STATE OF MONTANA

RETURN-TO-WORK PROGRAM MANUAL

Workers' Compensation Management Bureau
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Stay-at-Work/Return-to-Work Program Overview

Introduction

The Department of Administration's Workers' Compensation Management Bureau (WCMB) was established by statute (Montana Code Annotated Section 39-71-403(1)(b)(i)), in 2007 to address significant rising costs in workers' compensation insurance premiums for State of Montana agencies. The WCMB serves as the central resource for agencies in managing workers' compensation insurance, and works to enhance existing safety, loss-prevention, risk management and return-to-work activities. When State agencies encounter a significant number of on-the-job injuries or illnesses it leads to higher costs for State agencies, which ultimately affects the bottom line for the State of Montana and results in the need for increased tax revenue to pay workers' compensation insurance premiums.

The WCMB works closely with State agencies and the State's workers' compensation insurer (Montana State Fund) to help prevent injuries at work, assist in the management of workers' compensation insurance claims and the SAW/RTW process. Both work-related injuries (these happen at a specific point in time), and occupational diseases (these develop over time), can have long-term impacts on an agency's workers' compensation insurance premium costs and an injured employee's quality of life. Injuries, not addressed quickly, may lead to a long-term disability for an employee and being out of work can cause an employee to be impacted by a financial hardship. Preventing injuries is always the best practice for employees and State agencies.

The State of Montana's Return-to-Work Program Manual outlines the minimum requirements an agency should have in place to run an effective Return-to-Work Program. Participation in a Return-to-Work Program should be offered to every eligible injured employee. Once there is an indication by an injured employee's treating physician that an injured employee may return-to-work with restrictions in a light duty capacity, the Montana State Fund and the injured employee's agency safety/HR contact should work with the injured employee to identify temporary transitional duty work assignments that accommodate the injured employee's restrictions in the workplace and return the injured employee to work as soon as possible.

During recovery, it is extremely important that injured employees maintain contact with their supervisor and agency safety/HR contact. The injured employee's treating physician should provide a Medical Status Form (available from the treating physician, the WCMB website, or the Montana State Fund) to the injured employee indicating work restrictions (if any) after each medical visit. The employee needs to provide the Medical Status Form to their supervisor or agency safety/HR contact following each appointment. The employee's supervisor and agency safety/HR contact will work with the employee to determine transitional job duties approved by the injured employee's physician on the Medical Status Form until the injured employee is returned to full duty work without work restrictions.

An injured employee may revoke an election to participate in an agency's Return-to-Work Program. Under Montana law, an injured employee's election not to participate, or the revocation of a prior election to participate, may affect the injured employee's wage loss benefit. However, the injured employee's election should not be used to the injured employee's detriment regarding his or her other rights and benefits.

Employees should contact their agency safety/HR contact or the WCMB for assistance with return-to-work questions.

Why Have a Return-to-Work Program?

A Return-to-Work Program establishes communication among and between an injured employee, the health care provider treating the injured employee, and the state agency. A Return-to-Work Program is used to facilitate the injured employee's return to the workplace with approved job duties as quickly as medically possible following a work-related injury or onset of an occupational disease. A Return-to-Work Program is used to preserve the physical capabilities and the financial security of an injured employee and to provide a greater opportunity for full recovery.

A Return-to-Work Program provides temporary transitional duty assignments when an injured employee is unable to perform all essential functions of the position they were working at the time of injury. Transitional duty assignments are designed to accommodate the injured employee's capabilities as determined by the injured employee's health care provider. These assignments may be modified throughout the recovery period to address changes in capabilities as the injured employee heals. In some cases, restrictions may be permanent, and should be considered if the agency is able to accommodate the restrictions and the injured employee is able to complete meaningful job tasks safely.

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 employee 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 Manual: workerscomp.mt.gov/_docs/Sample_Safety_Program_Manual.pdf.

An agency should also comply with the State's Safety Program Manual provided by the WCMB. The State's Safety Program Manual incorporates all elements of the Montana Safety Culture Act and other applicable regulations.

Roles and Responsibilities

Employers

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.

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.

Report Occupational Injuries

Supervisors must ensure that all occupational injuries are reported to the State's workers' compensation insurer, Montana State Fund, using the First Report of Injury (FROI) (Attachment A). The FROI is available online at montanastatefund.com. Supervisors must notify their department's safety and/or human resource contact immediately or within 24 hours of notification of the injury. If medical care is necessary, the supervisor should encourage and assist the injured employee in obtaining any necessary medical care. **Supervisors and employees should be aware the Montana Health Centers cannot be used for work related injuries and illness.**

How to File a First Report of Injury (FROI)

1. Use the Montana State Fund's First Report of Injury (FROI) form. The form can be downloaded from the Montana State Fund's website at montanastatefund.com. Establish a password with the Montana State Fund and file the form online **or** print the 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 FROI or the report filing process, contact the WCMB at (800) 287-8266, TTY (406) 444-1421, or WCMB@mt.gov.

