



# WORKERS' COMPENSATION 101

Staff Version



# BRIEF HISTORY OF TEXAS WORKERS' COMPENSATION

Pre Workers' Compensation Laws  
The Industrial Revolution and its increased needs  
First State Wisconsin in 1911,  
Texas passed in 1913

# PRE WORKERS' COMPENSATION LAWS



*Contributory negligence \* The employer wouldn't be held liable if the worker was responsible for his own injury, regardless of how hazardous the machinery or work environment was. So if a worker slipped and lost a hand, they wouldn't receive compensation*

*The "fellow servant" rule \* If a fellow employee caused the worker's injuries, employers were not held liable.*

*Assumption of risk \* This doctrine held that employees accepted the hazards of their work when they signed their contracts. To make matters worse, many industries had employees sign contracts that relinquished their right to sue for injuries. That's why these unfair documents earned the grim moniker "death contracts."*

# FIRST STATE WISCONSIN IN 1911

Texas followed in 1913 with its first Workers' Compensation Law.

Modified many times in 1957, 1969, 1975, and completely overhauled in 1989.

Texas is one of 3 states not requiring coverage to private employers. (required coverage for public employers)

Self Insurance Pools created in 1973 and TML Workers' Compensation Fund started July 1, 1974.





# WORKERS' COMPENSATION DEPARTMENT OVERVIEW

6 field offices that cover local  
area claims  
71 total employees  
Centralized medical bill and  
check processing

# 6 FIELD OFFICES

## Workers' Compensation Region Map



[View full-size map](#)

-  **TMLIRP Austin** (800) 537-6655
-  **TMLIRP Corpus Christi** (800) 327-2780
-  **TMLIRP Harlingen** (800) 327-2857
-  **TMLIRP Houston** (800) 762-1818
-  **TMLIRP Lubbock** (800) 709-2667
-  **TMLIRP Mesquite** (877) 478-5031
-  **TMLIRP San Antonio** (800) 327-2660

# ADJUSTERS / SUPERVISORS / MANAGERS

## Workers' Compensation Manager

Mike Bratcher

## Assistant Claims Managers

Connie Higdon

Phil English

## Claims Management Specialists

Lane Caskey

Pat Dowling

Rhonda Myers (Mesquite)

Jon Norwood

## Bill Review Supervisor

Cindy Strait

## Adjusters

### Austin

Norma Acosta (512) 491-2439

Britt Allen (512) 491-2483

Lisa Ardila (512) 491-2408

Cindy Brown (512) 491-2540

George Carmona (512) 491-2470

Leticia Carrillo (512) 491-2458

Martha Dent (512) 491-2515

Debbie Key (512) 491-2583

Sadie Michael (512) 491-2541

Cade Mitchell (512) 491-2337

Elise Moore (512) 491-2442

Gracy Sanchez (512) 491-2375

Joni Sullivan (512) 491-2506

fax: (512) 491-2481

### Corpus Christi

Hermelinda Cruz (800) 327-2780

fax: (512) 491-3313

### Harlingen

Nora Garcia (800) 327-2857

fax: (512) 491-3314

### Houston

Shamira Jamal (800) 762-1818

Stephanie Kelley (800) 762-1818

fax: (512) 491-3315

### Lubbock

Mike Palmer (800) 709-2667

Tommie Rutter (800) 709-2667

Gary Ward (800) 709-2667

fax: (512) 491-3316

### San Antonio

Ronald Coleman (800) 327-2660

Keith Blackwell (800) 327-2660

fax: (512) 491-3318

### Mesquite

Jasmine Dickerson (877) 478-5031

Stacy Haverlah (877) 478-5031

Kathy Resendez (877) 478-5031

Erik Von Hatten (877) 478-5031

Ruth Winnicki (877) 478-5031

fax: (512) 491-3317



# CENTRALIZED MEDICAL BILL AND CHECK PROCESSING

All medical bills and checks are  
processed in the Austin Office

124,000 checks per year on  
average

# CLAIMS PROCESS

Assignment, Investigation &

Claim Documentation

Course and Scope/Compensability

Determination

Timely Payments and Disputes

Return to Work and modified duty  
members

Forms

## Workers' Compensation Claims Process



# ASSIGNMENT, INVESTIGATION, AND CLAIMS DOCUMENTATION

All claims are reviewed for course and scope, compensability, and lost time or medical only claims.

Medical only claims are handled routinely after initial screening to notify of requirements and pay the bills timely.

Lost time claims require detailed investigations depending on the nature of the claim. Most lost time claims require statements, witness contact and discussion with supervisor or coworkers.



