STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, February 7, 2019

CF OPERATING PROCEDURE
NO. 60-40, Chapter 7

Human Resources

MANAGING WORKERS' COMPENSATION CLAIMS AND DISABILITY LEAVE

7-1. Purpose. This operating procedure establishes the Department's disability leave policy for all employees and volunteers who sustain a job-connected disability that is compensable under Chapter 440, Florida Statutes (F. S.), and for returning employees to work.

7-2. Scope. This operating procedure applies to all employees and volunteers of the Department of Children and Families.

7-3. References.

a. Section 216.251, F.S., Salary Appropriations; Limitations.

b. Section 284.42(1)(b), F.S., Reports on State Insurance Program.

c. Sections 284.50(3) and (4), F.S., Loss Prevention Program.

d. Workers' Compensation, Chapter 440, F.S.

e. Rule 60L-34.0061, Florida Administrative Code (F.A.C.), Disability Leave.

f. Article 18, Section 5 (Disability Leave) of the AFSCME Council 79 Master Contract.

g. Article 18, Section 1 (Leaves) of the State Fire Service Agreement.

h. Article 22, Section 1 (Disability Leave with Pay) and Section 2 (Alternative Duty) of the Professional Health Care Unit Agreement.

i. Article 22, Section 2 (Disability Leave with Pay) and Section 3 (Alternative Duty) of the Security Services Unit Agreement.

j. Article 16, Section 4, of the SES Physicians Bargaining Unit Master Contract.

k. Article 18, Section 4, of the SES Supervisory Non-Professional Bargaining Unit Master Contract.

l. Article 16, Section 6, of the SES State Employees Attorneys Guild Master Contract.

m. Workers' Compensation System Guide, Revised December 2017.

n. Division of Risk Management, Bureau of State Employees' Workers' Compensation Claims – Employer Facts Brochure found at https://www.myfloridacfo.com/Division/WC/pdf/information_brochure_for_employers_ENG_print.pdf

This operating procedure supersedes CFOP 60-40, Chapter 7, dated July 20, 2013.
OPR: ASHR
DISTRIBUTION: A

o. Department of Financial Services, Division of Risk Management, Model Return-to-Work Program Guidelines dated June 18, 2010 at the following website: Model Return-to-Work Program Guidelines. The Department of Children and Families' Return-to-Work Program is incorporated herein.

7-4. Definitions.

a. Department. Department of Children and Families.

b. Medical Case Management Provider. A vendor contracted by the Division of Risk Management to provide medical case management services for the workers' compensation program. An employee or volunteer may only receive treatment for a workers' compensation injury from the Medical Case Management Provider. In a medical emergency, the injured employee or volunteer should be taken to the nearest medical facility or 911 should be called to summon an ambulance to transport the employee. Otherwise, medical care must be arranged and authorized through the Medical Case Management Provider.

c. Alternate Duty. Temporary duties established away from employee's regular work area/responsibilities and within the "functional limitations and restrictions" stated on the DWC-25. Alternate duty is evaluated with each subsequent physician visit when functional restrictions are updated.

d. Modified Duty. Temporary duties established within the employee's regular position and within the functional limitations and restrictions as reflected on the DWC-25. Modified duty is evaluated with each subsequent visit to an authorized treating physician when functional restrictions and limitations are updated.

e. Full-Pay Status. Accrued compensatory, annual or sick leave in coordination with the normal workers' compensation benefits.

f. Workers' Compensation Benefits. Compensation at sixty-six and two-thirds percent (66 2/3%) of the employee's pre-injury average weekly wages. The weekly benefit can never exceed the maximum compensation rate for the year in which the employee's accident or illness occurred.

g. Prognosis. A prospect of recovery as anticipated from the usual course of disease or peculiarities of the case as determined by the treating physician.

h. Temporary – Partial Disability. Benefits paid for disability while allowing an employee to work in a limited capacity during recovery.

i. Maximum Medical Improvement. The date in which further recovery from, or lasting improvement to, an injury or disease can no longer reasonably be anticipated, based upon reasonable medical probability.

j. Workers' Compensation Coordinator. The role assigned to the Leave Management Unit within the Human Resources Service Center with statewide responsibility.