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

The MCA 39-71-119(a) defines an occupational injury as "internal or external physical harm to the body that is established by objective medical findings."

Investigate Workplace Accidents

Supervisors are responsible for conducting incident investigations and for ensuring that all injured employees report injuries immediately or at least within 24 hours of the incident.

Supervisors will work with the injured employee and the designated department safety contact to identify the hazardous conditions that lead to the injury. The supervisor will document all facts and opinions regarding the cause of the accident on the Accident/Incident Investigation Report (Attachment B). Supervisors must review the circumstances surrounding the injury, sign the Accident/Incident Investigation Report, and submit the report to the designated department safety contact within 48 hours of notification.

Medical Status Form

A Medical Status Form (Attachment C) is a document that serves as a tool for the injured employee's health care provider to indicate the appropriate level of functional ability for an injured employee. The functional ability of the injured employee typically progresses over time as the individual heals. The Medical Status Form, once completed by the injured employee's health care provider, serves as a roadmap for the agency in developing transitional duty.

Supervisors should provide a Medical Status Form to the injured employee to take to the initial visit to his/her health care provider. If not supplied by the supervisor, the injured employee's treating physician can also provide a Medical Status Form to the injured employee indicating work restrictions (if any) after the medical visit.

How to Use the Medical Status Form

1. Send the Medical Status Form, found at workerscomp.mt.gov/Return-To-Work-Program/Tools-and-Forms or Attachment C of this document, with the injured employee to the initial appointment with the injured employee's health care provider.
    a. The injured employee takes the Medical Status Form to the health care provider's office for completion.
    b. The injured employee returns the form to his/her supervisor or safety/HR contact.
    c. The supervisor and safety/HR contact must ensure the Medical Status Form is completed properly.
    d. The injured employee, supervisor, or safety/HR contact must provide the completed Medical Status Form to the Montana State Fund.

2. Make sure the injured employee understands his/her responsibility is to return the completed Medical Status Form to their supervisor or safety/HR contact immediately after the initial appointment with the injured employee's health care provider and all future appointments.
3. Monitor and evaluate the Medical Status Form over time for any authorized changes as the injured employee heals. Update transitional duty functions as the health care provider recommends.

Stay at Work/Return-to-Work (SAW/RTW)

When an employee is injured on the job, agencies must be committed to providing return-to-work opportunities as soon as the employee is medically able. Transitional duty is a requirement of the Return-to-Work Program. Transitional duty is defined as modified, temporary work assigned by an agency to an injured employee that allows the injured employee to return-to-work prior to the time when he or she is medically able to perform all required job functions. Transitional duty promotes quicker recovery, and a smoother transition to regular duty. The longer an employee is away from work, the less likely they will return to their time of injury position. Finding transitional duty for an injured employee is essential to the recovery of the employee and morale of the work force. Transitional duty is a temporary assignment with the understanding that the duties will increase as medical restrictions are adjusted in transition toward a full duty release. Transitional duty does not always mean time of injury job duties.

Each agency is responsible for providing transitional duties to bring back an injured employee when the individual is medically able. Agencies will create modified temporary assignments and adjust accordingly to medical restrictions. The WCMB strongly recommends that each agency creates a light duty job bank which outlines tasks that can be completed for individuals in transitional duty. The WCMB is available to assist in identifying transitional duties for injured employees and provide guidance in the area of SAW/RTW.

Employees

Employees must report all work-related injuries/occupational diseases to their supervisors immediately or at least within 24 hours of an incident. If medical care is necessary, the employee will submit a completed and signed Medical Status Form from their health care provider to the supervisor and safety/HR contact after each medical appointment. Employees must provide a signed Medical Status Form indicating there are no restrictions before returning to their time of injury position.

It is important that employees:

1. Participate in new employee orientation at time of hire
2. Participate in on-the-job task specific safety training
3. Follow all agency policies regarding safety, workers' compensation, and SAW/RTW
4. Report incidents and accidents to a supervisor immediately or at least within 24 hours
5. If a workers' comp claim is filed, employee must work closely with Montana State Fund claims examiners
6. Work closely with treating physician to ensure that Medical Status Forms are completed accurately and timely
7. Submit a completed Medical Status Form to supervisor and safety/HR contact for SAW/RTW evaluation after each medical appointment
8. Support co-workers participating in SAW/RTW transitional duties

Montana State Fund

Montana State Fund is responsible for coordinating workers' compensation claim services and promoting return-to-work in order to improve outcomes and reduce disability costs. They assist the injured worker through the healing process and serve as a liaison with the treating physician and will maintain constant communication throughout the process.

