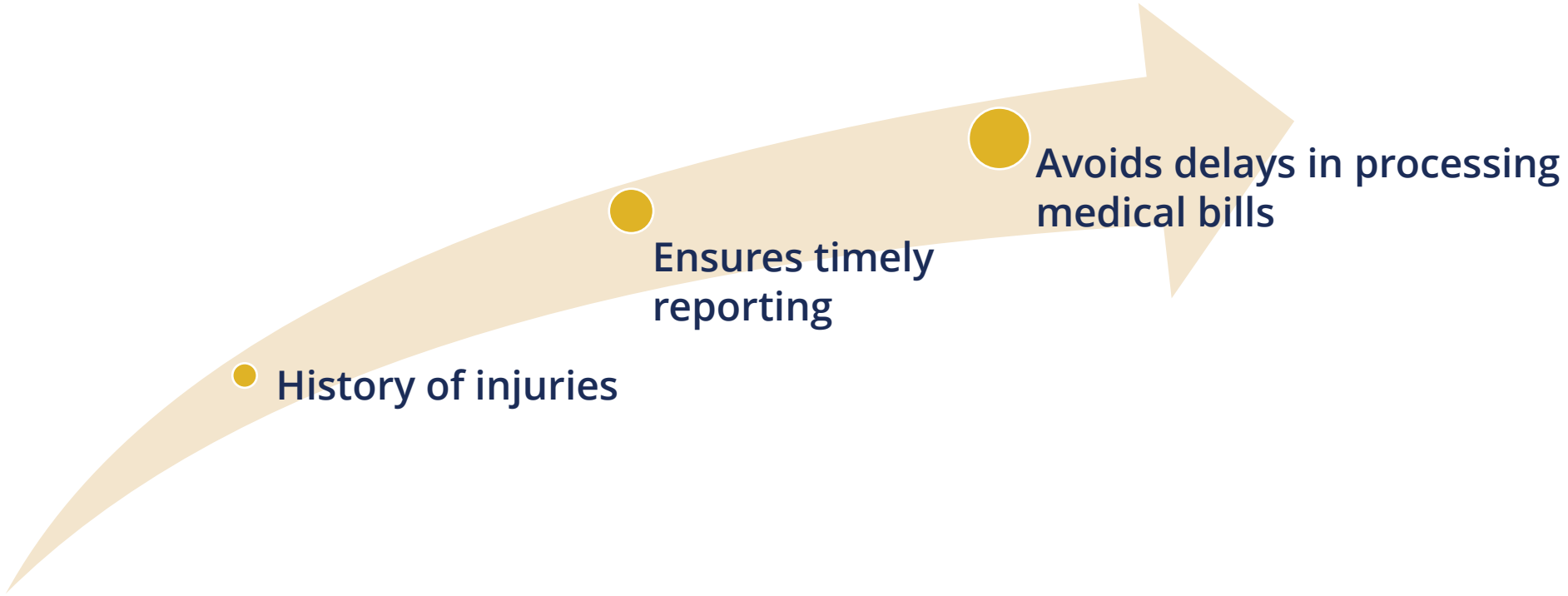
Injuries that do not require medical attention such as exposure should be reported

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).

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

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

Claims Process

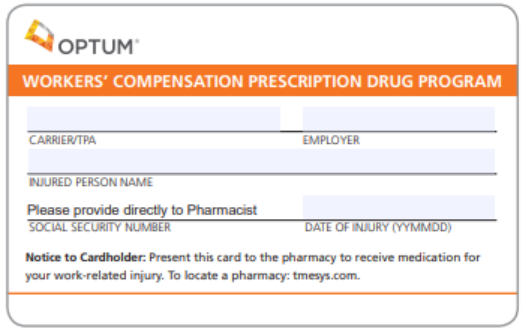
- Assignment, Investigation & Claim Documentation
- Course and Scope/Compensability Determination
- Timely Payments and Disputes
- Return to Work and modified duty members

TML RISK POOL

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

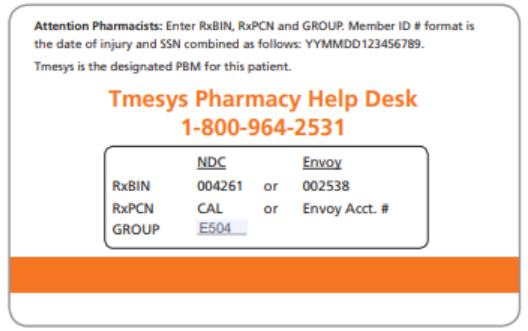
INJURED PERSON NAME

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

	NDC		Envoy
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?

Gather additional facts and information

Have the injured employee and/or witnesses available for interview

Ask questions about the workers' compensation process or share any questions or concerns

Communicate and educate!

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

TML Risk 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

3724O 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

8742I Inside Volunteers

8888V Police Reserves-Motorcycle

Presumption Claims
Chapter 607 of the Government Code

Firefighters and EMTs	Peace Officers
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	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

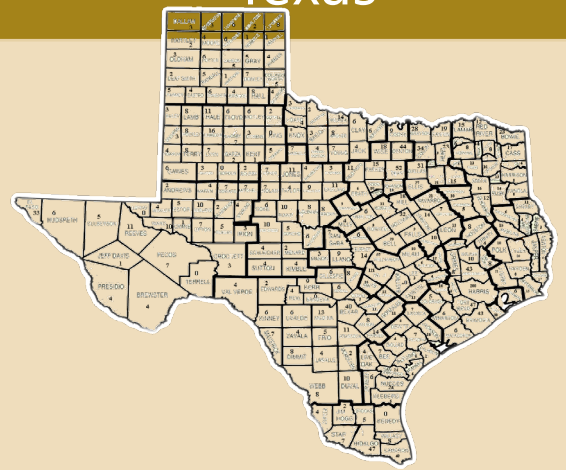
- 1st Responders may or may not be covered

Jurisdiction

Approved

Division of Workers' Compensation (DWC)