7-5. Policy on Disability Leave.

a. An employee, who sustains a job-connected injury that is compensable under Workers' Compensation statute (Chapter 440, F.S.) and is not able to return to work on a full-time basis, shall be carried in full-pay status for a period not to exceed seven (7) calendar days immediately following the injury, for a maximum of forty (40) disability leave (code 0065) hours if taken intermittently, without being required to use accrued leave, beginning immediately following the onset of the injury. This leave may be used intermittently to cover appointments to health care providers, physical therapy, and similar

activities provided that these activities are directly related to the employee's workers' compensation injury.

b. An employee who returns to work, upon presentation of written confirmation from the treating physician, and who has exhausted the forty (40) hours of disability leave (code 0065) will be granted additional disability leave not to exceed forty-eight (48) hours for follow-up appointments to health care providers, physical therapy and similar activities required by the authorized treating physician for a particular injury and/or illness.

c. If the employee has not been released to return to work by the treating physician at the end of the forty (40) hour period provided in paragraph 7-5a above, the employee may continue on full-pay status while covered by workers' compensation as follows:

(1) The employee may elect to use accrued sick, compensatory, or annual leave in an amount necessary to achieve full-pay status.

(2) In no case shall the employee's salary and workers' compensation benefits exceed the amount of the employee's regular salary payments:

(3) For each eight-hour workday that an employee is out, the employee may charge up to (two and three quarters) 2.75 hours of accrued leave and (five and one quarter) 5.25 hours of workers' compensation leave without pay (code 0060).

(4) If the employee elects not to use accrued leave, or after the employee has exhausted all earned leave credits in accordance with paragraph 7-5c(1) above, the employee shall:

(a) Be placed on workers' compensation leave without pay (code 0060) and shall revert to normal workers' compensation benefits only.

(b) An employee covered by workers' compensation shall continue to earn and accrue full leave credits while on disability leave. However, employees with an active workers' compensation disability claim are not eligible for sick leave donations.

(5) An Other Personal Services (OPS) employee will receive workers' compensation benefits for the first seven (7) working days, after being on workers' compensation leave without pay for twenty-one (21) days.

(a) OPS includes residents employed at institutions.

(b) Volunteers will only receive the benefit of medical and prescription coverage**.**

7-6. Policy on Alternate/Modified Duty. An employee who sustains a job-connected injury or illness may return to work in an alternate/modified duty capacity at the regular rate of pay after the injury was sustained as follows:

a. Florida's Workers' Compensation Uniform Medical Treatment/Status Reporting Form DWC-25 (Attachment 2 to this chapter, and available in DCF Forms) is completed by the physician and reviewed by the Division of Risk Management. If the form states the employee cannot perform normal duties but can perform some type of work (within the medical restrictions) beneficial to the Department, the Division of Risk Management will determine the employee is entitled to receive temporary partial disability benefits. (Section 440.15, F.S.)

b. The Workers' Compensation Coordinator shall notify the supervisor of any medical restrictions that have been imposed by the treating physician as outlined on the DWC-25 and as communicated by the Medical Case Management Provider.

c. The supervisor shall determine the alternate/modified work to be performed by the employee based upon the restrictions imposed. The employee shall be compensated at his/her regular rate of pay. The supervisor may consult with the Workers' Compensation Coordinator and/or the Employee Relations Representative if there are any questions regarding the employee's restrictions and the assignment of alternate/modified duty.

d. If the employee refuses to perform the alternate/modified duty assignment, the Supervisor must notify the Workers' Compensation Coordinator and consult with the Employee Relations Representative for further guidance. The Workers' Compensation Coordinator will advise the supervisor on completion of the timesheet and notify the Medical Case Management Provider and the Division of Risk Management Claims Adjuster of the employee's refusal to perform the alternate/modified duty assignment. The Workers' Compensation Coordinator will provide consultation to the Employee Relations Representative and Supervisor as needed. The Employee Relations Representative will advise if disciplinary action is appropriate or not for the employee's refusal to perform the work.

e. When the employee becomes able to perform regular duties, the Department shall return the employee to normal working status. Once Maximum Medical Improvement (MMI) has been determined, in no event shall the employee be allowed to continue performing the alternate/modified duty unless a reasonable accommodation has been granted in accordance with CFOP 60-10, Chapter 1. The Department shall maintain appropriate records of employees removed from alternate/ modified duty using the Return to Work Agreement, (form number RTW001, Attachment 1 to this chapter, and available in DCF Forms). (Chapter 60L-33, F.A.C.)

