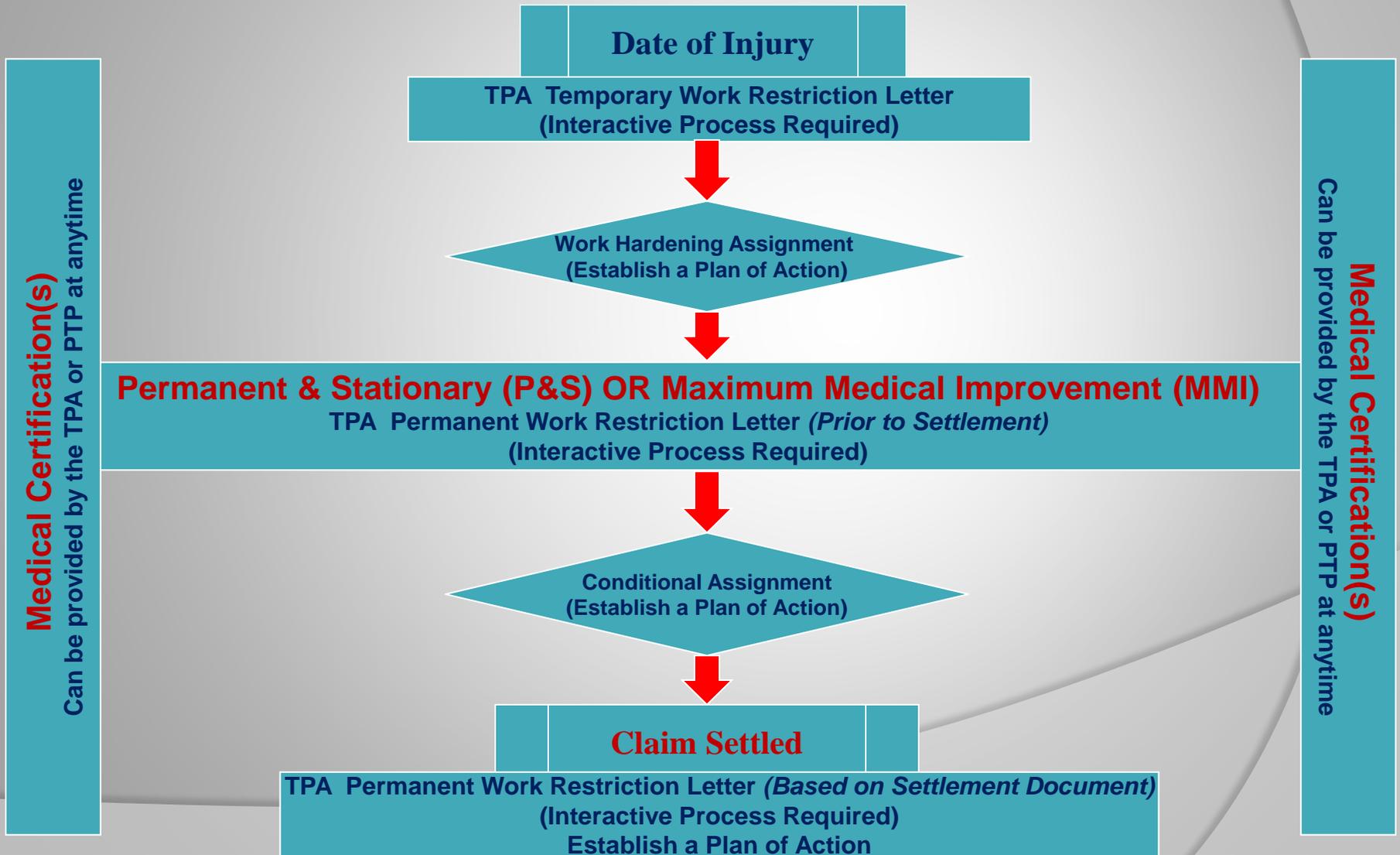


THE INTERACTIVE PROCESS PROTOCOL (USING JOB OFFER FORMS)



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

THE INTERACTIVE PROCESS



IPM - Usual and Customary Work

● **Trigger:**

- ✦ The department is notified either by the Third Party Administrator (TPA), or the employee's treating health care professional that the employee can return to work in their U&C position.