# COURSE AND SCOPE / COMPENSABILITY

**Course and Scope of Employment** means an activity of any kind or character that has to do with and originates in the work, business, trade, or profession of the employer and that is performed by an employee while engaged in or about the furtherance of the affairs of business of the employer.

**Compensable Injury** means an injury that arises out of and in the course and scope of employment for which compensation is payable under the statute.

**Statutory, Case Law, and Appeals Panel Decisions**



# TIMELY PAYMENTS AND DISPUTES

- Initial Temporary Income Benefit (TIB) payment due within 15 days of first notice received.
- Impairment Income Benefits (IIB) due within 5 days of receiving maximum medical improvement (MMI) and impairment rating.
- Supplemental Income Benefits (SIB) due within 7 days of the beginning of the monthly period (qualified quarterly).
- Death Benefits (DB) due no later than the 60<sup>th</sup> day from notice or within 15 days after receiving claim for death benefits.
- Disputes must be filed by day 15 or benefits are still due until dispute is filed. The claim must be disputed by day 60.

April 2017						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

# RETURN TO WORK AND MODIFIED DUTY

Full Duty/Full Pay

Modified Duty/Full Pay

Modified Duty/Reduced Pay or reduced hours

Modified Duty Policy Encouraged

Bona Fide Offer of Employment



# FORMS

DWC-1 First Report of Injury due within 8 days of the first date of lost time

DWC-3 Employer Wage Statement due within 30 days of the 8<sup>th</sup> day of lost time.

DWC-6 Supplemental Report of Injury due within 3 days or 10 days of change of work status, depending on why it is being filed.

The image displays a collection of forms from the University of Nebraska-Lincoln, specifically from the Services for Students with Disabilities office. The forms are as follows:

- TESTING ACCOMMODATION REQUEST FORM**: Includes fields for CLASS TIME, INSTRUCTOR'S NAME, INSTRUCTOR'S E-MAIL ADDRESS, and a table for listing accommodations.
- NOTETAKER FEEDBACK FORM**: Includes fields for Today's Date, Student Name, and Student ID Number.
- NOTETAKER REQUEST FORM**: Includes fields for CLASS NAME, SECTION, CLASS DATE, and CLASS TIME, along with a section for course notes.
- E-TEXT REQUEST FORM**: Includes fields for Name and Last.
- EARLY CLASS REGISTRATION FORM**: Includes fields for Today's Date, Student Name, Student ID Number, and a section for class registration.

\*Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.

1. Name (Last, First, M.I.)		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>	
3. Social Security Number	4. Home Phone ( ) -	5. Date of Birth (m-d-y) - -	
6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/>			
7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>		8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>	
9. Mailing Address Street or P.O. Box  City State Zip Code County			
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>			
11. Number of Dependent Children		12. Spouse's Name	
13. Doctor's Name			
14. Doctor's Mailing Address (Street or P.O. Box)  City State Zip Code			
15. Date of Injury (m-d-y) - -		16. Time of Injury : am <input type="checkbox"/> pm <input type="checkbox"/>	
17. Date Last Time Began (m-d-y) - -		18. Nature of Injury*	
19. Part of Body Injured or Exposed*		20. How and Why Injury/Illness Occurred*	
21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>		22. Worksite Location of Injury (stairs, dock, etc.)*	
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site  Street or P.O. Box County			
City		State Zip Code	
24. Cause of Injury(Ill, tool, machine, etc.)*			
25. List Witnesses			
26. Return to work date/or expected (m-d-y) - -		27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/>	
28. Supervisor's Name		29. Date Reported (m-d-y) - -	

30. Date of Hire (m-d-y) - -		31. Was employee hired or recruited in Texas? YES <input type="checkbox"/> NO <input type="checkbox"/>		32. Length of Service in Current Position Months _____ Years _____		33. Length of Service in Occupation Months _____ Years _____	
34. Employee Payroll Classification Code			35. Occupation of Injured Worker				
36. Rate of Pay at this Job \$ _____ Hourly \$ _____ Weekly		37. Full Work Week is: _____ Hours _____ Days		38. Last Paycheck was: \$ _____ for _____ Hours or _____ Days		39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input type="checkbox"/>	
40. Name and Title of Person Completing Form				41. Name of Business			
42. Business Mailing Address and Telephone Number Street or P.O. Box _____ Telephone (____) _____				43. Business Location (if different from mailing address) Number and Street _____			
City _____		State _____ Zip Code _____		City _____		State _____ Zip Code _____	
44. Federal Tax Identification Number		45. Primary North American Industry Classification System Code (5 digit)		46. Specific NAICS Code (6 digit)		47. Texas Comptroller Taxpayer No.	
48. Workers' Compensation Insurance Company				49. Policy Number			
50. Did you request accident prevention services in past 12 months? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, did you receive them? YES <input type="checkbox"/> NO <input type="checkbox"/>							
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) X _____ Date _____							



