The Ohio Manufacturers' Association
WORKERS' COMPENSATION SERVICES

# OFFER LIGHT DUTY TO AN INJURED WORKER

## WORKERS' COMPENSATION CLAIMS MANAGEMENT TOOLS FOR OHIO MANUFACTURERS

This guidance is provided to help you return an employee to light duty and document your process.

A series of communications should be sent to the treating physician (this is typically executed in conjunction with your managed care organization (MCO) representative, who will also be in contact the injured worker).

Maintain a record of any and all correspondence in the unlikely event that the return-to-work is opposed and referred to the Industrial Commission for hearing.

***Bringing an injured worker back to duty safely is good for everyone, the worker, his or her family, and you. We can help create return-to-work plans – under the physician's restrictions – that provide productive transitional work roles.***

Some of the mistakes that can occur when offering light duty include: not having proof that the injured worker received the written offer of light duty; waiting too long to provide the offer; making an offer that does not comply with the injured worker's restrictions; and, failing to update an offer to comply with restrictions that may have been updated or changed.

Always work with your OMA Account Manager and MCO to guide the process of offering light duty to an injured worker.

**STEP 1 – Have your MCO contact the nurse at the treating physician's office.**

- Be sure the physician's office has your direct contact information and request to be kept informed.
- Be sure the MCO advises the nurse that you would like the physician to review options for a potential light duty release.
- Obtain a fax number or email address where you can direct documents to the physician.

**STEP 2 – Have the MCO send your request to the physician for the employee's up-to-date work restrictions (see sample letter 1 below) together with a blank BWC MEDCO-14.**

This letter introduces you to the physician and informs him or her that your company is willing to offer light duty work to the injured worker. The letter requests that the doctor provide you with the employee's up-to-date work restrictions.

**STEP 3 – Request the physician to compare work restrictions to your job description.**

Only proceed to this step if you have obtained up-to-date work restrictions and if you can accommodate the restrictions.

Send a letter (see sample letter 2 below) informing the doctor that you have light duty work available that you believe is within the restrictions. This request asks the doctor to review your job description (with job title) and approve return-to-work in this transitional capacity.

**We have created model Jobs/Duties Description form for your use (see below).**

**STEP 4 – Advise your employee of the return-to-work authorization provided by the physician.**

Once the physician of record approves your job description in light of the employee's work restrictions, you are ready to instruct the employee to return to work.

Send a letter (see sample letter 3 below) to the employee to inform him or her of the date and time he or she is expected to return to work. We recommend sending this letter via both regular and certified mail.

Also, place a courtesy call to the employee. It is always in everyone's best interests to help an employee feel welcome to return to work.

## Light Duty - Sample letter 1

Place on your letterhead
To: Physician of record
Attach: BWC MEDCO-14 Physician's Report of Work Ability form

To: [Physician]

Re: Employee Return-To-Work
[Employee first name] [Employee last name]
[Claim #]
Date of injury: [Month][Day][Year]

We are the employer in the above referenced workers' compensation claim. As such, we would like to make you aware that we do have modified/light duty positions available that may provide an opportunity for this injured worker to safely return to work in a light duty/transitional capacity.

If you decide that the injured worker is capable of returning to work with restrictions, please forward a list or description of those restrictions. After we review the restrictions, we will, if appropriate, forward to you a job description for your review.

We look forward to working with you to safely return our employee to work. Should you have any questions, please do not hesitate to contact me at [contact information].

Respectfully,

[name]
[title]

enclosure: BWC MEDCO-14

## Light Duty - Sample letter 2

Place on your letterhead
To: Physician of record
Attach: Light duty job title and description

To: [Physician]

Re: Employee Return-To-Work
[Employee first name] [Employee last name]
[Claim #]
Date of injury: [Month][Day][Year]

We are the employer in the above referenced workers' compensation claim. As such, we have received a copy of the restrictions you have established for our employee.

At your earliest convenience, please review the attached job description and advise us if the employee can safely perform these job duties in light of the restrictions you have specified.

Please advise if there are any duties which the employee should not perform.

Finally, please indicate the specific date the employee could assume the duties of the attached job description.

So that we can have a complete record, please sign and date your response.

Should you have any questions, please do not hesitate to contact me at [contact information].

Respectfully,

[name]
[title]

enclosure: Job description

# JOB/DUTIES DESCRIPTION

 **EMPLOYER TO COMPLETE AND SUBMIT TO PHYSICIAN**

Injured worker name: _____ Claim no.: _____

Occupation/Job title: _____

General description of the injured worker's usual job duties: _____

_____

_____

Describe other job duties the injured worker may perform: _____

_____

_____

We can provide modified duty for this injured worker: *(circle one)* Yes No Possibly

Does the injured worker drive or operate heavy machinery? *(circle one)* Yes No

If yes, please describe, including the use of hand and/or foot controls.