● **What Should Occur:**

An Interactive Process Meeting (IPM) should be conducted to discuss the following issues:

IPM - Usual and Customary Work

cont...

- 1) Acknowledgement that employee has been released by a qualified health care professional;
- 2) Any restrictions and/or accommodations needed;
- 3) Essential Job Functions (EFJ) of U&C and comparison to restrictions to confirm restrictions do not conflict; and
- 4) Offer employee the opportunity to share/discuss any concerns they may have. If they do and it changes the above, they are to be seen by a qualified health care professional to be re-evaluated.

NOTICE OF OFFER OF REGULAR WORK FORM

DWC – AD 10118

This position is at the same location and shift as your pre-injury position.

This position is at a different location than your pre-injury position. The location is:

This position is for a different shift than your pre-injury position. The shift time is _____ — _____
(Start Time) (End Time)

You may contact _____ at _____ concerning this position.
(Name of contact person) Phone Number

You must return the completed form to the employer or claims administrator listed here:

Claims Administrator (To Be Completed By The Employer or Claims Administrator) (All information in this section must be completed)

Name

Claims Mailing Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

Claims Representative Phone

This position provides wages and compensation of \$ _____, that are equivalent to or more than
Weekly Wages

the wages and compensation paid to you at the time of your injury.

This position is expected to last for a total of at least 12 months of work. If this position does not last for a total of at least 12 months of work, you may be entitled to an increase in your permanent disability benefit payments.

I, _____
(Name of Claims Administrator)
have obtained the above job offer information from your employer.

NOTICE OF OFFER OF REGULAR WORK FORM

DWC – AD 10118

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

Case Number _____

The employee must accept, reject, or object to this offer for regular work and return this form to the employer or claims administrator listed on the form within 20 calendar days of receipt of the offer or it will be deemed that the employee accepted the offer and has waived the right to object to the location or shift.

If the job offered is at a different location than the job you held at the time of your injury, and you believe the commuting distance to this job from the residence where you lived at the time of your injury is not reasonable, you may object to the job offer as not being within a reasonable commuting distance.

You may also waive this commuting distance requirement. You will be considered to have waived this requirement if you accept the above offer of work or do not reject the offer within twenty calendar days of receipt of this notice. The employee should keep a copy of this form for his or her records.

First Name _____

MI _____

Last Name _____

Date Offer Received _____

MM/DD/YYYY

Claim Number _____

I understand that if my disability is permanent and stationary and the employer has fulfilled its legal obligations related to this offer, my remaining permanent disability payments will be decreased by 15% whether I accept or reject this offer.

Offer of Regular Work at Same Location and/or Shift

I accept this offer of regular work.

I reject this offer of work. Reason



NOTICE OF OFFER OF REGULAR WORK FORM

DWC – AD 10118

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

Offer of Regular Work at a Different Location and/or Shift

I understand that I have the right to object to a work offer when the location or shift is different than what I had at the time of my injury.

I accept the offer and waive my right to object to the job location or shift as not being within a reasonable commuting distance from the residence where I lived at the time of my injury.

I reject this offer of work. Reason

I object to this offer because the job location that has been offered is different than the job location I held at the time of my injury, and I do not believe this job allows a reasonable commute from my residence. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

I object to this offer because the job shift that has been offered is different than the job shift I held at the time of my injury. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director.

