HOUSTON INDEPENDENT SCHOOL DISTRICT

HISD Workers' Compensation Manager Training

Date:02/28/2019
Presenter:
HISD Workers' Compensation Department

Workers' Compensation Program

The district is committed to the health and safety of all employees in the workplace. The HISD WC 504 Provider Panel has been built to provide you with quality medical care.

Effective 05/20/2013, **Houston ISD implemented the HISD WC 504 Provider Panel as its workers' compensation health care provider panel**.

The panel is built around occupational health care providers for workers' compensation injuries to provide prompt, appropriate medical treatment aimed at early and safe return to work.

Who handles our 504 Provider Panel?

Cannon Cochran Management Services, Inc. (CCMSI) is the district's claims administrator for workers' compensation claims.

Corporate Remedies is the administrator of the HISD WC 504 Provider Panel.

Important actions to take

1. The injured employee must *immediately* report the incident to their Supervisor/Nurse.

2. The injured employee *and* their supervisor must complete an HISD Employee Injury and Treatment (EIT) Form.

3. The injured employee's supervisor must submit a copy of the EIT form to the HISD Workers Compensation Department via fax at (713)556-9224 to or email to HISDWorkComp@houstonisd.org to report the incident.

4. The supervisor must provide the injured employee with a copy of the completed EIT form.

In Case of an Emergency

- If you are injured and it is an emergency*, you should seek treatment at the nearest emergency facility or urgent care facility as soon as possible. This also applies if you are injured after normal business hours.

- If the injured employee is taken **via ambulance**, please contact the HISD Workers' Compensation Department immediately at 713-556-9200 (during business hours) and 214-551-8831 (after hours) and provide the following:
  - the injured employee's name;
  - school or location where the injury occurred; and
  - where the employee is being transported

**A "medical emergency" is defined in Texas law as the sudden onset of a medical condition manifested by acute symptoms, including severe pain that, in the absence of immediate medical attention, could reasonably be expected to result in placing the patient's health or bodily functions in serious jeopardy, or serious dysfunction of any body organ or part.*

How to Choose Your Treating Doctor from the Panel…

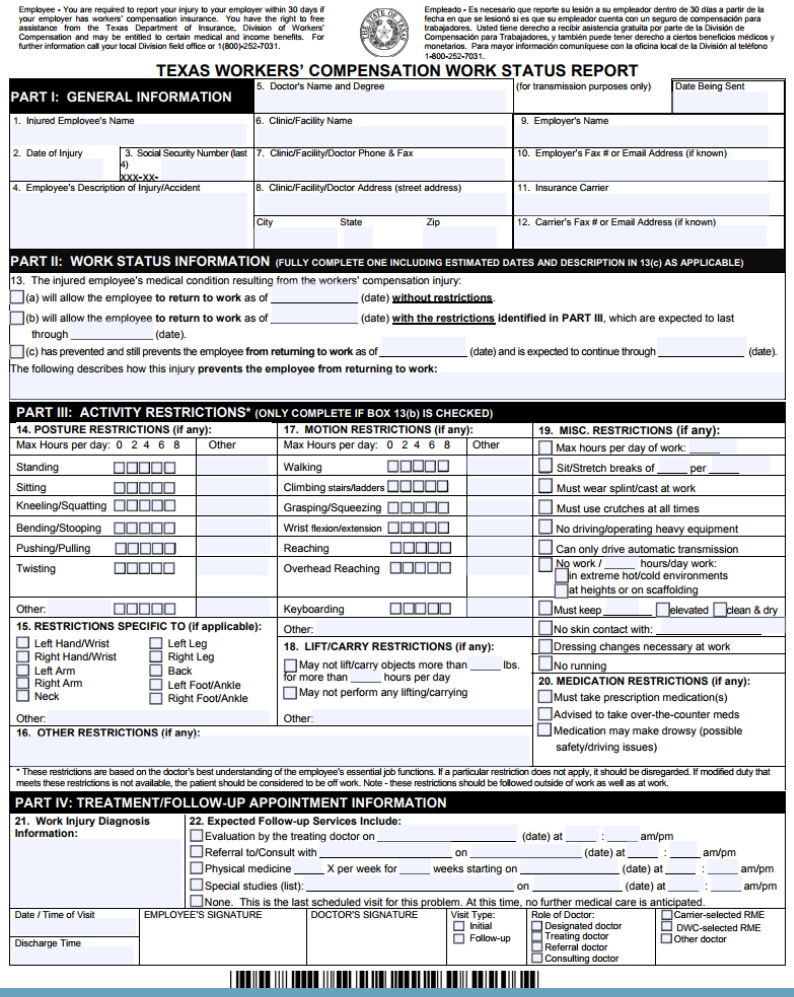
Follow the steps below to locate the 504 Provider Panel Physician Directory:

1. *Go to the HISD home page*
2. *Choose the "Directory" tab at the top*
3. *Select "Workers' Compensation"*
4. *Select* External Links Find A Treating Doctor *on the Workers' Compensation main page (located on the right side of the webpage)*

You do not need to contact HISD Workers' Compensation or CCMSI after you select your treating doctor from the panel.