Oversees Workers' Compensation in Texas



Handles Workers' Compensation disputes

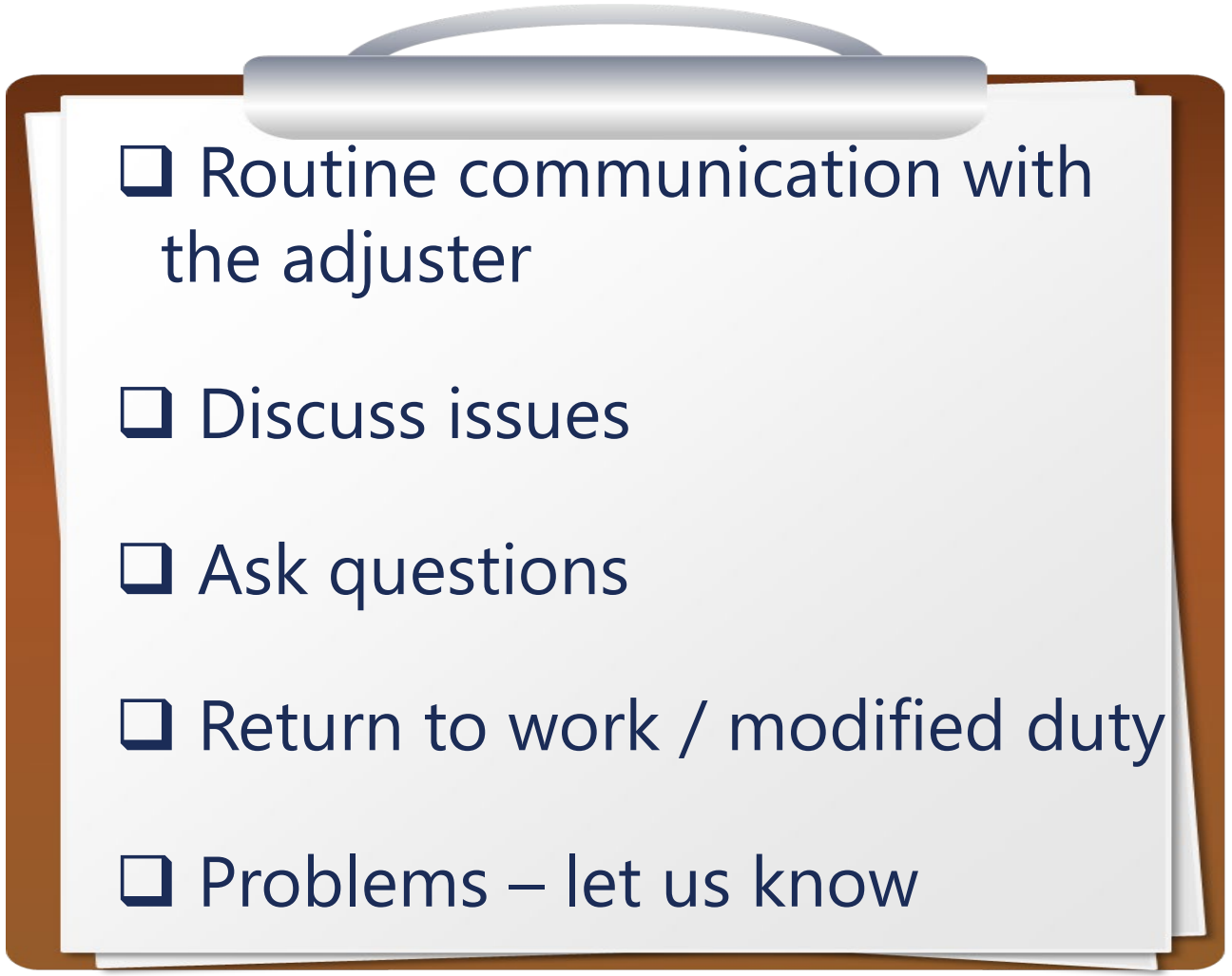
- Benefit Review Conference (BRC)
- Contested Case Hearing (CCH)
- Appeal Process

Assists injured workers (via OIEC)

Yolanda Garcia (512) 804-4173

firstresponderhelp@oiec.Texas.gov

Important Reminders!



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

Partnering with Local Governments Since 1974

DWC001

TDI Division of Workers' Compensation

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** ☐ Female ☐ Male ☐ Unknown	
9. Spouse's name (first, middle, last)		**10. Number of dependent children**	
11. Does the employee speak English? ☐ Yes ☐ 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** : ☐ a.m. or ☐ 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? ☐ Yes ☐ 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)		

DWC001 Rev. 10/24

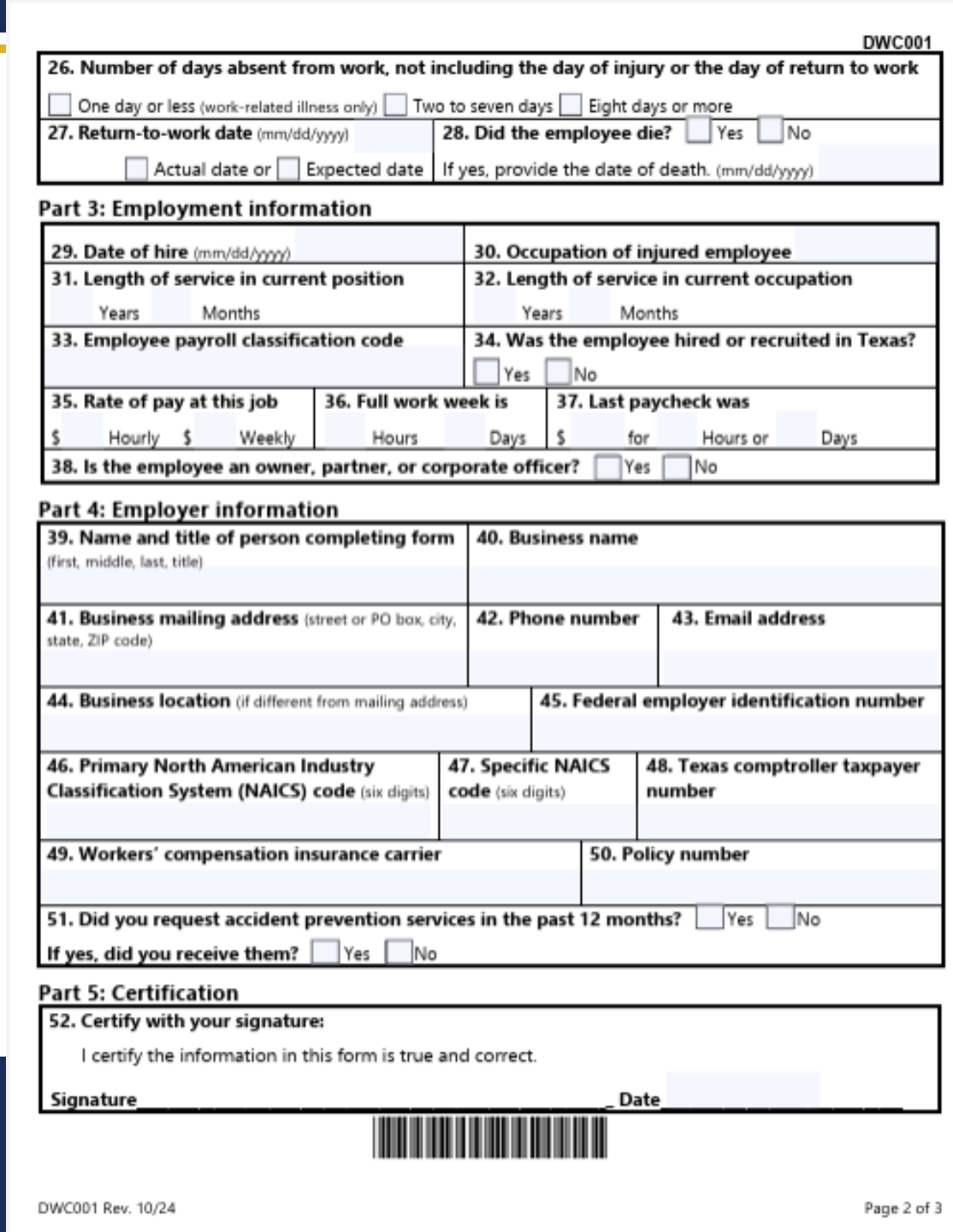
Page 1 of 3

First Report of Injury - DWC1

Information:

Employment
Employer

Partnering with Local Governments Since 1974



DWC001

26. Number of days absent from work, not including the day of injury or the day of return to work

☐ One day or less (work-related illness only) ☐ Two to seven days ☐ Eight days or more

27. Return-to-work date (mm/dd/yyyy)
☐ Actual date or ☐ Expected date

28. Did the employee die? ☐ Yes ☐ 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?
☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No

If yes, did you receive them? ☐ Yes ☐ No

Part 5: Certification

52. Certify with your signature:

I certify the information in this form is true and correct.

