

# OFFER LIGHT DUTY TO AN INJURED WORKER

## WORKERS' COMPENSATION CLAIMS MANAGEMENT TOOLS FOR OHIO MANUFACTURERS

The following guidance is provided to help you return your employee to light duty work and to advise you how to document your process. In the process, you will send a series of communications to the treating physician, and then to the injured worker. We recommend that you maintain a written record of your correspondence in the unlikely event that the return-to-work is opposed and referred to the Industrial Commission for hearing.

Mistakes that can occur in offering light duty include having no proof that the injured worker actually received the written light duty offer, 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. Therefore, always work with your OMA Account Manager who will guide the process of offering light duty to an injured worker.

***Bringing an injured worker back to duty safely is good for everyone, the workers, 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.***

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### **STEP 1 – Contact the nurse at treating physician's office**

- Introduce yourself
- Tell the nurse that you would like the physician to review options for a possible light duty release
- Obtain a fax number or email address where you can direct documents to the physician

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### **STEP 2 – Send your request to the physician for the employee's up-to-date work restrictions (sample letter 1 follows) with a blank BWC MEDCO-14 – Physician's Report of Work Ability form (also available from your OMA Account Manager)**

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.

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### **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 (see above) and if you can accommodate the restrictions.

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

**We have created model Jobs/Duties Description form for your use.**

#### **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 (sample letter 3 follows) 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 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

*Access Word version here*

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

This form provides important information about the injured worker's ability to work.

- The treating physician must submit this form each time he/she sees the injured worker unless the injured worker has been awarded permanent and total disability, has returned to work without restrictions within seven days of the injury, or is being treated after the treating physician has released him/her to his/her former position without restrictions.
- Please complete this form and provide a copy to the injured worker during his/her office visit. Fax a copy to the appropriate managed care organization (MCO) or to the injured worker's employer if self-insured.
- This form or an equivalent physician-generated document may support a request for temporary total compensation. The equivalent document must contain, at a minimum, the data elements required on this form. If you have submitted previously equivalent data elements that remain the same, indicate the name of the report that reflects the injured worker's current condition, e.g., May 15, 2015, office note.
- You may attach additional medical documentation such as diagnostic test results and a treatment plan to this form.
- Failure to provide complete detailed information may delay or suspend compensation payments to the injured worker.

## Instructions

**MEDCO-14 submission section:** You must select only one of the three choices by selecting the appropriate box. If you previously completed a MEDCO-14 and there are changes, you must indicate the changes in the appropriate section on the form, and select the yes box in that section. For all other sections, you would make no entry, and select the no box.

**Employment/occupation section:** Please indicate if you have reviewed a description of the injured worker's job held on the date of the injury. Please indicate all sources providing you a description of the injured worker's job. If you do not have a copy of the injured worker's job description, BWC or the MCO can help secure one.

**Work status/Injured worker's capabilities section:** Please complete this section as accurately and thoroughly as possible, as BWC will use this information to understand the injured worker's work status and help facilitate his/her appropriate and safe return to work either to his/her job held on the date of injury or an alternative job if he/she cannot return to the job held on the date of injury.

**3A:** Please indicate if the injured worker has any physical or health restrictions **related only to the allowed conditions in the claim**. If there are restrictions, please indicate if the restrictions are permanent or temporary. If there are no related restrictions you should check the release to work box. The date of the exam will be the release to work date.

**3B:** If there are restrictions **related only to the allowed conditions in the claim**, indicate whether or not the injured worker can return to **the full duties** of his/her job held on the date of injury. If you determine the injured worker cannot return to the full duties of his/her job held on the date of the injury, you must include the date for which you indicate the injured worker could not fully perform the duties of his/her job held on the date of the injury. You must also indicate an estimated date when you believe the injured worker should be able to fully perform the duties of the job held on the date of injury. **It is imperative that you follow all 3B instructions. This will facilitate appropriate processing of the injured worker's claim. Updates to dates in 3B requires 4A to be completed.**