(Signature)

Date _____
MM/DD/YYYY

IPM – Work Hardening Transitional Assignment Agreement

Using Job Offer Forms for Temporary Work Restrictions

● Purpose:

- ✦ A Work Hardening Transitional Assignment Agreement (WHTAA) is an agreement between the employer and employee that allows an employee to return to work in an assignment performing functions other than those usually assigned and is intended to allow an employee the opportunity to recover from their injury/illness while continuing to work.
- ✦ This agreement is temporary and should be revisited at least every 12 weeks up until the employee becomes Permanent and Stationary (P&S) or has achieved Maximum Medical Improvement (MMI).

IPM – Work Hardening Transitional Assignment Agreement

Using Job Offer Forms for Temporary Work Restrictions

cont...

● Triggers:

- Medical certification is received that indicates the employee is precluded from performing the Essential Job Functions of their Usual and Customary (U&C) position, but prior to P&S; or
- There are changes in the employee's disability status.

● What Should Occur:

- Upon receipt of medical certifications – compare to previous medical certifications on file, and:

IPM – Work Hardening Transitional Assignment Agreement

Using Job Offer Forms for Temporary Work Restrictions

cont...

- 1) Involve location supervisors in identifying light duty WHTAA assignment;
- 2) Discuss light duty options;
- 3) Itemize tasks employee can do based on his/her restrictions;
- 4) If the above is not feasible, create a list of tasks employee can perform that adheres to their restrictions;
- 5) Complete WHTAA document including signatures and a copy to the employee, Return-to-Work (RTW) Unit, and Third Party Administrator (TPA) / Adjuster; and
- 6) Develop and maintain a standard process to monitor WHTAA.

WORK HARDENING TRANSITIONAL ASSIGNMENT AGREEMENT FORM (WHTAA)

(YOUR DEPARTMENT NAME HERE)

COUNTY OF LOS ANGELES WORK HARDENING TRANSITIONAL ASSIGNMENT AGREEMENT (WHTAA)

*(To be used for work-related injury/illness - EE has not reached P&S or MMI,
but temporary work restrictions are established)*

Employee Name: _____ Employee Number: _____
Employee Payroll Title: _____
Claim #: _____
Date of Injury: _____ Facility: _____ Department #: _____
Pay Location#: _____

Dr. _____ has released you to return to work with the following temporary work restrictions:

In an effort to assist you in returning to work, we have identified a Work Hardening assignment that is compatible with your limitations (duties listed on page 2). Your placement on this temporary assignment is intended to prevent further injury or aggravation to your present condition. You must agree that you will work within your treating physician's work restrictions. Also, if given any duties outside these restrictions, you will immediately notify your supervisor.

The total length of your Work Hardening assignment may last at least 12 weeks or more, beginning on the date listed below. At or before the end date of your Work Hardening Transitional Assignment Agreement (WHTAA), an Interactive Process Meeting (IPM) will be conducted with you to determine if there is need for further accommodation.

Work Hardening Transitional Assignment: _____ to _____
Start Date End Date

(If an extension to this agreement is necessary, you may create a new agreement or note the extension date and re-sign this document.)

NOTE TO EMPLOYEE AND SUPERVISOR: It is important to note that the Department has the right and responsibility to investigate other accommodation(s) should this accommodation prove ineffective by either the department or the employee.

NOTE TO SUPERVISOR: Please review with the injured worker their work restrictions and WHTAA before signing. Complete and return signed original to your Department's Return-To-Work Coordinator.

Employee Signature	Print Name	Date
Supervisor Signature	Print Name	Date

IPM – CONDITIONAL ASSIGNMENT AGREEMENT

Using Job Offer Forms for Permanent Work Restrictions

● Purpose:

- This agreement is temporary and utilized when the department is conducting a department-wide or Countywide job search for a compatible position. This status is determined when an employee with an industrial Injury/Illness becomes Permanent and Stationary (P&S) or has reached Maximum Medical Improvement (MMI); or
- An employee with an Non-Industrial Injury/Illness obtains a work restriction (either temporary or permanent). If a position cannot be identified within the employee's department, then a Countywide Job Search shall be conducted pursuant to Department of Human Resources Policies, Procedures, and Guidelines (PPG – 621).

