



State of Montana

RETURN TO WORK PROGRAM

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Introduction to Return to Work

The State of Montana, in conjunction with Milt Wright & Associates, Inc., has developed this beneficial Return to Work Program designed to bring employees back to the workplace as quickly as possible following a work-related injury or occupational disease. An effective return to work program can help keep work-related injuries and occupational diseases from becoming permanent limitations or disabilities.

This guide discusses return to work primarily from the workers' compensation perspective. However, these Program components can be used for injuries and illnesses that occur outside of the workplace with the same benefits to employees and to the State of Montana.

This manual describes the State of Montana's minimum requirements for an agency's Return to Work Program. The Return to Work Program as described is a flexible program that can be customized by each agency as needed to achieve optimal effect.

The Workers' Compensation Management Bureau (WCMB) is available to assist all state agencies with every aspect of implementing their Return to Work Programs. This assistance may be accomplished through members of the WCMB temporarily sitting on Transitional Duty Teams to help Teams operate effectively. The WCMB can assist you with multiple training needs, including training on the workers' compensation system, New Employee Orientation, Transitional Duty for unique situations, and other topics.

The Return to Work Program includes the following Phases and Components:

PHASE I

Pre-Injury/Program Set up

COMPONENT 1:

Address Loss Control and Safety

An effective Return to Work Program is one component of a comprehensive loss control and safety program. State agencies should already be in compliance with state law mandating loss control and safety programs, and agencies must continue those efforts. The Safety Program provided by the Workers' Compensation Management Bureau gives the required steps for compliance. The Return to Work Program is not intended to replace programs directed at preventing work-related injuries and occupational diseases.

COMPONENT 2:

Management Commitment

The most important element of an effective Return to Work Program is management commitment. Management must establish an unwavering support for return to work within each state agency.

COMPONENT 3:

Provide Medical Status forms to every Injured Worker for the initial appointment with the Health Care Provider

A Medical Status form allows the Health Care Provider to release the Injured Worker to his/her normal duties, to provide medically safe boundaries for Transitional Duty for the Injured Worker, or to declare work not medically safe. The completed Medical Status form serves as a guide to the Transitional Duty Team in developing appropriate Transitional Duty.

COMPONENT 4:

Establish a Transitional Duty Team and Team Coordinator

A Transitional Duty Team is the group of individuals who routinely meet to administer the Return to Work Program on behalf of a particular Injured Worker. Individuals are routinely assigned to serve as part of the Team for an agency. The **Team Coordinator** should be an individual who participates in every Team meeting, and he or she would typically be a Disability Manager, Return to Work Specialist, or Human Resources representative.

Each Team will also include the Injured Worker and his/her supervisor, and the Team will work closely with other involved individuals including the Claims Examiner assigned by the Insurer and the Injured Worker's Health Care Provider if possible.

COMPONENT 5:

Role of Managers and Supervisors

Managers and Supervisors must commit to participate actively in the agency's Return to Work Program and support the Transitional Duty Team members, Human Resources, and employees in their roles.

COMPONENT 6:

Role of Human Resources

The Human Resources Department plays a key role in administering and supporting the Return to Work Program. HR provides guidance at all levels of state agencies in support of roles and responsibilities within the Return to Work Program. In some agencies, a Human Resource Officer may assume the duties of the Transitional Duty Team Coordinator.

COMPONENT 7:

Role of Employees

Employees are essential members of the Transitional Duty Team and the Return to Work Program. Employees must take Medical Status forms to all visits with the Health Care Provider when physically possible and return the completed forms to their supervisor or Team Coordinator immediately.

COMPONENT 8:

Address Confidentiality

Because the Return to Work Program may receive and use information pertaining to the health status of state employees, Transitional Duty Team members must be aware of the Return to Work Program standards and expectations for maintaining the confidentiality of such information.

COMPONENT 9:

Train Employees on Transitional Duty

In order to be responsive, Team members will ideally be trained in the policies and practices of the Return to Work Program prior to the time they are called upon to assist an Injured Worker. Training must be ongoing to maintain effectiveness, even in agencies or work groups where work-related injuries and occupational diseases are infrequent.

PHASE II **Time of Injury**

COMPONENT 10:

Make sure the Injured Worker receives appropriate medical attention

Immediate medical care is imperative to reduce the effects of a work-related injury or occupational disease. Team members, as well as supervisors and managers, must encourage Injured Workers to obtain appropriate medical care as soon as possible.

COMPONENT 11:

Report the work-related injury or occupational disease to the Insurer

Promptly report a work-related injury or occupational disease to the Insurer. Filing the report safeguards an Injured Worker's workers' compensation claim, thereby ensuring adequate access to necessary medical care and income protection.

COMPONENT 12:

Develop a Transitional Duty Tracking Form

The key to a successful Return to Work Program is returning an Injured Worker to the workplace as quickly as possible following a work-related injury or occupational disease. The primary responsibility of the Team is establishing appropriate Transitional Duty that considers the functional capacity of the Injured Worker.

COMPONENT 13:

Communicate with Health Care Provider

Prompt and ongoing communication with the Injured Worker's Health Care Provider regarding Job Functions, Transitional Duty opportunities, and the progress of Return to Work efforts on behalf of the Injured Worker will facilitate more meaningful interaction with and contribution by Health Care Providers. Team members will need to be familiar with strategies for communicating with Health Care Providers in light of applicable privacy laws.