DWC-73 Work Status Report

The injured employee will receive a DWC-73 Work Status Report from the Panel Physician that will indicate what capacity the employee can return to work.



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 and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)252-7031.

Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

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

(for transmission purposes only) Date Being Sent

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

13. The injured employee's medical condition resulting from the workers' compensation injury:
- ☐ (a) will allow the employee **to return to work** as of _____ (date) **without restrictions**.
- ☐ (b) will allow the employee **to return to work** as of _____ (date) **with the restrictions identified in PART III**, which are expected to last through _____ (date).
- ☐ (c) has prevented and still prevents the employee **from returning to work** as of _____ (date) and is expected to continue through _____ (date).

The following describes how this injury **prevents the employee from returning to work:**

PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):

Max Hours per day: 0 2 4 6 8	Other
Standing ☐☐☐☐☐	
Sitting ☐☐☐☐☐	
Kneeling/Squatting ☐☐☐☐☐	
Bending/Stooping ☐☐☐☐☐	
Pushing/Pulling ☐☐☐☐☐	
Twisting ☐☐☐☐☐	
Other: ☐☐☐☐☐	

17. MOTION RESTRICTIONS (if any):

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

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

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

Other:

18. LIFT/CARRY RESTRICTIONS (if any):
- ☐ May not lift/carry objects more than ____ lbs. for more than ____ hours per day
- ☐ May not perform any lifting/carrying

Other:

16. OTHER RESTRICTIONS (if any):

20. MEDICATION RESTRICTIONS (if any):
- ☐ Must take prescription medication(s)
- ☐ Advised to take over-the-counter meds
- ☐ Medication may make drowsy (possible safety/driving issues)

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

22. Expected Follow-up Services Include:
- ☐ Evaluation by the treating doctor on _____ (date) at ____ : ____ am/pm
- ☐ Referral to/Consult with _____ on _____ (date) at ____ : ____ am/pm
- ☐ Physical medicine ____ X per week for ____ weeks starting on _____ (date) at ____ : ____ am/pm
- ☐ Special studies (list): _____ on _____ (date) at ____ : ____ am/pm
- ☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit Discharge Time	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type: ☐ Initial ☐ Follow-up	Role of Doctor: ☐ Designated doctor ☐ Treating doctor ☐ Referral doctor ☐ Consulting doctor	☐ Carrier-selected RME ☐ DWC-selected RME ☐ Other doctor

DWC-73 Work Status Report

The Panel Physician will check one of three boxes on the work status report:

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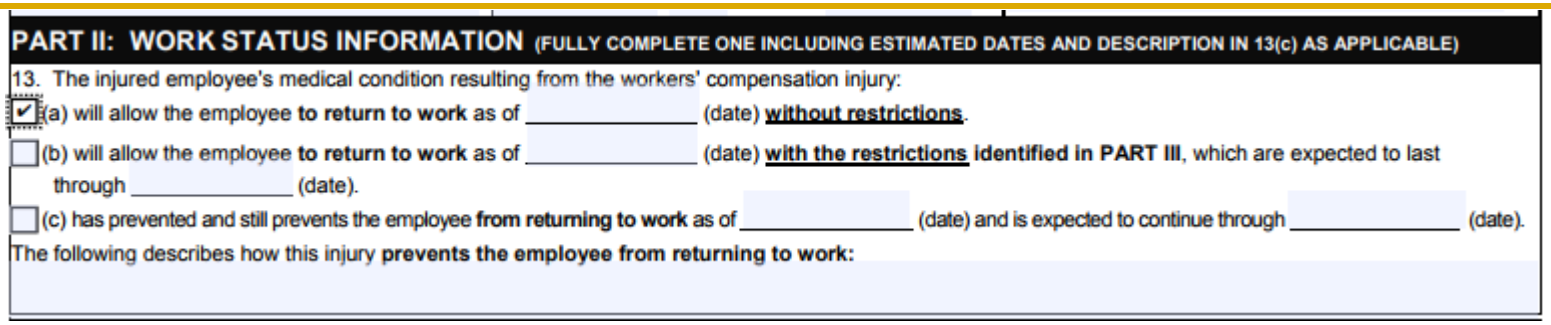
☐ (b) will allow the employee to return to work as of _____ (date) with the restrictions identified in PART III, which are expected to last through _____ (date).

☐ (c) has prevented and still prevents the employee from returning to work as of _____ (date) and is expected to continue through _____ (date).

The following describes how this injury prevents the employee from returning to work:

DWC-73: Released without restrictions



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☐ (b) will allow the employee **to return to work** as of _____ (date) **with the restrictions identified in PART III**, which are expected to last through _____ (date).

☐ (c) has prevented and still prevents the employee **from returning to work** as of _____ (date) and is expected to continue through _____ (date).

The following describes how this injury **prevents the employee from returning to work:**

If box (A) is checked on the DWC-73 Work Status Report from the Panel Physician, that indicates that the injured employee can **return to work without restrictions**. Please provide a copy of the DWC-73 to the Workers' Compensation Department.