Initial is required completion center <div style="border: 1px solid black; padding: 5px; margin: 5px 0;">           (Print and fill in name of employer)         </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <input type="checkbox"/> Initial    <input type="checkbox"/> Amended         </div> <div style="width: 55%; text-align: center;"> <h2 style="margin: 0;">EMPLOYER'S WAGE STATEMENT (DWC Form-003)</h2> </div> </div> <p>The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its insured compensation beneficiary center (benefit) and the statement of the claimant's representative, if any. The purpose of the form is to provide the employer's wage information to the center for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee to a beneficiary.</p> <p>The AWW is based on the wages the employee earned in the 12 weeks immediately preceding the date of injury for a total employee salary (if the employee did not work full time) or total "Wages" available to him or her of remuneration payable to an employee for personal services, including fringe benefits. To simplify things, employers may list wages in a weekly, biweekly, or monthly manner on this form.</p> <p><b>NOTE:</b> An employer who fails to submit good cause to deny for a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 405.003(a) and Workers' Compensation Rule 120 may be sanctioned by administrative penalty.</p>	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <div style="text-align: right;">CLAIM # _____</div> <div style="text-align: right;">CLAIMER'S CLAIM # _____</div> </div> <div style="width: 50%; text-align: center;"> </div> </div> <p>The employer shall timely file a complete wage statement to the benefit center presented by the Center.</p> <ol style="list-style-type: none"> <li>(1) The wage statement shall be filed (that means received) with the center, the claimant, and the claimant's representative (if any) within 30 days after the date of:</li> <ol style="list-style-type: none"> <li>(A) the employee's right day of injury;</li> <li>(B) the date the employee is notified that the employee is entitled to receive benefits;</li> <li>(C) the date of receipt of the claimant's notice of a compensable injury.</li> </ol> <li>(2) The wage statement shall also be filed with the Center within 30 days of receipt of a request from the Center (Only Once Requested).</li> <li>(3) A subsequent wage statement shall be filed with the center, employee and the employer's representative (if any) within seven days (7) of information obtained on the previous wage statement changes (such as the employee discontinues providing a compensating wage that was not confirmed after the date of injury).</li> </ol> <p><b>All applicable DWC notices can be found at: <a href="http://www.dwc.state.tx.us">http://www.dwc.state.tx.us</a></b></p>
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EMPLOYEE AND EMPLOYER INFORMATION				
Employee's Name (Last, First, MI)			Employee's Business Name	
Employee's Address (Street, Office or P.O. Box)			Employee's Mailing Address (Street or P.O. Box)	
City	State	ZIP Code	City	State ZIP Code
Social Security Number			Federal Tax ID Number	
Date of Birth			Name and Phone # of Person Providing Injury Information	
Date of Injury				
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><input type="checkbox"/> As of today's date, the employee is not back at work. <b>OR</b></p> <p><input type="checkbox"/> The employee intended to work on _____ and is working</p> <p><input type="checkbox"/> without restriction. <b>OR</b></p> <p><input type="checkbox"/> with restrictions and is earning wages of \$_____ per week/month (circle one)</p> </div> <div style="width: 50%;"> <p><b>I HEREBY CERTIFY</b> that this wage statement is complete, accurate, complies with the Texas Workers' Compensation Act and applicable rules and the listed wages include all necessary and compensating wages paid or received up to the 12 weeks prior to the date of injury (as described on page 1) and I understand that making a false statement about a necessary compensation claim is a crime that can result in fines and/or imprisonment.</p> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> <p><b>NOTE</b> - Rule 120.12 requires the employer file the Supplemental Report (DWC Form F003a) to report changes in Work Status and Payroll Status.</p> </div> <div style="width: 50%;"> <p>Signature _____ Date _____</p> </div> </div>				

EMPLOYMENT STATUS AT TIME OF INJURY (Circle all that Apply)	
<input type="checkbox"/> <b>Full-time:</b> Employee who regularly works at least 40 hours per week and whose schedule is similar to other employees of the company under whose employment is the same business or enterprise.	<input type="checkbox"/> <b>Part-time Regular:</b> Course of Conduct: Employee who regularly works less than 40 hours per week, but whose schedule is similar to other employees of the company under whose employment is the same business or enterprise.
<input type="checkbox"/> <b>Seasonal:</b> Employee who is employed on a seasonal basis for a limited period of time.	<input type="checkbox"/> <b>Part-time Casual:</b> Course of Conduct: Employee who works less than 40 hours per week, but whose schedule is not similar to other employees of the company under whose employment is the same business or enterprise.
<input type="checkbox"/> <b>Contractor:</b> Employee who is employed on a contract basis for a limited period of time.	<input type="checkbox"/> <b>Student:</b> Employee employed in a course of study in high school, college or other educational institution.
<input type="checkbox"/> <b>Other:</b> Employee who is employed on a basis other than full-time, part-time regular, part-time casual, seasonal, contractor, or student.	