IPM – CONDITIONAL ASSIGNMENT AGREEMENT

Using Job Offer Forms for Permanent Work Restrictions

cont...

● Triggers:

- Industrial Injury/Illness – An employee has reached P&S or MMI and is permanently precluded from performing their Usual and Customary (U&C) position; or
- Non-Industrial Injury/Illness – An employee has a temporary work restriction, or has reached P&S or MMI, and needs to be placed in another assignment.

IPM – CONDITIONAL ASSIGNMENT AGREEMENT

Using Job Offer Forms for Permanent Work Restrictions

cont...

● What Should Occur:

✦ Offer the employee the opportunity to share/discuss any concerns they may have during the required Interactive Process Meeting (IPM). Upon receipt of medical certifications – compare to previous medical certification on file and:

- 1) Identify tasks the employee can perform to assist the office while adhering to their work restrictions;
- 2) Itemize tasks employee can do based on his/her work restrictions;

IPM – CONDITIONAL ASSIGNMENT AGREEMENT Using Job Offer Forms for Permanent Work Restrictions

cont...

- 3) Complete the Conditional Assignment Agreement (CAA) form and include signatures;
- 4) Provide a copy to the employee, Return-to-Work Unit, and a copy to Third Party Administrator (TPA)/adjuster if work related; and
- 5) Develop and maintain a standard process to monitor CAA.

CONDITIONAL ASSIGNMENT AGREEMENT FORM (CAA)

(YOUR DEPARTMENT NAME HERE)

COUNTY OF LOS ANGELES CONDITIONAL ASSIGNMENT AGREEMENT (CAA)

(To be used when employee has reached P&S/ MMI and has been provided with Permanent Work Restrictions OR for Non-Industrial Injury/Illness for temporary accommodation and during search for permanent placement)

Employee Name: _____ Employee Number: _____
Employee Payroll Title: _____
Claim # (For workers' comp only): _____
Date of Injury: _____ Facility: _____ Department #: _____
Pay Location#: _____

Dr. _____ has released you to return to work with the following work restrictions:

In an effort to assist you in returning to work, we have identified a temporary Conditional Assignment (CA) that is compatible with your work restrictions (duties listed on page 2). Your placement on this CA is intended to prevent further injury or aggravation to your present condition. You must agree that you will work within your treating physician's work restrictions. Also, if given any duties outside these limitations, you will immediately notify your supervisor.

The total length of your Conditional Assignment may last at least 12 weeks or more, beginning on the date listed below. The length of this assignment will depend on both your permanent work restrictions and the time it takes to conduct a reasonable search, department wide and county wide, if necessary to identify a modified/alternative job. At or before the end date of your Conditional Assignment, an Interactive Process Meeting (IPM) will be conducted with you to determine if there is a need for further accommodation.

Conditional Assignment Agreement: _____ to _____
Start Date End Date

(If an extension to this agreement is necessary, you may create a new agreement or note the extension date and re-sign this document.)

NOTE TO EMPLOYEE AND SUPERVISOR: It is important to note that the Department has the right and responsibility to investigate other accommodation(s) should this accommodation prove ineffective by either the department or the employee.

NOTE TO SUPERVISOR: Please review with the injured worker their recovery limitations and CAA before signing. Complete and return signed original to your Department's Return-To-Work Coordinator.

Employee Signature	Print Name	Date
Supervisor Signature	Print Name	Date

IPM – MODIFIED/ALTERNATIVE POSITION

P&S/MMI with Permanent Work Restrictions

Purpose:

-  This protocol is to be utilized to provide permanent accommodation. Once the department is provided with permanent work restrictions from the Third Party Administrator (TPA) or a qualified health care professional, and the department is notified that the employee cannot return to their Usual and Customary (U&C) position, but may be able to return to a “modified/alternative” position within the County.

