Appendix "C" Transitional Duty Return to Work

Scope and Application

This policy applies to all locations or projects where a Return-to-Work Program may need to be implemented.

It is our goal to return employees, who have sustained a compensable injury, back to work as soon as possible.

Our Return-to-Work Program is developed to provide employees, who cannot return to their regular job, with modified/transitional duty during their medical recovery period. Modified/transitional duty is temporary work that is within the employee's physical abilities, knowledge, and skills. Employees with accepted disabling workers' compensation claims are eligible for this program. The Return-to-Work program will involve coordination by the injured employee, Workers' Compensation Claims person, the treating physician, and your insurer.

Implementation

It is the responsibility of management to administer the organization's Return-to-Work program. It is the responsibility of any employee or contractor involved to adhere fully to this policy.

Procedures

1.0 Return-to-Work Procedures:

1. Any incident, regardless of the magnitude, should be reported to the employee's supervisor.
2. When a supervisor is notified of a work-related injury, he/she should review the "Report of Injury Employee Responsibilities Checklist" with the employee.

   A first report of injury is completed and sent to the insurer.
3. If immediate medical treatment is necessary, medical care from the appropriate medical facility, by the most effective means, will be provided.
    1. When possible, the employee should take a "Return-to-Work Evaluation" to the physician for completion.

       If the employee cannot take the evaluation, the name of the physician should be obtained, and a copy forwarded to the physician immediately.
    2. If a job description for proposed modified/transitional duty and regular job description is available, this should also be sent.
    3. The employee should provide his or her supervisor with a completed "Return-to-Work Evaluation" after every visit to the treating physician.
4. If the job description was not previously provided to the treating physician, the "Return-to-Work Evaluation" should be reviewed by the employer contact.

1. A modified/transitional duty position should be considered that is within the employee's physical capacities. Keep in mind that modified and transitional duty does not mandate that the employee work a full workweek. You should contact FutureComp's claim team to determine the most effective means of brining the injured employee back to their original capacity.
2. The treating physician must approve all modified/transitional work. An important point to keep in mind is that a modified workload is not intended to be an open-ended proposition. With the help of FutureComp's claims team, you should determine a set time when the Light Duty assignment is to be reevaluated. The reevaluation should determine the following:

    a. Is the employee is making progress?

    b. Should the program continue?

    c. Is the employee able to return to unmodified duty?

    FutureComp's claims team and Nurse Case Management team can help with this evaluation.

5. A job description will be developed and provided to the treating physician for his or her approval.
6. When the treating physician has approved the job description, a job offer letter will be sent to the employee by certified and regular mail.
    1. The job offer letter will include a copy of the signed job analysis, a copy of the physician's release for work, the date the employee is to report to work, to whom the employee is to report to, where the employee is to report, time the employee is to report, wages, and estimated hours and overall duration of modified/transitional duty.
    2. The employee will be asked to indicate whether the job is accepted or declined. The employee will indicate acceptance with a signature.

        This information should be forwarded to the insurer after completion.
7. If an employee refuses to participate in the modified/transitional duty program, he/she may jeopardize their eligibility for the indemnity portion of their worker's compensation time-loss benefits.
8. When the employee reports to modified/transitional duty, the employer contact should carefully review the job approved by the physician.
    1. The restrictions should be reviewed.
        a. The employer contact should emphasize that the employee should perform only the job duties within the treating physician's restrictions and within the job description approved by the treating physician.
        b. Modified/transitional duty should be monitored to assure compliance and improvement of the person.

2. It is the employee’s responsibility to keep the company apprised weekly of their status after each physician visit.

9. As mentioned above, modified/transitional duty is a temporary program. An employee’s eligibility in a temporary assignment will be based on medical documentation and continued recovery of the employee as well as the discretion the employer.
10. The employer contact will monitor the employee's recovery progress and participation.
11. Any change in the original modified/transitional duty job must be reviewed by the employer contact and approved by the physician.
    A new job offer letter will be sent and signed by the employee.
12. Employees must provide a “Return to Work Evaluation” form indicating they are capable of returning to full duty.
    1. Permanent job restrictions will be evaluated on a case-by-case basis and relate to the performance of the essential functions of the job.
    2. No permanent light duty positions will be created.