DWC-73: Released with restrictions

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

13. The injured employee's medical condition resulting from the workers' compensation injury:

☐ (a) will allow the employee **to return to work** as of _____ (date) **without restrictions**.

☑ (b) will allow the employee **to return to work** as of _____ (date) **with the restrictions identified in PART III**, which are expected to last through _____ (date).

☐ (c) has prevented and still prevents the employee **from returning to work** as of _____ (date) and is expected to continue through _____ (date).

The following describes how this injury **prevents the employee from returning to work:**

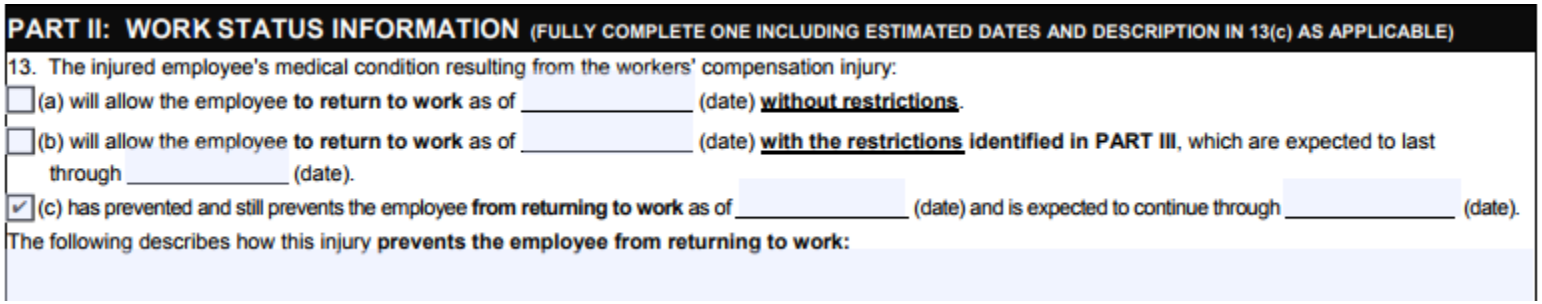
If box (B) is checked on the DWC-73 Work Status Report from the Panel Physician, that indicates that the injured employee can **return to work with restrictions**.

DWC-73: Released with restrictions

The DWC-73 must be sent to WC Department to verify that the restrictions can be accommodated. The injured employee cannot return to work *until* they speak with a WC Specialist about their accommodations.

- If the restrictions ***cannot be accommodated***, the injured employee will be taken off of work until there has been a change in work restrictions that can be accommodated or they are released to return back to work without restrictions.
- If the restrictions ***can be accommodated,*** a bona fide job offer (BJO) will be made available. The injured employee must sign the BJO prior to their return to work for their modified duty assignment.
- If the injured employee refuses to sign the BJO, they cannot return to work and will no longer be eligible for income benefits.

DWC-73: Taken Off Work



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☐ (b) will allow the employee **to return to work** as of _____ (date) **with the restrictions identified in PART III**, which are expected to last through _____ (date).

☑ (c) has prevented and still prevents the employee **from returning to work** as of _____ (date) and is expected to continue through _____ (date).

The following describes how this injury **prevents the employee from returning to work:**

If box (C) is checked on the DWC-73 Work Status Report from the Panel Physician, that indicates that the injured employee has been **taken off work**. Please provide a copy of the DWC-73 to the Workers' Compensation Department.

REMINDER!

The HISD Workers' Compensation Department will need to be contacted **IMMEDIATELY** any time the injured employee's work status changes.

This will ensure accurate payment of benefits and alleviate any overpayments on the injured employee's behalf.

Important Contacts

To report a Workers' Compensation claim please fax the EIT form to (713) 556-9224 or email to HISDWorkComp@houstonisd.org	
HISD Workers' Compensation Department:	Phone: (713) 556-9200 Fax: (713) 556-9224
Cannon Cochran Management Services, Inc. (CCMSI):	Phone: (713) 314-1470
Novare Nurse Case Management:	Phone: (713) 314-1492 *(during business hours)* Phone: (214) 551-8831 *(after hours)*
Corporate Remedies	Email: support@corporateremedies.com

HISD WC Contacts

Cynthia Cavazos-Fowler Workers' Compensation Specialist	Phone: (713) 556-9213 Claims with Last Name A, Q-Z
Lashondra Vaughn Workers' Compensation Specialist	Phone: (713) 556-9202 Claims with Last Name B-G
Gia McDay-Blackshear Workers' Compensation Specialist	Phone: (713) 556-9209 Claims with Last Name H-P
Assault Leave Administrator	Phone: (713) 556-9207
Detra Leary Manager, Workers' Compensation	Phone: (713) 556-9211
Tammy Young Senior Manager, Benefits Support	Phone: (713) 556-9201

HOUSTON INDEPENDENT SCHOOL DISTRICT

Thank you

Date: 01/28/19
Presenter:
HISD Workers' Compensation Department