Claims Examiner (CE)

Claims examiners are responsible for investigation and customer service on workers' compensation claims. The claims examiner maintains communication with the injured employee, the injured employee's health care providers, the injured employee's State agency, and the WCMB. The claims examiner must follow Montana Worker's Compensation statutes and applicable case law when determining compensability of an injured employee's claim. The compensability determination (whether a claim is accepted) is then relayed to parties involved. If the claim is compensable, the examiner is responsible for paying appropriate medical and indemnity (wage loss) benefits to the injured employee. The claims examiner is also responsible for timely medical treatment authorization reviews. The claims examiner sets claim reserves for expected treatment and benefits for the duration of the claim. The goal is to assist injured employees through recovery process and ensure proper and appropriate medical care is provided.

Safety Management Consultant (SMC)

The Safety Management Consultant role with state agencies intends to provide high value as a partner and consultant and focuses on both loss prevention in reducing the likelihood of an incident from occurring and reduction on the impact an incident may have. Primary emphasis is on mitigating agencies' exposures to major loss sources with the ultimate goal of preventing injuries, diseases, and fatalities for state employees. This, in turn, translates into better control of workers' compensation insurance costs. Accomplishing this involves a wide range of safety and risk management techniques, building relationships with members of agency leadership, and providing recommendations based on claim trends or recognized areas of improvement to shore up potential safety program shortfalls.

SMCs aspire to offer a high-level consultative product to inspire and enable each agency to have a high degree of ownership of their safety and risk management efforts and to foster a culture of safety. SMCs across the state serve as a professional consultant available to agency contacts, perform safety visit requests, help strengthen overall safety culture and deliver training surrounding safety or risk management topics. The more common requests include consultative input on a variety of safety and risk management topics such as SAW/RTW, walkarounds of facilities, job observations, providing professional expertise on safety committees, conducting ergonomic assessments, performing misc. training, and developing internal programs.

Underwriter (UW)

Underwriters are responsible for ensuring the premium charged to agencies is appropriate to cover their expected losses. Underwriters are responsible for providing agency policy renewals by analyzing loss data, reviewing past and future safety efforts, analyzing audit results, and reviewing business operations/expansions to determine the appropriate premium for the future policy year. Underwriters also engage with the agency's claims examiners, safety management consultant (SMC), and customer service specialist (CSS) to keep apprised of any noteworthy activity on the policy and assist in providing information, analysis, and relationship building wherever is needed.

Confidentiality

Federal HIPAA privacy rules do not apply to workers' compensation insurers, workers' compensation administrative agencies, or the employing state agency (unless they are a health care provider or health plan). Health care providers can disclose health information to workers' compensation insurers, as long as the injured worker has signed and submitted a FROI to the insurer. Providers may disclose information related to the worker's condition while the worker is claiming benefits. Montana Code Annotated § 50-16-527.

Montana's constitutional right to privacy further protects medical information for which an individual had a subjective or actual expectation of privacy and prohibits disclosure of that information without the prior written authorization of the individual. Therefore, health care providers cannot disclose confidential health information to employers, vocational rehabilitation contractors, or other non-insurer entities without the individual's prior written authorization to release that information.

Confidentiality is a legal requirement to protect the privacy of an individual's medical information. Do not discuss or divulge any individual's health information without the prior written authorization of that individual to disclose that information. All entities involved in the workers' comp process reserve the privacy for all employee medical records and ensure that this confidential health information is not released to anyone who was not authorized by the individual to have that information.

All medical information discussed is confidential and limited to the minimum necessary for the determination of SAW/RTW assignments for the injured employee. In general, the medical information used by the employer will be information from the employer's copy of the Medical Status Form on the injured employee's physical capabilities.

Training

Supervisors are responsible for a great deal of what goes on day to day in the workplace. Supervisors must ensure a safe and healthy workplace for employees and employees must be able to report unsafe workplace conditions or hazards to a supervisor without fear of retaliation. Supervisors must conduct orientation and training of employees so they can perform their work safely. Know what personal protective equipment (PPE) is needed for each task and how this equipment must be properly used, stored, and maintained. When there are mandated safety training courses, ensure that employees attend training, and that attendance/participation is appropriately documented. Every agency must train new and existing employees on the Return-to-Work Program and transitional duty.

Supervisors must ensure injured employees are supplied with the Medical Status Form prior to initial and all future medical appointments. The supervisor must notify the safety/HR contact and provide them with a copy of the Medical Status Form prior to the employee returning to work. Please consider these forms may contain private protected information and use extreme caution when sharing an employee's medical status.

Employees must be encouraged to return-to-work as soon as medically possible. The longer an employee is away from work, the less likely they will return to their time of injury position. Light or limited duties should be identified and considered to assist in returning the employee to work. The WCMB is available to assist in identifying transitional duties for injured employees and provide guidance in the area of SAW/RTW. Supervisors should make every effort to return injured employees to work as soon as medically possible. The WCMB highly encourages supervisors to create a job bank of transitional duties that can be performed by individuals who are under restrictions.

