

THE INTERACTIVE PROCESS PROTOCOL AND FILE MANAGEMENT



**CHIEF EXECUTIVE OFFICE
RISK MANAGEMENT
RETURN TO WORK UNIT**

WHAT IS INTERACTIVE PROCESS?

- Interactive Process Meeting (IPM) is a dialogue between an employer and employee with a known disability to determine whether there is a reasonable accommodation that would enable the employee to perform the essential functions of the job.

TRIGGERS

- **Most common triggers:**
- ✿ Verbal – Employer approached by employee
- ✿ Non verbal – Employer observes change in performance
- ✿ Medical certification from employee's treating health care professional
- ✿ Work restriction letter from Third Party Administrator (TPA)

GOOD FAITH

Includes a cooperative effort in a neutral environment

- ❖ Good faith implies ongoing communication with employee in various forms.
- ❖ Multiple IPMs may be necessary and often are required in providing an effective reasonable accommodation.
- ❖ Being respectful, courteous and objective when communicating with employees is crucial in establishing and maintaining ongoing good faith interaction through the process.



WHO CAN ATTEND AN IPM

- Return-to-Work (RTW) Coordinator.
- Line Supervisor of Usual and Customary (U&C) position and/or light duty assignment.
- Subject matter expert, as necessary.
- Employee representative, if necessary.

PREPARATION OF IPM

Whenever possible, to ensure a productive meeting the RTW Coordinator should:

- Obtain all current medical certification(s);
- Verify employee's current work status;
- Review disability and/or workers' compensation files;
- Identify potential temporary tasks that adhere to the employee's known restrictions;
- If the restrictions are the result of a workers' compensation claim, contact the TPA to obtain current claim status;

WHAT SHOULD OCCUR:

-  IPM's can be done in person or telephonically.
-  Prepare/gather the IPM document and any other documents, as appropriate.
-  Discuss and review Essential Job Functions (EJF) of U&C.
-  Review medical certification.
-  Cooperative discussions to achieve an appropriate resolution to the employee's status.

WHAT SHOULD OCCUR:

-  All IPMs should be documented as such on the IPM document, and the employee should receive a follow up letter reflecting all that was discussed and a “Plan of Action” including a specific follow up date, when appropriate.
-  All IPM documents must include signatures of all who were present at the meeting. If telephonic, note it on the signature line.
-  Follow up with employee and supervisor to ensure there are no problems and document all interactions;

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)



AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

County of Los Angeles Department of (_____)
Department Name

EMPLOYEE/APPLICANT:

Name/Previous Names _____ Birth Date _____ Employee Number _____

Street Address _____ City, State, Zip _____

AUTHORIZES:

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other _____ Name of Agency (Department) _____

Street Address _____ Street Address _____

City, State, Zip Code _____ City, State, Zip Code _____

INFORMATION TO BE RELEASED:

Applicant/Employee's condition and the major life activity that is limited. The duration of the limitation(s) and the physician's/qualified professional's opinion as to what type(s) of accommodation may be appropriate.

PURPOSE OF DISCLOSURE:

_____ Applicant/Employee's Request
_____ Other (Specify below)

This office works cooperatively with the applicant/employee to determine effective employment reasonable accommodations pursuant to the Americans with Disabilities Act (ADA) and the Fair Employment and Housing Act (FEHA). In order to successfully accommodate applicant's/employee's requested accommodation, it is necessary to obtain appropriate verification of disability to ensure the disability rises to the protected level and to determine the availability of reasonable accommodation.

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date _____ / _____ / _____
Month Day Year

"To Enrich Lives Through Effective and Caring Service"

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)



AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to receive a Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Revoke This Authorization – I understand that I have a right to revoke this Authorization at any time by telling (Department Name) in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

Contact Person

Department Name

Street Address

City, State, Zip

I also understand that revocation will not affect the ability of any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

Conditions: None. This authorization does not have anything to do with my ability to obtain treatment. In the event that I refuse to sign this authorization, (department name) will be unable to process my request for reasonable accommodation.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Applicant/Employee

Date

If signed by other than the client, state relationship and authority to do so: _____

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

REVOCATION OF AUTHORIZATION

SIGNATURE OF
APPLICANT/EMPLOYEE: _____

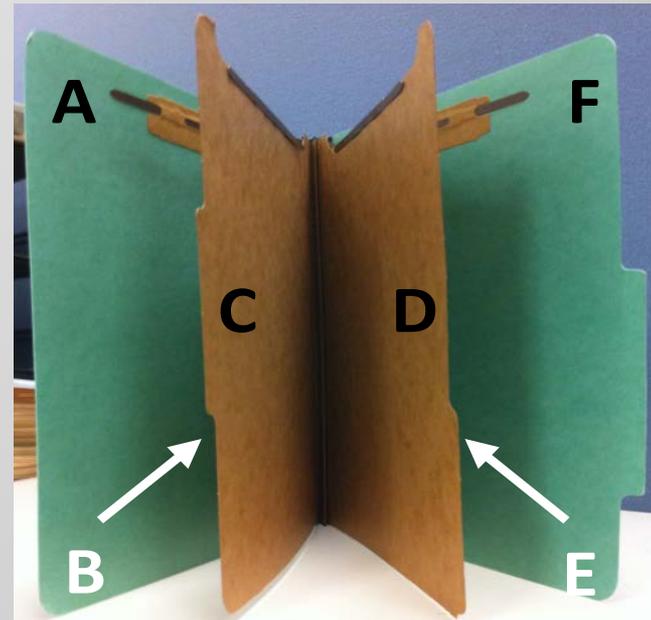
If signed by other than client, state relationship and authority to do so: _____