Signature _____ **Date** _____

DWC001 Rev. 10/24

Page 2 of 3

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) ☐ **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:

- ☐ **Full-time:** The employee regularly works 30 hours or more per week.
- ☐ **Part-time regular course of conduct:** The employee regularly works less than 30 hours per week.
- ☐ **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.
- ☐ **Seasonal:** The employee does temporary work to meet the employer's needs during certain times of the year.
- ☐ **Apprentice:** The employee is learning a new skilled trade by on-the-job training and studies.
- ☐ **Minor:** The employee is under 18 years of age and not married or emancipated by court action.
- ☐ **Student:** The employee is enrolled in a course of study (such as high school, college, or technical training).
- ☐ **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	

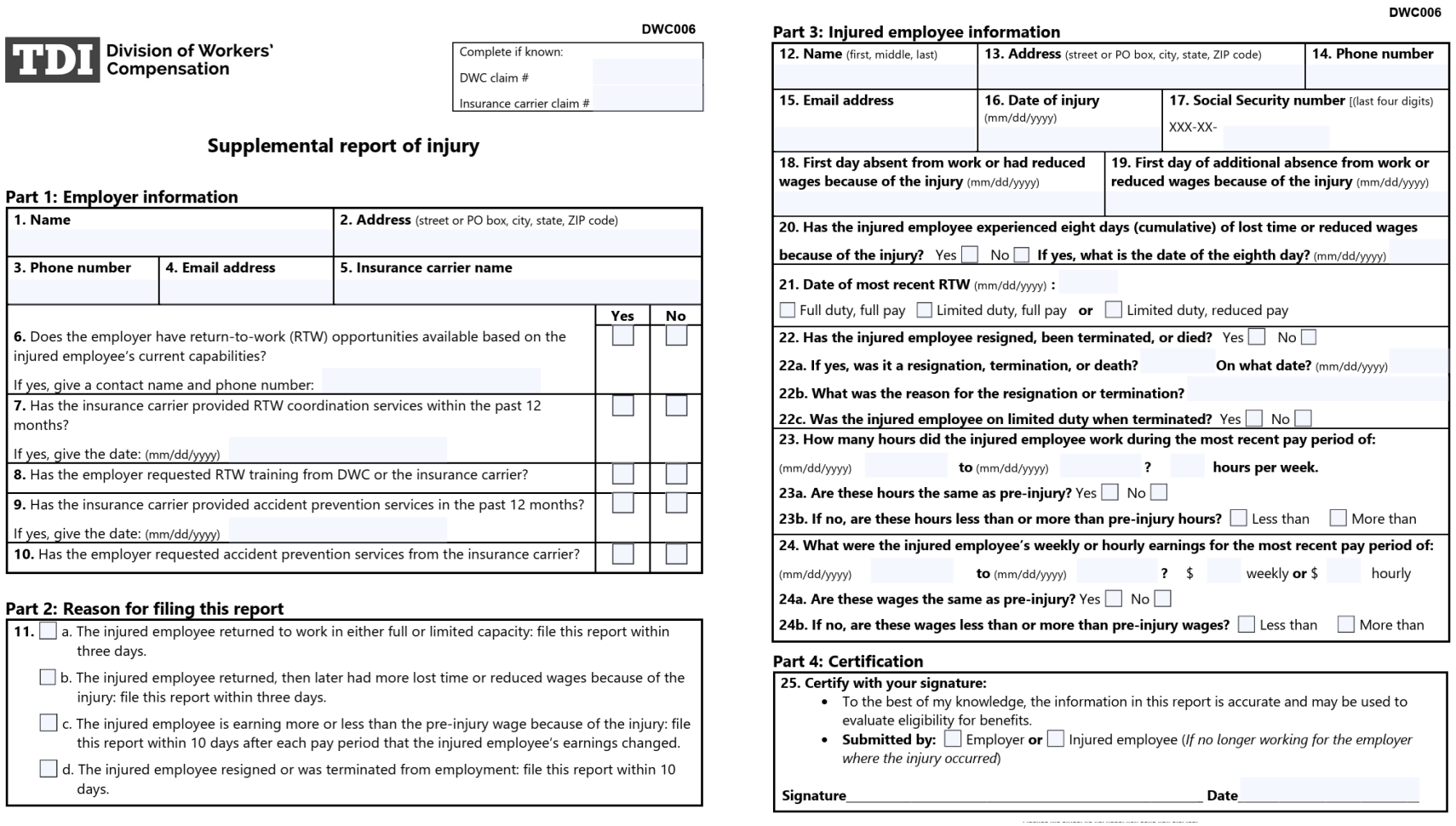
Wage Statement - DWC3

- 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

Supplemental Report of Injury DWC6

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



DWC006

TDI Division of Workers' Compensation

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

	Yes	No
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:	☐	☐
7. Has the insurance carrier provided RTW coordination services within the past 12 months? If yes, give the date: (mm/dd/yyyy)	☐	☐
8. Has the employer requested RTW training from DWC or the insurance carrier?	☐	☐
9. Has the insurance carrier provided accident prevention services in the past 12 months? If yes, give the date: (mm/dd/yyyy)	☐	☐
10. Has the employer requested accident prevention services from the insurance carrier?	☐	☐

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.

