

Formal Modified Duty Process

Modification, Termination or Suspension of Temporary Disability Benefits Process – Rule 6

The Colorado Workers' Compensation Act, Rules of Procedure, allows a claims representative to terminate/modify temporary disability benefits without a hearing for employees who do not voluntarily return to work. The claims representative files an Admission of Liability Form with the following information:

“A certified letter to the claimant or copy of a written offer delivered to the claimant with a signed certificate of service, containing both an offer of modified employment, setting forth duties, wages and hours and a statement from an authorized treating physician that the employment offered is within the claimant’s physical restrictions. A copy of the written inquiry to the treating physician shall be provided to the claimant by the insurer at the time the authorized treating physician is asked to provide a statement on the claimant’s capacity to perform the offered modified duty. The claimant is allowed a period of 3 business days to return to work in response to an offer of modified duty. The 3 business days run from the date of receipt of the job offer.”

**Workers’ Compensation
Rules of Procedure, Rule 6(6-1(A)(4))**

To comply with the above rule, these steps must be followed:

- 1) Type the **Letter to Treating Provider** on your company letterhead. Under the Job tasks, list the hours per day and days per week you want your injured worker to work. Then list the actual job tasks the injured worker will perform at your company.
- 2) Fax or e-mail the above letter to your return-to-work specialist. The return-to-work specialist will forward the letter to the treating provider, mail a copy to the injured worker, and fax a copy to the injured worker’s attorney if he/she has one. You may contact the treating provider if you do not received a timely response. **Note: The letter must be signed by a licensed treating physician. The licensed physician must cosign signatures from a physician’s assistant or nurse practitioner.**
- 3) After the approval is received from the treating provider, type the **Certificate of Service Letter** on your letterhead. Fill in all the blanks. **Note: The Certificate of Service must be signed and dated at least three business days prior to commence date.**
- 4) Hand-deliver the following to your injured worker: **Certificate of Service Letter**, and a copy of the **Letter to Treating Provider** with the physician’s approval of modified duty work. Fax copies of both letters to your return-to-work specialist on the same day of delivery. The return-to-work specialist will fax a copy to the injured worker’s attorney.
- 5) If your injured worker does not voluntarily return to work or you are unable to hand deliver the **Certificate of Service Letter**, you must send a **Certified Job Offer Letter** via certified mail. Type the **Certified Job Offer Letter** on your company letterhead. Fill in all the blanks and include the certified mailing number on the letter. Include a copy of the **Letter to Treating Provider** with the physician’s approval of modified duty work. Send this mailing certified with return receipt requested to your injured worker. Send a second copy to him/her by regular mail. If injured worker has an attorney, send

a copy of the *Letter to Treating Provider* with the physician's approval of modified duty work and a copy of the *Certified Job Offer Letter* to the attorney by certified mail. Give the injured worker a minimum of seven business days from the date of certified mailing to report to work. If the worker is out-of-state, allow him/her 10 business days from the date of certified mailing to report to work.

- 6) Make copies of all mailings for your records and one for your return-to-work specialist. This includes a copy of the purchase receipt of the certified letter and the green return receipt card you will receive from the postal service.

Your return-to-work Specialist will be happy to assist in any way with this process.

**Sample Letter to Treating Provider
(on company letterhead)**

Date: _____

Dr: _____

Facility: _____

Address: _____

Fax Number: _____

Re: (Claimant/Employee)

Claim # _____

TIME SENSITIVE: _____

URGENT RESPONSE REQUIRED

FAX to: _____

Attn: _____

Phone: _____

Dear Dr. _____:

Our employee, _____, is currently unable to perform the work required of his/her regular job. We do have a temporary (full-time/part-time) position that I have outlined for your reference.

JOB TASKS

Work Shift: 8:00 a.m. – 5:00 p.m., Monday – Friday

- _____ Purchasing of parts. Utilize phone to call vendors in order to purchase supplies or parts.
- _____ Serve as a troubleshooter. Provide verbal instructions/advice to mechanic and others in procedures to be used in making repairs. May alternate sitting and standing.
- _____ Assist in maintaining of equipment files and records related to each vehicle and piece of equipment. May alternate sitting and standing. No lifting over five pounds.
- _____ Assist in the warehouse office, organizing and distributing of daily paperwork, making Xerox copies of work orders, using a magic marker to cross out various items on orders. May alternate sitting, standing and walking.
- _____ Operate automatic transmission vehicle to run errands one to two times a day to pick up parts. This job task would require driving for a maximum of 20 minutes at one time and picking up 15 lbs. frequently.

Employer's Signature

Patient is able to perform the tasks checked above.

COMMENTS: _____

Doctor's Signature

Date

Cc: Injured worker
Cc: Attorney if appropriate

**Sample Certificate of Service Letter
(on company letterhead)**

Date:

Name of Employee:

Employee Address:

Claim No.

Date of Injury:

Dear Employee:

Your treating physician, Dr _____, has released you to modified work. We have identified a temporary position for you, which your physician states you will be able to perform. Please refer to the attached job task letter.

The job is: see attached: You will receive \$ _____ per hour.

This modified duty job will commence at _____ on _____, please report for work on this
Time Date
date and time.

Your work schedule is as follows:

Hours/day & days/week: _____ Report Time: _____

Modified Duty Supervisor: _____

Work Site Location: _____

We wish you a continued recovery.

Sincerely,

Employer Signature:



Certificate of Service

I _____ hereby certify that I hand delivered the above job offer to
_____ on _____, 200_.

Employer's Signature

Date

**Sample Certified Job Offer Letter
(on company letterhead)**

Date:

Name of Employee
Employee Address

Certified Mail
Return Receipt Requested
Certified Mail #

Claim #:
Date of Injury:

Dear Employee:

Your treating physician, Dr. _____, has released you to modified work. We have identified a temporary position for you, which your physician states you will be able to perform. Please refer to the attached job description.

The job is: _____. You will receive \$___/hour.

This modified duty job will commence at _____ on _____, please report for work on this
Time Date

date and time.

Your work schedule is as follows:

Hours/day & days per week: _____ Time: _____

Modified Duty Supervisor: _____ Phone: _____

Location: _____

We look forward to seeing you and wish you a continued speedy recovery.

Sincerely,

Employer

Enc.: Signed copy of Letter to Treating Physician with signature dated _____

Cc: Pinnacol Assurance
Cc: Attorney if appropriate

Return To Work Verification Statement

Date:

Employer:

Address:

Re:

Claim #:

To correctly adjust your injured workers compensation benefits, as a result of his/her return to work on modified duty, we need to have you fill out the following form and fax it to your return to work specialist at 303-_____.

Date returned to work: _____

Is injured worker back at regular hours? ___ Yes ___ No

Is injured worker back at regular wages? ___ Yes ___ No

If you answered **no** to both questions above, please provide the following:

Current wage rate: _____ Hours per week _____

Work status: (check one) full time: _____ part-time _____

Employer's Signature

If your employee is working part-time or full-time, we would like to have copies of all their payroll records, to determine if any differential benefits are owed.

Sincerely,

Return to Work Specialist