IPM – MODIFIED/ALTERNATIVE POSITION

P&S/MMI with Permanent Work Restrictions

cont...

● Triggers:

- ✦ The employee has permanent work restrictions that are not compatible with the employee's U&C position; however, employee may be suitable for a modified/alternative position.

● What Should Occur:

- A. Offer the employee the opportunity to share/discuss any concerns they may have during the required Interactive Process Meeting (IPM).
 - 1) Conduct a department wide search for a comparable position to assess the feasibility of the employee remaining in their own department.

IPM – MODIFIED/ALTERNATIVE POSITION

(P&S/MMI with Permanent Work Restrictions)

cont...

- 2) If no position is found within the department refer to the Department of Human Resources' Policies and Procedures Guidelines (PPG 621).
- 3) Once a position has been identified with either employee's home department or another County department, complete a Notice of Offer of Modified/Alternative work (DWC-AD 10133.53 or DWC-AD 10133.35 depending on date of injury) with employee and return the employee to modified/alternative assignment.
- 4) Follow up with employee and supervisor to ensure there are no new or reoccurring problems and document all interactions.

IPM – MODIFIED/ALTERNATIVE POSITION (P&S/MMI with Permanent Work Restrictions)

cont...

WHAT SHOULD OCCUR:

- B.** If the employee disagrees, but the department believes the assignment is compatible, do the following:
 - 1) Send the job description of the modified/alternative position to the appropriate health care professional for review and comment; and
 - 2) When a written response is received from the health care professional, follow up with the employee again.

NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

For injuries occurring on or after 1/1/04

DWC – AD 10133.53

POSITION REQUIREMENTS (All information in this section must be completed)

Actual job title: _____

Wages: \$ _____ Per hour Week Month

Is salary of modified/alternative work the same as pre-injury job? Yes No

Is salary of modified/alternative work at least 85% of pre-injury job? Yes No

Will job last at least 12 months? Yes No

Is the job a regular position required by the employer's business? Yes No

Work location: _____

Duties required of the position:

Description of activities to be performed (if not stated in job description):

DWC-AD form 10133.53 (SJDB) Rev: 1/2013- Page 2 of 4

NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

For injuries occurring on or after 1/1/04

DWC – AD 10133.53

Physical requirements for performing work activities (include modifications to usual and customary job):

Name of doctor who approved job restrictions (optional): _____

Date of report: _____
MM/DD/YYYY

Date of last payment of Temporary Total Disability: _____
MM/DD/YYYY

Preparer's Name: _____

Preparer's Signature: _____

Date: _____
MM/DD/YYYY

THIS SECTION TO BE COMPLETED BY EMPLOYEE (All information in this section must be completed)

I accept this offer of Modified or Alternative work.

I reject this offer of Modified or Alternative work and understand that I am not entitled to the Supplemental Job Displacement Benefit.

I understand that if I voluntarily quit prior to working in this position for 12 months, I may not be entitled to the Supplemental Job Displacement Benefit.

Signature: _____ Date: _____
MM/DD/YYYY

I feel I cannot accept this offer because:

DWC-AD form 10133.53 (SJDB) Rev: 1/2013- Page 3 of 4

NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

For injuries occurring on or after 1/1/04

DWC – AD 10133.53

NOTICE TO THE PARTIES

If the offer is not accepted or rejected within 30 days of receipt of the offer, the offer is deemed to be rejected by the employee.

If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director.