DWC006

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 ☐ No ☐ If yes, what is the date of the eighth day? (mm/dd/yyyy)

21. Date of most recent RTW (mm/dd/yyyy) :
☐ Full duty, full pay ☐ Limited duty, full pay **or** ☐ Limited duty, reduced pay

22. Has the injured employee resigned, been terminated, or died? Yes ☐ No ☐
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 ☐ No ☐

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 ☐ No ☐
23b. If no, are these hours less than or more than pre-injury hours? ☐ Less than ☐ 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 ☐ No ☐
24b. If no, are these wages less than or more than pre-injury wages? ☐ Less than ☐ 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**_____

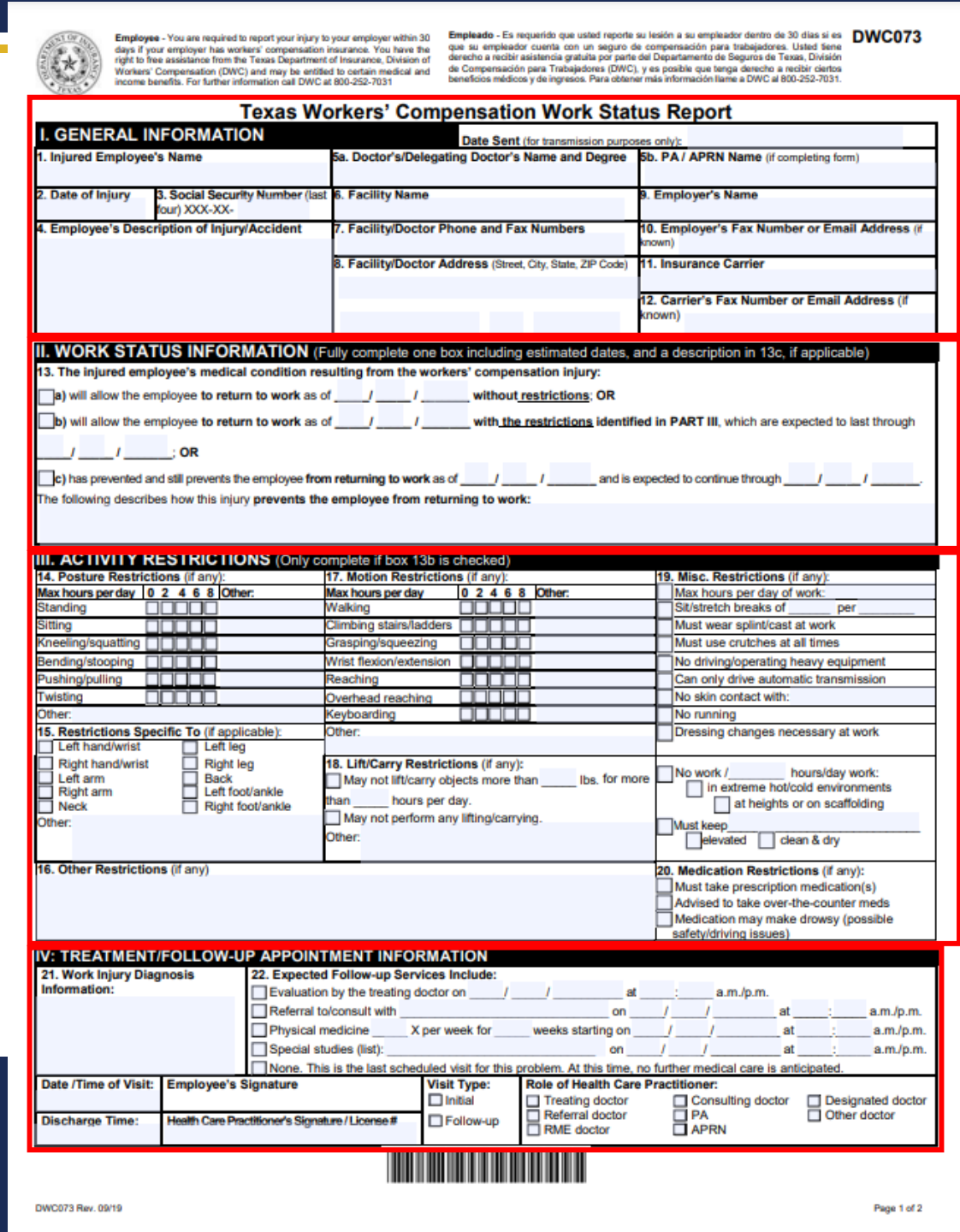
Supplemental Report of Injury – DWC6

- 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:

☐ 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:						

15. Restrictions Specific To (if applicable):

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

16. Other Restrictions (if any)

17. Motion Restrictions (if any):

Max hours per day	0	2	4	6	8	Other:
Walking	☐	☐	☐	☐	☐	
Climbing stairs/ladders	☐	☐	☐	☐	☐	
Grasping/squeezing	☐	☐	☐	☐	☐	
Wrist flexion/extension	☐	☐	☐	☐	☐	
Reaching	☐	☐	☐	☐	☐	
Overhead reaching	☐	☐	☐	☐	☐	
Keyboarding	☐	☐	☐	☐	☐	
Other:						

18. Lift/Carry Restrictions (if any):

☐ May not lift/carry objects more than ____ lbs. for more than ____ hours per day.
☐ May not perform any lifting/carrying.
Other:

19. Misc. Restrictions (if any):

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

20. Medication Restrictions (if any):

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

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

Page 1 of 2

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

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

Members/Employers → Purchase coverage and services → Risk pools → These risk pools manage the claims and fund the Alliance → The Alliance contracts with healthcare providers and manages the network to treat injured workers