COMPONENT 14:

Maintain Contact with the Injured Worker

The Injured Worker is an important participant in his or her Return to Work process by being a member of the Transitional Duty Team. Participation on the Team maintains the Injured Worker's sense of connection to the workplace and sense of control over his or her own Return to Work process. Additionally, frequent appropriate contact with the Injured Worker reminds him/her that he/she is cared for and appreciated by colleagues.

PHASE III

Administration of the Return to Work Program

COMPONENT 15:

Report as Required to the Workers' Compensation Management Bureau

The Workers' Compensation Management Bureau (WCMB) is responsible for oversight of the state government's workers' compensation programs and processes. We are here to help you establish and manage your Return to Work Program and are ready to assist you in developing effective programs and case management.

The WCMB is also responsible for tracking the overall compliance and effectiveness of state agencies in their management of work-related injuries and occupational diseases. In order to meet its oversight and reporting obligations, the WCMB must receive information from each state agency detailing its efforts and outcomes.

Component 1: Address Loss Control and Safety

DESCRIPTION

To be effective, the Return to Work Program is intended to be one significant piece of an agency's overall efforts to reduce work-related injuries and occupational diseases and the consequent losses that affect both the Injured Worker and the agency. Aside from implementation of a Return to Work Program, as described in this manual, specific steps toward achieving workplace safety and loss control are provided in the state's Safety Program.

REQUIREMENT

An agency must comply fully with the state's Safety Program provided by the Workers' Compensation Management Bureau. The state's Safety Program incorporates all elements of the Montana Safety Culture Act and other applicable regulations.

IMPORTANT REMINDER

*** Compliance with the Montana Safety Culture Act is required by law.**

Component 2: Management Commitment

DESCRIPTION

Management commitment is a critical element of an effective Return to Work Program. Management must provide adequate authority and resources to employees in supporting their effort to meet assigned responsibilities. Management must help employees at all levels understand their responsibilities and must hold employees accountable for compliance with the Return to Work Program.

REQUIREMENT

The Agency Director or appropriate manager will appoint the Transitional Duty Team Coordinator by identifying an existing position within the agency and assigning the responsibility and authority to serve as the Transitional Duty Team Coordinator.

Directors, managers, and supervisors must set a good example of return to work by following Return to Work policies consistently with all employees within operational constraints.

Management will monitor its Return to Work Program on a periodic basis to ensure continued effectiveness. The Transitional Duty Team Coordinator will report to the Director and management team at least quarterly on the status of the Return to Work Program.

Component 3: Send the Medical Status Form to the Initial Appointment with the Health Care Provider

DESCRIPTION

A Medical Status form is a document that serves as a tool for the Health Care Provider to indicate the appropriate level of functional ability for an Injured Worker. The functional ability of the Injured Worker typically progresses over time as he or she heals. The Medical Status form, once completed by the Health Care Provider, serves as a roadmap for the Transitional Duty Team in developing Transitional Duty.

REQUIREMENT

Supervisors must provide a Medical Status form to each Injured Worker to take to the initial visit to his/her Health Care Provider. If this is not physically possible, the supervisor or Team Coordinator should provide the form to the Health Care Provider within 24 hours.

How to Use the Medical Status Form

1. Fill in the **Injured Worker's name** at the top of the page. Send the Medical Status form provided at <http://benefits.mt.gov/workerscomepearlyreturn.mcp> and in the Appendix to this document with the Injured Worker to the initial appointment with the Health Care Provider.
 - A. The Injured Worker takes the Medical Status form to the Health Care Provider's office for completion.
 - B. The Injured Worker returns the form to his/her supervisor or Transitional Duty Team Coordinator.
 - C. The Transitional Duty Team Coordinator provides the completed Medical Status form to the Team to develop transitional duty.
2. Make sure the Injured Worker understands his/her responsibility is to return the completed Medical Status form to the supervisor or Team Coordinator immediately after the appointment with the Health Care Provider, to the extent this is physically possible.
3. Pay close attention to any authorized changes over time as the Injured Work heals. Be sure to update transitional duty functions as the Health Care Provider recommends.

IMPORTANT REMINDERS

*** Let the Injured Worker know he/she is responsible for returning the completed Medical Status form to the supervisor or Team Coordinator.**

Component 4: Establish Transitional Duty Teams

DESCRIPTION

A Transitional Duty Team is a group within an agency that manages the Return to Work Program for the agency. An agency may have more than one Team and will assign Transitional Duty Teams based on the location of work units, numbers of employees, and incidence of work-related injuries and occupational diseases typically occurring.

REQUIREMENT

Each agency will establish and train the Team(s) as necessary to manage the Return to Work program for the agency based on the volume of Transitional Duty needs anticipated for the agency, and will establish a meeting schedule for the Team(s).