Maintain Contact with the Injured Employee

The supervisor should communicate with the injured employee throughout the duration of the claim. Communication should be documented in order to track the progress of the injured employee. The initial contact should be as soon as possible after a work-related injury or occupational disease occurs, and should be via email, TEAM messenger, text message, or phone call to the injured employee. The purpose of making contact, is to acknowledge and express concern about the work-related injury or occupational disease.

The supervisor should also provide information about the agency's Return-to-Work Program and what to expect. Educate the injured employee regarding maintaining contact with their claims examiner to discuss what benefits will be received, which forms need to be completed, and what the injured employee may expect from the claim's examiner during the claim process.

Supervisors should maintain weekly contact, even when the injured employee has returned to transitional duty. Keep in mind the injured employee is likely to be under significant stress and will need support and reassurance. If an injured employee experienced a work-related injury or occupational disease serious enough to be unable to perform any form of transitional duty, maintaining contact is crucial.

Document all contact with the injured worker on a Contact Log (Attachment D) or use any other form of documentation that meets the needs of the agency.

Develop the Transitional Duty Tracking Form

The Transitional Duty Tracking Form (Attachment E) is a document that provides a map for transitional duty from start to finish. The Transitional Duty Tracking Form also serves as documentation for the protection of all participants in the SAW/RTW process. The Transitional Duty Tracking Form includes the abilities and/or restrictions for the injured employee regarding transitional duty; start and review dates; and places for feedback from the injured employee and the supervisor. The intent is to ensure all parties are in agreement and the injured employee is able to work safely within their restrictions to prevent further injury. This Return-to-Work Program Manual includes an example (Attachment E) of a Transitional Duty Tracking Form or use any form of documentation that meets the needs of the agency.

Workers' Compensation Management Bureau

The Department of Administration, Workers' Compensation Management Bureau (WCMB), has a statutory responsibility to manage workers' compensation insurance coverage for all state agencies. Under statute, the State of Montana is required to purchase workers' compensation coverage from the Montana State Fund under one or more policies – Montana State Fund currently issues individual policies to each state agency. WCMB works closely with Montana State Fund to ensure service expectations are met for the State of Montana and all state agencies, this includes oversight of the activities of Montana State Fund safety management consultants, claims examiners, and underwriters.

In addition to the oversight of the State's workers' compensation insurance coverage, the WCMB establishes guidance and provides support to all state agency workers' compensation and safety programs; and promotes effective program management utilizing workers' compensation program goals, objectives, strategies, and performance measures.

The WCMB's goal is to improve employee safety and health in collaboration with State agencies through: ensuring compliance with all federal, state, and local regulation; maintaining open communication with agency representatives; developing training and education programs; providing workers compensation and safety program guidance and support; conducting policy review meetings;

organizing and leading quarterly State Safety Group Meetings; distributing quarterly performance metric reports; and supporting agencies and Montana State Fund.

Reasons you may interact with Workers' Compensation Management Bureau:

- When return-to-work or temporary duty question arise due to a workplace injury or illness
- OSHA 300 log questions or for assistance
- Workers' compensation premium related questions
- Dividend or retention plan questions
- WCMB schedules the annual renewal meetings that occur in June with each State agency

The WCMB is here to help you navigate through the SAW/RTW process.
Please contact us for assistance.

(800) 287-8266
TTY (406) 444-1421
WCMB@mt.gov
workerscomp.mt.gov

ATTACHEMENT A
FIRST REPORT OF INJURY FORM

Voice: 800-332-6102 • Email: stfclaim@mt.gov • Fax: 406-495-5020
PO Box 4759 Helena, MT 59604-4759
You can also file your claim online by visiting montanastatefund.com

Injured Employee

Last Name*	First Name*	M.I.	Gender*	Date of Birth*	Social Security Number*
			○ Male ○ Female ○ Unknown		

Mailing Address*				Injured Employee's Email Address	Phone Number*
Address	City	State	Postal Code		

Physical Address				Education Level
Address	City	State	Postal Code	○ Less Than High School ○ GED or High School Diploma ○ Beyond High School

Wages

Date Hired*	Date Last Worked*	Employment Status*	Worked Next Scheduled Shift	Off Work More Than 4 Work Days	Full Wages Paid for Date of Injury	Salary Continued
		○ Full Time ○ Part Time ○ Seasonal ○ Volunteer ○ Other ○ Piece Worker	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Pay Frequency	Wage Rate	Is Sick Leave Available	Was Sick Leave Used	Returned to Work Date
○ Hour ○ Day ○ Week ○ Month ○ Bi-Weekly		○ Yes ○ No	○ Yes ○ No	

Accident Description

Date of Injury*	Time of Injury	Description of Accident*

Cause of Injury	Part of Body*	Job Title*	Date Disability Began*	Date of Death

Name of Witnesses	Accident Reported To*	Accident on Employer's Premises
1. 2.		○ Yes ○ No

Loss Location*				Date Employer Notified*	Safety Equipment Provided	Safety Equipment Used
Address	City	State	Postal Code		○ Yes ○ No	○ Yes ○ No

Injured Employee Signature

"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease, or death of the above named worker. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer (and its agents) and to the Montana Uninsured Employers' Fund of: Social Security records; rehabilitation records; and all health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA), that are directly relevant to the claimed injury, disease, or death. I also understand that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft."