**3C:** Although an injured worker may not be able to fully return to the job held on the date of injury, understanding the injured worker's capabilities will assist in identifying appropriate and safe work that an injured worker may be able to perform. If an injured worker may return to available and appropriate work with restrictions accommodated, please indicate the possible return to work date. Further, to facilitate BWC's efforts to safely return an injured worker to appropriate work, indicate which of the activities listed in this section, the injured worker can perform. The following definitions apply to the section on Lifting/carrying, Pushing/pulling and Activity with the percentages reflected as they relate to an eight-hour workday:

- Never – 0 percent;
- Occasionally – 1 percent to 33 percent, four to six repetitions per hour;
- Frequently – 34 percent to 66 percent, six to 12 repetitions per hour;
- Continuously – 67 percent to 100 percent, greater than 12 repetitions per hour.

Please note that if the "yes" box is checked in response to the question of whether the injured worker has functional restrictions based only on allowed psychological conditions the MEDCO-16 should be referenced as needed.

We encourage you, in the space provided, to provide any additional information you believe would benefit the injured worker's safety and care relative to any return to work considerations.



**Instructions continued**

**4A: Disability period information section:** It is critical that if you answered No to 3B or made changes to dates in 3B this section is fully completed: Please furnish the narrative description of the diagnosis(es), site/location and International Classification of Diseases code for only allowed conditions being treated. You must indicate by checking the appropriate box whether the allowed condition is preventing the injured worker from returning to the job held on the date of injury.

**4B:** In this area you should list all other relevant conditions that impact treatment of the allowed conditions in the claim.

**Clinical findings section:** Provide medical rationale for the delay in the injured worker's recovery and the barriers to return to work.

**Maximum medical improvement (MMI) section:** Provide the MMI date or explain why the injured worker has not reached MMI. Provide the proposed treatment plan, including estimated duration.

**Vocational rehabilitation section:** If the injured worker is not a candidate for vocational rehabilitation, explain and recommend actions to help the injured worker return to employment.

**Treating physician's signature section:** Sign and date this form. Your signature indicates you have answered the questions as truthfully and completely as possible.

**For more information or assistance**

Please contact your local BWC customer service office, or call 1-800-644-6292. You can obtain BWC forms at [www.bwc.ohio.gov](http://www.bwc.ohio.gov), at all BWC customer service offices, or by calling 1-800-644-6292 and listening to the options to reach a BWC customer service representative.



Injured worker name			Claim number
Date of injury	Date of last appointment/examination	Date of this appointment/examination	Date of next appointment/examination

**MEDCO-14 submission (Select one of the options below.)**

1  I have never completed a MEDCO-14. *Proceed to section 2.*  
 I have previously completed a MEDCO-14, and all of the information remains the same. *Proceed to and complete section 8.*  
 I have previously completed a MEDCO-14, and I am providing updates appropriately checking Yes or No on each section.

**Employment/Occupation (Complete this section and proceed to section 3.)** (Updates Yes  No )

2 Have you reviewed the description of the injured worker's job held on the date of injury (former position of employment)? Yes  No   
**If yes** - please indicate who (select all sources) provided the job description  Injured worker  Employer  MCO  BWC

**Work status/Injured worker's capabilities** (Updates Yes  No )

3A Does the injured worker have any physical or health restrictions related to allowed conditions in the claim? Yes  No   
**If yes**, are the restrictions:  Permanent  Temporary *Proceed to section 3B.*  
**If no**, please check the box to indicate the injured worker is released to work as of the date of this exam.  *Proceed to section 8.*

3B If there are restrictions, can the injured worker return to the full duties of his/her job held on the date of injury (former position of employment)? Yes  No   
**If yes**, please check the box to indicate that the injured worker is released to work as of the date of this exam.  *Proceed to section 8.*  
**If no**, please indicate when the injured worker could not do the job held on the date of injury for this period of restricted duty.  
Date: \_\_\_/\_\_\_/\_\_\_\_.  
Please estimate when the injured worker should be able to return to the job held on the date of injury for this period of restricted duty.  
Date: \_\_\_/\_\_\_/\_\_\_\_. *Proceed to section 3C.*

**Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is No.)**  
If the injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, please indicate the possible return to work date: \_\_\_/\_\_\_/\_\_\_\_.  
The injured worker can perform simple grasping with:  Left hand  Right hand  Both  
The injured worker can perform repetitive wrist motion with:  Left hand  Right hand  Both  
The injured worker's dominant hand is:  Left  Right  
The injured worker can perform repetitive actions to operate foot controls or motor vehicles with:  Left foot  Right foot  Both  
If the injured worker is taking prescribed medications for the allowed conditions in this claim, can the injured worker safely:  
\*Operate heavy machinery:  Yes  No \*Drive:  Yes  No \*Perform other critical job tasks as defined by any source listed above in section 2:  Yes  No

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously					Lifting/carrying				Pushing/pulling										
Activity	N	O	F	C	Activity	N	O	F	C	0 - 10 lbs.	N	O	F	C	0 to 25 lbs.	N	O	F	C
Bend					Reach above shoulder					11 - 20 lbs.					26 to 40 lbs.				
Squat/kneel					Type/keyboards					21 - 40 lbs.					41 to 60 lbs.				
Twist/turn					Work with cold substances					41 - 60 lbs.					61 to 100 lbs.				
3C Climb					Work with hot substances					61 - 100 lbs.					100 + lbs.				

How many total hours can the injured worker work: \_\_\_ per week \_\_\_ per day?  
In an eight-hour workday, how many total hours can the injured worker: Sit: \_\_\_ hours  Continuously  With break  
Walk: \_\_\_ hours  Continuously  With break Stand: \_\_\_ hours  Continuously  With break  
Does the injured worker have any functional restrictions based only on allowed psychological conditions?  Yes  No If Yes, please describe in space provided below. Note: If Yes is indicated please reference the MEDCO-16 as needed.  
Additionally, in this space, please provide any additional information addressing the injured worker's capabilities and/or job accommodations which may not be addressed above. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Injured worker name		Claim number	Date of injury	
<b>Disability information (If 3B above is "NO" or dates updated - all 4A fields, including site/location if applicable must be completed)</b>				(Updates Yes <input type="checkbox"/> No <input type="checkbox"/> )
Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and International Classification of Diseases (ICD) code(s) for the condition(s) being treated due to the work-related injury/disease. Please indicate if the condition is preventing the injured worker from returning to job duties he/she held on the date of injury.				
4A	Narrative description of the work-related allowed condition	Site/location if applicable	ICD code	Is the condition preventing full duty release to the job injured worker held on the date of injury?
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
				Yes <input type="checkbox"/> No <input type="checkbox"/>
4B	List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).			
<b>Clinical findings: You can reference office notes in lieu of writing clinical findings below.</b>				(Updates Yes <input type="checkbox"/> No <input type="checkbox"/> )
5	The injured worker is progressing: <input type="checkbox"/> As expected <input type="checkbox"/> Better than expected <input type="checkbox"/> Slower than expected Provide your clinical and objective findings supporting your medical opinion outlined on this form. List barriers to return to work and reason, for the injured worker's delay in recovery.			
<b>Maximum medical improvement (MMI)</b>				(Updates Yes <input type="checkbox"/> No <input type="checkbox"/> )
6	MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the definition above? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give MMI date: ____/____/____. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).			
Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. Thus, periodic medical treatment may still be requested and provided.				
<b>Vocational rehabilitation</b>				(Updates Yes <input type="checkbox"/> No <input type="checkbox"/> )
7	Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please explain why and provide your recommendations to help the injured worker return to employment.			
<b>Treating physician signature - mandatory</b>				
8	I certify the information on this form is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may be punished, under appropriate criminal provisions, by a fine or imprisonment or both.			
	Treating physician's name (please print legibly)		Address, city, state, nine-digit ZIP code	
	Treating physician's signature			
BWC provider (Peach) number		Date	Telephone number	Fax number

## Light Duty - Sample letter 2

*Access Word version here*

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

PAGE 1 of 2

EMPLOYER TO COMPLETE AND SUBMIT TO PHYSICIAN

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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

**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

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Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Light Duty - Sample letter 3

*Access Word version here*

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 compensation benefits through workers' 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 compensation.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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