7-7. Procedure for Assigning Employees to Alternate/Modified Duty.

a. Each Supervisor will identify alternate/modified duty tasks that may be performed by employees with job-connected injuries based on the restrictions and/or functional limitations provided by the Workers' Compensation Coordinator from the DWC-25. The Supervisor may consult with the Workers' Compensation Coordinator.

(1) These tasks will involve some type of work that is beneficial to the Department; however, the employee may be required to perform work outside of the employee's assigned work area. These tasks will be assigned with consideration of any medical restrictions.

(2) Performance standards will be developed to reflect the alternate/modified duties and shall be discussed with the employee during performance planning in accordance with CFOP 60-35, Chapter 1, paragraph 1-8.

(3) An appraisal of the employee's job performance will be completed quarterly.

b. The Supervisor will determine if an employee is a candidate for alternate/modified duty based on the work limitations provided by the Workers' Compensation Coordinator from the DWC-25. The supervisor will ensure the employee accurately reports work hours on the employee's timesheet.

c. If alternate/modified duty is approved, the Supervisor will provide the Workers' Compensation Coordinator with the Return to Work Agreement (form number RTW001, Attachment 1 to this chapter, and available in DCF Forms) indicating the employee's limitations and alternate/modified duties. The agreement will be effective for up to 180 days from the date signed, or until the employee is released to full duty by the treating physician or reaches MMI, whichever occurs

first, unless a different placement becomes necessary based on the needs of the organization. After 180 days on the agreement, if the employee is unable to return to work and perform all the essential functions of the employee's position, the employee will be placed on workers' compensation until the employee is able to resume all the essential functions of the employee's position or the employee reaches MMI. The Return to Work Agreement shall only be valid for up to 180 days, and the employee is expected to comply with all workers' compensation program requirements including attending any regularly scheduled or other required medical appointments and furnishing medical certification every 30 days or as required by the workers' compensation program administrators.

d. The Workers' Compensation Coordinator will provide regular updates on the employee's work status and restrictions as provided on the DWC-25s received and will follow-up with the Medical Case Management Provider as needed.

e. The Supervisor should report any concerns about an employee's workers' compensation medical treatment plan or any missed appointments to the Workers' Compensation Coordinator.

f. An employee approved for alternate/modified duty may be required to undergo re-examination at the request of the Supervisor and upon approval of the Medical Case Management Provider, in consultation with the Workers' Compensation Coordinator.

g. The employee will be returned to work and will be expected to work the number of hours required for the type and severity of the injury sustained.

7-8. Department Performance Metrics and Evaluation of Program by Division of Risk Management.

a. Human Resources will assist the Department's General Services Loss Prevention Program with the collection of any workers' compensation and return-to-work data reporting requirements. For example, Human Resources will assist with production of the monthly Return-to-Work (RTW) Dashboard Report required by the Division of Risk Management. (RTW Dashboard Report Instructions, Attachment 3 to this chapter).

b. The Department's General Services Loss Prevention Program shall coordinate with the Division of Risk Management on the Department's performance metrics and benchmarks that may be required pursuant to Section 284.42(1)(b), F.S., and Sections 284.50(3) and (4), F.S.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

SHELBY JEFFERSON
Acting Human Resources Director

SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL

The revisions to this operating procedure include, but not limited to, the following:

1. Updated references to include all applicable DCF collective bargaining agreements.
2. Added language to paragraph 7-4f that defines the maximum weekly benefit.
3. Changed “disability” to “injury” in paragraph 7-5a and paragraph 7-6.
4. Added language in paragraph 7-6e addressing reasonable accommodation.
5. Clarified paragraph 7-7f regarding re-examination for alternate/modified duty.
6. Deleted paragraph 7-8a and renumbered the remaining paragraphs.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
WORKERS' COMPENSATION

RETURN TO WORK AGREEMENT

Employee Name	Employee ID	Date

Because of a work-related injury on (date) _____, I have received medical certification from (name of health care provider) _____ for the stated medical problem(s) which has resulted in the following recommended restrictions:

The alternate/modified restrictions are valid until I can perform my regular work assignments or until the terms of this agreement expires. I understand my alternate/modified work assignments and alternative work performance standards are binding until I am relieved from my restrictions.