Assigning Members to a Team

1. Each Team will have a **Team Coordinator**. A Team Coordinator will be a Disability Manager or a Return to Work Specialist. If an agency does not have either, the Team Coordinator will be a Safety Specialist, Human Resources representative, or employee assigned by the agency's management.
 - A. The Team Coordinator is the Team member responsible for scheduling and running Team meetings; complying with all documentation requirements; and being the point of contact with the Workers' Compensation Management Bureau.
2. The agency will assign other Team members as needed, including: budget staff, a Human Resources representative; a Safety and/or Return to Work Specialist; or any other staff assigned by the agency's management.
3. The Transitional Duty Team assigned to each Injured Worker will have ad hoc Team members. The Injured Worker and his/her immediate supervisor will be Team members. Other ad hoc Team members may include: the Claims Examiner appointed by the Insurer; the Injured Worker's Health Care Provider or representative; the Injured Worker's union representative; or others. Ad hoc Team members may participate in portions of the Team meetings addressing that Injured Worker.

Scheduling Team Meetings

1. Teams will meet as frequently as necessary to manage the active Medical Status forms and Transitional Duty Tracking forms.
2. Meeting schedules will be developed based on the specific needs of each Injured Worker. The objective of the Team is to assist the Injured Worker through the Return to Work process and back to full functioning as quickly as possible.

Team Meeting Objectives

1. Review active Transitional Duty Tracking forms and update according to the most recent Medical Status form provided by the Health Care Provider, feedback from the supervisor, and any other relevant information.
2. Provide the Injured Worker with a Medical Status form to take to the Health Care Provider at the time of the Injured Worker's next visit.
3. Document all Team meetings using the Transitional Duty Tracking form.

Documentation Requirements

1. At every Transitional Duty Team meeting, use the most recent Medical Status form to update the Transitional Duty Tracking form for each Injured Worker. Review the Contact Log for compliance.
2. Provide copies of the Medical Status forms and Transitional Duty Tracking forms to the WCMB immediately after each Team meeting. Provide the Contact Logs to the WCMB upon request.

Transitional Duty Team Meetings

Frequency of Meetings

1. Ensure that meetings are scheduled frequently enough to develop and monitor Transitional Duty.
2. Verify that there is a process in place for holding unscheduled meetings to deal with unexpected situations.

Participation in Meetings

The absence of key members from scheduled meetings may prevent the Team from making timely decisions. Attendance is mandatory for Team members who are at work when meetings are scheduled. The effectiveness of the Team depends on the participation of Team members.

Meeting Effectiveness

Using a formal process such as **Roberts Rules of Order** may be beneficial in addressing issues involving varied opinions about Team decisions. By doing so the Team remains productive in making Team decisions.

Component 5: Role of Agency Managers and Supervisors

DESCRIPTION

Managers and supervisors must ensure that Return to Work Program is consistently available for all injured workers. Transitional duty is subject to operational constraints.

REQUIREMENT

Agency supervisors will:

1. Report accidents and injuries within 24 hours;
2. Participate in transitional duty team meetings as needed;
3. Assist with safety activities under the guidelines of the state Safety Program;
4. Work to instill a positive, cooperative culture for Return to Work within the agency.

Component 6: Role of Human Resource Officer

DESCRIPTION

The Human Resource Officer plays an important role in making sure this Program is followed by all employees, at all levels of employment.

REQUIREMENT

The Human Resource Officer will:

1. Make sure all new employees receive Return to Work orientation.
2. Work with supervisors:
 - a. To ensure documented special needs of Injured Workers are met;
 - b. To promote consistency in Return to Work implementation.
3. Serve as the coordinator for workers' compensation claims management.

Component 7: Role of Agency Employees

DESCRIPTION

Injured Workers must take the Medical Status form to the Health Care Provider and return the form to the supervisor or Team Coordinator. Injured Workers should participate as members of the Transitional Duty Team. Participation on the Team is important. Choosing not to participate could affect an Injured Worker's eligibility for wage loss benefits.

REQUIREMENT

Employees will:

1. Participate in new employee orientation at time of hire;
2. Participate in on the job Return to Work training;
3. Report incidents and accidents to a supervisor as soon as possible;
4. Participate in agency safety training;
5. Support co-workers participating in Return to Work activities.

Component 8: Address Confidentiality

DESCRIPTION

Confidentiality is a legal requirement to keep certain communications privileged. Do not discuss or divulge any information to third parties.

REQUIREMENT

All members of Transitional Duty Teams must comply with confidentiality requirements including, but not limited to, signing a confidentiality agreement and adhering to the agreement.

Maintain Confidentiality:

All information shared in the Team meetings is discussed on a need to know basis only. *The team generally needs to know only the Injured Worker's physical abilities related to Return to Work.*

Members of the Team will sign a confidentiality statement that documents all information discussed within the Team meetings may not be released. A sample confidentiality agreement can be found in the appendix to this guide.

Component 9: Train Employees on Transitional Duty

DESCRIPTION

This training is designed to teach employees the benefits of continuing to work or returning to work as soon as medically possible after a work related injury or occupational disease. Additionally, this training prepares employees to participate on Transitional Duty Teams.

REQUIREMENT

Every agency must train new and existing employees on the Return to Work Program and Transitional Duty.