PERIOD # (Week #) 1  
 14 weeks (40 hrs) (20 lessons)

[illegible]



CLAIM # \_\_\_\_\_  
Carrier # \_\_\_\_\_

### SUPPLEMENTAL REPORT OF INJURY

#### Part I EMPLOYER INFORMATION

1. Employer business name	2. Employer phone #
3. Employer mailing address	
4. Insurance carrier name	
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes <input type="checkbox"/> no <input type="checkbox"/> If so, identify contact person and phone # _____	
6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes <input type="checkbox"/> no <input type="checkbox"/>	Date _____
7. Has the employer requested RTW training from DWC or the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/>	Date _____
8. Has the insurance carrier provided accident prevention services in the past 12 months? yes <input type="checkbox"/> no <input type="checkbox"/>	Date _____
9. Has the employer requested accident prevention services from the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/>	Date _____

#### Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. <input type="checkbox"/> a. The injured worker returned to work in either a full or limited capacity. File this report within 3 days.
<input type="checkbox"/> b. The injured worker is earning more or less than the pre-injury wage because of the injury. File within 10 days.
<input type="checkbox"/> c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury. File within 3 days.
<input type="checkbox"/> d. The injured worker resigned or was terminated from employment. File within 10 days.

#### Part III INJURED WORKER INFORMATION

11. Injured worker name	12. SSN (last 4 digits) xxx-xx-	13. DOB
14. Injured worker mailing address and phone #		
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)	16. First day of additional lost time or reduced wages (mm/dd/yyyy)	
17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes <input type="checkbox"/> no <input type="checkbox"/> If yes, the date of the 8th day (mm/dd/yyyy) _____		
18. Date of most recent RTW _____ <input type="checkbox"/> Full duty, full pay <input type="checkbox"/> Limited duty, full pay <input type="checkbox"/> Limited duty, reduced pay	19. Has the injured worker resigned, been terminated or died? yes <input type="checkbox"/> no <input type="checkbox"/> date of resignation _____ date of termination _____ date of death _____ 19a. Reason for resignation/termination _____ 19b. Was the injured worker on limited duty when terminated? yes <input type="checkbox"/> no <input type="checkbox"/>	
20. Hours the injured worker was working during the pay period of _____ to _____ : _____ hours per week		21. Weekly/hourly earnings for the pay period of _____ to _____ : \$ _____ weekly or \$ _____
Indicated hours are: <input type="checkbox"/> Increase from pre-injury <input type="checkbox"/> Same as pre-injury <input type="checkbox"/> Decrease from pre-injury		Indicated wages are: <input type="checkbox"/> Increase from pre-injury wage <input type="checkbox"/> Same as pre-injury wage <input type="checkbox"/> Decrease from pre-injury wage

*This form to be filed with:* The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.  
Submitted by: ☐ Employer ☐ Injured Worker (if no longer working for the employer where injury occurred.)

Signature and Title of person completing this form \_\_\_\_\_

Date \_\_\_\_\_



# INDEMNITY BENEFITS



Temporary Income Benefits (TIBs) paid at 70% to 75% of average weekly wage

Impairment Income Benefits (IIBs) 3 weeks paid per % of rating based on permanent impairment by the doctor-paid at 70%

Supplemental Income Benefits (SIBs) long term benefits to those >15% that are not able to earn 80% of pre-injury average weekly wage

Lifetime Income Benefits (LIBs) 7 circumstances, 3% increase annually

Death Benefits (DBs) beneficiaries and duration varies-paid at 75%



# MEDICAL BENEFITS- THE ALLIANCE



## Political Subdivision Workers' Compensation Alliance (PSWCA)

The Alliance was created as a result of legislative changes to chapter 504 of the Texas labor code which allowed direct contracting with medical providers. The Alliance was formed by 5 pools that support political subdivisions and units of local government including cities, schools, counties, community centers, and water districts. The sole focus is to make sure the best medical providers are available to treat member employees when they are injured at work.