Report of Injury - Employee Responsibilities Checklist

- All work-related accidents, injuries, and near misses must be reported immediately to [enter department] supervisor.
- If an incident such as an injury or near miss occurs, but does not require professional medical treatment, the supervisor must be informed immediately, and an incident report must be completed. If necessary, the employee may receive first aid on-site.
- If an injury occurs which requires medical attention, the employee will follow the emergency response plan. The employee must fill out a Workers' Compensation First Report of Injury form as soon as possible.
- If medical attention is sought, the employee should inform the physician, that [Company Name] has a return-to-work program with modified duty jobs available.
- The employee should be given a "Return-to-Work Evaluation Form" and completed "Job Description" (if available) from [enter department] supervisor. This should be given to the treating physician and should be returned to [enter department] supervisor following the initial medical treatment.
- If the treating doctor releases the employee to return to modified duty, as indicated on the "Return-to-Work Evaluation Form" and "Job Description Form", both forms must be returned to [enter department] within 24 hours for a modified duty work assignment. The employee must report for work at the designated time. The employee may not return to work without a release from the attending doctor.
- If the employee returns to a modified duty job, they must perform within the limits of the duties of the job, or their treating doctor's restrictions. If at any time, job restrictions change, the supervisor is to be notified immediately, and be provided with a new medical release from the physician.
- If after treatment, the employee is unable to report for any kind of work, the employee must call their supervisor each week to report their medical status.
- It is the responsibility of the employee to supply [enter department] supervisor with a current telephone number and an address where the employee can be contacted while not working.
- The employee will notify their [enter department] supervisor within 24 hours of all changes in medical condition.

I have read and understand the above information.

Employee Signature_____ Date_____

Request for Return-to-Work Evaluation from Treating Physician

(*Type on Company Letterhead*)

Date

Physician's Name
Address
City, State, Zip

RE: Injured Employee:
Date of Injury:
Employer:

Dear Dr._____:

We appreciate your prompt treatment of our employee. We have a Return-to-Work Policy. In an effort to return our employee to work we would like you to complete the attached "Return-to-Work Evaluation". We can provide modified/transitional duty from the sedentary range up to modifications of the employee's regular position.

Once we have reviewed the completed Return-to-Work Evaluation, we will provide a job analysis that is within the employee's physical capacities for your review. We will then make a job offer to our employee.

We appreciate your concern for our employee and look forward to your response. Feel free to contact us if additional information is needed.

Sincerely,

Employer contact
[enter phone number]

Return-to-Work Evaluation Form

Patient_____Date of Injury_____

Employer_____Claim Number _____

1. In an 8-hour day, patient can stand / walk:

   _____None _____1-4 hrs. _____4-6 hrs. ____6-8 hrs.

2. In an 8-hour workday, patient can sit:

   _____1-3 hrs. _____3-5 hrs. _____5-8 hrs.

3. Patient can lift:

   _____Up to 10 lbs. _____10-20 lbs. _____20-50 lbs.

4. Lifting as indicated in item 3 can be performed during the workday:

   _____Occasionally _____Frequently _____Continuously

5. Patient can use hands for repetitive:

   a. Simple grasping b. Pushing and pulling c. Fine manipulation

   ___Yes ___No ___ Yes ___No __Yes ___No

6. Patient can use feet for repetitive movement as in operating foot controls:
   _____Yes _____No

7. Patient is able to:

	Frequently	Occasionally	Not at All
a. Bend	_____	_____	_____
b. Squat	_____	_____	_____
c. Climb	_____	_____	_____

8. Confirm number of hours patient can perform duties:

   _____2 hrs. _____4 hrs. _____6 hrs. _____8 hrs.

9. Other restrictions as indicated by the doctor:

10. Anticipated date for release to regular work:

Physician's Signature:_____ Date: _____

Print Physician's Name:_____

Job Description

Employer Address _____
_____
_____
_____

Employee Address _____
_____
_____
_____

Phone/Fax Nos. _____ Phone No. _____

Contact Person _____ Claim No. _____

SS# _____ Job Title _____

Duration _____

Job Duties:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Job Description (continued)