1. Work Assignments Under Employee's Work Restrictions:

2. Follow Up Period:

This agreement will be effective for up to 180 days from the date signed, or until the employee is released to full duty by the treating physician or reaches Maximum Medical Improvement (MMI), whichever occurs first, unless a different placement becomes necessary based on the needs of the organization. The employee must comply with all workers' compensation program requirements including attending any regularly scheduled medical appointments and furnishing medical certification every 30 days or as required by the workers' compensation program administrators.

Employee's Name (Please print and sign)	Date
Supervisor's and/or Workers' Compensation Coordinator's Name (Please print and sign)	**Date**

Failure to comply with this Performance Agreement may result in disciplinary action up to and including termination.

Form RTW001, July 2, 2013

Florida Workers' Compensation Uniform Medical Treatment/Status Report

BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS
NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.

1. Insurer Name:	2. Visit/Review Date: / /	5. FOR INSURER USE ONLY
3. Injured Employee (Patient) Name:	4. Date of Birth: / /	
6. Date of Accident: / /	7. Employer Name:	8. Initial visit with this physician? ☐ a) NO ☐ b) YES

SECTION I CLINICAL ASSESSMENT / DETERMINATIONS

9. ☐ No change in Items 9 – 13d since last reported visit. If checked, GO TO SECTION II.

10. Injury/Illness for which treatment is sought is:
☐ a) NOT WORK RELATED ☐ b) WORK RELATED ☐ c) UNDETERMINED as of this date

11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable.
☐ a) NO ☐ b) YES ☐ c) UNDETERMINED as of this date
If YES or UNDETERMINED, explain:

12. Diagnosis(es):

13. Major Contributing Cause: When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11.

a) Is there a pre-existing condition contributing to the current medical disorder?
☐ a_1) NO ☐ a_2) YES ☐ a_3) UNDETERMINED as of this date

b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition?
☐ b_1) NO ☐ b_2) exacerbation ☐ b_3) aggravation ☐ b_4) UNDETERMINED as of this date

c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?
☐ c_1) NO ☐ c_2) YES

d) Given your responses to the Items above, is the injury/illness in question the major contributing cause for:
☐ d_1) NO ☐ d_2) YES the reported medical condition?
☐ d_3) NO ☐ d_4) YES the treatment recommended (management/treatment plan)?
☐ d_5) NO ☐ d_6) YES the functional limitations and restrictions determined?

SECTION II PATIENT CLASSIFICATION LEVEL

☐ 14. LEVEL I – Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patient's subjective complaints. Treatment correlates to the specific findings.

☐ 15. LEVEL II – Key issue: regional or generalized deconditioning (i.e., deficits in strength, flexibility, endurance, and motor control). Treatment: physical reconditioning and functional restoration.

☐ 16. LEVEL III – Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.

☐ 17. LEVEL UNDETERMINED AS OF THIS DATE.

SECTION III MANAGEMENT / TREATMENT PLAN

☐ 18. No clinical services indicated at this time. If checked, GO TO SECTION IV

☐ 19. No change in Items 20a – 20g since last report submitted. If checked, GO TO SECTION IV

20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary.
*** THIS IS A PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICES. ***

☐ a) Consultation with or referral to a specialist. Identify principal physician: _____
Identify specialty & provide rationale: _____
☐ a_1) CONSULT ONLY ☐ a_2) REFERRAL & CO-MANAGE ☐ a_3) TRANSFER CARE

☐ b) Diagnostic Testing (specify): _____

☐ c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:
☐ c_1) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.
☐ c_2) Physical Reconditioning (Level II Patient Classification)
☐ c_3) Interdisciplinary Rehabilitation Program (Level III Patient Classification)
Specific instruction(s): _____

☐ d) Pharmaceutical(s) (specify): _____

☐ e) DME or Medical Supplies: _____

☐ f) Surgical Intervention - specify procedure(s): _____
☐ f_1) In-Office: _____
☐ f_2) Surgical Facility: _____
☐ f_3) Injectable(s) (e.g. pain management): _____

☐ g) Attendant Care: _____

Florida Workers' Compensation Uniform Medical Treatment/Status Report

Patient Name:	D/A: / /	Visit/Review Date: / /

Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.

☐ 21. No functional limitations identified or restrictions prescribed as of the following date: / /

☐ 22. The injured worker's functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g., hospitalization, cognitive impairment, infection, contagion), as of the following date: / / . *Use additional sheet if needed.*

☐ 23. The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part: _____.

Use additional sheet if needed.