Signature of injured Employee, Beneficiary or Guardian _____ **Date** _____

Medical

Attending Physician and/or Hospital		Medical Provider Address			
Physician:	Hospital:	Address	City	State	Postal Code

Medical Provider Phone Number	Type of Medical Treatment Received*				
	○ No Treatment	○ Treatment Will Be Sought	○ Emergency Room/Hospital	○ Treatment On-Site by Employer or Medical Staff	○ Clinic/Urgent Care

Employer

Employer Name*	Doing Business As*	Federal Employer Identification Number (Tax ID)

Mailing Address*				Phone Number*	Location of Operation, If Different From Mailing Address
Address	City	State	Postal Code		

Do you have any reason to question this accident?* If yes, we will contact you for more information.	Prepared By*	Official Title*	Phone Number*	Date
○ Yes ○ No				

Policy Number*	Contact Person*	Contact Person's Phone Number*	Contact Person's Email

Payroll classification code under which you report employee's wages	**Authorized Employer's Signature**	**Date**

* Indicates required field

ATTACHMENT B

INCIDENT INVESTIGATION FORM

Objective: This form assists state agencies to recognize and correct workplace and/or job site hazards and prevent future incidents.

Section A: Information			
State Agency Name:		**Date:**	
Investigator (or) Team Name(s) and Titles: 			
Name	**Title**		
Report Type: ☐Injury	☐Illness	☐Occupational Disease	☐Near Miss
Date & Time of Incident Investigation:			

Section B: Incident Description/ Injury Information
1. Name of Injured Employee:
2. Age of Injured Employee:
3. Employee's Time of Injury Job Title:
a. Type of Employment: ☐*Full-Time* ☐*Part-Time* ☐*Temporary* ☐*Seasonal* ☐*Other* *If other, please explain:*
b. Length of time with agency:
c. Length of time in current position:
4. Date & Time of Incident:
5. Accident Location:
6. Date Incident Reported:
7. Supervisor's Name:
a. Supervisor's Job Title:
8. Injury Type (e.g. sprain/strain, cut/laceration/puncture, etc.):
9. Part(s) of Body Affected:
10. Equipment used related to the incident? ☐ YES ☐ NO *If yes, please explain:*
CLAIM #:

INCIDENT INVESTIGATION FORM

Section C: Identifying Root Causes

*Accident Description: Please provide a **detailed** description of the accident, including relevant events leading up to, during, and after the incident. Relevant information can include but is not limited to: environmental conditions at the time of the incident, what was happening when the incident occurred, how the incident occurred, where the incident took place, who was all involved, etc. (It is preferred that this information is provided by the injured employee).*

INCIDENT INVESTIGATION FORM

Witness Description: Include description of the incident from eye witnesses or additional employees with knowledge of the event, including specific details leading up to, during, and after the incident. Include name(s) of person(s) interviewed, job titles, and time/date of interviews.

Witness Name:
Time/Date:
Witness Job Title:

Description:

Witness Name:
Time/Date:
Witness Job Title:

Description:

Witness Name:
Time/Date:
Witness Job Title:

Description:

Use additional pages, if needed

INCIDENT INVESTIGATION FORM

Section D: Root Cause Analysis							
Preliminary Root Cause Analysis for Consideration (check all that apply)							
Contributing Actions				**Contributing Actions**			
Use of safety devices	☐	Lost balance	☐	Exposure	☐	Condition of surface	☐
Use of PPE	☐	Housekeeping	☐	Noise	☐	Ergonomic	☐
Equipment condition	☐	Use of tools	☐	Chemicals	☐	Warning device	☐
Appropriate equipment	☐	Guards	☐	Fire hazard	☐	Tools/equipment	☐
Procedural issues	☐	Clothing	☐	Radiation	☐	Tools/equipment not available	☐
Speed of operation	☐	Authorization	☐	Sharp object	☐	Lighting/Temp/Ventilation	☐
Lifting technique	☐	Awareness	☐	Inclement weather	☐	Work area	☐
Operator skill	☐	Material Handling	☐	Training	☐	Other	☐

Root Cause Narrative: Based on your analysis, please describe what caused this Incident. The Root Causes are the underlying reasons the incident occurred and are the factors that need to be addressed to prevent future incidents. If safety procedures were not being followed, why were they not being followed? If a machine was faulty or a safety device failed, why did it fail? Continue to ask 'why' for at least 5 levels, until you get to the root cause or causes:
1)
2)
3)
4)
5)
Narrative:

INCIDENT INVESTIGATION FORM

Section E: Corrective Action(s)							
Possible Corrective Action(s) for Consideration (check those items that help prevent recurrence)							
Isolate & guard hazard	☐	Procedure change	☐	Respirator	☐	Face shield	☐
Automate process	☐	Safety training	☐	Safety glasses	☐	Cut/Puncture items	☐
Design out/remove hazard	☐	Ventilation	☐	Safety shoes	☐	Lab coat	☐
Add warning signs	☐	Improve Housekeeping	☐	Hearing Protection	☐	Other Click or tap here to enter text.	☐
New tools or equipment	☐	Gloves	☐	Hard hat	☐		

Recommended Corrective Actions to Prevent Future Occurrence:
Corrective Actions Taken/Root Causes Addressed:
Person responsible for ensuring these corrective actions are completed: Name: Title:
Corrective actions to be completed by (date):

Section F: Safety Committee Review	
1. Were the corrective actions adequate to prevent recurrence? **Comments:**	☐YES ☐NO ☐N/A
2. Will the corrective actions result in any new hazards? **Comments:**	☐YES ☐NO ☐N/A

X _____

Completed by

Date:

Attachment C
Medical Status Form

Employer Contact Information (Optional)

Employee Info

Employee's Name (Last, First) _____ Date of Birth (mm/dd/yyyy) _____ Provider Timestamp _____

Claim Number _____ Date of Injury (mm/dd/yyyy) _____ Provider Contact Information _____

Released for Work?

- ☐ Employee Released to Full Duty — Date _____ To _____
- ☐ Employee Released to Modified Duty (See Work Abilities) — Date _____ To _____
- ☐ Employee May Work Limited Hours: Hours Per Day — Date _____ To _____
- ☐ Employee May Work Part-time: — Date _____ To _____
- ☐ Employee Not Released to Work — Date _____ To _____
- ☐ Capacity Duration (Estimate Days): ☐ 1-10 ☐ 11-20 ☐ 21-30 ☐ 30+ ☐ Permanent

Modified Work Abilities

Blank Space = Not Restricted (NR)	Continuous	Frequent	Occasional	Never
Hand/Wrist L ☐ R ☐ B ☐	☐	☐	☐	☐
Grasping L ☐ R ☐ B ☐	☐	☐	☐	☐
Pushing/Pulling L ☐ R ☐ B ☐	☐	☐	☐	☐
Fine Manipulation L ☐ R ☐ B ☐	☐	☐	☐	☐
Reaching L ☐ R ☐ B ☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Lifting 01-10 lbs.	☐	☐	☐	☐
Lifting 11-20 lbs.	☐	☐	☐	☐
Lifting 21-25 lbs.	☐	☐	☐	☐
Lifting 26-50 lbs.	☐	☐	☐	☐
Lifting 51-70 lbs.	☐	☐	☐	☐

Number of Hours Employee May: Sit Stand Walk

List Other Restrictions:

Signatures

Employee Signature	Date
Provider Signature	Date

☐ Copy of Medical Status Form to Employee

Date of Next Visit

Treatment Plan

Employee Progress:	☐ As Expected/Better Than ☐ Expected Slower Than Expected
Current Rehab:	☐ PT OT Home Exercise ☐ Other:
Surgery:	☐ Not Indicated ☐ Possible ☐ Planned
Comments:	

☐ Treatment Concluded by Provider:

☐ Max. Medical Improvement (MMI):

Care Transferred To:

Consultation Needed With:

Study Pending:

Medications:

Opioids Prescribed for: ☐ Acute Pain ☐ Chronic Pain

Diagnosis:

MEDICAL STATUS FORM

Employer Contact Information (Optional)

Employee Info

Employee's Name (Last, First) _____ Date of Birth (mm/dd/yyyy) _____ Provider Timestamp _____

Claim Number _____ Date of Injury (mm/dd/yyyy) _____ Provider Contact Information

Released for Work?

☐	Employee Released to Full Duty	Date		To	
☐	Employee Released to Modified Duty (See Work Abilities)	Date		To	
☐	Employee May Work Limited Hours: Hours Per Day	Date		To	
☐	Employee May Work Part-time:	Date		To	
☐	Employee Not Released to Work	Date		To	
☐	Capacity Duration (Estimate Days): ☐ 1-10 ☐ 11-20 ☐ 21-30 ☐ 30+ ☐ Permanent				