Schools and Community Colleges

Texas Association of School Boards Risk Management Fund

Cities and other units of local government

Texas Municipal League Intergovernmental Risk Pool

Counties and special districts

Texas Association of Counties Risk Management Pool

Community centers

Texas Council Risk Management Fund

Water districts and authorities

Texas Water Conservation Association Risk Management Fund

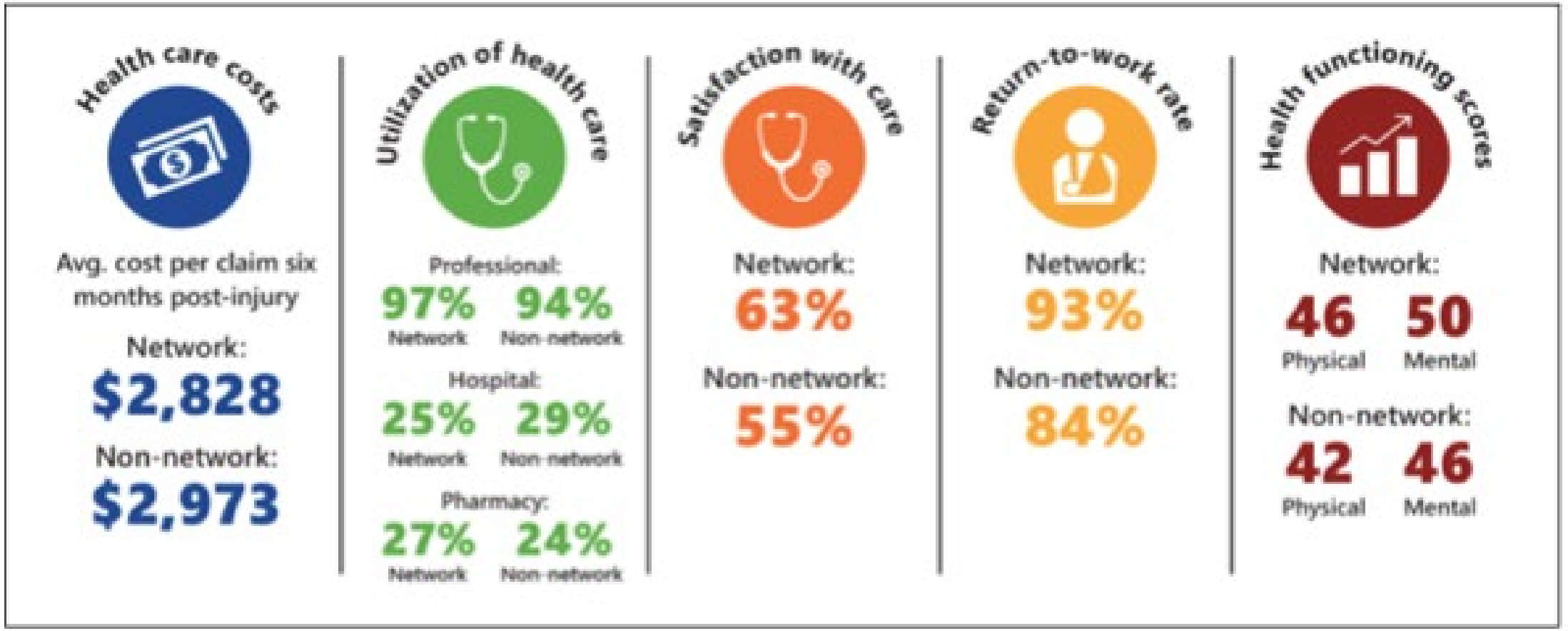
POLITICAL SUBDIVISION WORKERS' COMPENSATION ALLIANCE

Health Care Providers

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

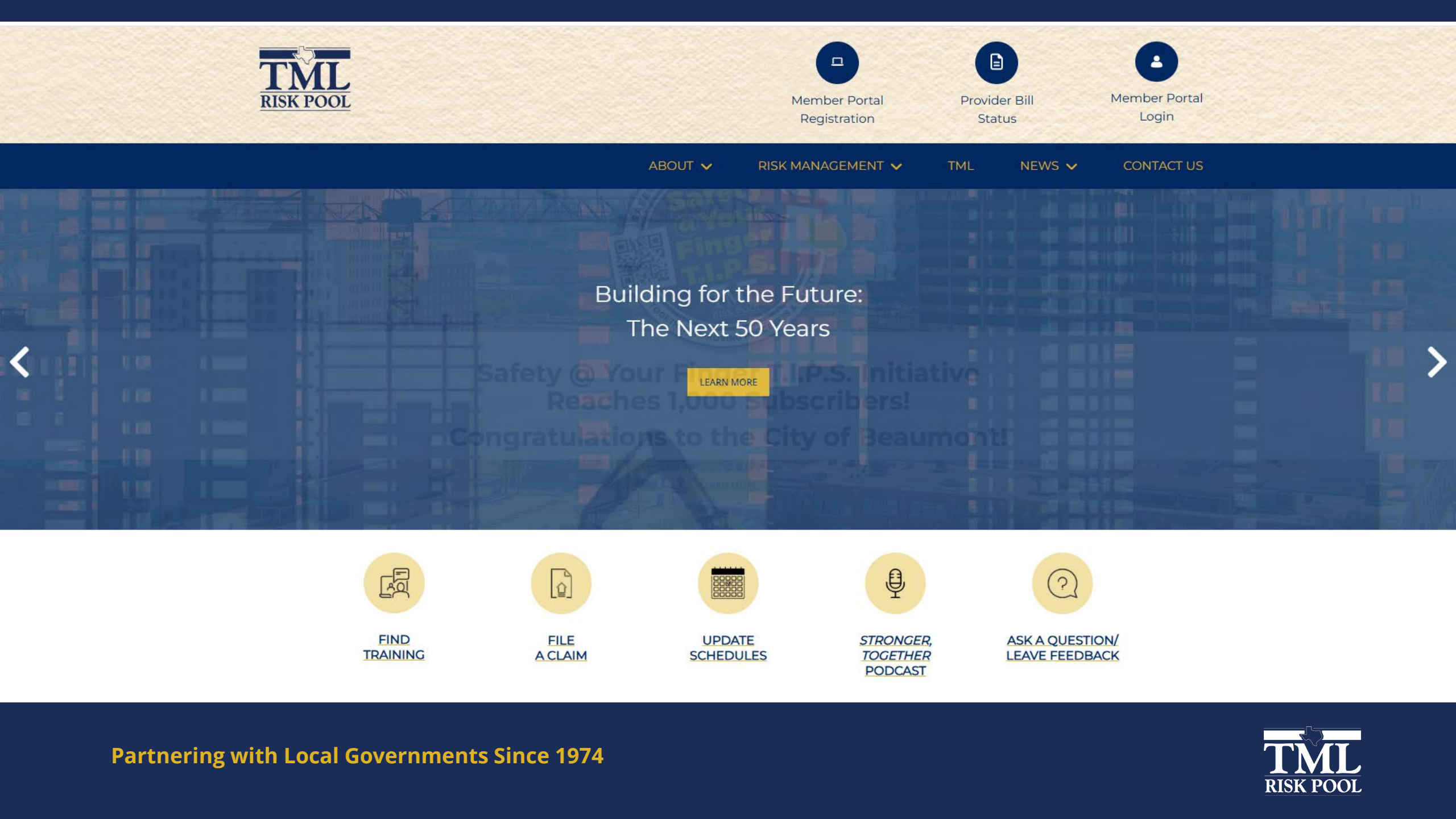
Keep employees connected

- 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?