ENDURANCE

Hours at one time		**Total hours in an 8-hour day**
Sit	0	0

Stand	0	0	
Walk	0	0	

Lift	Never 0%	Occas. 33%	Freq. 45-66%	Cont. 67-100%		Never 0%	Occas. 33%	Freq. 45-66 %	Cont. 67-100 %
1 to 10 lbs.	☐	☐	☐	☐	Bend	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐	Twist	☐	☐	☐	☐
21 to 50 lbs.	☐	☐	☐	☐	Crouch	☐	☐	☐	☐
51 to 75 lbs.	☐	☐	☐	☐	Kneel	☐	☐	☐	☐
76 to 100 lbs.	☐	☐	☐	☐	Crawl	☐	☐	☐	☐
					Walk-level surface	☐	☐	☐	☐
Carry					Walk-uneven surface	☐	☐	☐	☐
1 to 10 lbs.	☐	☐	☐	☐	Climb stairs	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐	Climb ladder	☐	☐	☐	☐
21 to 50	☐	☐	☐	☐	Reach above shoulder	☐	☐	☐	☐
51 to 75 lbs.	☐	☐	☐	☐	Repetitive use arms	☐	☐	☐	☐
76 to 100	☐	☐	☐	☐	Repetitive use wrist	☐	☐	☐	☐
					Repetitive use hands	☐	☐	☐	☐
Push					(a) Grasping	☐	☐	☐	☐
1 to 10 lbs.	☐	☐	☐	☐	(b) Squeezing	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐	Operate foot control	☐	☐	☐	☐
21 to 50	☐	☐	☐	☐					
51 to 75 lbs.	☐	☐	☐	☐					
76 to 100 lbs.	☐	☐	☐	☐	**Environment**				
					Inside	☐	☐	☐	☐
Pull					Outside	☐	☐	☐	☐
1 to 10 lbs.	☐	☐	☐	☐	Heat	☐	☐	☐	☐
11 to 20	☐	☐	☐	☐	Cold	☐	☐	☐	☐

21 to 50 lbs.	☐	☐	☐	☐	Dusty	☐	☐	☐	☐
51 to 75	☐	☐	☐	☐	Noisy	☐	☐	☐	☐
76 to 100 lbs.	☐	☐	☐	☐	Other	☐	☐	☐	☐

Job Description (continued)

PHYSICIAN'S COMMENTS:_____
_____
_____
_____

Job Appropriate Yes ☐ No ☐

Date of Release_____

EMPLOYER SIGNATURE DATE

PHYSICIAN'S SIGNATURE DATE

Modified Job Description Letter

(*Type on Company Letterhead*)

Date

Physician's Name
Address
City, State, Zip

RE: Injured Employee:
Employer:
Claim #:
Date of Injury:

Dear Dr.[enter doctor name]:

Thank you for providing the current work restrictions for our employee, [enter injured employee's name]. We have attached a copy of a modified job description that is within the restrictions that you have provided. Do you feel [enter employee name] is capable of performing the attached job as described?

Yes_____ No_____

Signature_____ Date_____

If he/she is not capable of performing this job please provide an explanation of job duties that should be further modified.

Comments_____
_____
_____
_____

Thank you in advance for your time and consideration in this matter. We look forward to your prompt response.

Sincerely,

Name
Title

Injured Employee Letter

(*Type on Company Letterhead*)

Date

Name:
Address:
City:

RE: Claim No.:

Date of Injury:

Dear **[**enter injured employee's name**],**

Your treating physician has released you for modified work and has approved the attached job of [enter job title].

You will receive $ [enter rate] per hour. We will supplement your worker' compensation benefits if this salary is less than your average weekly wages.

Information regarding your modified job is listed below:

Date: Supervisor to report to: _____

Time: Hours per day/week: _____

Location: Duration of modified job: _____

If you receive this letter after the report to work date, please contact [enter name of supervisor] at [enter phone number] immediately.

Your benefits may be adversely affected if you choose not to accept this modified job offer.

We look forward to your return to work on the above date.

Sincerely,

[enter name, title, phone no.]

I have read and understand the above information. I accept the above job as offered.

YES **NO** (circle one)

_____ _____

Employee's Signature Date