Functional Activity	Load	Frequency & Duration	ROM / Position & Other Parameters
☐ Bend			
☐ Carry			
☐ Climb			
☐ Grasp			
☐ Kneel			
☐ Lift – floor > waist			
☐ Lift – waist > overhead			
☐ Pull			
☐ Push			
☐ Reach – overhead			
☐ Sit			
☐ Squat			
☐ Stand			
☐ Twist			
☐ Walk			
☐			
☐ Other:			
COMMENTS:			

Other Choices: Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions (e.g., heat, cold, working at heights, vibration); Auditory; Specific Job Task(s); etc.

NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date.
Specify those functional limitations and restrictions in Item 23, which are permanent if MMI/PIR have been assigned in Item 24.

SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING

24. Patient has achieved maximum medical improvement?
☐ a) YES, Date: __ / __ / ____ ☐ b) NO ☐ c) Anticipated MMI date: __ / __ / ____
☐ d) Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated: ☐ e) YES ☐ f) No
☐ Comments: _____

25. ____% Permanent Impairment Rating (body as a whole) Body part/system: _____

26. Guide used for calculation of Permanent Impairment Rating (based on date of accident – see instructions):
☐ a) 1996 FL Uniform PIR Schedule ☐ b) Other, specify: _____

27. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?
☐ a) YES ☐ b) NO ☐ c) Undetermined at this time.

SECTION VI FOLLOW-UP

28. Next Scheduled Appointment Date & Time: / / : .m.

SECTION VII ATTESTATION STATEMENT

"As the Physician, I hereby attest that all responses herein have been mad, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient. I certify to any MMI/PIR information provided in this form."

Physician Group: _____ Date: __ / __ / ____

Physician Signature:_____ Physician DOH License #: _____

Physician Name: _____ (print name) Physician Specialty: _____

If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below:

"I hereby attest that all responses herein relating to services I rendered have been made in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

Provider Signature:_____ Provider DOH License #: _____

Provider Name: _____ (print name) Date: __ / __ / ____

Form DFS-F5-DWC-25 (revised 1/31/2008)

DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF RISK MANAGEMENT
STATE OF FLORIDA LOSS PREVENTION PROGRAM
MONTHLY RETURN-TO-WORK DASHBOARD REPORT
*** I N S T R U C T I O N S ***

The agency or university workers' compensation coordinator of record will need to complete and return the monthly Return-to-Work (RTW) Dashboard Report to the Division of Risk Management as specified below. Please read these instructions completely before filling out the report.
The following dashboard columns will be automatically populated by STARS.

- Claim Number
- Claimant Name
- Accident Date
- Location Level C

The following dashboard columns may be automatically populated by STARS if the data is available in STARS at the time the report is run. If controvert date is blank, please leave blank.

- MMI (Maximum Medical Improvement) date if obtained when report is run.
- Controvert date will be entered automatically if claim is denied by the adjuster.

The agencies will be responsible to populate the remaining dashboard columns with the following data.

- Report Only – Please indicate if this is a report only claim with a "Yes" or "No"
- Initial Date of Disability
- RTW Date
- Number of Days Out of Work (OOW)
- First date of alternate or modified duty
- Number of days of alternate or modified duty
- Rate of Pay
- Date of RTW full duty
- MMI Date

The RTW Dashboard Report will be sent by e-mail on the fifth business day of each month to the workers' compensation coordinator, who will need to complete and submit the report to Juana Powell at Juana.Powell@myfloridacfo.com by the 20th of the same month. If there are any questions, please contact Ms. Powell by e-mail or at 850-413-4781.

RTW Dashboard Definitions

Alternate Duty: Temporary duties established away from employee's regular work area/responsibilities and within the "functional limitations and restrictions" stated on the DWC-25. Alternate duty is evaluated with each subsequent physician visit when functional restrictions are updated.

Controvert Date: This field will be auto populated by STARS if the adjuster has made the determination that the "accident" is not a compensable accident or condition as defined in FL Statute 440. The adjuster is responsible for making the determination of compensability.

Maximum Medical Improvement (MMI): The medical condition at which further recovery from, or lasting improvement to, an injury or disease can no longer reasonably be anticipated, based on reasonable medical probability.

Modified Duty: Temporary duties established within the employee's regular position and within the functional limitations and restrictions as reflected on the DWC-25. Modified Duty is evaluated with each subsequent visit to an authorized treating physician when functional restrictions and limitations are updated.