Texas Association of School Boards - Utilization Review Agent - Preauthorization

Optum (formerly PMI) - Pharmacy Benefit Manager

# SPECIAL CLAIMS



- Volunteers- 7 types of covered volunteers
- Presumptions Claims- Firefighters / EMT's for heart attacks and cancer claims.
- Multiple Employment- payment of benefits can include wages from multiple employers - Subsequent Injury Fund allows for reimbursement upon request.



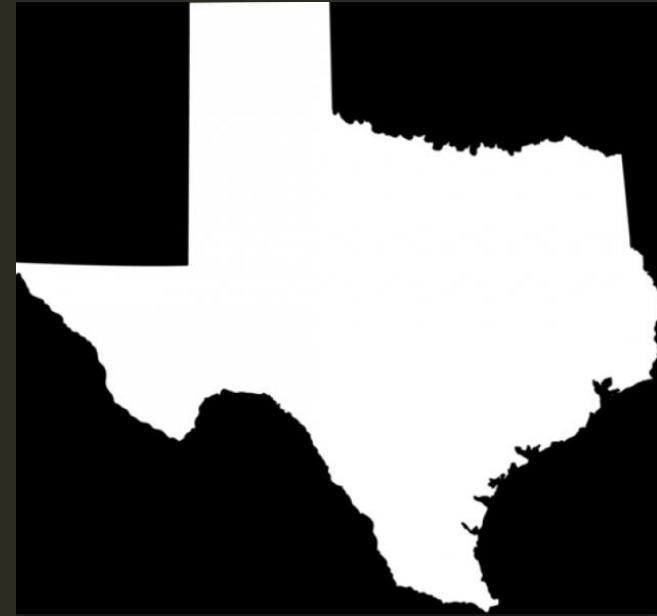
# PRESUMPTION CLAIMS

## Chapter 607 of the Government Code

- Only firefighters and EMTs including volunteers are covered
  - Heart Attacks - Cancers (certain cancers-IARC)
  - Strokes
  - Other respiratory illnesses
- Exclusions
  - Employed as a firefighter for less than 5 years
  - Tobacco user
  - Spouse is a smoker
  - Prior physical exam showing no disease

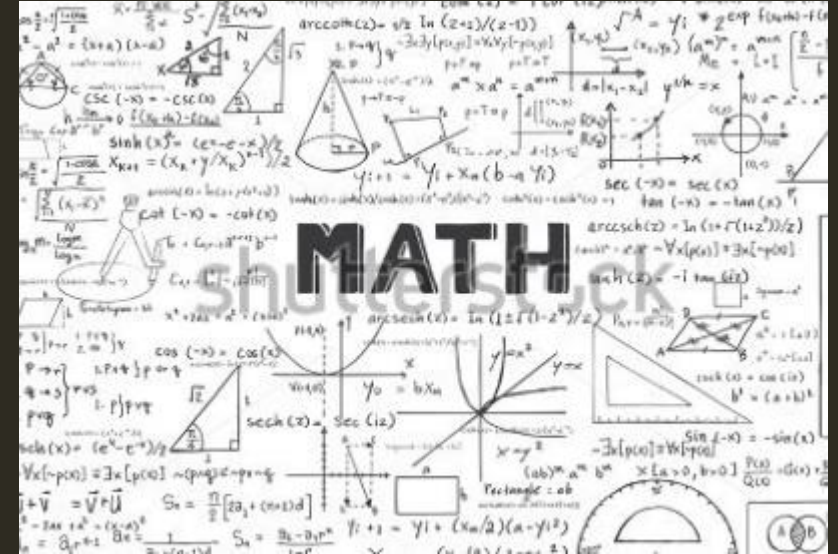


# MULTIPLE EMPLOYMENT



- Applies to all employees and not just volunteers
- Wages from injury and non injury employer are added together to come up with AWW
- Reimbursement sought from Texas SIF for benefits paid based upon non injury employer
- Subject to max rates applies (no min for DBs applies)
- Paid out of unallocated expenses thus does not affect member rates

# BENEFIT CALCULATION EXAMPLES



*Basic TIBs AWW of \$1000 @ 70% so TIB rate \$700 per week*

*With child support order of \$200 per week-max is 50% of weekly tibs so*

*AWW \$ 500 so TIBs rate is \$350 (Half or \$175 to claimant and \$175 to AGs office)*

*TIBs with Multiple Employment (vol so member AWW zero) Real Job is Dr so AWW is \$2500 per week*

*\$2500 @ 70% give comp rate of \$1750 (max weekly is \$913 currently) Min rate is \$137*

*\$137/wk paid from member claim and \$776 from ME*

*Death Benefits-AWW of \$1000 @75% so weekly rate is \$750. Half to widow and half split between qualifying children.*

# DISCUSSION/QUESTIONS