Modified Work Abilities

Blank Space = Not Restricted (NR)	Continuous	Frequent	Occasional	Never
Hand/Wrist L ☐ R ☐ B ☐	☐	☐	☐	☐
Grasping L ☐ R ☐ B ☐	☐	☐	☐	☐
Pushing/Pulling L ☐ R ☐ B ☐	☐	☐	☐	☐
Fine Manipulation L ☐ R ☐ B ☐	☐	☐	☐	☐
Reaching L ☐ R ☐ B ☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Lifting 01-10 lbs.	☐	☐	☐	☐
Lifting 11-20 lbs.	☐	☐	☐	☐
Lifting 21-25 lbs.	☐	☐	☐	☐
Lifting 26-50 lbs.	☐	☐	☐	☐
Lifting 51-70 lbs.	☐	☐	☐	☐

Number of Hours Employee May: Sit Stand Walk

List Other Restrictions:

Signatures

Employee Signature	Date
Provider Signature	Date

☐ Copy of Medical Status Form to Employee

Date of Next Visit

Treatment Plan

Employee Progress:	☐ As Expected/Better Than ☐ Expected ☐ Slower Than Expected
Current Rehab:	☐ PT ☐ OT ☐ Home Exercise ☐ Other:
Surgery:	☐ Not Indicated ☐ Possible ☐ Planned
Comments:	

☐ Treatment Concluded by provider:

☐ Max. Medical Improvement (MMI): Care Transferred To:

Consultation Needed With:

Study Pending:

Medications:

Opioids Prescribed for: ☐ Acute Pain ☐ Chronic Pain

Diagnosis:

MEDICAL STATUS FORM

Employer Contact Information (Optional)

Employee Info

Employee's Name (Last, First) _____ Date of Birth (mm/dd/yyyy) _____ Provider Timestamp _____

Claim Number _____ Date of Injury (mm/dd/yyyy) _____ Provider Contact Information

Released for Work?

- ☐ Employee Released to Full Duty — Date _____ To _____
- ☐ Employee Released to Modified Duty (See Work Abilities) — Date _____ To _____
- ☐ Employee May Work Limited Hours: Hours Per Day — Date _____ To _____
- ☐ Employee May Work Part-time: — Date _____ To _____
- ☐ Employee Not Released to Work — Date _____ To _____
- ☐ Capacity Duration (Estimate Days): ☐ 1-10 ☐ 11-20 ☐ 21-30 ☐ 30+ ☐ Permanent

Modified Work Abilities

Blank Space = Not Restricted (NR)	Continuous	Frequent	Occasional	Never
Hand/Wrist L ☐ R ☐ B ☐	☐	☐	☐	☐
Grasping L ☐ R ☐ B ☐	☐	☐	☐	☐
Pushing/Pulling L ☐ R ☐ B ☐	☐	☐	☐	☐
Fine Manipulation L ☐ R ☐ B ☐	☐	☐	☐	☐
Reaching L ☐ R ☐ B ☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Lifting 01-10 lbs.	☐	☐	☐	☐
Lifting 11-20 lbs.	☐	☐	☐	☐
Lifting 21-25 lbs.	☐	☐	☐	☐
Lifting 26-50 lbs.	☐	☐	☐	☐
Lifting 51-70 lbs.	☐	☐	☐	☐

Number of Hours Employee May: Sit Stand Walk

List Other Restrictions:

Signatures

Employee Signature	Date
Provider Signature	Date

☐ Copy of Medical Status Form to Employee

Date of Next Visit

Revised 12/2013

Employer Copy

Montana Department of LABOR & INDUSTRY
Employment Relations Division

Medical Status Form Instructions

The purpose of the Medical Status Form is 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.

The Medical Status Form is a statutory requirement. MCA 39-71-1036 says, "The department shall create a medical status form to be provided to a health care provider providing treatment for a compensable injury or occupational disease." An insurer may request additional information not contained in the form from the health care provider. The treating physician (or a designee) is now required to complete the form following every office visit with the worker.

This three-part form is designed to transmit the correct and essential information to the appropriate parties, easily and accurately.

Employer Contact Information: Enter the name, address, phone number and facsimile number of the Employer. (Optional)

Employee Info: Enter Patient/Employee Name, Date of Birth, Claim Number and Date of Injury.

Provider Time Stamp: Health Care Provider may enter timestamp if necessary.

Provider Contact Information: Enter the name, address, phone number and facsimile number for the Provider.

Released for Work? The Medical Status Form will allow for more than one option to be selected. Check all the applicable boxes and enter the effective date, which in most cases is the date of current office visit. The "To" box is in most cases is the follow-up visit date and can be considered the "Anticipated MMI date" by the payer. See below for steps for each option.

Patient/Employee Released to Full Duty: If selected, enter the effective date, and skip to Signature and Treatment Plan.

Patient/Employee Released to Modified Duty: If selected, enter the effective date, answer the Capacity Duration (estimate days) and continue to the next section (Modified Work Abilities).

Patient/Employee Released to Limited Hours: If selected, enter the number of hours per day, enter the effective date, answer the Capacity Duration (estimate days) and skip to the questions at the bottom of the next section (Modified Work Abilities).