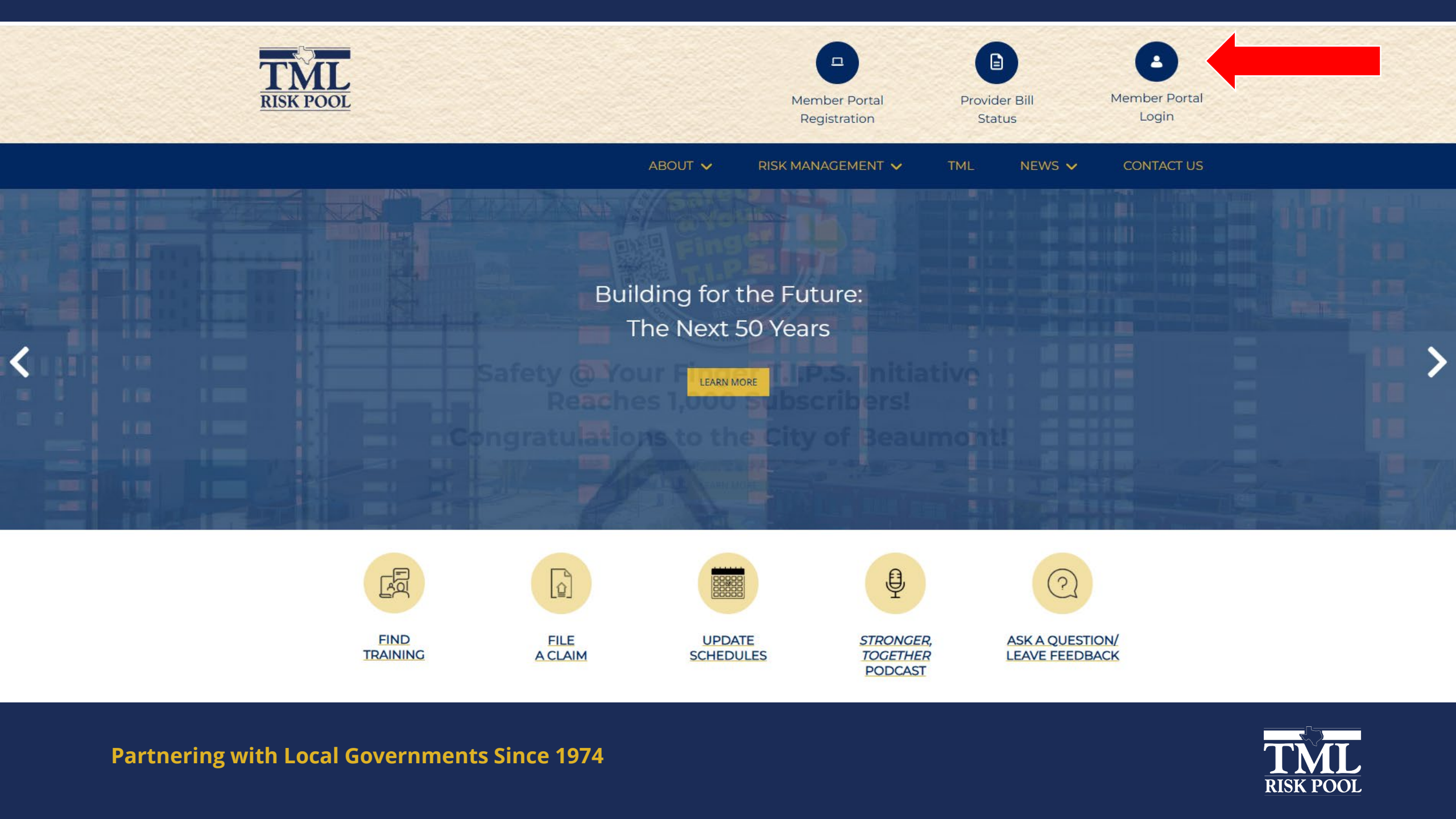
TML Risk Pool

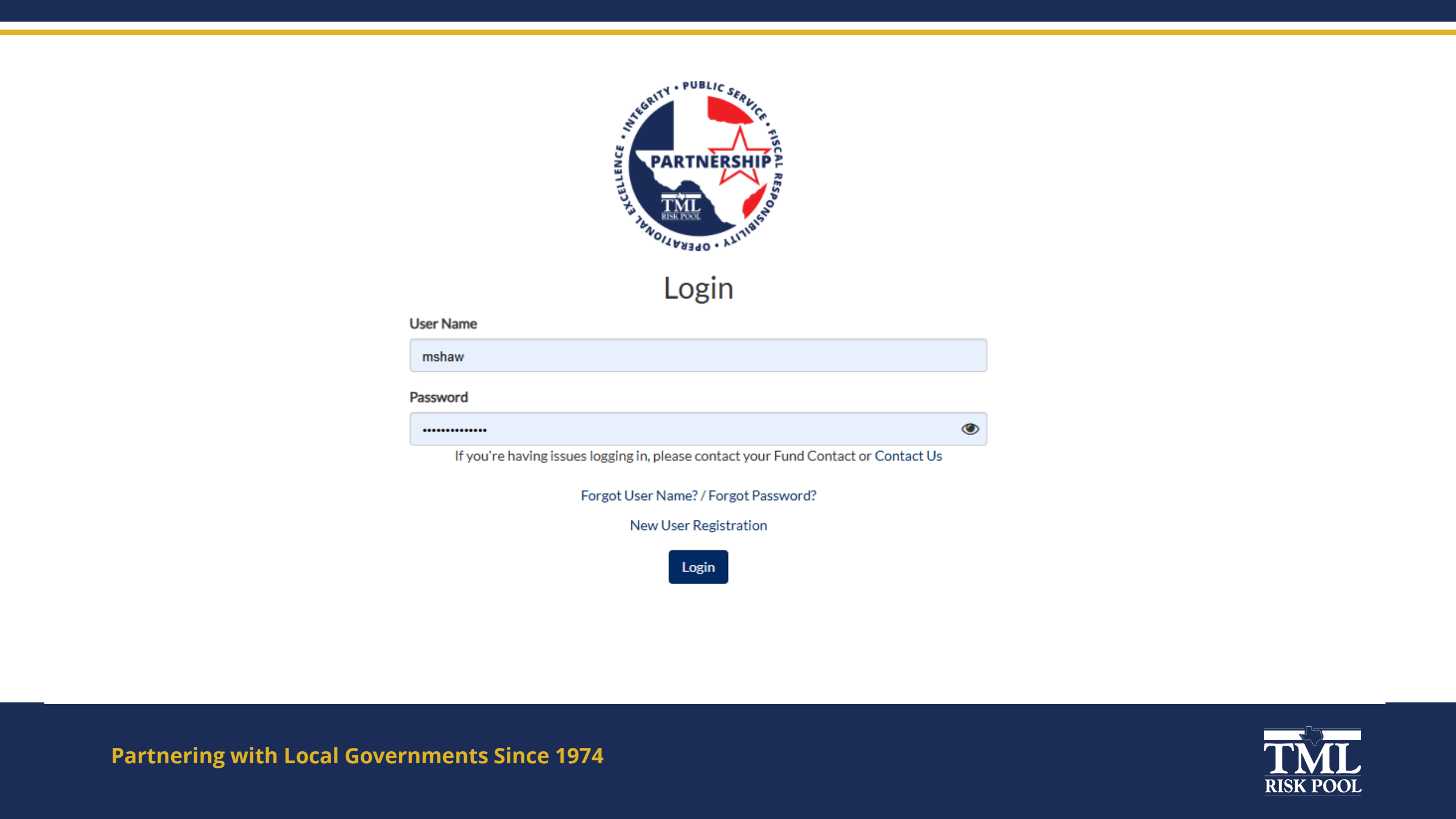
Portal



Partnering with Local Governments Since 1974

TML RISK POOL


TML
RISK POOL
Member Portal Registration
Provider Bill Status
Member Portal Login
ABOUT
RISK MANAGEMENT
TML
NEWS
CONTACT US
Building for the Future:
The Next 50 Years
LEARN MORE
FIND TRAINING
FILE A CLAIM
UPDATE SCHEDULES
STRONGER, TOGETHER PODCAST
ASK A QUESTION/ LEAVE FEEDBACK


PUBLIC SERVICE
INTEGRITY
FISCAL RESPONSIBILITY
OPERATIONAL EXCELLENCE
PARTNERSHIP
TML
RISK POOL
Login
User Name
mshaw
Password
If you're having issues logging in, please contact your Fund Contact or Contact Us
Forgot User Name? / Forgot Password?
New User Registration
Login

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

Listen Now

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 survi
healthy 31-year-old Seguin firefighter who passed away after a months-long b

Further information:
Texas Department of State Health Services Vaccine Information Web Page

Listen Now

Episode 7

"Disciplining and Terminating Employees: Liability and t
You Fire' Hotline"

Posted July 28, 2021

Explains: (1) that you may be liable for improper employment actions; and (2) th
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