DATE: ____/____/____
Month Day Year

FILE SECTIONS

The Return-To-Work File
Effective September 15, 2013

- Section A** - Initial Reporting
- Section B** - Logs/Notes
- Section C** - Medical Certifications and Restrictions
- Section D** - Accommodations & Agreements
- Section E** - Employee Communications
- Section F** - Miscellaneous



FILE MANAGEMENT

RTW Files should be maintained in a six-section folder and include, but not be limited to:

A. Initial Reporting

Employee Profile Sheet on top (Mandatory)

5020

DWC-1

EE Receipt of Packet

Employee's Incident Report

RU-91 (Job Description)

RTW Timeline Checklist (Optional)

FILE MANAGEMENT

cont...

B. Logs/Notes

- Activity Log on top (Mandatory)

- Phone Logs

- Legal Correspondence

C. Medical Certifications and Restrictions

- Medical Certifications

- Work Restriction Letters

- OHP Documentation

- Authorization for PHI

FILE MANAGEMENT

cont...

D. Accommodations and Agreements

- IPM Summaries including job offer letters

- Work Hardening Transitional Assignment Agreements

- Conditional Assignment Agreements

- Job Offers (state forms)

- Medical Releases

E. Employee Communication

- Benefit Notices

- ERTW Letters

- Clarification/assessment letters sent to doctors

- FMLA notifications and documentation

FILE MANAGEMENT

cont...

F. Miscellaneous

STD/LTD Documents

Wage Statements

Job Skills Interview forms

Job Placement Request forms

EMPLOYEE PROFILE

(I/A and NON - I/A)

County of Los Angeles
Return-To-Work
EMPLOYEE PROFILE

Industrial Accident (I/A)

Non-Industrial Accident (Non-I/A)

Date: _____

PERSONAL INFORMATION			
Employee Name	Employee Number	DOB	Retirement Plan
Payroll Title	Physical Class	Hire Date	
Home Address			
Home Phone	Other Contact Number		Other IA/Non-IA Files: <input type="checkbox"/> No <input type="checkbox"/> Yes Comments: _____ _____ _____
Work Location	Supervisor	Contact Number	
LEAVE HISTORY			
Date of Injury/Illness	Leave Start Date		
WC Third Party Administrator	Adjuster Name/Number	Claim Number	
CLAIM STATUS			
<input type="checkbox"/> Delayed _____ Date	<input type="checkbox"/> Denied _____ Date	<input type="checkbox"/> Accepted _____ Date	<input type="checkbox"/> Closed _____ Date
Benefits :			
<input type="checkbox"/> TTD <input type="checkbox"/> Post TD <input type="checkbox"/> PD <input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Other _____		Litigated: <input type="checkbox"/> Yes <input type="checkbox"/> No	
WORK STATUS			
Working <input type="checkbox"/> No <input type="checkbox"/> Yes RTW Date: _____			
<input type="checkbox"/> U&C <input type="checkbox"/> Mod/Alt <input type="checkbox"/> Temporary <input type="checkbox"/> Long Term Leave (6 months or more)			
WORK RESTRICTIONS (for actual restrictions, please see Work Hardening Transitional Assignment Agreement or Work Restriction Document)			
<input type="checkbox"/> TEMPORARY _____ Date Received	<input type="checkbox"/> PERMANENT _____ Date Received	<input type="checkbox"/> P&S/MMI _____ Date Received	
ACCOMMODATIONS AND AGREEMENTS			
Work Hardening Transitional Assignment Agreement (WHTAA)			
WHTAA Start _____	End _____	Extended To _____	
WHTAA Start _____	End _____	Extended To _____	
WHTAA Start _____	End _____	Extended To _____	
Conditional Assignment Agreement (CAA)			
CAA Start _____	End _____	Extended To _____	
CAA Start _____	End _____	Extended To _____	
CAA Start _____	End _____	Extended To _____	
PRIOR ACCOMMODATIONS / ERGONOMICS:			
EMPLOYMENT STATUS			
<input type="checkbox"/> Medical Release <input type="checkbox"/> Retirement <input type="checkbox"/> Disability Retirement <input type="checkbox"/> Return-To-Work <input type="checkbox"/> Resignation <input type="checkbox"/> Termination			

QUESTIONS???