Key Elements in Training

1. Teach long term financial consequences of time lost from work.
 - A. When an Injured Worker has been off work for six months, they have only a 40% chance of ever coming back to their job.
 - B. When an Injured Worker has been off work for a year, they have less than a 10% chance of ever working again.
2. Explain the decrease in benefits related to losing time from work.
 - A. Injured Workers off work due to a work-related injury or occupational disease generally do not continue to accrue retirement or annual or sick leave.
 - B. After a period of time, the Injured Worker must pay out of pocket his/her state's share of health insurance costs.
3. Clarify quality of life factors that may be affected by lost time.
 - A. Mental health – staying appropriately active as allowed by the Health Care Provider and staying connected with co-workers decreases the risk of depression following a work-related injury or occupational disease.
 - B. Rate of recovery – much like physical therapy or work hardening, physically appropriate Transitional Duty can become an extension of the medical treatment process and speed recovery.
 - C. Ability to maintain physical conditioning – just as regular exercise helps keep people healthy, appropriate physical activity after a work-related injury or occupational disease may help maintain muscle tone and cardiovascular fitness.
4. Not returning Injured Workers to work is the single most expensive decision a supervisor will make.
 - A. Direct claims costs;
 - B. Hidden costs such as lost productivity, increased work load on existing staff, and the cost of temporary employees.

Component 10: Make sure the Injured Worker Receives Appropriate Medical Attention

DESCRIPTION

Prioritizing medical attention is mandatory. All aspects of Return to Work can be addressed in a timely fashion; however, Return to Work may not usurp medical attention.

REQUIREMENT

Supervisors or the person to whom an injury is reported must encourage the Injured Worker to get appropriate and timely medical care.

How Timely Medical Care May Look

1. If the Injured Worker would like, a supervisor may drive the Injured Worker to the Health Care Provider if the work-related injury or occupational disease does not require emergency treatment.
 - A. Supervisors who take an Injured Worker to the initial Health Care Provider's evaluation are there to support their employee. Simply put, it is the right thing to do. The purpose of taking the Injured Worker to this initial Health Care Provider's evaluation is to show care and support for the employee.
 - B. If there is any question about the severity of the work-related injury or occupational disease, the supervisor or co-worker may call 911 and stay with the Injured Worker until emergency medical personnel arrive.

IMPORTANT REMINDERS

- * Always provide a Medical Status form for the Injured Worker to take with him/her to the first medical evaluation.**
- * Make sure the Injured Worker returns a copy of the Medical Status form to the Supervisor or Team Coordinator as soon as possible following the initial Health Care Provider evaluation.**
- * Supervisors are then responsible for communicating the Injured Worker's Medical Status form with the Team Coordinator to determine the appropriate process to follow.**

Component 11: Promptly Report the Work-Related Injury or Occupational Disease to the Insurer

DESCRIPTION

Prompt reporting is the process that ensures an Injured Worker receives any benefits for which he/she is eligible in a timely and appropriate manner.

REQUIREMENT

Work-related injuries must be reported immediately using the Insurer's 1st Report of Injury. If immediate reporting cannot be achieved, the form should be filed within 24 hours. Occupational diseases must be reported as soon as possible once a determination has been made that the condition is work-related.

How to File a 1st Report of Injury

1. Use the Insurer's 1st Report of Injury. This form can be downloaded from the Insurer's website at: www.montanastatefund.com. You can establish a password with our Insurer and file the form online **or** print this form, fill it out, and fax to the number on the top of the form. Contact Montana State Fund for more details.
2. If you have any questions or concerns about filling out the first report of injury or the report filing process, contact the WCMB at **(406) 444-7462** or **(800) 287-8266**.

IMPORTANT REMINDERS

- * **Timely reporting can have a positive impact on every aspect of the Injured Worker's claim experience.**
- * **The benefits of prompt reporting include reduced disability, reduced litigation, reduced claims costs, and reduced fraud.**

Component 12: Develop the Transitional Duty Tracking Form

DESCRIPTION

The Transitional Duty Tracking form is an active document that provides a map for Transitional Duty from start to finish. This Tracking form also serves as documentation for the protection of all participants in the Return to Work process. The Tracking form includes the abilities and/or restrictions for the Injured Worker regarding Transitional Duty; start and review dates; and places for feedback from the Injured Worker and the supervisor. This document completed at each meeting of the Transitional Duty Team may serve as communication with the Health Care Provider in the form of regular updates.

REQUIREMENT

Every Team must use the Transitional Duty Tracking form for each Injured Worker participating in Transitional Duty. This Tracking form must be updated at each Team meeting. Copies of the Tracking form will be forwarded to the WCMB. We recommend a copy be sent to the Health Care Provider.

How to Use the Transitional Duty Tracking Form

1. At the earliest possible time or at the next scheduled Team meeting, fill out the Transitional Duty Tracking form. Use the Medical Status form that the Injured Worker took to the first Health Care Provider's appointment.
 - A. If the Injured Worker is not able to attend this initial meeting in person, include him or her via conference call to participate in Transitional Duty development.
2. Update the Transitional Duty Tracking form at each subsequent meeting to:
 - A. Document progress by the Injured Worker;
 - B. Document feedback from the Injured Worker and the supervisor.

IMPORTANT REMINDERS

*** Special Note on ADA and FMLA:** As your Team works through the Transitional Duty process, you may recognize potential ADA or FMLA issues emerging. Your Team needs access to your legal, Human Resources, State ADA personnel, and other specialists to address specific issues as they arise.