Episode 10a - Part 1

"Workers' Comp: Taking Care of Your Employees"

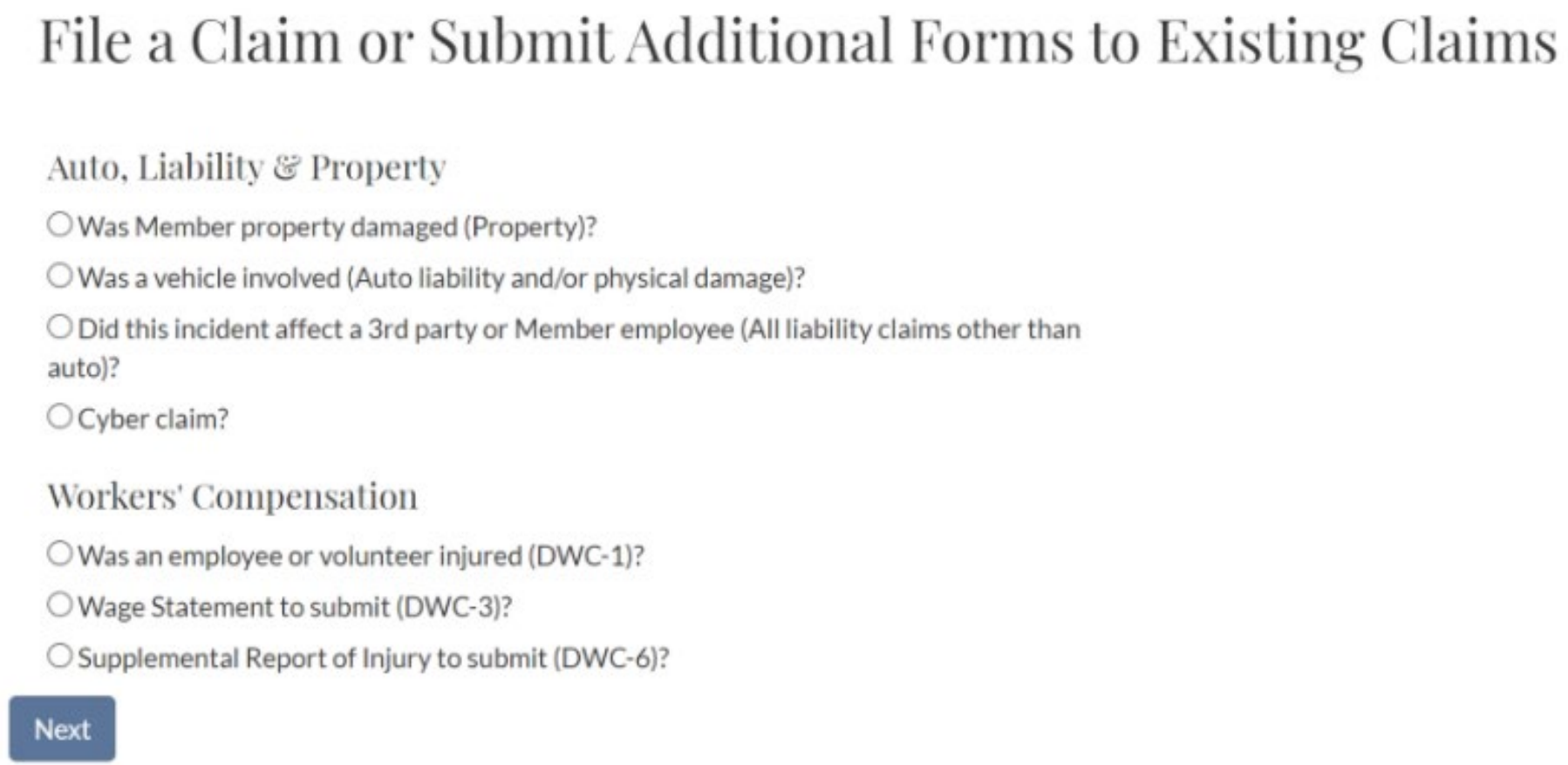
Posted October 14, 2021

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.

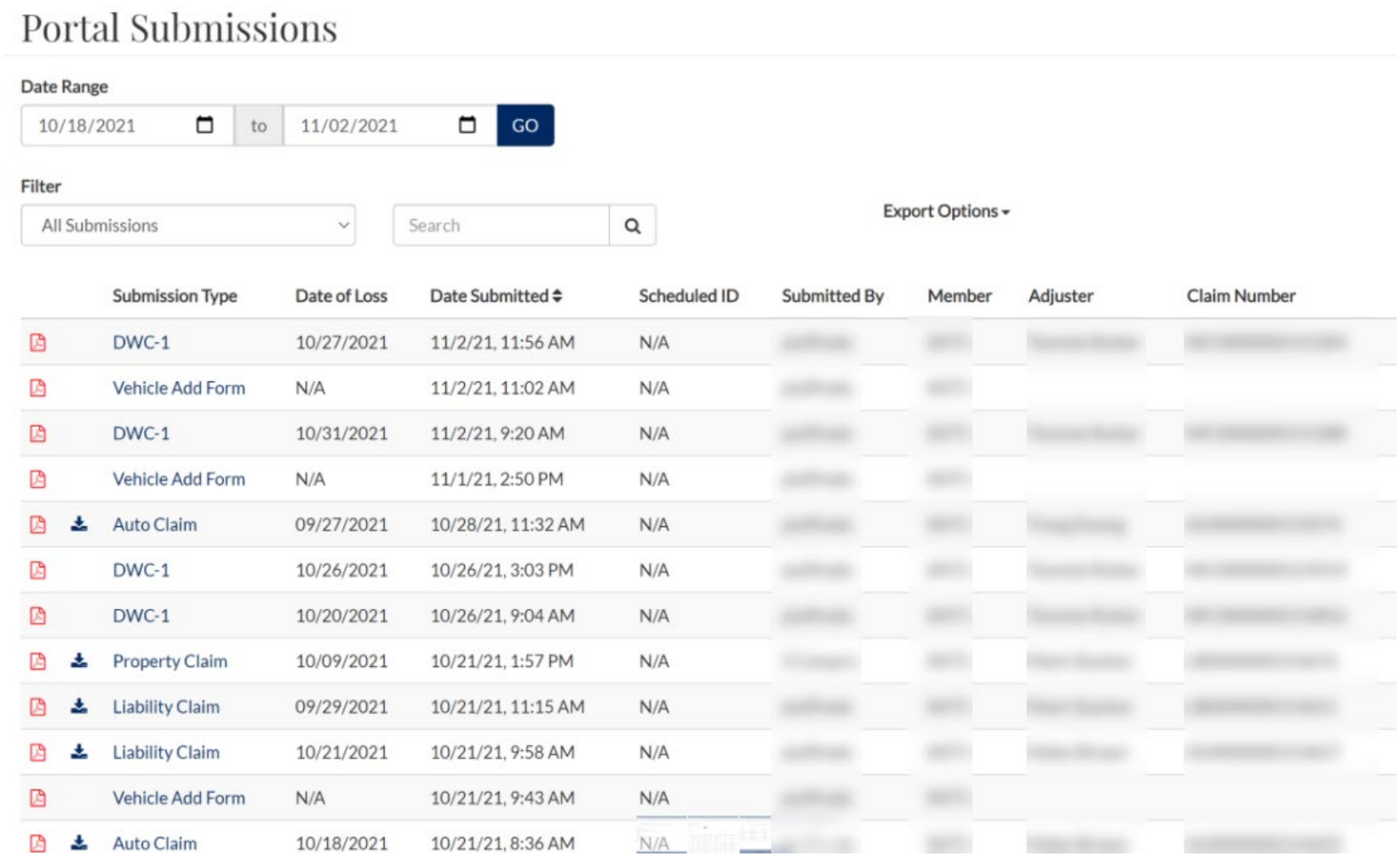
Further information:
Texas Political Subdivision Workers' Compensation Alliance
Texas Department of Insurance - Division of Workers' Compensation
Division of Worker's Compensation – Performance-Based Oversight Results