_____

_____

_____

**Please circle the physical requirements of the injured worker's job.**

**Lifting/carrying requirements** *(circle one for each weight group)*

| | | | | |
|---|---|---|---|---|
| 0 to 10 lbs | Never | Occasionally | Frequently | Continuously |
| 11 to 20 lbs | Never | Occasionally | Frequently | Continuously |
| 21 to 40 lbs | Never | Occasionally | Frequently | Continuously |
| 41 to 60 lbs | Never | Occasionally | Frequently | Continuously |
| 61 to 100 lbs | Never | Occasionally | Frequently | Continuously |

**Pushing/pulling requirements** *(circle one for each weight group)*

| | | | | |
|---|---|---|---|---|
| 0 to 25lbs | Never | Occasionally | Frequently | Continuously |
| 26 to 40 lbs | Never | Occasionally | Frequently | Continuously |
| 41 to 60 lbs | Never | Occasionally | Frequently | Continuously |
| 61 to 100 lbs | Never | Occasionally | Frequently | Continuously |
| 26 to 50 lbs | Never | Occasionally | Frequently | Continuously |
| 100 plus lbs | Never | Occasionally | Frequently | Continuously |

CONTINUED ▶

# JOB/DUTIES DESCRIPTION

 **EMPLOYER TO COMPLETE AND SUBMIT TO PHYSICIAN**

**Use of hands for simple grasping** *(circle one for each hand)*

| | | | | |
|---|---|---|---|---|
| Right hand | Never | Occasionally | Frequently | Continuously |
| Left hand | Never | Occasionally | Frequently | Continuously |

**Use of hands for fine manipulation** *(circle one for each hand)*

| | | | | |
|---|---|---|---|---|
| Right hand | Never | Occasionally | Frequently | Continuously |
| Left hand | Never | Occasionally | Frequently | Continuously |

**Use of feet/legs for controls** *(circle one for each foot/leg)*

| | | | | |
|---|---|---|---|---|
| Right foot/leg | Never | Occasionally | Frequently | Continuously |
| Left foot/leg | Never | Occasionally | Frequently | Continuously |

**Other requirements** *(circle one for each motion)*

| | | | | |
|---|---|---|---|---|
| Bending | Never | Occasionally | Frequently | Continuously |
| Squat/Kneel/Crawl | Never | Occasionally | Frequently | Continuously |
| Twist/turn | Never | Occasionally | Frequently | Continuously |
| Climb | Never | Occasionally | Frequently | Continuously |
| Reach above the shoulder | Never | Occasionally | Frequently | Continuously |
| Work with cold substances | Never | Occasionally | Frequently | Continuously |
| Work with hot substances | Never | Occasionally | Frequently | Continuously |

| | |
|---|---|
| Sitting | ____ hours per day |
| Standing | ____ hours per day |
| Walking | ____ hours per day |

Completed by:_____ Date: _____

Title: _____

Phone: _____ Email: _____

## Light Duty - Sample letter 3

Place on your letterhead
Send regular and certified mail

Employee name
Employee address

Re: [Claim #]
Date of injury: [Month][Day][Year]

Dear [Injured Worker Name]:

We sincerely hope that recovery from your work-related injury is progressing satisfactorily.

Your physician has provided physical restriction information to allow you to return to work as soon as possible while still achieving full recovery from your injury. Dr. [Physician Name] has indicated you are able to work with the following limitations:

[Insert physician's restriction information]

We would like to take this opportunity to extend an offer for your return to work in a capacity that meets the above-noted restrictions. You will be paid your regular salary [hourly rate] regardless of any limitations your doctor has set on hours worked or duties performed. The job involves the following tasks:

[Insert job description information]

These job duties are temporary in nature, and you may transition back to your regular job assignment when your doctor has determined you are capable. The position will have a start date of [insert date.] The job hours will be [specify hours]. You will report to [Supervisor's Name] and the work will be performed at [location]. All [Company Name] policies, including attendance, punctuality and call off procedures, will apply as usual during this transitional work period.

Please notify us of your interest in this position by [date approximately 5 days after mailed to allow for delivery].
A failure to respond will be considered a refusal of this offer of suitable transitional work. You should be aware that refusing to accept work within your physician's medical restrictions may end your Temporary Total Disability compensation.

Your reply and any questions regarding this transitional work offer should be directed to [Employer Workers' Compensation Coordinator Name] at [phone number]. We look forward to hearing from you and having you back as a member of our team.

Respectfully,

[Signature]
[Title]

This agreement shall be in effect until such time as the physician of record feels that you are physically capable of resuming regular work, and for a period not to exceed [number] days from the date of the agreement.

Check one:

☐ I accept this transitional work offer. I agree to keep my employer advised of any changes in my physical restrictions and will promptly advise my employer upon release to full duty by my physician.

☐ I do not accept this transitional work offer. I acknowledge that this refusal may result in denial of my Temporary Total Disability compensation.

Employee Signature: _____Date: _____

cc: [Employee's Attorney's Name, if applicable]
Bureau of Workers' Compensation