*** The Workers' Compensation Management Bureau staff can provide this assistance and/or help direct you to the appropriate person.**

*** The Transitional Duty Tracking form can be found in the appendix to this guide.**

Signs of Success in Transitional Duty Development

1. The Team should be able to develop Transitional Duty for Injured Workers who have well-defined abilities and/or restrictions.
2. Most Injured Workers accept and participate in Transitional Duty.
3. The Team is flexible and practical about changing or postponing plans when circumstances dictate.
4. The Team solicits and values the Injured Worker's ideas and suggestions for Transitional Duty.
5. The Team is able to reinitiate Transitional Duty after interruptions when appropriate.
6. Transitional Duty does not lead to aggravations of existing or development of new work-related injuries or occupational diseases.
7. Managers and supervisors are well-trained and comfortable with what they need to do to supervise Injured Workers participating in Transitional Duty.

Component 13: Communicate with Health Care Providers

DESCRIPTION

Communicating with Health Care Providers means letting them know that the State of Montana as the employer will provide Transitional Duty when Transitional Duty is medically appropriate. In doing so, we allow the Health Care Provider to update his/her statement of work abilities as the Injured Worker progresses in recovery from a work-related injury or occupational disease. Methods of communication may be in writing through the Medical Status form and Transitional Duty Tracking forms, by phone, electronically, or in person.

REQUIREMENT

When an Injured Worker goes to see his/her Health Care Provider, the Injured Worker must have a Medical Status form for the Health Care Provider to complete. If taking the Medical Status form to the visit is not physically possible, a Team member should deliver or fax the Medical Status form to the Health Care Provider's office immediately or no later than within **24 hours** of the Injured Worker's initial visit to the Health Care Provider.

How to Communicate with the Health Care Provider

1. Provide the Medical Status form to the Health Care Provider at each of the Injured Worker's visits, and instruct the Injured Worker to return the Medical Status form to his/her supervisor or Team Coordinator immediately following each visit.
 - A. If the Health Care Provider approves return to normal Job Functions on the Medical Status form, the Injured Worker will be returned to his/her time-of-injury position.
 - B. If any required modifications can be provided by the supervisor in the normal work environment, the supervisor may make the changes immediately. However, the supervisor must communicate the changes to the Team Coordinator so a plan is in place for getting the Injured Worker back to full duty as soon as medically possible.
 - C. If any required modifications cannot be provided by the supervisor immediately, the Team will use the Medical Status form to develop Transitional Duty for the Injured Worker.
 - D. If the Health Care Provider restricts the Injured Worker from all Job Functions, the supervisor, Team Coordinator, and Team members will maintain contact with the Injured Worker and the Health Care Provider in order to provide entry back into the work environment as soon as medically possible.
2. Pay close attention to any authorized changes in the Medical Status form. Transitional Duty **should** change as the Injured Worker gets better over time. The Health Care Provider may authorize increases in work over time until the Injured Worker is able to return his/her time of injury job.

IMPORTANT REMINDER

*** The Transitional Duty Tracking forms filled in at Team meetings should be copied to the Health Care Provider as well. This gives the Health Care Provider essential feedback from the Injured Worker and the Team about how Transitional Duty is progressing for everyone involved.**

Component 14: Maintain Contact with the Injured Worker

DESCRIPTION

The supervisor, Team Coordinator, and Transitional Duty Team members will communicate with the Injured Worker in multiple ways. By being on the Team, the Injured Worker is involved in the development and progress of his/her Transitional Duty. Team members should talk with the Injured Worker at work to show support for him/her. When the Injured Worker is not physically at the work site, supervisors and Team members may call and update the Injured Worker on work-related events.

REQUIREMENT

Each Team must maintain a Contact Log to ensure consistent communication with the Injured Worker. The Team Coordinator is responsible for the log. The WCMB may audit Contact Logs periodically to identify trends in communication.

Methods for Maintaining Contact with the Injured Worker

1. The initial contact should be as soon as possible after a work-related injury or occupational disease. Examples of contact are a handwritten note or a phone call to the Injured Worker by one of the Team members. Acknowledge and express concern about the work-related injury or occupational disease.
2. Provide information about the Transitional Duty process and what to expect. Let the Injured Worker know how to contact his/her Claims Examiner regarding when time-loss or related benefits will start, what benefits will be received, which forms need to be completed, and what he/she may expect from the Claims Examiner.
3. Maintain weekly ongoing contact. Even if the Injured Worker returns quickly to Transitional Duty, remember that he/she is still likely to be under significant stress and will need support and reassurance. If an Injured Worker experienced a work-related injury or occupational disease serious enough to be unable to perform any kind of Transitional Duty, contact is even more crucial.
4. Track phone calls and/or visits with the Injured Worker on the Contact Log.

WARNING Contact with Injured Workers should not be used to investigate the claim or check up on Injured Workers. Investigatory contacts must be entirely separate from Transitional Duty. If contacts are perceived as a form of spying, then attempts to communicate with the Injured Worker will be counterproductive.

Consistent, Positive Communication after an Injury

1. Team members should contact Injured Workers in a timely, positive manner.
2. Make sure that all Injured Workers are contacted.
3. Train supervisors and Team members about what they may say to Injured Workers.
4. Team Coordinators should randomly survey Injured Workers to identify if post-injury contact with Team members is perceived as aggressive or threatening.

Component 15: Workers' Compensation Management Bureau

DESCRIPTION

The Workers' Compensation Management Bureau (WCMB) is responsible for oversight of the state's loss control and safety efforts, including the Return to Work Program. The WCMB will provide oversight, training, and facilitation for state agencies for both implementation and management of the agency's Return to Work Program. In addition, the WCMB is charged with tracking the effectiveness of the state's Return to Work Program. The WCMB will be reporting Program progress to the Governor's office, agency Directors, and executive management and will make legislative recommendations to further the intended purposes of the state's Return to Work Program.

REQUIREMENT

Each Transitional Duty Team is required to provide certain information to the WCMB for oversight and tracking purposes. Agencies must copy the WCMB with Medical Status forms and Transitional Duty Tracking forms. Contact Logs are subject to audit by the WCMB.

The WCMB as a Resource to Help You

1. Visit our website at <http://benefits.mt.gov/WorkersComp.asp> or contact the Return to Work Specialist at (406) 444-7462 for more information.
2. Ask for assistance with training or ideas for Transitional Duty.
3. Contact the WCMB if a serious injury occurs. We want to help from the very beginning.
4. The WCMB will attend *all* stewardship meetings with our Insurer.

MONITORING PROCESS COMPONENTS

Listed here are some of the criteria your agency and the WCMB will utilize to evaluate agency specific Return to Work Programs.

Long Term Criteria

1. Total Claims Experience – the total amount of claims and associated expenses.
2. Average Experience Per Claim – the total expenses divided by the number of claims. This ensures that Program success can be identified regardless of the number of claims filed.
3. Premium Allocation – the premium required by our Insurer reflecting the 3 and 5 year retroactive experience of the agency and evaluation of the experience modification factor.

Short Term Criteria

1. Average number of work days lost per wage loss (indemnity) claim;
2. Average cost of lost-time days per claim;
3. Average medical cost per claim;
4. Medical-only-to-indemnity ratio – claims where no wage loss has been paid but the employee is being treated for a work-related injury or occupational disease compared to wage loss claims. An example would be that for every five work-related injuries or occupational diseases, one would result in a lost-time case. Here the medical-only-to-indemnity ratio would be 4 to 1.

OTHER MEASURES TO TRACK

1. Total hours of Transitional Duty per month: A high monthly number of Transitional Duty hours may show that the Return to Work Program is successful in creating opportunities for Injured Workers.
2. Temporary Employee Costs: The Return to Work Program should reduce expenses related to hiring temporary replacements for Injured Workers.
3. Productivity Losses: An analysis of lost productivity caused by the absence of Injured Workers (and their replacement by potentially less skilled employees) provides useful information about the Return to Work Program.

IMPORTANT REMINDER

The WCMB is here to help you navigate through the Transitional Duty process. Please contact us for any assistance.

**<http://benefits.mt.gov/WorkersComp.asp>
(406) 444-7462 or (800) 287-8266**

Glossary of Terms

“Claims Examiner” – a Claims Examiner as defined in MCA 39-71-116.

“Contact Log” – the form used to track contacts with the Injured Worker.

“First Report of Injury” or “First Report” – the initial report of a work-related injury or occupational disease that must be provided to our workers’ compensation Insurer to establish a claim. The First Report of Injury form is provided by our Insurer for reporting all work-related injuries or occupational diseases; the form can be found online at www.montanastatefund.com.

“Health Care Provider” – the licensed health care professional providing care to an Injured Worker for a work-related injury or occupational disease.

“Injured Worker” – an employee of a State agency who experiences a work-related injury or occupational disease.

“Insurer” – as used in this manual is the Montana State Fund (406) 495-5000 or (800) 332-6102.

“Return to Work Program” or “Program” – the State of Montana program establishing a process to bring an employee back to work after a work-related injury or an occupational disease.

“Transitional Duty” – modified, temporary work assigned by a State agency to an Injured Worker that allows the Injured Worker to return to the work place prior to the time when he or she is able to perform all normal job functions; fosters faster, more complete recovery.

“Transitional Duty Team” or “Team” – a team of individuals established by a State agency to administer its Return to Work Program.

“Transitional Duty Tracking Form” or “Tracking Form” – the form that documents the Transitional Duty assigned to an Injured Worker and the Injured Worker’s progress in the Return to Work Program.

“Medical Status Form” – the form sent to the Health Care Provider establishing the work capacity of an Injured Worker.

**TRANSITIONAL DUTY TEAM MEMBER'S
AGREEMENT TO KEEP INJURED WORKER INFORMATION CONFIDENTIAL**

I, the undersigned, have agreed to act as a member of the Transitional Duty Team for purposes of managing the Department's Return to Work program. My participation on the Transitional Duty Team may be a regular assignment, or may be an *ad hoc* assignment related to a work-related injury or occupational disease suffered by a co-worker or employee I supervise. In either case, I understand that my participation as a Transitional Duty Team member will involve my having access to sensitive personal information pertaining to one or more employees who meet the definition of Injured Worker for the Department's Return to Work program, which sensitive information may include, but will not necessarily be limited to, information pertaining to the health status of the Injured Worker provided by the Injured Worker or by his/her Health Care Provider.

I agree to maintain the confidentiality of the sensitive personal information I have access to through my participation as a Transitional Duty Team member, including that:

1. I will access only that sensitive personal information necessary to perform my duties as a Transitional Duty Team member;
2. I will not repeat, reveal, discuss, or otherwise further provide or disclose sensitive personal information pertaining to an Injured Worker other than to persons authorized to have such information in furtherance of the objectives of the Department's Return to Work program, or as otherwise required to perform my functions as a Transitional Duty Team member;

I agree that, if I have questions about what information is sensitive personal information or about who is authorized to receive such information from me, I will contact the Workers' Compensation Management Bureau for clarification.

I understand that the inappropriate access, use, or disclosure of sensitive personal information could cause the Injured Worker who is the subject of the sensitive personal information embarrassment or damage, and that my inappropriate access, use, or disclosure of sensitive personal information can result in disciplinary action, up to and including termination of employment. I also understand that my inappropriate access, use, or disclosure of sensitive personal information may result in civil or criminal complaints against me personally.

My signature below is my acknowledgement that I have read, understand, and agree to abide by the terms of this Confidentiality Agreement. This Confidentiality Agreement shall be effective as of the date of my signing.

Printed Name

Signature

Date

Transitional Duty Tracking Form

Injured Worker's Name:	Today's Date:
Job Title:	DOI:
Supervisor:	Team Coordinator:
Did the Injured Worker take a Medical Status form to the 1 st visit with the Health Care Provider? <input type="checkbox"/> Yes / <input type="checkbox"/> No	
If "no," check <input type="checkbox"/> to confirm that a Medical Status form has been completed by the Health Care Provider.	
Meeting #1	
Transitional Duty <i>Initial</i> Start Date:	Next Review Date:
Check <input type="checkbox"/> to confirm that a review has been completed today of the Transitional Duty Job Functions and current restrictions (see attached Medical Status form). Enter notes of that review in the space provided below.	
Injured Worker Feedback:	
Signature:	
Supervisor Feedback:	
Signature:	
Team Coordinator Feedback:	
Signature:	
Meeting #2	
Today's Date:	Next Review Date:
Check <input type="checkbox"/> to confirm that a review has been completed today of the Transitional Duty Job Functions and current restrictions (see attached Medical Status Form). Enter notes of that review in the space provided below.	
Injured Worker Feedback:	
Signature:	
Supervisor Feedback:	
Signature:	
Team Coordinator Feedback:	
Signature:	

Transitional Duty Tracking Form (continued)

Injured Worker's Name: _____

Meeting #3	
Today's Date:	Next Review Date:
Check <input type="checkbox"/> to confirm that a review has been completed today of the Transitional Duty Job Functions and current restrictions (see attached Medical Status Form). Enter notes of that review in the space provided below.	
Injured Worker Feedback:	
Signature:	
Supervisor Feedback:	
Signature:	
Team Coordinator Feedback:	
Signature:	
Meeting #4	
Today's Date:	Next Review Date:
Check <input type="checkbox"/> to confirm that a review has been completed today of the Transitional Duty Job Functions and current restrictions (see attached Medical Status Form). Enter notes of that review in the space provided below.	
Injured Worker Feedback:	
Signature:	
Supervisor Feedback:	
Signature:	
Team Coordinator Feedback:	
Signature:	
Status at the conclusion of Meeting #4 and an overview of next steps:	

State of Montana Employees Return to Work Authorization Form for Release of Information

A. Identification

This document authorizes the use and/or disclosure of confidential protected health care information about:

Employee Name: _____

Address: _____

Employee Date of Birth: _____

Daytime Phone Number: _____

Employee ID Number: _____

B. Directions for Release

This authorization applies in accordance with my directions as checked below:

I authorize the release of information from:

___ My Physician/Provider (Name): _____

___ Montana State Fund Workers' Compensation Fund

___ Other (Name or describe): _____

to release and/or use protected health information **pertaining to my current and expected medical restrictions and functional abilities and expected recover timelines related to my work-related injury or occupational disease**. The information may also include medical opinions and evaluations of potential transitional duty assignments and/or return to work activities.

I authorize the disclosure of information to:

___ Transitional Duty Team Members within the WCMB and the Department of _____

___ Other (Name or describe): _____

I authorize the disclosure and/or use for the following reasons:

1. To evaluate the appropriateness of transitional duty assignments;
2. To assist the transitional duty teams in the development of transitional duty assignments;
3. To evaluate ongoing transitional duty assignments;
4. To evaluate the appropriateness of returning to full unrestricted duties.

C. Right to Revoke

I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire on the date I am declared maximally medically improved (MMI) by my Health Care Provider for my work-related injury or occupational disease. To revoke the Authorization, I understand I must contact the following person in writing: _____
Transitional Duty Team Coordinator, Dept of _____

D. Authorization and Signature

I authorize the release of my confidential health information as described in my directions in Section B. I understand that this authorization is voluntary, that some of the information to be disclosed *may* be protected by law, and the use/disclosure is to be made to conform to my directions.

I, _____, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions.

Employee Signature

Date

Signature of Witness

Date

Complete, Sign, and Return this form to your Transitional Duty Team Coordinator

MEDICAL STATUS FORM

This form is intended to: 1) facilitate communication between a worker with a work-related injury or occupational disease, the employer, and the health care provider for Stay at Work/Return to Work; and 2) provide necessary medical status to the insurer.

Patient/ Employee Info	Patient/Employee Name (Last, First)		Provider Info	Timestamp for Health Care Provider
	Date of Injury (mm/dd/yyyy)	Claim Administrator Number		Health Care Provider Name & Address
	Date of Next Visit			

Please select ONE of the following: (Note: Temporary, alternate and full duty return dates are subject to re-assessment)

<input type="checkbox"/> Condition Unchanged from Last Report	
<input type="checkbox"/> Patient/Employee Released to Full Duty	Effective Date
<input type="checkbox"/> Patient/Employee Released to Modified Duty (SEE WORK ABILITIES)	Effective Date
<input type="checkbox"/> Time Loss Authorized - objective findings indicate worker should remain off work	Effective Date
▶ Anticipated date patient/employee can perform temporary alternate work	Anticipated Date
▶ Anticipated date patient/employee can return to full duty	Anticipated Date

Total Number of Hours/Day Patient/ Employee May Work:		Number of Hours										NR = Not Restricted	Patient/Employee <input type="checkbox"/> Should / <input type="checkbox"/> Must Alternately <input type="checkbox"/> Sit / <input type="checkbox"/> Stand / <input type="checkbox"/> Walk Every _____ hours
	_____ days per week	Sit	0	1	2	3	4	5	6	7	8	NR	
	_____ hours per day	Stand	0	1	2	3	4	5	6	7	8	NR	
	Walk	0	1	2	3	4	5	6	7	8	NR		

	Never	Occasionally	Frequently	Continuously	Permanent Upon MMI
	Example of an eight hour work day: NEVER equals 0%, OCCASIONALLY equals 1% to 33% (1-2.6 hours), FREQUENTLY equals 34% to 66% (2.6-5.2 hours), and CONTINUOUSLY equals 67% to 100% (5.3+ hours).				
Hand/Wrist Work <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/Pulling <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine Manipulation <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 01-10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 11-20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 21-25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 26-50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 51-70 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is the patient/employee involved in treatment and/or medication related to the work-related injury/occupational disease that might affect their ability to work safely in any capacity? No Yes If yes please explain _____

Will the patient/employee be required to use any devices or braces? No Yes If yes please explain _____

Additional comments specific to patient/employee's work abilities _____

Can the patient/employee return to work at time of injury occupation? No Yes

Signatures	Patient/Employee Signature	Date
	Health Care Provider's Signature	Date

Medical Status Form 8/31/11

This section contains private information for the MEDICAL PROVIDER, INSURER AND PATIENT/EMPLOYEE ONLY and is NOT to be given to EMPLOYER

Diagnosed condition _____

Treatment plan to increase functional improvement until next appointment _____

Identity of medication prescribed _____

Anticipated MMI date _____ Actual MMI date _____ Perm WP Impairment Rating _____ %

MEDICAL STATUS FORM

This form is intended to: 1) facilitate communication between a worker with a work-related injury or occupational disease, the employer, and the health care provider for Stay at Work/Return to Work; and 2) provide necessary medical status to the insurer.

Patient/ Employee Info	Patient/Employee Name (Last, First)		Provider Info	Timestamp for Health Care Provider
	Date of Injury (mm/dd/yyyy)	Claim Administrator Number		Health Care Provider Name & Address
	Date of Next Visit			

Please select ONE of the following: (Note: Temporary, alternate and full duty return dates are subject to re-assessment)

<input type="checkbox"/> Condition Unchanged from Last Report	
<input type="checkbox"/> Patient/Employee Released to Full Duty	Effective Date
<input type="checkbox"/> Patient/Employee Released to Modified Duty (SEE WORK ABILITIES)	Effective Date
<input type="checkbox"/> Time Loss Authorized - objective findings indicate worker should remain off work	Effective Date
▶ Anticipated date patient/employee can perform temporary alternate work	Anticipated Date
▶ Anticipated date patient/employee can return to full duty	Anticipated Date

Total Number of Hours/Day Patient/ Employee May Work: _____ days per week _____ hours per day	Number of Hours											NR = Not Restricted	Patient/Employee <input type="checkbox"/> Should / <input type="checkbox"/> Must Alternately <input type="checkbox"/> Sit / <input type="checkbox"/> Stand / <input type="checkbox"/> Walk Every _____ hours
	Sit	0	1	2	3	4	5	6	7	8	NR		
	Stand	0	1	2	3	4	5	6	7	8	NR		
	Walk	0	1	2	3	4	5	6	7	8	NR		

	Never	Occasionally	Frequently	Continuously	Permanent Upon MMI
	<small>Example of an eight hour work day: NEVER equals 0%, OCCASIONALLY equals 1% to 33% (1-2.6 hours), FREQUENTLY equals 34% to 66% (2.6-5.2 hours), and CONTINUOUSLY equals 67% to 100% (5.3+ hours).</small>				
Hand/Wrist Work <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/Pulling <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine Manipulation <input type="checkbox"/> L, <input type="checkbox"/> R, <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 01-10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 11-20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 21-25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 26-50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 51-70 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is the patient/employee involved in treatment and/or medication related to the work-related injury/occupational disease that might affect their ability to work safely in any capacity? No Yes If yes please explain _____

Will the patient/employee be required to use any devices or braces? No Yes If yes please explain _____

Additional comments specific to patient/employee's work abilities _____

Can the patient/employee return to work at time of injury occupation? No Yes

Signatures	Patient/Employee Signature	Date
	Health Care Provider's Signature	Date