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

File a Claim or Send Additional Forms



Portal Submissions



Portal Submissions

Date Range

10/18/2021 to 11/02/2021 GO

Filter

All Submissions Search

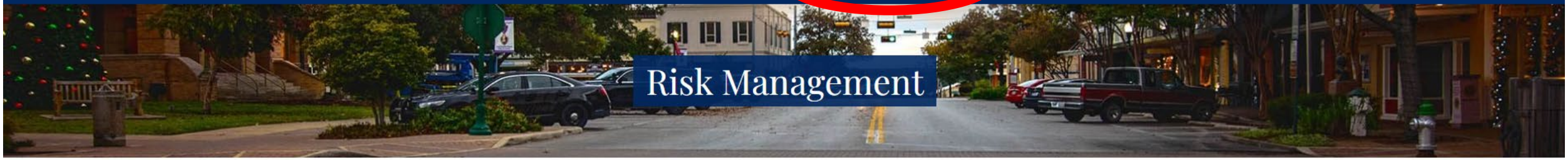
Export Options

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				

TML RISK POOL

Member Portal Registration | Provider Bill Status | Member Portal Login

ABOUT | RISK MANAGEMENT | TML | NEWS | CONTACT US



Multimedia Library

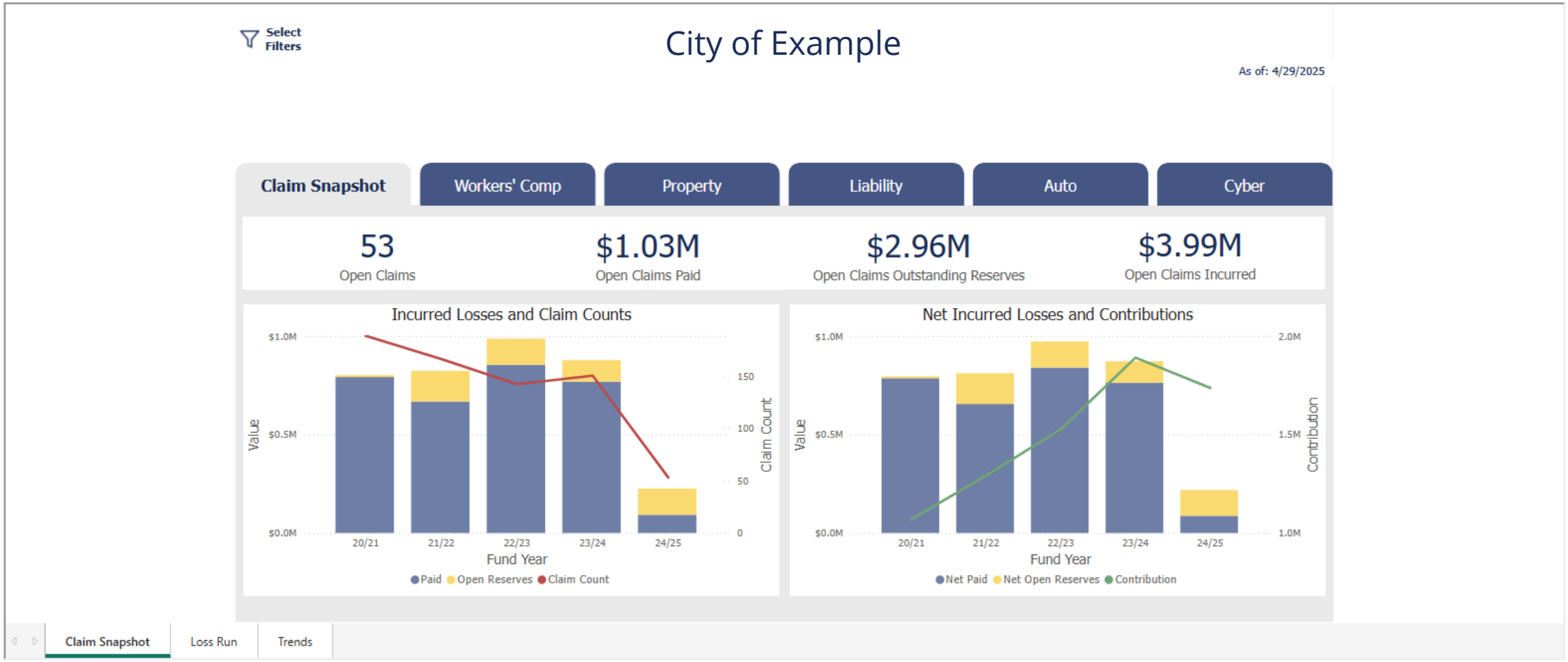
Online Learning Center

Upcoming Training Programs

See recorded webinars on YouTube. Future webinars will be posted here

The Pool Offers Loss Prevention Education & Training for Our Members at No Extra Cost

Member Dashboard



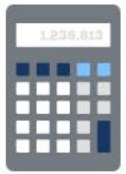
Download PDF

TML eRiskHub

Dashboard

REPORT A BREACH

GET TRUSTED HELP WHEN YOU NEED IT



TOOLS & CALCULATORS

UNDERSTAND YOUR EXPOSURE

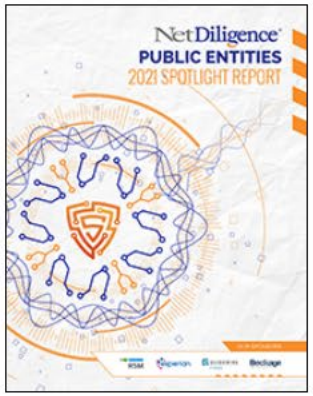
CYBERSECURITY TRAINING

INCREASE YOUR SECURITY AWARENESS

RANSOMWARE RESOURCES

BE A TOUGHER TARGET
LEARN HOW

Public Entities Spotlight Report



Featured Content

- The Economic Impact of Cyber Attacks on Municipalities
- NetDiligence 2020 Cyber Claims Study

Manage
Documents & Forms

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

Stay tuned....
More to come!

Thank you!

TML RISK POOL

OUR WHY? To partner with local governments so that Texas communities are **STRONGER TOGETHER**