NOTICE OF OFFER OF REGULAR, MODIFIED OR ALTERNATIVE WORK For injuries occurring on or after 1/1/13 DWC – AD 10133.35

State of California
Division of Workers' Compensation
Retraining and Return to Work Unit



**NOTICE OF OFFER OF REGULAR, MODIFIED, OR
ALTERNATIVE WORK**
For injuries occurring on or after 1/1/13
DWC - AD 10133.35

THIS SECTION COMPLETED BY CLAIMS ADMINISTRATOR (All information in this section must be completed):
Claims Administrator Type: (Please Choose One)

Insurance Company
 Third Party Administrator
 Employer

_____ is offering you _____
Employer (name of firm)

the position of a _____
Name of Job

This offer is for: Regular Work
 Modified Work
 Alternative Work

You may contact _____ concerning this offer. Phone No.: _____

Date of offer: _____ Date job starts: _____
MM/DD/YYYY MM/DD/YYYY

Claims Administrator

Claims Representative Claim Phone Number: _____

Claims Address Claim Number: _____

Name of employee: _____ _____
First Name Last Name

(Choose only one)

a specific injury on _____ MM/DD/YYYY
_____ and ended of _____

a cumulative trauma injury which began on (START DATE: MM/DD/YYYY) _____ (END DATE: MM/DD/YYYY)

Date of Birth: _____
MM/DD/YYYY

You have 30 calendar days from receipt to accept or reject the attached offer of work. However, if you fail to respond in 30 days or reject this job offer, you will not be entitled to the supplemental job displacement benefit unless the offer is for modified work or alternative work and:

A. You cannot perform the essential functions of the job; or
 B. The job is not a regular position lasting at least 12 months; or
 C. Wages and compensation offered are less than 85% paid at the time of injury; or
 D. The job is beyond a reasonable commuting distance from residence at time of injury.

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DWC-AD form 10133.35 (SJDB) Effective 1/1/13 - Page 1 of 4

NOTICE OF OFFER OF REGULAR, MODIFIED OR ALTERNATIVE WORK For injuries occurring on or after 1/1/13

DWC – AD 10133.35

POSITION REQUIREMENTS (If the offer is for regular work, skip this page)

Actual job title: _____

Wages: \$ _____ Per hour Week Month Year

Is salary of modified/alternative work the same as pre-injury job? Yes No

Is salary of modified/alternative work at least 85% of pre-injury job? Yes No

Will job last at least 12 months? Yes No

Is the job a regular position required by the employer's business? Yes No

Work location: _____ Same as Pre-Injury Position

Position is for a different shift. The shift time is _____ - _____
(Start Time) (End Time)

Duties required of the position:

Description of activities to be performed (if not stated in job description):

DWC-AD form 10133.35 (SJDB) Effective 1/1/13 - Page 2 of 4

NOTICE OF OFFER OF REGULAR, MODIFIED OR ALTERNATIVE WORK For injuries occurring on or after 1/1/13

DWC – AD 10133.35

Physical requirements for performing work activities (include modifications to usual and customary job):

Name of doctor who approved job restrictions (optional): PTP QME AME

Date of report: _____
MMDD/YYYY

Proof of Service by Mail
(To Be Completed By the Employer or Claims Administrator)

I declare that: I am over the age of eighteen and not a party to this action. My business address is:

On _____,
I served the attached on: _____

by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United States mail.
 by personal service.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was executed on: _____ at _____, California.

Signature: _____
Print Name: _____

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DWC-AD form 10133.35 (SJDB) Effective: 1/1/13 - Page 3 of 4

NOTICE OF OFFER OF REGULAR, MODIFIED OR ALTERNATIVE WORK For injuries occurring on or after 1/1/13

DWC – AD 10133.35

THIS SECTION TO BE COMPLETED BY EMPLOYEE (All information in this section must be completed)

I accept this offer of Regular, Modified, or Alternative work.

I reject this offer of Regular, Modified, or Alternative work and understand that I may not be entitled to the Supplemental Job Displacement Benefit.

I understand that if I voluntarily quit prior to working in this position for 12 months, I may not be entitled to the Supplemental Job Displacement Benefit.

Signature: _____ Date: _____
MM/DD/YYYY

I feel I cannot accept this offer because:

NOTICE TO THE PARTIES

If the offer is not accepted or rejected within 30 days of receipt of the offer, the offer is deemed to be rejected by the employee.

If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director.

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QUESTIONS???