Patient/Employee Released to Work Part-time: If selected, enter days of the week, enter the effective date, answer the Capacity Duration (estimate days) and skip to the questions at the bottom of the next section (Modified Work Abilities).

Patient/Employee Not Released to Work: If selected, enter the effective date, answer the Capacity Duration (estimate days) and "To" date. Skip to Signature and Treatment Plan.

Capacity Duration (estimate days) is the provider's estimation of how long the current work restrictions will last. Are the work restrictions permanent? The capacity duration can also be used to estimate "Anticipated MMI Date" by the payer.

Modified Work Abilities: This section must be completed if Patient/Employee Released to Modified Duty was checked in the previous section. All categories should be completed if there are restrictions. If there is no restriction; BLANK SPACE means this area is normal and not restricted.

Work Abilities (Continuous/ Frequent/ Occasional/ Never): Check the appropriate box for each activity. If there is limitation to use just one side or hand check the appropriate "L" for left, "R" for right or "B" for bilateral box.

Number of Hours (Sit/Stand/Walk): Enter the maximum number of hours for each activity the patient/employee is limited to per day if these hours of limitations exceed normal break and lunch periods and are not accommodated by normal breaks and lunch periods in an 8-hour day.

List Other Restrictions: 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? --*A response is required.* Enter in free text area of **List Other Restrictions. Will the patient/employee be required to use any devices or braces? --*A response is required.*** Enter in free text area of **List Other Restrictions. Additional comments specific to patient/employee's work abilities --*A response is required.*** Use the **List Other Restrictions** area to indicate any unaddressed limitations, such as driving restrictions.

Signatures: *The signature of the patient/employee is for the sole purpose of acknowledging receipt of the information on the form.*
Provider Signature to complete and date as indicated. Check box if copy of form is given to employee. Date of Next (scheduled) Visit.

The information above is automatically transferred to the Page Two (yellow copy of triplicate form) and Page Three (pink copy triplicate form) of the form. Page Three (pink copy) is for employer ONLY. The bottom section on Page One (white copy) and Page Two (yellow copy) contains confidential information for the medical provider, insurer, and patient/employee only and is NOT given to the employer without the patient/ employee's authorization.

Employee Progress: When slower than expected is checked this communicates to payer that more intervention or assistance may need to be undertaken to improve employee's progress.

Current Rehab: select appropriate category if applies.

Surgery: select one.

Comments: free text area to communicate further information regarding treatment plan or special circumstances or need for aggressive interventions to the payer; or Stay At Work/Return to Work.

Treatment concluded by this provider: select if this provider has no further treatments or interventions to offer the Employee. Enter effective date.

Max Medical Improvement (MMI): select if the Employee has reached MMI. Enter effective date.

Care Transferred to: complete if transferred indicating name of provider and specialty.

Consultation needed with: complete if necessary and indicate specialty and/or name of provider.

Study Pending: complete if there are diagnostic studies ordered and awaiting results.

Medications: complete for all medications whether OTC or prescribed for the work injury.

Opioids Prescribed for: indicate if Employee is receiving opioids and whether they are for acute (less than 30 days) pain or for chronic (greater than 30 days) pain.

Diagnosis: Enter the work injury/work disease diagnosed condition(s).

ATTACHMENT D
INJURED EMPLOYEE CONTACT LOG

Injured Employee:

Employee Contact Information:

Date of Injury:

Claim Examiner:

Date	Contacted By	Next Contact Date	Notes

ATTACHMENT E
TRANSITIONAL DUTY TRACKING FORM

Employee Name (print):	Employee's Job Title:
Supervisor Name (print):	HR Generalist Name (print):

☐ Medical provider completed medical status form

☐ Current restrictions have been reviewed

Duties Employee is Unable to Perform:	**Transitional Duties or Modifications to Job or Schedule:**

I understand that I am engaging in the "Early Return to Work Transitional Duty Program" to request ***a.)*** *transitional duties and/or* ***b.)*** *modifications to my job duties or work schedule for the* ***temporary*** *physical restrictions identified by my medical provider. I agree to abide by all restrictions as outlined by my medical provider and to inform my supervisor immediately of any changes to my restrictions. I agree to provide medical status updates to my supervisor. I also agree to inform my Human Resource Generalist immediately upon learning that my restrictions are permanent or that I require a leave of absence related to my condition/restrictions. I* ***understand that transitional duties, job duty modifications, and schedule modifications are temporary*** *and will only be available to me if the duties I perform are meaningful and productive for both myself and the department.*

Employee Signature:	Date:

To be completed by the Supervisor and HR Generalist

I understand the above-mentioned employee has medical restrictions and is limited in performing one or more of the essential functions of the position. I understand it is my responsibility to provide oversight to ensure this employee does not operate outside of the scope of said restrictions. It is also my responsibility to communicate medical status changes and any related absences to my HR Generalist.

Supervisor Signature:	Date:
HR Generalist Signature:	Date:

Next Health Care Provider Appointment: